Being a Nurse the Indian Way

An exploration of the lived experiences of Indian nurses, who came to the United Kingdom (UK) for higher education studies and work

A thesis submitted for degree of Doctor of Philosophy

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Abstract

This thesis ethnographically documents the experiences of a group of Indian nurses – predominantly Christians from Kerala and the Punjab – who came from India to the United Kingdom (UK) for higher education studies and work. Uniquely, in a field where research has so far been limited, the thesis draws on longitudinal participant observation and interviews conducted over a period of three and a half years, beginning in various locations in India – where the nurses were initially trained and recruited to overseas nursing courses – and then following them on their learning trajectory as they came to the UK and, subsequently, either returned to India, or took up nursing jobs in Britain. The thesis explores their motivations to become nurses, as well as the other factors that inform their decisions. This includes an investigation of how gender, caste and class, and religion all have an impact on the experience of being an Indian nurse in the diaspora. My research highlighted the differences – historically, as well as in the present – in what it means to be a nurse in different cultural contexts, and it also explores the impact of these differences. I show, for example, that while Hindu notions of purity and pollution have had a negative impact on how nurses are viewed within India as compared to the UK, seen through the lens of class, the opportunity to migrate and increase one's earning potential has also enhanced the status of the Indian nurse in a globalising world. At the same time, different styles of nurse training in India, and different expectations of what a nurse should be, also have an impact on the effectiveness of their training once they come to the UK. In highlighting these differences, the thesis aims to enhance understanding among employers and educators of Indian nurses in the UK.

Contents

Maps

Figures

Acknowledgements

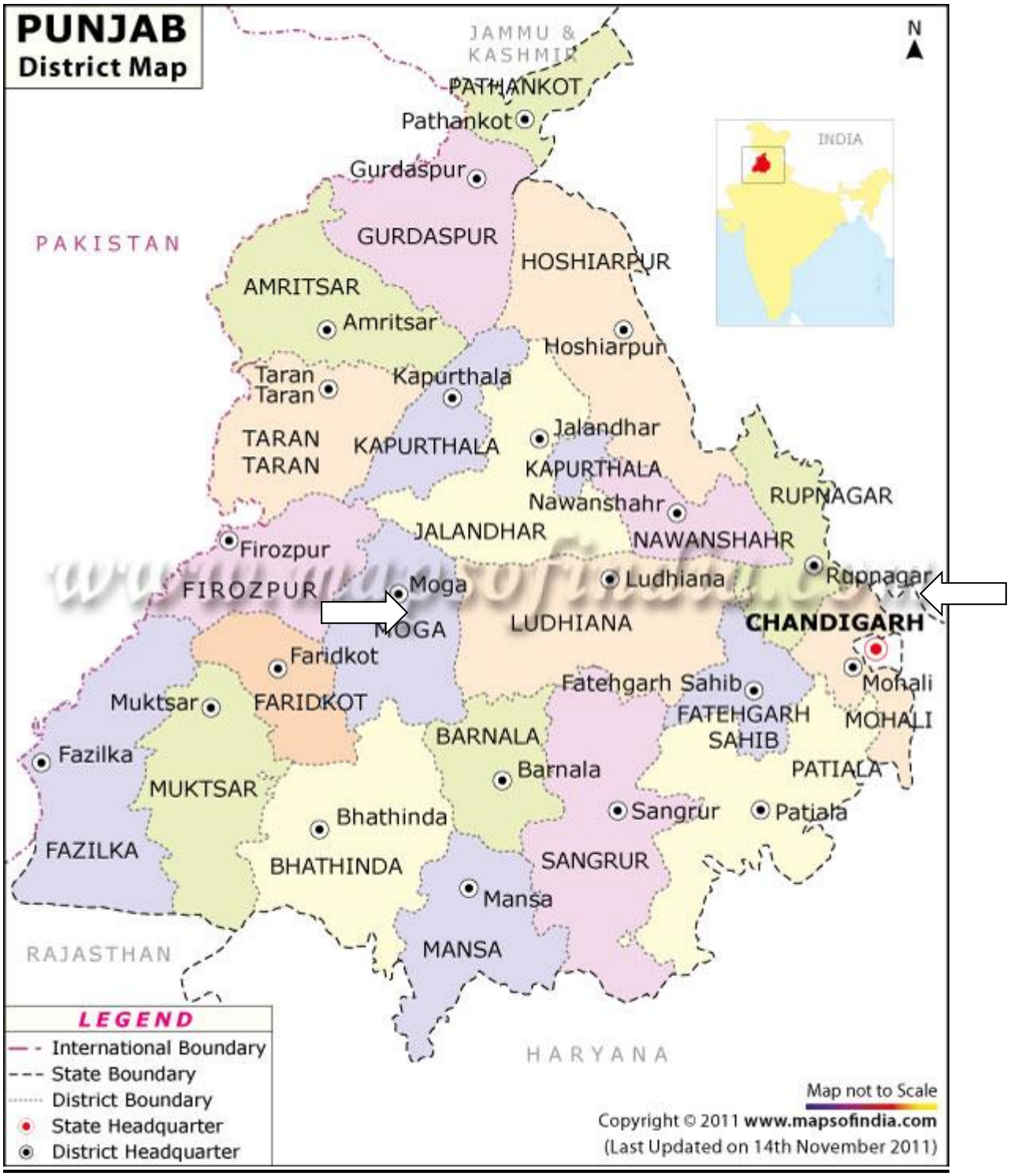
First and foremost I would like to show my appreciation to the nurses in my study. They were both generous with their time and their hospitality. I have learned a great deal from them about nursing per se and India. The families I stayed with and relatives that I meet were all engaging and again I benefited from their time and willingness to converse with me.

My supervisor James Staples has been instrumental in me developing this thesis and he has been immensely patient with me over the years this has been undertaken over. James has shared his knowledge about India and has been instrumental in me developing as a researcher, an anthropologist and an academic.

A big thank you goes to my friends and family, many of whom have been on this journey with me and some of whom now know as much about Indian nursing as I do.

Map 1: Kerala – most of the respondents came from the districts of Ernakulum and Kottayam

Map 2: The Punjab – the respondents mainly came from Chandigarh, Ludhiana or nearby towns/ villages



Chapter One – Introduction

Introduction

This thesis is an exploration of the lived experiences of Indian nurses, predominantly Christians from Kerala and the Punjab, who came to the United Kingdom (UK) for higher education studies and work. Although Indian nurses have been migrating to the UK for a long time, they constitute a group which, historically, has been under-investigated. I analyse the professional, educational, and personal experiences of qualified Indian nurses who trained in India and spent their formative years there, and who subsequently came to the UK for additional training and, in some cases, to seek work. The thesis asks *who* these nurses are, and explores, ethnographically, the similarities and differences between them as a group. It also asks *why* they took the decision to study or work in the UK (and considers the extent to which the decision was theirs to make), and it explores how and why the status of nursing in India has changed over the past 30 years or so.

There were a number of key themes that emerged from research, a three and a half-year, longitudinal study which – uniquely – followed nurses right from their recruitment in India to UK nursing top-up and MSc degrees, to their subsequent lives in the UK or elsewhere. These themes included gender, and its impact on outcomes for the nurses with whom I conducted this research; the importance of class – and, in particular, of 'middle-class' status; and the significance of ideas – long discussed in the ethnography of South Asia – of Hindu ideas about ritual pollution and purity. I also use my data to ask more general questions about the experience of education and learning, and about the experience of living and working in the diaspora.

By way of introducing the thesis, in this chapter I begin with a review of the literature relevant to the anthropology of nursing within which I situate my own work. The chapter then moves on to explain the specific contexts of my own research: how it was conducted (methodology), and the ethical considerations I needed to consider. I also devote significant space – because it is very important to what follows in subsequent chapters – to describing my informants and their situations in the UK, as well as the community, regional, and class backgrounds that travelled with them from India. Finally, I provide a brief outline of the subsequent chapters to offer a roadmap to the thesis as a whole.

Situating the research in the literature

Nursing in India

In terms of the existing literature, Somjee's (1991) research, while now a little dated, offers what is perhaps the most comprehensive review of the Indian nursing profession by a social scientist to date. Geeta Somjee is a professor of political science from Kerala who contributed to a book on the anthropology of nursing (Holden & Littlewood, 1991). She undertook comparative studies on women in urban and rural India, as well as women in the Indian health service. She drew on work with nurses and student nurses, and highlighted and explored the notion that nurses and nursing have different meanings in different contexts. Her work offered some useful insights into the development of contemporary Indian nursing. She explored the improvement in student nurses' status from the view of the students, and the attitudes projected from Indian society towards becoming a nurse in India in the late 1980s. Somjee's (1991) research reported an elevation in the social standing of nurses and nursing in India. Nursing has been associated with lower-status; that is, for the lower classes, or as a profession that widows, orphans, or Christians enter into. This was reflected in the class status and less diverse backgrounds of the nursing students in the 20 years prior to Somjee's study. The change is significant, as historically nursing in India has been associated – as I will explore in more detail later in the thesis – with impure activities, such as dealing with bodily fluids, and with ritual pollution. The consensus in Indian society was that nursing in India was seen as a low social status job (Somjee, 1991). Since the 1990s, there has been a gradual change in attitudes toward nurses, due to the reduction in ritual pollution, the improved job opportunities in India for women, and increasing opportunities for nurses to move abroad. This precipitated a change in status and more positive attitudes towards those who undertook to nurse. It has become more acceptable for women of middle classes to work outside the home (Donner & De Neve, 2011).

Colonial influences on nursing

According to Littlewood (1991), notions of morality attached to nursing in the west have different meanings than in India. When Indian nursing was still developing as a profession in the early 19th century, UK nursing was organised and more professional in terms of training and career progression, attracting well-educated middle and upper middle-class women who took on leadership roles. These nurses were seen as having high moral standards and devotion to their patients (Littlewood, 1991). This high moral standing was made visible by their starched white uniform, strict rules of conduct, and the fact that many nurses did not

marry and stayed loyal to the nursing profession (Littlewood, 1991). Such attitudes, as Somjee (1991) makes clear, have carried over into perceptions of nursing in India through colonialism.

Holden (1991) explored colonial nursing in Uganda, and reached similar conclusions to Littlewood. The historical development of nursing in Uganda was likewise shaped by British nurses. These nurses imparted their views and values of nursing as per British expectations; namely, the right type of nurse came from a good middle-class background. The nurses portrayed the image of a sexual morality using the position, and even the white uniform, to convey this. Marks (1994) likewise highlighted, in her work in South Africa, that the 'lady' nurse was highly sought after in colonial nursing regimes, where the tropes of service and religious purity were dominant. Such motivations, as I will show in subsequent chapters, remain important to my own interlocutors from India. The nurses in colonial Uganda had their lives controlled inside and outside of the nursing practice, as a way of protecting their image and suppressing sexuality, keeping them separate from the male expatriates (Holden 1990).

Reddy (2015) offers a more contemporary view of Indian nurses than Somjee (1991) through her interdisciplinary exploration of the profession, charting the history of nursing under British and American influence post-partition through to migration to the United States (US) from Kerala. What Reddy does not give much consideration to is the education of Indian nurses outside India. Of course, living and working in the UK is a different experience for the nurses in my study as opposed to those described by Reddy (2015), who had migrated to the US. Reddy's (2015) work highlighted the racism experienced by the Indian nurse in the US. This is not a theme or feature that emerged through my own study. Only one nurse from Delhi raised the issue of racism, and then only very briefly; she experienced this when she lived in a different part of England. One reason for this is many of the nurses lived in areas of London or the South East that had large South Asian communities of multi-ethnic communities where they felt less like outsiders.

Diaspora and Migration

This brings me to another area of the literature that needs to be considered: that relating to diaspora and migration. A strong Indian diaspora has existed and grown at least since the 1960s in Britain. This has had a fundamental impact on the nurses, particularly affecting their decision about where to live: in or near London. Economic liberalization in the 1990s saw the opening up of India's borders to trade and commerce (Gangly-Scrase & Scrase, 2009). It saw partnership with overseas companies and greater opportunities for Indian nationals to travel and work aboard. This resulted in the rapid expansion of Indian migration to the UK and beyond. Initially, unskilled migrants made up the bulk of the migrants to the UK. However, since 2002, Indian nationals have become the largest group of skilled migrants to the UK (Raghuram, 2008). There has also been an increase in the number of students, as well as women, migrating from India. A significant proportion of these were nurses recruited to the National Health Service (NHS). My respondents contribute to and are unavoidably influenced by their diaspora and the enactment of beliefs and norms from India in the UK. The increase in skilled workers has also seen the rise of Indian middle classes migrating to the UK who may enter the British education and work systems (Robinson, 1988). The nurses I worked with are representative of this phenomenon. Nurses have been an important part of this globalisation. In the early 1990s nurses migrated to the Gulf States (Osella & Osella, 2000), but from the early 2000s, larger numbers of nurses began to travel to the UK for work, and later, for study.

Migration, as I discuss throughout this thesis, has served to improve the social status of nursing, and not just in India. It has also been observed in South Africa where migration and work overseas have had a positive impact on nursing status (Hull, 2010). While status has improved through migration, it has caused frictions within the profession. What Hull (2010) identifies in the difficult situations many nurses find themselves in, is that they have become the primary wage earner within their marriages. The criticism levied at the migrant nurses is aimed at the perception (by other nurses) of the reimagining of the responsibilities in the social world and within their marriages. Interestingly, the problems associated with migration and marriage in India are shown in two cases discussed in chapter seven. But this is where the comparison ends: far from being criticised for migrating, nurses in India are pushed into doing so by their families and their educators.

Income generation, for most of the South African nurses who migrate, as Hull's work demonstrates, can be dramatically improved, and provides financial security. Nurse families experience higher status and social enhancement through nursing overseas. Many South African nurses found that they did not realise financial or career opportunities in the post-apartheid era that they had expected (Hull, 2010). Hull argued that nursing in South Africa can be difficult and limited in its effort to improve social status. What I show, in contrast to the South African nurse's experience, is the improved status of nursing in India, and even more so for the migrating family. In South Africa, the opportunities for social advancement for migratory nurses is tangible, but it also correlates with negative feelings towards these migrants by non-migrant nurses. Also, the perspective of the non-migrant nurse in South Africa is that their migrant co-workers take the senior positions. Migratory nurses thus represent a threat to the stability of nursing (Hull, 2010). In South Africa, many of the nurses were married, and they would return for extended holidays to see family. This, as Hull (2010) explored, could put a strain on the family and marriages. The majority of the nurses I worked with, by contrast, were single women, bar Somm and Deepa who migrated as a couple, and Sadhika and Supinder, who migrated with their non-nurse husbands. In general, the Indian nurse and their families would wait for the nurse to have completed their academic work and to have found jobs in the UK before planning for the nurse's marriage. The status of the nurse and family were improved by being a migrant. Migration aspirations are a unique way through which the Indian nurses approach this career development.

Shula Marks (1994) also explored nursing in South Africa. Racial tensions were volatile at the time of her work and were very much linked to the political situation in that country. Marks identified a hierarchy in healthcare of South Africa, within which doctors occupied the highest status positions. A similar finding was identified by Hull (2010), who noted that doctors take direct control over nursing practice. In a South African context, this meant that nurses had limited influence over improving nursing, much the same as in India. This is a common struggle in nursing; my nurse respondents also noted similar hierarchies in India and, by coming to the UK, they found a greater level of autonomy and control within nursing practice. Both Marks (1994) and Hull (2010) identified the onset of higher education of nurses as being a factor in raising the profile of nursing and attracting the middle classes to the profession. This has been seen as a major driver in the professionalism of nursing (Hull, 2010). Education also enables the opportunity to migrate for continued studies and for the

realization of middle-class aspirations, as a means of sustaining the nurse middle-class status (Hull, 2010). This is applicable to South Africa and India alike, as I show in this thesis.

Purity and pollution

Where the Indian context differs from some of the other post-colonial contexts I have described, is in the historical importance within Hinduism (or, at least, in the scholarship on Hinduism) of purity and pollution to everyday human interactions. Within Anthropology, Louis Dumont dominated early explorations of what this meant for those living in the sub-continent. According to Dumont (1970), the highest Hindu castes, the Brahmins, were the most ritually pure, with those at the bottom of the hierarchy the most relatively impure. Untouchables and those outside the Hindu case system altogether – such as Christians – were, according to Dumont's analysis, seen as the most impure of all. These demarcations influenced how a person lived, and who was assigned what tasks, roles, or jobs. A Brahmin's purity, in this model, is relational to those of the lower castes: that is, the purity of the Brahmin was directly related to the impurity of the Untouchable (Dumont, 1970). Contemporary literature on the Indian middle classes and nursing propose that adherence to notions of ritual purity and pollution have lessened in impact (Nair & Healey, 2006; Percot, 2006) and this, as I demonstrate in this thesis, has changed the ways in which nursing is perceived within India.

Other anthropologists have investigated purity and pollution more generally. Mary Douglas (1966), for example, famously explored and examined purity, taboos, and pollution in different societies around the world and at different times. Central to Douglas's argument was the use of taboos to order the social world. The enactment of taboos will shape how individuals live collectively in a social context. Taboos provide order. If taboos are fractured, then aspects of morality and decency may be breached. Douglas (1966:172) argued that, in India, the lower castes were kept in a lowly position through the enforcement of purity and pollution rules. Considering the profession of nursing, such rules did exactly that: the act or nursing fractured or blurred the imaginary lines between what was taboo, pure, or impure in a symbolic, but also physical way. Nursing involves intimate touch and close proximity to different caste members from higher castes to lower castes, thus crossing boundaries perceived by high caste Hindus, and that between purity and pollution. As such, nursing was viewed as fit only for widows, orphans, or Christians, as these groups were considered very low in society's hierarchy by the high caste elite (Somjee,1991). It follows that being a

nurse—if you were high caste—would have meant a reduction in status for the nurse and their family; nurses could be shunned by their families, and could experience a decrease in marriage prospects.

To be successful, as Douglas expands, taboos needed to be accepted by all of the community. Taboos acted as the building blocks of a stable society. Taboos may appear rigid but change can occur when those who maintain the boundaries of taboos see new ways of doing or viewing taboos (Douglas, 1966). They then dissolve or dissipate into a new form of acceptability. I would argue this has occurred in nursing in the latter stages of the twentieth century and now in the twenty-first century, and is evidenced by higher caste Hindus and the middle classes increasingly electing to join the profession (Reddy, 2015: 209). These groups previously shunned such work. Applying this premise to Indian society we can see how, through changing beliefs and views, higher caste Hindus have altered their life paths. For example, through women working outside the home this has become less of a taboo, certainly for those families I worked with most closely.

Christianity and nursing

Fuller (1976) studied Christians in Kerala, arguing that they had their own separate hierarchy, separate from, but comparable to, Hindu caste (Fuller, 1976). The Christian nurses I worked with discussed their own belief system and taboos, even though they distanced themselves from caste. For example, they would not marry outside their religion or class. Within Christian denominations in Kerala, Fuller shows, there exists a hierarchy: Syrian Christians occupy the top end, Latin Catholics are below them, and converts, such as Presbyterians, are at the lower end of this hierarchy. Converts in the early twentieth century would have been those that boosted nursing numbers and helped the profession to grow. Training in nursing offered a good option for low-class and low-caste women; they were provided with the education on an agreement to convert. It was unacceptable within Christian society for higher status Christians to nurse until later in the twentieth century, following independence. This has altered over time and in response to processes of globalisation.

The shift I have described is not exclusive to Christians: my respondents from the Punjab, who are mostly Hindus, also reinforced this perspective. The Punjabi nurses I encountered believed that nursing has developed a much more positive image. The rewards that nursing offers can be two-fold through service and the prospect of a long career and work abroad.

This resonates with Douglas's (1966) argument that strict pollution and taboos can be at odds with 'charitable acts' – what my own interlocutors described as 'service'. Nursing became widespread in India through charitable acts. The work of missionaries who carried out nursing as a service to God and His people saw care delivery become synonymous with being good and honourable. Today, some of the nurses in this study felt it was good to provide care as a way of enacting their religious beliefs.

Contemporary nursing in India

Nursing continues to occupy an ambiguous status in India, depending on the lens through which it is viewed. Nursing can be status enhancing, as many of my informants contested to, but in certain contexts, it could also challenge one's status. In Kerala, for example, nursing is seen by many as an acceptable profession, and this has given rise to greater status (Osella & Osella, 2000: 62; Reddy, 2015: 193). Nair & Healey (2006) explored extensively the status of nursing in India. They argued that the perceived higher status that nurses gave themselves varied greatly from how nursing was viewed outside the profession. Nurses saw themselves as highly skilled professionals delivering a service. However, to the wider society, their moral status was in question, as nurses' work involved interaction outside the family, and with strangers, and men. This brings into question the moral nature of the work of a nurse (George, 2005 & Percot, 2006).

A further problematic issue for nurses was their work with strangers. These were likely to be low caste individuals from the sweepers' caste (or the porters on a ward, as would be the equivalent in modern nursing). The sweepers had low caste and class status due to their work revolving around menial and unskilled tasks, such as emptying bedpans and cleaning the ward areas. Because the nurse worked so closely with these 'sweepers' in the work environment, there would have been some transference of this lower status attached to them (Somjee, 1991). This was not the case for the medical profession of doctor. Doctors were viewed in a more favourable light, with a limited stigma attached to them. The nature of their work meant less physical contact with the patients, and that profession was dominated by men who experienced higher status in society (Somjee, 1991).

Overall, then, my work sets out to address some of the gaps in the literature to add a clearer picture of the specifics of nursing in India, and how those particularities might be thrown into sharp relief when Indian nurses start to practice their profession in the UK. The unique

position of nursing in an Indian context is that men are now choosing to join a female-dominated profession, a move that challenges gender stereotypes in India, where nursing has long been associated with the feminine pursuits and the concepts of motherhood – that is, to care and nurture.

Methodology and research design

The research I undertook was qualitative in nature and grounded in ethnography. Ethnography is the study of the social world which explores the social interactions and resulting behaviours. This can be for an individual, a group or a community (Reeves et al,2008). The nurses I worked with represented a particular social group and that is what initially drew me to ethnography. A key feature of ethnography is that it can provide a deep and rounded view of people's beliefs and ways of living or being. This can include the location/space occupied by the group studied.

The research was acarried out cross-continentally between May 2010 and the end of 2014. Initial scoping fieldwork was carried out in India in Kerala. This was in order to explore the history of nursing in India, and to gain some context for nursing today and the nurse training/education in India. It was also an opportunity to gain explanations for why so many nurses migrate from India for work and education. There was also an opportunity for me to return to India to meet with and visit nurses who have returned to India for work or for their marriages. In the UK I engaged with the nurses in educational and informal settings in their social world. I had initially planned to also observe the nurses in their work spaces but as the study progressed I realised I was gaining rich and plentiful data on the nurses lived experiences in the UK.

Several methods of ethnographic data collection, such as participant observations, interviews (both structured and semi-structured), lengthy conversations, and the use of photographs, particularly appealed to me as this is how I envisaged I would engage with the nurses and did, in fact, pan out when I commenced my study. The nurses form part of an under-researched group, of which little is known in terms of what motivates and drives them to nurse, and what happens when they relocate to the UK through migration. As Hammersley (1997) described it, ‘the task of ethnographers is to document culture, their perspectives, and practices of people in these settings.’ In other words, the intention is to get inside the way each group

performs. This was my aim was to get inside what makes the nurses who they are and gives them a unique identity of Indian nurses living in the UK.

In my research proposal, I outlined how I would conduct my study primarily through participant observation, interviews and lengthy conversation/dialogues, and spending time with them in their social world where they lived and worked, all of which are a natural fit with ethnography. In addition, as my relationship with the nurses progressed, I became much more involved in their educational experience and, more importantly, on the social world away from work and university. This extended to India where I undertook initial fieldwork and attended two weddings and stayed with the nurses' families. Over the period of my study, I very much became included in the nurses' world in both private and social spaces. This enabled me to 'get inside' the lives of the nurses. Some of connections I made were particularly strong, and some have continued to this day.

Ethnography is less about hypotheses and more about exploring a particular social phenomenon, generating less structured data which do not lead to a closed set of analytical categories. As such, ethnography is an analysis of information and data/observations and how human actions are explained and verbally explored. To analyse the data, I used a thematic approach where I examined the data to identify and categorize concurrent themes. This was coupled with reflexivity where my close relationship with the nurses gave me a clear link to the nurse's world that I was studying. I was able to create a broad description of the setting and nurses based on my time spent with them (Hokkanen 2017). My analysis is a mixture of auto-ethnography where my perspectives and thoughts from my time with the nurses formed a central base for the arguments supported by ethnography and anthropological studies which help developed new insights and knowledge about who the nurses are.

Data gathering began in the UK after my initial fieldtrip to India to gain background information around nursing in India, and I followed this up with semi-structured interviews in the UK. The initial interviews were used to gather background data on the nurses, their family/social history, their reasons for becoming a nurse, and subsequently the reason(s) they came to the UK to study. The type of questions I asked to stimulate conversation were:

Would you like to just tell me just a little bit about yourself, what you, you know, your family, where you came from and sort of what made you come into nursing.

Why is nursing important to you?

What did your parents think about you wanting to be a nurse?

What do you think people thought about a man being a nurse?

What made you decide to come to England rather than maybe doing a BSc in India?

What do you think people thought about a man being a nurse?

These questions facilitated quality conversation, and I was then able to tease out deeper answers from the nurses when asking them about their social status, why the nurses thought that they were middle class, and the perception of nursing as a profession in India.

Subsequent interviews gleaned data on the respondents' lives and journeys in the UK. My interviews and lengthy dialogues were undertaken outside of the academic environment at a time and place that was convenient to the nurse. Each interview was taped and transcribed verbatim. Interviews, whether formal or informal, can reveal valuable data about the subjects or subject matter (Madden, 2010). Observations and interactions were carried out with the respondents in their homes in the UK, in the UK classroom, and through joining them in daily activities in the areas in the UK in which they lived. This involved dining out, shopping, and attending places of worship. This was carried out over a period of three and a half years. The purpose of observations was to establish what effect a UK-based academic education has had on the respondents from a personal and professional perspective, and to assess the impact on their practice and the practice of others.

A sample of 50 respondents was drawn from the undergraduate and postgraduate Indian cohorts, including 31 of whom I initially engaged with. The larger number of respondents initially used was to assist in defining the population to be studied (Reeves, 2008), as well as gather general demographic data about the nurses. I anticipated that some nurses would not carry on with my study for personal or logistical reasons. The sample was then narrowed down to those who continued to want to engage with the study. I carried out taped interviews with 12 respondents from mostly the BSc top-up programme, as well as Sonija and Minu (from the MSc Nursing Cohorts). This gave me insight into why they had chosen nursing, and issues around the stigma of nursing in India. I engaged with these nurses for 18 months

and then lost touch with 10 of them, but to date am still in contact with Minu and Sonija. The remainder of the respondents came from the MSc Nursing Cohorts and ONP programme. In total, I engaged with 14 of sample of nurses for the duration of the study, and I am still in touch with some of them.

My position in the research

My role as a researcher developed through professional work as a lecturer in nursing while working in a higher education institute in the UK. This involved teaching Overseas Adaptation Nurses (ONP[1]) undertaking a course validated by the Nursing and Midwifery Council[2] (NMC), an MSc in Nursing, and a BSc top-up degree in Nursing for Indian nurses for six years. Once the nurses had completed their studies, I began my fieldwork and interaction with them. The initial reason for this study was borne out of my personal curiosity as to what happens to Indian nurses who study in the UK, in terms of not just their professional careers and how their perspectives on nursing might shift, but also their everyday lives. This interest in international nurses has developed through teaching them over the six years; Indian nurses, in particular, have constituted a primary teaching focus from 2008 until summer 2014.

Before I begun this study, I had a narrow view and limited spectrum of knowledge about the Indian nurse which was gained through teaching and supporting a few Indian nurses in practice (through the ONP programme). I was eager to expand my knowledge and to improve how I supported Indian nurses I taught, but also hoped to broaden my scope for teaching other overseas nurses. I anticipated that the data gathered would inform and improve the experience for the overseas nurse, in both the clinical and academic environment, and enable a better understanding of their particular social and cultural needs whilst studying in the UK. To achieve this education, teaching need to be tailored to the Indian nurse, recognising their different experiences and expectations of education. One important area was looking at our approach and how different they were to the nurses' learning journeys in India. The concept of independent study was new to them, as were the types of assessment used (mainly written assignments), as opposed to the examinations they were accustomed to in India. These points

[1] In order to work in the UK, nurses from overseas must successfully complete an Adaptation Course that is verified by the NMC, the nursing ruling body.

have informed my own teaching, that of past colleagues, and curriculum development and review. In order to gain ethnographic information about the nurses, I explored their initial experiences on their arrival in the UK, as well as how they adapted to life in the UK. Consideration has also been given to how the UK Higher Education Institute (HEI) adapts to the Indian nurses. An example of this can be seen in the approach to teaching delivery and curriculum design and development for the students within the UK university environment.

Ethical considerations

Before commencing my study I had obtained ethical approval from my employer (an HEI) and from Brunel University, where I was enrolled for my PhD. During the process of seeking ethical approval from my employer, I was asked to have an independent person conduct my initial interviews. I argued successfully that did not fit with how ethnography was carried out and in order to get rich data I need to be much embedded in the process from the very beginning. It was not just about how questions were verbally answered, but also the non-verbal aspects, such as facial expression and vocal tone, as well as having the ability to ask additional questions or to seek clarity on points raised. I also began to see patterns emerge in commonalities between how the nurses responded to questions, in particular, their motivation to nurse, which subsequently became one of the themes for the thesis.

My conflicting roles as researcher, teacher, and friend is something I was very conscious of, and explains why I did not begin the more involved aspects of my study, such as the initial interviews, until the nurse had completed their different programmes of study. Aside from the HEI ethics committees, including Brunel's, I followed the Association of Social Anthropologists (ASA) guidelines. Equally important was the The Nursing and Midwifery Code (NMC,2018) to which all registered nurses must adhere. One of the key principles of the Code is 'Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education, or research' (NMC, 2015:3). I have been a registered nurse since 1996, and the Code has been very much part of my working life in both clinical and academic roles. I am very conscious that not adhering to the Code could have been detrimental to the nurses and also to my own career. In terms of gaining consent in ethnography this a relational

process that lasts throughout the research where trust develops with the relationship between the researcher and the respondents. (Parker, 2007).

I was very conscious from the start of my study that I was in a position of authority over the nurses as the programme director for their courses of study. To mitigate any potential issues, I met the nurses away from the campus, and conducted my main interviews after they had received their results for their academic work.

Ethical considerations centred around the impact on those who participated in interviews and being observed in practice. There was no anticipated harm, physical or psychological, to the participants associated with this study, therefore the impact on the individual has been minimal, as I would have predicted. The benefits to the respondents may also be minimal, though they may gain insights into their own careers and learning styles. Some of the respondents felt self-conscious being observed or interviewed during the research. However, as I became immersed in the environment in which the observation periods and interviews took place, the nurses became more comfortable. When interacting with the main respondent group, it was explained what the study was about, its aims and objectives, and what their contribution would be. I assigned pseudonyms to each of the respondents as a means to protect identifies. I gained permission to use photographs from those respondents pictured. I explained to the wider family members I engaged with what my study was about when it was needed. This was mainly for attending two weddings in India and when involved with a nurse's family and wider circle of friends and relatives. The nurses were provided with verbal and written information regarding the study. One further ethical consideration was that English is not the first language for the respondents of this study. However, all had undertaken IELTS[3], and gained a level 6 as the minimum, which negated the need for translation of written and verbal material, as the English comprehension was more than adequate for the information supplied.

The nurses and locations for my study

This section offers a more detailed exploration of the nurses I interacted with in India and in the UK. My respondents in India were student nurses, principals of schools and colleges of

[2] IELT – International English Language Test

nursing, and a superintendent of a hospital. My UK respondents were nurses I worked with in my study who had to be Indian nurses registered on a UK based programme of study at the HEI I worked with at the time or the study commencing.

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Initial exploratory fieldwork in and around Cochin Southern India was carried out in May/June 2010. This location was selected due to ease of access and my professional link in the area. Kerala is an important area for nursing, as this state trains a large number of nurses and nurse educators. The majority of this study's respondents came from Kerala. Within the nursing profession in India, Kerala nurses are known to migrate and travel for work and education (Osella and Osella, 2000 & Reddy, 2015). In Kerala, I met four principals of nursing colleges, three of whom were nuns, and one Christian, and one superintendent of a hospital. All were female. Attendance at two weddings, one in June 2013 in Kerala and one in November 2013 in the Punjab, also provided valuable additional information and insights with regards to what the nurses meant when they told me that they were middle class. The students that I met at the various colleges and schools[4] of nursing in India were all in their late teens to early twenties, and all were female. The majority of them were Christian, but there was one Hindu student and one Muslim student. In India, 30% of nurses are Christian, despite only 3% of the population being Christian (Simon, 2009). The predominate denomination was Catholic (Simon, 2009) who were identified within the 3%. Nursing in India has strong links with Christianity and colonialism; this explored in Chapter Two, The History of nursing in India.

All of the principals were female and nurses by background. Three were middle-aged and estimated to be in their 50s. The Christian principal of one of the colleges of nursing was much younger than the others, approximately in her late 30s. All of the principals of the colleges and schools of nursing were well educated, to at least Master's degrees or above, and one of the nuns had done a considerable amount of research. For the most part, they had extensive experience of teaching and nursing in India and abroad. Each one of the principals was very proud of her particular institute and the student nurses that went through it. The principals and the superintendent subscribed to the idea that nurses should go abroad and

[4] Nursing Colleges offer nursing courses at degree level or above, and schools of nursing offering diplomas in nursing; these are often attached to a hospital, and the course fees are lower.

work as a means of improving their economic status. I questioned the principals about what they felt regarding the 'drain' on nursing resources in India. Each one of them believed that there were enough nurses in India and queried whether it mattered that a few went abroad. This contradicts a report from the World Health Organisation (WHO) stating that there are shortages of nurses, with some 2.4 million unfilled vacancies, and that there are issues with retention in India (Senior, 2010). One of the principals felt that it was shameful that the 'good nurses are the ones that go' (abroad to work). However, many of them do return to India (as she had done herself), bringing back with them new skills and ideas to nursing.

The nurse tutors at the various colleges and schools of nursing were mostly in their late 20s early 30s, and around half of them had come straight from completing a nursing degree into teaching. This contrasts with the UK, where a nurse needs to work an average 8-10 years in clinical practice, and to have achieved a senior position before he or she would be considered suitable to teach and train nursing students. In the time spent with them, it was possible to discuss some of the key aspects of their teaching styles and undertake observations in the classes of some of the tutors.

Academic and professional background of the nurses in my study

Each of the nurses was registered with the Indian nursing council. The programmes of study in India qualified them as general nurses. This comprises of adult, child, mental health and learning differences nursing. In the UK, these four areas are considered as separate branches of nursing. When carrying out the ONP at the HEI (in the study area), the nurses were only eligible to register in the UK as adult nurses, as dictated by the NMC decision letter. This was established by the NMC through careful consideration of the nurse's clinical work and experience in India.

Table 1 below explains the academic pathways of study the nurses were undertaking in the UK.

Course	Entry Requirements	Length of Study
MSc Nursing Level 7	Registered Nurse (India) BSc in Nursing (from India) Level 6.5 in IELTS	12 months option to extend to 18 months to enable completion of dissertation. (learning took place in the HEI only)
BSc Nursing (top up) Level 6	Registered Nurse (India) Diploma in Nursing (from India) Level 6 in IELTS	12 months (learning took place in the HEI only)
Overseas Nurse Programme (ONP) Level 6 or 5	Registered Nurse (India) Decision letter from the NMC to allow the nurse to complete ONP Clinical Placement approved by the HEI Level 7 in all four IELTS elements	3 months for Academic element 3-6 months clinical placement depending on NMC decision letter.

UK-based nurses

My main research activity took place in the UK. I worked with 31 of the group, 14 of whom I had regular contact with one or two of the nurses, or sometimes a group, were met most weeks during the research period. This would be either at their homes, their workplaces, or in coffee shops or a restaurant near where they lived. The majority of the nurses lived in Southall and Hayes, four lived in Banbury and two (a married couple) lived in High Wycombe. There is statistical data available (see below) on the number of Indian nurses who come to the UK to register and work, but nothing concrete on what effect being exposed to a UK education and life has on these individuals. Since 1998, the number of Indian nurses who register to work in the UK with the Nursing & Midwifery Council (NMC) has steadily increased. In 1989/1990, 30 Indian Nurses registered for the first time in the UK[5], and by 2008, 1020 registered – a sharp increase. As of March 2017, there were 12,170 Indian nurses registered. Indian nurses are the largest number of overseas nurses by nation to register to

[5] A nurse from outside the UK must register with the NMC when they arrive, and for each year they practice after that.

work in the UK, with Filipino nurses number two on the list, with 10,695 registered (NMC, 2017).

The primary group of male nurses lived together in Southall in one large house (housing 10 total), in addition to Jinu, a female nurse, who moved into the house. All of the nurses came from Kerala, and most of them knew each other's families or knew of them. The house was a quite large rented semi-detached, with four bedrooms. There was no separate sitting room, but they had a very large kitchen with a couple of decrepit sofas and a large dining room table. They spent a lot of time cooking and socialising in the kitchen/lounge. The first time I visited their house they showed me a rota for cleaning duties and cooking duties pinned up on the wall to which they all adhered.

Most of the nurses' homes[6] had a similar ambience to a group of the male nurse's home. This group was made up of Jey, Vin, Abin, Luke, Jib and Arun .They liked to call themselves 'the boys' and this is something I have used in the thesis when their collective voices forms part of my conversations and time with them.. Their house had: outdated furniture and curtains that looked like they belonged to the 1960s, with thread-bare carpets. The bedrooms looked similar, with blankets and sheets on the beds, and not duvets, as many UK homes have. The nurses had a few personal items on display – photos and other personal items, toiletries, and so on. However, mainly the rooms were quite bare. Another common feature was that most of the nurses' residences had evidence of damp and mould. The front bedroom in 'the boys' house, where four of them slept, had floor to ceiling mould on the outside wall. The room felt and smelt damp; my observation of over-the-counter cough medicine suggested this may have been impacting upon the occupants' health. The extent and severity of the mould was shocking, particularly with regard to its potential impact on health through implied degree of damp and lack of ventilation. I asked the study participants if the property owner knew. They said that he did, but they bemoaned that the owner's priority was the rent and little else. After my first visit, I bought the occupants a bottle of mould spray, which was applied. The wall was pristine and mould-free on my next visit.

[6] Individual homes/location will be described in more detail when discussing the particular respondent.

Hospitality: My first meal at Jey and his housemates' house. The meal was a celebration of both Jinu and Cecil passing the degree programs and as a way of thankyou to me for supporting them through their course. The meal was cooked by Arun and Jib both.

Figure 1: A tasty Kerala curry and appam

Figure 2: Jinu and Luke

Figure 3:Being served by Jey with Arun standing behind him.

This particular house was in a worse state of repair than the other residences, but each of them had patches of mould in rooms in need of repair to windows and so on. I experienced the poor state of the house when the glass front door jammed after one of my visits. Attempts by 'the boys' to solve this issue were a source of both amusement and embarrassment. In the end, one of the nurses had to climb out of a ground floor window to push the door from the other side. Lack of natural light was another common feature in most of the homes, along with a dinginess that comes with poor housing. Each visit to the nurses added to my concern about the sub-standard state of the housing, but they were quite accepting of the poor state of their homes. The rents paid were low, approximately £150 a month each, when the average for the London borough they lived in was £412 in 2011, the year in which I first visited their house (Gov, 2017). To individuals on low incomes, these rents were, nevertheless, 'high'. Press coverage has shown exploitation of migrant workers in and around UK and London to be widespread, as discussed by Jones (2011) and Grice (2011). My observations during this research suggest that the nurses I worked with had also been victims of this to some extent. Suki, Somm and his wife, and Minu's homes were well maintained, well furnished, with no evidence of mould. However, they paid more rent and were living in High Wycombe, Banbury, and Uxbridge, away from Southall.

Key factors I observed during my research visits were the marked generosity and hospitality of the respondents. Jinu, Donna, and Luke were the first respondents visited at home. They offered milky tea and two different types of cake. The cakes were dense sponges filled with butter cream and topped with an abundance of icing. Despite the refreshments not being to my taste, it was considered impolite to turn down such hospitality (Siby, 2009). Three of them had limited disposable income, so the fact they had made considerable efforts to entertain was respected and noted. Melke, Simram, and Jit had cooked a spicy vegetarian curry, and offered soft drinks as refreshments. It became apparent early in the research that it was very hard to turn down refreshments without causing offence.

On the first visit to Jey and the others in the house, Jinu and Luke had not long moved in with them; a feast had been laid out for me and the other visitors. The celebration was to mark Luke and Jinu successfully passing their top-up degrees and my visit. Arun and Jey explained that their father would be disappointed with them if they did not offer a guest food. In addition, Arun and Jey had cooked and were demonstrating their culinary skills. They had cooked a Kerala chicken curry, rice, and appams. There was an embarrassing moment for me when it became apparent that only me, Jinu and Luke were sitting the around the dining table to eat. The others served and just watched us eating, and took photographs while the food was eaten. This I realised was the normal practice and I noted this happened when I stayed with two of the nurses' families in India (Osella & Osella, 2000:29). The entire experience was positive. In addition, it was the first time I had seen Jinu smiling in several months. Out of all the respondents, she had felt the strongest sense of separation from her family, her children and husband; she seemed to have suffered the most in some respects. Apart from one occasion, each time I had been offered food, I was the only diner. The respondents would watch, or maybe have a drink, but seldom join in the meal. The only time that I shared a table and ate a meal with someone was when there was a research visit to Kiran at her flat. Her boyfriend had cooked a chicken curry and rice. Kiran accompanied me in eating the curry in her room and had a general conversation over the meal. This time, there were no photographs and no observers. The relaxed way in which the nurses invited me into their homes helped to set the tone for the relationships I developed with them. They were quite informal, and they were more than willing to open up about their lives with me.

I made no particular effort to ingratiate myself with the nurses I worked with. They all seemed generous, and had been raised to be hospitable and welcoming to guests. There also

seemed to be a particular significance to their being visited by their former tutor; there was an element of pride that their tutor would visit them and pay an interest in their lives. As Jib said (he lived with Jey and the others) 'we were concerned about you coming'. He said this as he was sweeping the hallway in his pyjamas. 'But actually, it's okay'. They gave the impression that they thought I may be checking up on them. However, at the time of the visit, there was very little talk about academic work. The focus of my visit was to meet with the nurses and hear their stories. It has been my experience that people respond better when an interest in them and their lives is shown. I sought to satisfy my curiosity in finding out as much as possible about day-to-day life in India, the lives in the UK of the respondents, where they came from and where they thought they should be going. It was unclear precisely why they were so open to participation in the research. One reason may have been my professional background; experience as a district nurse meant that visiting patients and families in their own homes and eliciting information from people about their lives, lifestyles and health beliefs could draw heavily on previous practice and skills. Getting people to naturally open up and want to talk had not been a particular challenge for me, either prior to or during this study.

The nurses' identity, gender, class and religious background.

This section aims to identify the people—the nurses I worked with—in terms of who they were in respect to gender, class/social, and religious backgrounds. The common link for the entire group was that they were nurses; this was regardless of gender, religious, class and caste background. This gave them a form of recognisable identity. It was therefore important when discussing nursing to recognise that the term 'nurse' has different meanings in different countries, and can be difficult to define and classify. There is, however, a common link: caring for those who are sick—the scope of practice—is what defines nursing across the globe (Holland & Hogg, 1991).

Nursing is a profession that has long been associated with the female gender, and this is true in India as well (Somjee, 1991). Nurses were regarded as the 'hand-maidens' to the male doctor in India in 19th and 20th centuries until approximately the last 20 years (Somjee, 1991). In recent years, there has been an increase in the number of male nurses. One reason may be that male nurses are much more attracted to nursing due to career prospects than they were in the past (Senior, 2010). In Chapter Three, I explore the reasons for the acceptance of men taking up nursing. Jey recalled that, in 1999, there was an increased amount of

recruitment to the US from India, and this resulted in more male nurses. Occupational therapy nurses or industry nurses were also attracted into the profession. ‘The boys’ report that, if they had been born 20 years earlier, they would probably not have been nurses, as the profession was not acceptable at that time for middle-class men. We had a discussion of globalisation and the impact of this over the last 20 years on nursing. ‘The boys’’ assumptions are given credence by contemporary literature where it has been observed that globalisation in Indian gained momentum in the late 1980s and early 1990s (Gangly-Scrase & Scrase, 2009: Nair, 2012).

New imaginations of the gender of gender and family came about in India through ‘cultural globalisation’ which offers new possibilities for women (Derne, 2008). Clare-Deces (2014)explored daily life in Tamil rural society and conclude that there had been restructuring and detraditionalisation of gender with the rise in the age of marriage, increase in school education, and improved family planning, all of which close the gender gap, as well as new forms of work for women—women who are seen to be an integral part of the improving fortunes of middle-class families. Guilmoto supports this view, and proposes that gender has been reshaped through family structures within the middle classes; in particular, the social and economic factors which include wanting their children to complete additional post-secondary education to give them a better advantage for the future. Women working outside the home has helped realise this goal for the education of children, as shown through the nurses’ narratives.

The new middle classes, as I discuss throughout this thesis, see women in a privileged position, and has led to a revised definition of gender. These new gender roles comprise part of their middle-class identity, where women are more easily visualized operating outside the home. Nursing, as I will shown, is a strong example of how a previously low-status profession has gained more respect and has given women the potential to be the breadwinners in the family; opportunities for migration are key in maintaining and strengthening middle-class status, where men can capitalize on the nurses’ opportunities. It has been noted by Van Hollen (…) that there is higher gender equality in South India than in North India, with a higher level of education and literacy for women and girls. I will not speculate why this is, as it is not the focus of my thesis, but it is interesting to note that most of my respondents were from Kerala in Southern India, where nursing has a long history of being accepted, and hence

women working outside the home was not a new phenomenon. For the nurses from Punjab, nursing offers them a way to elevate their status and increase marriage prospects and career potential, thereby closing the gap between men and earning/career potential.

Busby (2000) explored the lives of the people in a fishing village in Kerala and suggested that gender is an elation of equality, which is interdependent and complementary. Men and women need each other to be fully productive and reproductive; the connection between the opposite sexes is vital to achieving this. Her respondents were Christian, and as with Hindu society, Busby purported that where Christian patriarchy exists and men remain as head of the household, the performance of gender is complex. Contemporary India offers a different perspective on the interdependence between genders, as Busby proposes. As noted, nursing in India has been a female-gendered profession that reflects the elements of caring for motherhood. Many of the female nurses, when asked why they wanted to be nurses, suggested that it was about doing service. Snell-Rood (2015: 53) noted that 'seva' (the Hindu word for service) was used to describe women's roles in social settings, which encompassed the work of feeding, nurturing, cleaning, and ritual deference. Whereas men's roles were generalised to being a support for relatives, and traditionally men were the economic providers, this has shifted in contemporary India, with it being more acceptable for women to work outside the home (Busby, 2000). This shift asks the question: within the nursing profession, are men acting out females' roles, or do they bring a different dimension to nursing? The male nurses certainly suggested that they came into nursing to earn good wages, to offer career prospects, and to benefit themselves and their families—in essence, protecting their maleness in the female world of nursing. This warrants further scrutiny, and would be something I would like to explore in a further study. A clear division in labour in nursing was apparent in my research: many male nurses worked in mental health (which was seen as too demanding for female nurses), and many aspired to be managers and tutors rather than clinical or hands on nurses.

Religious background

All of the respondents spoke of their religious backgrounds and most continued to practise their faiths in the UK. Out of 57 respondents I engaged with, two were Sikh, seven were Hindu, and the rest were Christian. Of the Christian nurses, one was Syrian Catholic, three were Pentecostal, and the remainder were Latin Catholic. There were no Muslim nurses. The

statistics indicate that Christians make up 3% of the population total of India; yet, the number of Christian nurses was much higher at 30% (Simon, 2009).

Divided states: the Punjab and Kerala

The divide between the respondents from the Punjab in the North and Kerala in the South West was a feature I first observed in the classroom setting. In the group of 13 nurses who were studying a top-up BSc, the three from Kerala – Jinu, Donna, and Luke – all sat together, and the nine from the Punjab likewise sat together. There was little interaction between them, apart from group work. Suki from Delhi conversed with both groups, but made friends in particular with Jinu, from Kerala.

While reflecting on this 'divide', Luke said maybe 'it's a different culture', by which he meant that each group, whether from the Punjab or Kerala, felt had they had little in common with each other. Jey and Arun noticed the facts that the language and foods were very different: 'in the north, they use ghee, we use coconut oil, [and] our food is fresher'. In the MSc group, the divide was more biased towards Kerala, and this was the largest group (27 out of 29 came from Kerala). Minu, the two other girls, and one boy (Amar) from the Punjab sat together. The other 27 students who were all from Kerala sat in groups together. Luke talked about having no friends when he first arrived in the UK to live in the house he shared with fifteen 'Punjabi boys'. 'First of all, it was too difficult because I don't have much friends'. He went on to say:

> So whenever I speak with them [his flatmates at the time], I have to use some Hindi language. Hindi is our national language, so I have to speak that. I don't know... but I can manage Hindi, only a little bit Hindi.'

He initially struggled, as felt had little intimidated with 'boys from the Punjab' as they have a 'different culture'. Luke later moved in with Jey and his housemates 'who are all from the South'. He was much happier, content and felt socially included. Jinu also pointed out the difference, again related to education. She looked almost disdainful when she talked about people from Northern India. Some of this might have been what Jinu described as 'the 100% literacy in the south' and that she and 'the boys' seemed to feel superior to those from the North. The language difference was discussed with Saju and Nithin. They felt language was an issue; Malayalam is spoken in Kerala in the South, and Hindu/Punjabi mainly in the

Punjab, in the North. Saju said 'Kerala is different from (The Punjab); there is 100% literacy in Kerala.' He also felt 'family bond[s are] stronger (in Kerala and amongst Christian), and Christians were in a strong position, being the dominate religion.

Minu reflected on the divide as well, 'you know what they were like'. What she meant by this was that she had little if no interaction with her fellow classmates because she was from the Punjab. She had no contact with her classmates, bar one other girl, a Pentecostal nurse whom was in the subsequent MSc group. Minu may not have initially made friends with anyone in her MSc group, but did when she worked in a take-away shop in Southall. She became close friends with Aava from another MSc group; indeed, they were both interviewed together in Chandigarh. Aava, who is from Kerala, was bullied and ostracised for her modern ways by her MSc group (only 9 students), all from Kerala. The class mocked her hairstyle, repeatedly told her that her dress was inappropriate, and that she needed to consider her morals. They also would not talk to her, which made her feel even more isolated. She might be considered a 'trendy dresser', dressing in fashionable western style clothes; the others in her group did not approve of this. She seemed to have a difficult time in the classroom, but being friends with Minu outside the classroom helped make her life tolerable. It was a shame that the two girls were isolated in this way and did not have a strong support network, as the MSc student group/respondents had in particular. The MSc respondents from the south, and 'the boys' in particular, supported each other when they were homesick, with their academic work, by celebrating birthdays, and by helping each other deal with the adjustment to living in the UK. Minu was included in this in the latter stages of their MSc studies, and she became close friends with Sonija, when they both undertook the ONP course.

The division between the Punjab and Kerala nurses came as a surprise to me. Some differences were predicted due to class and caste, but not geography. This divide seemed to go beyond simply location. In a way, it made sense; the languages are different, the food that is eaten has a unique identity in both areas, and the status of nursing differs. The nurses from Kerala seemed to look down on those from the Punjab because of their enhanced education and pursuit of traditional values (as the Malayali's saw it : Malayali means 'someone from Kerala'). In Kerala, as Nithin and Saju pointed out, 'girls are more reserved (in Kerala), family ways and family bond is stronger. For the society is male dominated and women still are seem to be obeying their husband'. To both of these nurses, 'the north' – as they phrased it – had different values and fewer morals. All the female nurses from the Punjab, bar Minu,

stayed at home on their time off, and only ventured out for shopping and college. None of then took up part-time work, while the nurses from Kerala did. The nurses from Kerala had part-time jobs, and many would go out for coffee, the cinema, or to socialise at each other's houses. Discussing these aspects of their life in the UK, the nurses from Kerala already had supportive links to the diaspora of Southall and surrounding area. The accommodations for the nurses from the Punjab was arranged through social networks and/or through their families. Ballard (2009) investigated the South Asian diaspora and discussed 'networks' which were formed prior to coming to the country of migrating. In the contemporary setting, the use of the Internet and other modern technologies has further aided this. The diasporic networks are important to building relationships, but need a level of 'transaction of some kind' that benefits both (Ballard, 2009:145). Using Jey as an example, his aunt ran a nursing home where Jey and four of the other students worked. This provided them with cash to support their stay in the UK, and his aunt benefitted as well, as she was able to fill vacancies for Health Care Assistants (HCA) that she had been struggling to fill. A further advantage for the Kerala nurses was that many knew each other from Kerala, either as relatives, because they had studied nursing together back in India, or they were from the same village. This gave them a ready-made social network that they used to fill their leisure time.

Summary of the aims of the thesis

The central argument of my thesis is that the nurses did not come to the UK just to work and upgrade their studies. A primary reason behind their migration is based on the good status nursing has in the UK, where notions of purity and pollution are less significant. I observed different ways of enacting gender in the migratory nurses in this study. This thesis aims to gain further insights into a selected group of Indian nurses' views and experiences of being migratory nurses. My research offers a platform for the nurses to articulate their experiences of being an Indian-educated nurse experiencing education and life in the UK for the first time. Previous research has concentrated on mainly negative experience of Indian and overseas nurses in the UK in terms of racism and poor career progression (Mackintosh, 2006; Buchan et al, 2005). I draw out some of the more positive aspects of being in the UK. In this thesis, I argue that there is a tendency in the literature to see 'the nurse' un-problematically as an objective category. Nursing, however, actually varies considerably in practice, both literally – in terms of what nurses are expected to do – and in terms of what people understand it to be. 'To nurse' means to care, and, historically, nursing has been seen as a

feminine pursuit: one closely linked with motherhood but, as both Somjee (1991) and Zwerner (1995) suggest, nursing has developed in different ways cross-culturally. In the UK and Australia (as elsewhere in the West), for example, nursing was changed by the suffrage movement and by women's' subsequent gaining of the right to vote (Lewenson, 2013). In Indian society, by contrast, the development and the emergence of a strong nursing identity came later, in the latter part of the twentieth century. Nevertheless, nursing has remained predominantly a female occupation, even in contemporary India, and, as gender roles have been redefined in Indian society, nursing has begun to follow suit.

In addition, I ask how nurses navigate the differences between nursing in India and in the UK when they come from India to pursue training and work as nurses. The assumption that nursing is a universal category means that these differences – which themselves might vary across time and *within* the two geographical regions where the research was based – are often under-explored.

Key questions that this thesis poses and addresses, then, include: What happens when nurses raised and trained in India come to the UK? What factors influence whether the Indian nurse achieves or not in a UK-based post-registration education? As such, my research is an intervention into the anthropology of education, investigating and developing an understanding of how the nurses navigate through two spheres of education: in the first instance, undergraduate nurse training in India; and, secondly, postgraduate education in the UK. One challenge in relation to the latter was being taught in English when English was not the nurses' primary language. I show that, while some thrive in the UK education setting, others were unsuccessful in gaining a BSc or MSc.

The thesis also raises important questions about relative status and class. In many ways, the nurses I worked with epitomised what is described as the 'new' middle class in India (Donner, 2011). I argue that their (often precarious) status is maintained by several factors, including post-school education, financial security, and travel overseas. What my research offers to discussions about class in India is the exploration of male nurses entering a female-dominated profession; other research on class has focused on professions where the opposite has been the case (Fuller & Narasimhan, 2008). For example, women have been entering the IT profession, which was previously a male-only domain.

Finally, by exploring the nurses as migratory workers, the thesis presents contemporary knowledge of my interlocutors' motivations to nurse and travel, and provides insights into the growth of popularity of nursing as a respectable profession for India's middle classes. In particular, my research has shown how the nurses develop levels of independence they did not experience in India, and how they shape their own futures, as they want them to be. Both male and female perspectives have been considered, and offer insights into the contemporary world of nursing in India.

Chapter outlines

This thesis is composed of seven additional chapters. Chapter Two explores and examines the historical development of the nursing profession in India. This allows the context of contemporary nursing in India to be understood and lays the foundation for the thesis by charting the significant improvement in the status of nursing and the nurse in India. The association of nursing with moral pollution has diminished, which leads to an exploration of the motivation to become a nurse in Chapter Three. In this chapter, I show that nursing is considered an acceptable middle-class profession by the nurses I worked with. It can offer job stability, a steady income, and can improve marriage prospects. Additionally, nurses and their families can reap the benefits of working overseas. This is a considerable draw to both the male and female nurses. Nursing is not universally viewed in a positive light, but through the nurse's narratives, I show that it now expanding out of the realm of Christians and lower caste nurses, to a career sought out by Hindu and Sikh nurses who offered similar motivations as the Christian nurses. Chapter Four continues the discussion with an examination of the nurses as migrants, charting their journey to the UK, which is not straight-forward and entails sacrifices for both the nurse and his/her family. The initial experience of the nurses' time in UK is explored, as this has bearing on how they settle into the diaspora (or not), and how they experience learning in the UK. I show that the rewards of nursing outweigh some of the negative connotations, and that benefits are felt by the nurses and their families as a whole, which sustains and maintains the status of the family and adds to their middle classness.

Chapter Five considers what it means to be 'middle class' for the nurses; this is centred on English-medium schooling, post-school study, plus travel for education and work overseas. The nurses do not aspire to be middle class, but hold the universal belief that they are already middle class. This belief is examined against the context of being a middle-class Indian, with

comparisons drawn with the nurse's contemporaries to reveal the nurse world-view and their understanding of being middle class.

Chapter Six discusses and examines learning and education which are fundamental to the nurses being middle class. I investigate their experience in India, and then in the UK, against concepts of learning and the apprentice-style education. How the nurses were able to compensate for a different form of education is linked to how they succeeded or not once in the UK. This sheds light on nurse education of Indian nurses. Chapter Seven delves into the nurse's experience of being in the UK, whether part of the diaspora or not. I consider not just the impact of an education in the UK, as explored in chapter six but extend the argument to concepts of independence and freedom of mind and body as articulated by the female nurses in particular. This illuminates some of the changes in the way young Indians view the world and how they feel and act about their position with their families in India. The concluding chapter examines the aims and questions of this thesis, and the implications of the findings in respect to nurse education and theoretical frameworks of middle class and migration.

Conclusion

Nursing in India is a profession that has gained status and prestige through its association as a demanded profession, and because of what it offers. It offers a career for life with a steady income but, more importantly, the opportunity to work and receive education overseas. It is the latter point that is attractive to young middle-class Indians (of both sexes); being a nurse can sustain social status and makes the nurse attractive in the marriage field. The rest of this thesis – in addressing a gap in the academic literature – explores and analyses the day-to-day experiences, over a period of several years, of Indian nurses who have migrated to the UK for training and employment.

Chapter Two – The History of Nursing in India

Sister Anne proclaimed Ms Nightingale to be the '*founder of nursing, nursing developed from her and taking care of the old and the sick.'*

Introduction

This chapter explores and examines the historical context and forms a central factor in development of the nursing profession in India and of this thesis. This in turn shows that nursing has a unique meaning in an Indian context. How the profession has developed offers insights into the emergence of nursing as a middle-class occupation, the influences of gender, ritual purity and pollution, as well as migration in contemporary India.

The origins of a formalised nursing system in India are inextricably linked to the colonial era, as well as to military and missionary nursing. Nursing in India has been shaped by the hierarchy of the colonial system, which saw deference to the medical profession as being superior to nursing (Somjee, 1991). The influence of missionary nursing and other international nurses became significant in India in the early 20th century and continued until 1970s. Caste and social class influences in India played, and continue to play, an important role in the development of the nursing profession (Somjee, 1991 & Reddy, 2015). These will be discussed in more detail later in Chapter Five. Nursing in contemporary India has seen the improved status of nursing as a career, which goes hand-in-hand with the improved status of women and the increased acceptability of women working outside the home, as observed by Fuller and Narasimhan (2014:137) in their exploration of middle class Tamil Brahmans. Exposure to post-school education for women has seen wider acceptance of work outside the home as a means of social development for the family. Women's exposure to public work is less shunned by the higher castes, and is more acceptable to the middle classes than in the past, as observed by Donner (2011) in her extensive study of the middles classes in Kolkata, West Bengal. Osella and Osella's (2000:45) work supports these arguments; they noted that the notion of 'inside' work in the home was practiced by the Hindu family. Christians were seen to do both: that is, they did 'outside' work beyond the home as well and 'inside' work in the home. They observed a change in the social world, which saw some Hindus taking up nursing. These developments in the social worlds of India have informed and re-defined

nurses and nursing in contemporary India. The phenomenon of Indian nurses migrating has influenced the improved status that is afforded to the nurse, as well as better pay and conditions outside India (migration is discussed in more detail in Chapter Four). Social factors associated with class and, in particular, caste, and the notions of purity and pollution, have affected the nursing of today. Notions of purity and pollution enacted in the social world on Indian Hindus and other faiths, have become less stringent and, in essence, changed over time, reducing the stigma attached to some aspects of pollution. These changes support the premise that the status of nursing has improved in contemporary India. This chapter explores and examines the development of nursing in India, and highlights the context of contemporary nursing in India.

Florence Nightingale's influence

The most prominent figure that stands out in the development of nursing in India is Florence Nightingale. Nursing, as we might currently understand it in the UK, did not exist in India prior to Nightingale's influence. Nursing across India was fragmented and piecemeal, carried out by family members and physicians (Somjee, 1991). Her influence began in the 1860s. She was a woman with strong political influence; further, she was highly educated, and her name was recognisable amongst the British public. Her father was a wealthy landowner and her family mixed socially with members of Parliament and other wealthy upper-class families. She was an influential and powerful woman in a time when men dominated politics and society (Nelson & Rafferty, 2010). It is important to point out that Florence Nightingale's initial work was focussed on British military nursing, and that she was fundamental to the overhaul of military nursing in India. Despite the fact she never visited the country, she shaped the development of nursing schools, which, in turn, led to the training of Indian nationals as nurses. This she did through her writings, correspondence, advice, and political influence (Wilkinson, 1958). The effects of her influence filtered down to local healthcare over time, due to the British nurses she sent to practice in India. Another factor is that Ms Nightingale was a staunch Christian, and a proponent of Christian values in nursing, as well as in life. Nightingale's status in India is founded on the fact that she represented Christian values, faith, and nursing, as well as professional ideals.

Wilkinson[7] (1958), in particular, was a supporter of Florence Nightingale and argued that, through her thorough investigation and time spent suggesting the implementation of reforms of British army healthcare, she was able to influence in turn other public healthcare systems. Godden (2010) identified the origins of this development in nursing and healthcare in India, which began when Florence Nightingale instigated a Royal Commission on the healthcare of the British army. This led to a second Royal Commission (1858-1863), reviewing the British army in India. This was authorised by the Crown and the Government. The hope was to reform healthcare delivery and improve the conditions for members of the British army and their families. These conditions were often be poor, and the care given could be sporadic. There was no uniformity of standards among the different army stations.

Nightingale sustained an interest in India for 40 years, even though, as stated above, she never once visited (Godden, 2010). After the Indian Mutiny of 1857, Nightingale became aware of the poor living conditions in the country, which included healthcare in the general Indian population under colonial rule. Not only did she want to reform healthcare in the army, she was also committed to improving the health of the general population after learning of their situations under colonial rule. She was committed to the fight against preventable disease throughout India; improving sanitation was one aspect of this. As Nelson and Rafferty (2010) argue, Nightingale had constructed a positive reputation for innovations in the care of the sick during the Crimean War. She was instrumental in the establishment of the first school of nursing affiliated with St Thomas's Hospital, London, and there she continued to professionalise British nursing, thus cementing her status as a woman that would act on her desires for social reform and improvement of the public's health. Her upper-class status added a level of respectability to the causes she undertook, meaning that she recruited other high-class women to support her initiatives. Nightingale's influence was demonstrated in her acquisition of such a comprehensive knowledge of India that each Indian Viceroy would meet with her before they took up office. Her own correspondence and journals document her influence over health matters in India and the wider Empire.

[7] Alice Wilkinson was an English nursing Sister who arrived from England in 1908. She was one of the founders of the Trained Nurses Association of India, and president of the association from 1942-1948 (TNAI, 2016).

Florence Nightingale kept meticulous and detailed notebooks documenting her correspondence, the feedback from her enquiries, and her solution and ways to improve healthcare (Nightingale[8], 1865). From Nightingale's own accounts (Nightingale, 1865) and those written by others on her work (Magnello, 2010), she systematically corresponded with each of the commanders of the 200 military bases throughout India. She asked for detailed information in the form of a 'circular of enquiry', asking for information on regulations, health, sanitation, mortality and morbidity figures, and administration of healthcare facilities, such as military hospitals, clinics, and other providers of healthcare to military personnel. The commanders responded in turn, and supplied the required information. While I have not seen the responses, her journal documents the summary of findings. There does not seem to be any recorded opposition to her enquiries. However, it took four years for Nightingale's final report to be published, the delay being attributed to the slow responses of some commanders and, in some cases, data was lacking. With the information she had gathered, Nightingale established a health history of each area, utilising information and reports going back the preceding ten years. Through this work, she developed a comprehensive picture of military healthcare. Nightingale's reports made suggestions on how to run and administer military hospitals, linked to the information she sought in the enquiries. Mortality rates were higher amongst British soldiers than Indian soldiers. It was thought at the time that the climate was the main cause of this, but the report's conclusions highlighted that sanitation, including a cleaner water supply, could keep the soldiers healthy in India (Magnello, 2010). The findings led to a better diet, improved sanitation, and, in turn, better health for the British soldier.

While working on her report, Nightingale also set out to improve and develop nursing, as well as general healthcare across the Empire. Her proposals for nursing in the British army in India included that female nurse candidates should be aged between 30-40 years of age and should be European or Anglo-Indian widows or wives of non-commissioned officers in the army. The ideal nurses should be "intelligent women of middle age, of cheerful disposition, sober habits, good temper and neat and orderly, able to read and write" (Nightingale, 1865). She added that the nurse's uniform needed to be clean and neat, that they must remain calm in difficult situations, and, of course, they needed to be literate in order to follow care plans

and read patient notes. Nightingale (1865) also made recommendations to do with pay, pensions, dress code, and disciplinary matters. These were significant, as there were no rules governing nursing and nurses at the time in India, and many were unpaid. Nightingale highlighted where the need was greatest, and where the nurses would be posted. No mention was made in any part of the report on the inclusion of Indian nationals in the development of nursing in India.

Nightingale's involvement in Indian army nursing did lead to the exploration of the female role in nursing outside the military (Somjee, 1991 & Wilkinson, 1958). Military nursing did set out the foundation for a more regulated and professional nursing service in India and care of the general populace. This, however, took time, and is the colonial legacy that pushed forward the growth of the profession to a more recognisable format. Parallel to Nightingale's interest in India, she was influential in developing nursing across the empire more generally. In 1865, Nightingale petitioned the Indian Government to develop a female nursing service. This, she envisaged, through the enactment of a Nursing Act of India, would be similar to those she had developed in Australia. The Act aimed to set out a system to train nurses overseen by the India Government. Nightingale waited for two years for a response to the Act, only to have it rejected by the Indian Government. This was a 'bitter blow' to her plans for reform (Godden, 201:68). The Act was not sanctioned until 1947. The primary reason why it was rejected was that it was seen as impractical to develop nursing in a vast country such as India. Godden (2010:63) argues that there was also a general lack of interest in healthcare *per se* from the Indian Government at the time, and it took many decades for the role and training of the nurse to become priority in the political sphere (Godden, 2010: 63).

Despite the Nursing Act being vetoed, Nightingale still pursued her vision of a nursing service for India from her recommendations. The first British army nursing superintendents and sisters were dispatched to India in February 1888. These were handpicked from the Nightingale Training School at St Thomas's Hospital in London (Godden, 2010). These nurses were tasked with the job of organising nursing and nurse training in military hospitals throughout India. This was the forerunner to more organised and defined military nursing service in India. The nurses were hailed as being responsible for the development of the finest military nursing service in the world (Wilkinson, 1958). What this development did create

was an Indian nursing service based on British standards and cultural norms, one where the hierarchy prevailed, with the British nurses occupying the senior nursing positions across India. It remained like this until independence in 1947 (Walton-Roberts, 2012). Indian nurses were few and far between at the time, and they were found in lowly positions imposed by the hierarchy. Diet, water, sanitation, and infection control regimes were imposed under the guidance of the Nightingale nurses; this was based on the experience of British hospitals, and may not have always reflected the needs of patients being nursed in India.

Reddy[9] (2015) is more sceptical about Nightingale's vision for nursing, arguing that what Nightingale was seeking was a 'good nurse' who was primarily a 'good woman'. Selecting this sort of candidate for nursing, however, was also a way of reducing the stigma associated with nurses, in that they had previously been seen as less than respectable with loose morals. Associating nursing with Christianity and seeing nurses heading on a mission would also serve to improve the status of the British Nightingale trained nurse. The nurse would take the lead in sanitation as it was nurse's work, and Nightingale promoted the nurse as the handmaiden of the doctor and enforced the division of labour between a doctor and nurse, which reflected their gender roles; that is, the doctor cured and the nurse cared. This applied to Nightingale's vision of nursing in the UK and across the Empire. Being the handmaiden of the doctor was a step up for the nurse as the doctors enjoyed a higher status and they were largely drawn from the upper middle and the upper classes. The nurse's role was to complement and enhance the work of the doctor. Considering Reddy's interpretation of Nightingale's vision, the nurses were not competitors for the role of the doctor.

Reddy (2015) further argues that the good and virtuous middle-class woman selected for nursing was a natural fit for the Victorian woman: an extension of her role in a male-dominated society. This manifested as bringing the private, caring nature of women into the public domain, but with the new level of respectability associated with the middle/upper-class background of the Nightingale nurse. The fact that the nurse obeyed the doctor's orders illustrates the point further. Hierarchy in healthcare continued to develop at this time in the UK and India as Nightingale's influence increased. The nurse had no autonomy. The doctor

[9] Reddy wrote extensively on Indian nursing and migration of nurse to the United States. This included exploration of the history of Indian nursing and the influence of British and American Imperialism.

held the top position; the nurse was subordinate to the doctor, as were the hospital orderlies and domestic staff (who occupied the lower echelons on the hierarchy) to the nurse. Reddy's (2015) argument does bear some relation to contemporary nursing in India where the nurse is often subordinate to the doctor, as reflected on by the majority of the nurses in my study.

Florence Nightingale's influence from the mid-1860s onwards for the next 40 years saw the instalment of the first woman superintendents of nursing in India, a Miss Locke (Somjee, 1991). In addition, a Miss Foxley was posted to various parts of India to develop and improve the standards of care within military hospitals. They faced opposition from some quarters of the army who did not want female nurses. Male orderlies and ward servants took on the role of nurse in the past; Nightingale's proposals saw them replaced by female nurses (Wilkinson, 1958). The nursing sisters sent to India in 1870s by Nightingale set about taking in women to train as nurses and up-skilled some of the male orderlies, giving nursing a higher status than had previously been present in military hospitals. Military nursing in India continued to exclude Indian nationals throughout the First World War period. These nurses, and those that followed, had been through a rigorous interview process that focussed on their social class and character as good women (Nair & Healey, 2013). This was an important time for military nursing, as nurses were recognised as being essential to the military effort for the first time.

The general standard of health of the soldier improved under the new regime and this served to lend a certain amount of acceptability to the female nurses. The work was successful but was limited in scope due to the low numbers of nursing staff. During this period, little mention is made in nursing and Indian literature of any widespread developments in a nursing service for Indian nationals, and the development that did occur was sporadic. The general populace of India did not benefit from the development of nursing; this was reserved for the military and their dependents. The impact comes from the regulation of military and care practice that were later translated and applied to India nationals through the spread of missionary and further colonial nursing.

Further military development began to influence nursing care in India, albeit indirectly to start. The Queen Alexandra (QA) Imperial Military Nursing Service for India emerged from

the influence of military healthcare. This was created in 1902 (National Archives) by Royal Warrant from nurses who served in military and Indian station hospitals. Like Nightingale's nurses, there was much snobbery and class distinction between the QA nurses and Indian nurses, and also towards British nurses that were not from the upper middle-class as the QA nurses were. The QA nurses did not want to nurse Indian nationals, and felt this was the job of an Indian nurse or a British wife of a merchant or businessperson. This form of snobbery was a further contributory factor in the late development of nursing for the Indian national.

Healey (2013), an independent researcher based in London, carried out an exploration and critique of Indian nursing history, and supports the assertion that Florence Nightingale remains an influential figure in India and a role model of professional nursing (Healey 2013: 37). Other developments in Indian nursing by Indian nationals took place in isolated places with limited networks to spread the developments. Another hypothesis is that no strong Indian nurse leader emerged that was universally recognised across the vast country of India. The principals of the nursing colleges and schools I visited on a field trip to India in June 2010 for the purposes of this study spoke of how Nightingale had shaped modern nursing in India. They all held her in high esteem; in each of the schools or colleges of nursing I visited, there was a picture or print of Florence Nightingale somewhere within the premises. In one college principal's office (Sister Anne), I noted a large picture of Florence Nightingale on the wall behind her desk and commented on it. Sister Anne proclaimed Ms Nightingale to be the "founder of nursing, nursing developed from her and taking care of the old and the sick" (meaning Nightingale's development of nursing). Whilst I was in India, Florence Nightingale was hailed a heroine and the founder of Indian nursing by all the respondents, whether they were student nurses, tutors or principals of colleges and schools of nursing. Nightingale's ethos fit well with the Christian ideals of my nurse respondents from Kerala. The majority of the nurse in my study and other nurses I met are Christian, and comprise around 30% of nurses in India. The principals of the colleges and schools I visited are, in my opinion, innovators in their own right as they are nurse educators, but very few of them discussed their own influence on modern nursing.

My review of the data and literature on nursing in India showed that Nightingale had continued influence outside of Kerala. Minu[10], who trained at a Christian college in the Punjab, remembers Nightingale as a key figure in the development of nursing. Christian colleges of nursing are widespread across India, so it follows that Florence Nightingale's legacy continues through those Christian faith colleges that have readily embraced her as a figurehead for Indian nursing. Each of the nurses I studied had attended Christian colleges, whether they were Christian by faith or not. I surmise from this that this is also the legacy of both the missionary colleges that proliferated in Kerala in early 20th Century and the movement of these Christian nurses around India setting up new schools and colleges of nursing. These nursing institutes were slowly able to attract nurse trainees from outside the Christian faith. It is worth noting that nursing was less stigmatised amongst Christians; they did not experience the barrier to nursing that ritual purity could impose (Fuller, 1976). The act of caring for the sick and needy overrode stigma (Somjee, 1991).

There was more experience of nursing amongst Christian nurses in the early 20th Century, and they were well-placed to develop the profession across India. A report from the Nursing Survey of India from 1974 shows that the highest number of nurses working outside their state were from Kerala, which was well ahead of the other Indian states (CAHP, 1974). More recently, the Census of India (2011) showed that Tamil Nadu had the highest number of registered nurses (with 268,696), Karnataka second (with 245,002), Kerala third (with 173,464), and in the Punjab, there were 66,537 registered nurses. In term of registered nurses to population, Kerala was first with 5.192 nurses per 1000 population; in second was Karnataka, with 4.10 nurses per 1000 population. This, I surmise, indicates that the influence of Kerala nurses continued well after the initial increase in nurses in the colonial period. Considering the experience of the nurse and these figures, this may still be the case.

Formalising nursing in India - the continued colonial influence and missionary nursing

Another significant development in the training of Indian women as nurses comes from the influence of missionaries in the early 20th century; nursing remained under colonial influence through British rule (Wilkinson, 1958). After the First World War, Indian women were recruited into military nursing, but senior positions, such as those of ward sister and matron,

[10] Minu was 23 years old when I met her. She is a Jat Sikh from near Chandigarh in the Punjab, North India.

remained in the domain of UK-trained nurses. This continued for a number of years and, pre-1940, Indian nationals who trained as nurses, were often paid a piecemeal salary. This meant that they could not afford decent housing, and often even had to pay for their own training. The social prejudice levied on the female nurse saw it regarded as a lowly or inferior profession fit for widows, orphans, low class Christians, and Anglo-Indian women only (Healey, 2013). However, despite the negative connotations about nursing, it was a step towards independence for the nurse and the start of a career (Somjee, 1991).

The experience of missionary nurses is captured by Noordyk (1921), an American missionary nurse who went on to be the first superintendent of Scudder Memorial Hospital in Ranipet. Noordyk offers some insight into the training of nurses in India, the status of nursing and reflections on her early time nursing in India in the early 20th Century. She reflected that nursing was seen as a lowly profession, and that if girls studied post-school, then teaching was a preferable career to nursing as it was considered more honourable. While this is from Noordyk's perspective on what she observed, and was relayed to her by other superintendents and trainee nurses, it is nonetheless reflective of what was being written about nursing in this era. This links with the association of nursing with polluting factors (Somjee, 1991) and was one element that made it less respectable than teaching. Further to this was the poor condition of hospitals; these were often poorly maintained and the lack of investment in them served to heighten the poor status of nursing, as they were not seen as fit for use. Treatment regimens and equipment were also limited by the poor investment in the hospitals. Nursing leadership at the time was fragmented; there was no unified organisation or leader in the early 20th century. Without a strong voice or unified front, there was no one to champion the professionalism and importance of the role of the nurse to either the public or political arena (Healey, 2013).

Noordyk (1921) believed that training of nurses in India was an uphill struggle. She observed that nurse training was hard for Indian nurses since time off from duties was hard to achieve, and their movements were restricted by family expectations and hospital rules. (In Chapter Six, I look more closely at the restrictions placed on trainee and qualified nurses during and after their education). The primary restriction was that the trainee nurses she taught were not permitted to leave the hospital unless a family member accompanied them. The trainees were

also escorted to and from the hospital for their shifts, and they saw little of life outside the hospital. Noordyk (1921) saw this as a burden on the trainee nurse; she felt they did not need to be monitored at all times, even when they were not on duty. This increased the workload of the overseas nurses carrying out the training. The trainees, Noordyk reflected, exhibited poor communication strategies, as they were not used to conversing with people outside their family and their community circle. This made it difficult for some nurses to communicate with not only patients and their relatives, but also with other medical co-workers.

Noordyk (1921) was quite critical in her observations of training the Indian nurses. She indicated that a lot of patience was needed to teach patient care, and what she saw as appropriate bedside manners. She noted that much repetition was required, and likened the trainee nurses to children in their need for support. She appeared to have no sense of the difficulties of learning in English when it was not their primary language. Noordyk (1921) also pointed out that many more good Christian females were needed to sustain and develop nursing, and to help trainees resist the 'temptations' that the Indian nurses were exposed to. She stated that 'only Christianity will install the principles that will give them (trainee nurses) the backbone to withstand the temptations that beset them' (Noordyk, 1921: 228). What their temptations might be she does not elaborate on. Noordyk cited Florence Nightingale and God as role models for nurses from 'home who wish to come and educate in India and develop nurses' (1921: 229). The first schools of nursing were indeed developed by Christian organisations/ missionaries and they did begin to attract Christian women from higher classes who saw the work of a nurse as charitable, as one of duty, and as one that was interesting (Rajan & Percot, 2007).

In the early 20th Century, nursing in India began to be more widely formalised, following on from Nightingale and other British nurses' influence. It was proposed that the nurse, the patient, and the doctor work in harmony together with medicine (Raghavachari, 1990). Zwerner (1995) argues that how nursing developed in different parts of the world was dependent on what position women hold in a particular society and culture. Zwerner (1995) further suggested that nursing has developed at a faster pace where women have greater rights and more freedom in their social worlds. In Kerala, Southern India, the attitudes towards women working and studying away from the home became more liberal (Osella &

Osella, 2000). This was due to a mixture of need and acceptance of women working as nurses. The need arose from those whose families were in agriculture which saw the production of crops becoming financially less rewarding. Women began to contribute financially in order to meet the needs of high dowry payments. Working as a nurse became more acceptable to Christian women as it was a career with guaranteed employment and a steady income (Nair, 2013:44). However, the religious connotations associated with the motivation to nurse diminished: in the 1970s, the attractiveness of career prospects moved to the forefront of the discourse around nursing. Women could contribute to their dowries, and the government paid an allowance to nursing students which meant they did not impinge on the family finances (Nair, 2013: 45). International migration is a huge draw; nearly half the world's migrants are women, with the highest proportion of them in health-related roles (Healey, 2013). Southern India, in particular Kerala, is a prolific supplier of nurse migrants. Other states, such as the Punjab, where nine of the nurses in my study came from, are beginning to export more nurses, as Walton-Roberts et al (2017:1) have investigated.

Caste and class placed restrictions on Indian women becoming nurses as well as those restrictions levied by the colonial era and military system in India. No higher caste Hindu or Muslim women were permitted pre-20th Century to become nurses. To become a nurse in this era was to go against the norms and practices of high caste society. The apparent battle with caste sensibilities is largely based on the way nursing is enacted: that is, through contact with bodily fluids, touching male patients, and working with people from different castes. This objection to nursing as a profession was also present amongst lower caste women and those of Christian origin, as it was not a profession of choice (Healey, 2013). Healey (2013) argued that successive Indian governments failed to recognise the need for high quality nurses, and this lack of support for the profession served to reinforce the stigma attached to nursing (Healey, 2013). Further exploration and analysis on caste and nursing can be found in Chapter Five.

The sustained influence of Catholic and other Christian denomination missionaries in particular did help develop the interest of Christian women, and the development of nursing in general, in the early 20th Century (Somjee, 1991). This influence on nursing has continued through to the present day: many of the modern Schools and Colleges of Nursing are run by

Catholic orders of nuns or Christian missionaries. The number is approximately 250 in Kerala and 500 in Bangalore, of which the majority are Christian colleges, and several of my respondents from the Punjab trained at Christian colleges. Reviewing statistics on who runs colleges produced by the Indian Nursing Council (INC) revealed that private, faith, or charitable organisations proliferated between 1970 and 2005 (INC, 2005). Today, in south India, many of the schools and colleges of nursing are faith establishments or are run by charitable organisations, both of which are classed as private institutions. Three out of the four nursing colleges I visited in Kerala were run by Catholic orders of nuns, and one by a charitable organisation. These institutes were classed as private and therefore no financial assistance to attend these nursing colleges was offered, Students who attended Government Colleges received some financial assistance. All the nurses I worked with in my research studied in privately-run colleges that have a Christian ethos underpinning their practice and teaching. This may be due in part to some colleges actively encouraging their students to go overseas, as my respondents experienced. I discuss migration further in Chapter Four. In Kerala, if we look at General Nursing, there are 425 training places in Government-run institutions and 5,980 in private institutions (INC, 2017) which reflects the Kerala-based nurse's training experience.

In the early 20th Century, two societal influences did start to change the poor image and status of nursing: first, the development of professional nurse training; and secondly the growing desire of Christian women to want to give good care. This arose from the religious discourse of British nurses and missionaries promoting self-sacrifice, service, obedience, and nursing as a vocation. The spread of Nightingale's ideals for nursing was one which promoted nurses as women who were undertaking a noble profession that needed to preserve their purity and honour. The starched white uniform and caps worn by the nurses further promoted the image of the nurse as being pure in a Christian sense, and the representation of white as a demonstration of purity. This ideal of purity that the missionary and Nightingale nurses were trying to promote was in stark contrast to that of ritual purity as understood and experienced by Hindus, as discussed in Chapter One. This idealised image of nursing that had prevailed in the UK had seen an improvement of status of the profession. Nightingale believed the status of nursing in India could improve and was achievable in India. Senior British nurses practising in India noted that Indian women were needed to expand the nurse numbers across the country to cater for the growing population, and to improve the overall delivery of quality

care. This spurred an interest in nursing development and saw further growth of missionary healthcare (Wilkinson, 1958 & Somjee, 1991). Catholic missionaries emerged as a strong influencing factor on the development of nursing in Kerala, in particular. The period from 1910 to the present day saw a huge rise in missionary hospitals and a subsequent increase in the numbers of nurses and women who went through nurse training (Nelson & Rafferty, 2010). By the end of the Second World War, the majority of trained nurses in India were educated at Missionary Hospitals. This created a lack of diversity in nursing (by religious background), and was why most of the schools of nursing could be found in Southern India where the majority of Christians lived (Nair, 2012).

Despite the influence of the missionary nurses, there was still a lack of nurses overall, partly due to missionary (Mission) hospitals having limited financial resources and a limited pool of nurses that remained insufficient to cater to the population. Anglo-Indian nurses were still attracted to military nursing, and this trend continued up until the Second World War. This was the result of the nurses experiencing reasonable pay, good working conditions, and the high status of British nursing, following on from the reforms of the mid-19th century. British nurses were regarded as well-educated amongst the British and colonial elite across the British Empire. They were viewed as professional and disciplined, and were mainly drawn from the middle and upper classes, which also sustained the higher status afforded to them (Somjee, 1991 & Godden, 2010). In India, the dominant social groups (higher caste) still attached great stigma to nursing, despite the advent of education for nurses and its increasing professionalism (Healey, 2013). For the Hindu family, the negative ideas associated with nursing were often related to notions of ritual purity, which held people back from allowing female members to become nurses. The missionaries, therefore, turned to recruiting from orphanages, where women had little chance of a good career. This further contributed to the poor image of nursing. Many Christians still considered nursing degrading, but candidates did come forward mainly due to religious reasons and the wish to provide care for the sick and needy (Somjee, 1991).

Both colonial nursing and the missionaries were trying to impart Western ideals regarding nursing and medicine (Nelson & Rafferty, 2010); Noordyk's reflections (1921) are just one example. This gave little scope for the Indian nursing service to develop its own identity. In

spite of the negative image of nursing in India, the nursing professional in India did start to strengthen and develop. Nursing took on various forms of formalisation and development. An example of one such development has been recorded as far back as 1867, when doctors and nursing superintendents set up a three-year training programme for nurses. This programme, instituted at St Stephen's Hospital in Delhi, included written examinations and pay agreements, and was influenced by senior doctors with limited input from nurses (Wilkinson, 1958). Tuberculosis and leprosy specialist nurse roles were also developed (Somjee, 1991).

The overseas nurses postulated that a major hurdle to the development of nursing in India post-independence was the 'poor characteristics' of Indian nurses. This opinion arose from a poor and often limited understanding of Indian women and their own Western ideals as to how a woman should behave and act in the role of a nurse. Indian nurses were criticised for not having the capacity for self-reliance and a limited understanding of human characteristics and the psychosocial issues associated with nursing patients. The solution to this problem was essentially to redesign the personalities and characteristics of the women that entered the nursing profession. To achieve this, intensive training was instigated to manipulate the Indian nurses and nurse trainees into adopting more Western ideals (Walton-Roberts, 2012). This included how to dress, how to behave, and other aspects of maintaining ward hygiene and cleanliness. They did not take into account social behaviour and attitudes to health and illness of the Indian population. There was also an element of trying to impose Christian values on the nurses and patients. Some missionaries would offer training as a nurse in exchange for the student nurse converting to Christianity, as noted by Walton-Roberts (2012) in her exploration of the development of nursing. This created problems for the trainer and the trainees, which manifested from a poor understanding on the part of the trainer of the cultural context and social standing that nursing held in India at the time. This did not take place in all training programmes. Problems arose when nurses who had undertaken these programmes interacted with nurses who had developed through more Indian-centred training programmes. There was mismatch of ideas about how to nurse that could provide conflict in the workplace. There was an observable unwillingness on the part of foreign nurses to adapt to the needs of Indian nurses and, therefore, the Indian population (Walton-Roberts, 2012).

In 1911, the Nursing Council of the South India Medical Association formed. Missionary nurses have been credited with helping to develop and sustain the national Trained Nurses Association of India (TNAI) that was formed in 1908 (Balfour, 1923). In 1948 after Independence, the TNAI developed codes of practice for nursing in India. This meant that, nationally, all nurses in India had to register with this organisation and adhere to its rules and guidance (Wilkinson, 1958). This also gave a voice for nursing in India, as well as legitimacy through regulation and cohesion.

Following on from independence, international nurse leaders from overseas continued to travel to India to oversee the development of nursing in India. These nurses were often senior nurses acting in an advisory capacity, many of whom were backed by large American corporations (such as the Rockefeller Foundation) and other development agencies. The World Health Organisation (WHO) was also involved in the development of nursing in India in the late 1940s through until the mid-1960s (Walton-Roberts, 2012). Foreign nurses were expected to be able to develop and influence the professionalization of Indian nursing. At the time of independence, the number of nurses in India was insufficient to meet the needs of the population. This may be linked to the problem that healthcare for the population in India was limited and flawed in its delivery (Arnold, 1994). Nursing was paid very little attention to by the government at the time (Healey, 2010). However, an important contribution to the development of nursing was the recognition by the government of India that the healthcare system needed drastic overhaul and improvements (Arnold, 1994). The Bhore Report (1946) explored the development of a healthcare system in India, similar to that of the National Health Service (NHS) in Britain. Amongst the considerations of this report was support for the expansion of the number of trained specialist nurses to work in midwifery and public health through to the development of training auxiliary nurses. The report also proposed and supported university education of selected groups of nurses who would become nurse tutors and leaders of nursing in India (Jeffrey, 1996). The 1947 Nurses Act (which is still in use today) also contributed to the change in attitude by the government towards nursing. Pockets of growth of modern nursing had begun to appear. A government-run college of nursing was established in Delhi in 1946. The college was the first to offer a degree in nursing, and the aim was to attract ‘fine young women who would not enter it (nursing) otherwise’ (Craig, 1951: 238). This was at a time when obtaining a degree held strong interest across India and, in turn, was hoped to help improve the image and numbers of those attracted to nursing. Only

four students in the first group successfully finished the degree but the numbers of successful students slowly increased.

The making and meaning of contemporary nursing in India – an era of change

When discussing nursing, it is important to recognise that the term 'nurse' is difficult to define and classify. Somjee (1991) showed that women who did nurse in the early 20th century were Anglo-Indian, Christians, or Parsees, and all of a low social status. Sunjani Reddy, an American Studies scholar who wrote extensively on Indian nursing and migration of nurses to the US, used in-depth inteviews and archival material to make a number of observations regarding Indian nursing. One was that no respectable girl would nurse, as this entailed being in the public domain in the early 20th Century. She included an exploration of the history of Indian nursing and the influence of British and American nurses. A level of acceptability by different Hindu castes existed for women who worked as domestic staff for other castes, as this was considered 'womenswork' and did not step out of a women's role. Nursing crossed these boundaries, as it entailed women working in a visible profession, one in which they interacted with patients, families, and other health sector employees. When they are in the public domain, it may bring shame to their families, as they are working outside the sphere of women's work (Dube, 2001). Reddy (2015), in her review of nursing and from interviews conducted, formed an opinion that is mirrored in other literature, including Somjee's work (1991). Reddy (2015) noted that only families in financial hardship would permit their daughters to nurse. This heightened the association of nursing with 'dirty work' and reduced the marriageability of the nurse in the early 20th Century (Reddy 2015: 4). Reddy (2015) surmised that the association with 'dirty work' has shifted and this, as I show later on in Chapter Three, is the experience of the nurses in my study, for whom nursing is seen in a more favourable light in the current social climate of India. Reddy (2015) contended that Christian women were not subject to the segregation their gender brought, as they were more likely to operate outside caste restrictions. As Osella and Osella (2000) identified in their work, Christian women were often already working outside the home, whether in domestic work or, for example, for the family business, and this may be another factor in determining why they took up nursing (I explore the motivation to nurse in Chapter Three). These Christian women had already crossed a social boundary. It has been commented that, as the needs of society change, so do the requirements for nurses (Johnson, et al., 2014). This

can be reflected in the improved status of nursing in contemporary India and the need for a nursing workforce to support the large and ever-expanding population of that country.

Somjee (1991) highlighted the role of the nurse as the doctor's assistant, indicating the qualities they should possess. The doctor's assistant should have knowledge of drug preparation and administration. They should also be compassionate, be able to address the patient's nutritional needs, be able to cook curry well, and they should be able to assist with bathing and the patient's mobility. Training was given to these assistants to help the doctors and to assist the patient by caring for them throughout their treatment. Other qualities that the doctor's assistant should possess were that they were friendly, non-critical, physically strong, competent at the care of the sick, and obedient to the doctor (Leslie & Wujastyk, 1991).

The gender of the assistant pre-nineteenth century (19th Century) was determined by the gender of the patient. A male patient would have a male assistant to attend to them, and likewise a female patient would have a female assistant to care for them and work alongside the doctor (who was always male). There is no indication in the literature that the doctor treated male assistants differently or more favourably. It was more the case that the doctor would occupy the top end of the hierarchy and the assistant would be subordinate to him. The only significant and recognised separate female role caring for the sick would have been the female midwife, or Dai. The women's role in healthcare, with the exception of being an assistant, was largely to serve food and conduct other domestic tasks (Leslie & Wujastyk, 1991). Some of the qualities of the doctor's assistant remain relevant to contemporary nursing in India. From the recollections of the nurses in my study, they see themselves very much as the doctor's aid; it is the doctor who decides treatment and plans of care, which the nurse must then follow.

In the late 19th century and early part of the 20th century, UK nurses were likewise very much observed as the handmaids of the doctor; a role that has developed in line with specialist roles and responsibilities being given to the nurse, with many nurses enjoying a higher status and autonomous roles (Hughes, 2002). This was the case in my own nursing career, as a district nurse and nurse prescriber, managing a caseload of patients. As indicated, the role of the nurse in India, in many instances, remains very much one of working for the

doctor as his assistant, rather than as an autonomous practitioner (Zwerner, 1995). Nursing development in India has been overseen and shaped by the medical profession up to as recently as the early 1990s. According to the nurses, the medical professions still exert a level of control over nursing and what nurses do. This includes dictating what a nurse can do for the patients and changes in care plans, all of which a nurse in the UK would manage. Nursing may have higher status in contemporary India than it did in the past, but nurses still lack autonomy and control of their working lives and defer to medical personnel as they have throughout the historical development of nursing.

Exceptions do exist: Sonija, one of my interlocutors in the present study, was in her 20s when I met her, and she had been handpicked straight from nursing college to be part of a specialised neurology team, led by a consultant neurologist and a senior nurse. Decisions regarding patient care were made through collaboration between nurses and medical staff and, even as a junior nurse, she felt she had a level of autonomy that her college classmates did not. Sonija's experience of nursing in India is indicative of small areas of change in the role of the nurse, with greater autonomy and influence over the care of patients. This element of change, however, was not experienced by any of the other nurses in this study.

The issues above were noted by the central government in India and, in order to address the lack of autotomy and poor status of the profession experienced by Indian nurses, the Saronji Varadappan committee was established in 1991 (Walton-Roberts, 2011:181). The committee produced a report highlighted the shortage of nurses across India, the over-reliance on student nurse labour, inadequate resources in schools of nursing as well as unsatisfactory pay and conditions. The report also reinforced the view that doctors made the decisions regarding patient care and the poor status of nursing, generally. Nurses are still seen as the poor relation to the medical practitioners. This influenced and reinforced the poor image of nursing (Walton-Roberts, 2012) through the autonomy of the medical practitioners and their high status which reflected poorly on the nurse, who was very much as the bottom of the ladder in terms of healthcare. In a further move to address the problems with nursing, a working group was developed to deal with education and labour issues faced by nurses. This did herald the establishment of a PhD in nursing, along with a review of the nursing curriculum, but the success has been limited in terms of increasing the numbers of trained nurses. Only about

40% of the 900,000 nurses registered in India are working; the others are not practising (Sinha, 2007). Sinha (2007) further highlighted that, while India could train 100,000 nurses a year, upwards of 20% of the nurses will migrate each year. Nursing simply does not attract enough students, and this is despite efforts to address the shortage by lowering the entry criteria and requirements to accredit nursing courses (Walton-Roberts, 2012). These issues have had an impact on nurse numbers in India, as well as the nurse to patient ratio. The lure is that when a person becomes a nurse, there is the opportunity to travel, earn better pay, with better working conditions, but this is also where the problem lies: something needs to be done to attract more nurses to stay and not migrate to ensure good patient care in India. I will highlight the labour issues further in Chapter Four. The table below illustrates the number of nurses in English-speaking countries. As can be seen, in comparison with other countries included in the study, the ratio of nurses to 10,000 patients is the lowest in India.

Country	Number of Nurses	N per 10,000 Population
Australia	201,000 (+6.9%)	96 (97)
Canada	350,000 (-1.8%)	101 (101)
India	**1,431,000 (+4.3%)**	**13 (13)**
New Zealand	44,000 (+33.3%)	108 (89)
Philippines	488,000 (+1.4%)	60 (61)
South Africa	184,000 (0%)	41 (41)
United Kingdom	621,000 (-16.1%)	103 (128)
United States of America	2,927,000 (+9.6%)	98 (94)
Total	**6,223,000 (+13.7%)**	

Table 1: World Health Statistics Report (WHO, 2011).

Somjee (1991:35) commented that a significant change in Indian nursing occurred in the 1970s and 1980s. This was perhaps when Indian nurses finally had the space to develop a nursing profession for Indian patients. This I have linked to, and coincided with, the lessening of post-independence influence of international nurses, which began to dwindle from the mid-1960s onwards, thus allowing Indian nurses to influence the profession. Indian nurses were now the senior nurses and tutors at the nursing colleges. There was also the beginning

of more acceptance of nursing as an acceptable profession for young women. This was not just amongst the Christian population, but other religious groups, too. Nursing in India continued to grow and develop through to the 1990s with the development of a diploma and expansion of degrees in nursing. These courses were affiliated to regulated universities.

The 1990s saw the next significant period in Indian nursing through the advent of economic liberalisation from 1991 onwards. Economic liberalisation was adopted by the India Government in 1991 following unsuccessful attempts by previous governments in the 1980s to do so (Chowdhury, 2011). The focus of such was to encourage overseas investment in India public and financial sector following to denationalisation of many such areas of the economy. The policy was aimed at closely aligning with global capitalist economies. Liberalisation was also viewed by the Government as a means to lessen poverty and promote social and economic progress (Chowdhury, 2011). Liberalisation has certainly proved very positive for the middle classes, in particular, the ‘new middle class' whose position in society has been elevated through this economic policy. They have become the consumer of goods that have been made possible by being employed in areas of growth such as the IT industry. Reforms were introduced by the government, which enabled trade and free movement of goods and services. This made it easier for nurses to seek employment overseas with new and established links of migration being developed and supported by the government (Ganguly-Scrase & Scrase, 2009).The nurses have benefitted as well from liberalisation they have become consumers of the possibility of working and studying overseas through closer ties and links UK employers and HEI's through agencies such as NRcol (the agency most of the nurses used). Liberalisation has been favorable for such groups as the nurses and helps affirm their middle-class status which is a focus through this thesis.

Through the 1990s, the country opened its borders to commercial opportunities and India began to enter the global markets. Areas such as rural infrastructure received some funding from trade and foreign investment (Ganguly-Scrase & Scrase, 2009). The healthcare sector saw an increase in investment with specialised and technologically world-leading hospitals developing in major cities such as Mumbai and Delhi. Running adjacent to liberalisation was a more visible support for nursing from central government. As noted above, in 1990, the Sarojini Varadappa Committee was established to explore and examine nursing across India.

The committee highlighted difficulties and problems hindering the growth of the profession. These include insufficient nurse numbers, the overreliance on student nurses to bolster the nursing numbers, and poor pay and conditions. It was reported that schools of nursing were under-resourced. The lack of autonomy and lack of respect from the medical profession were identified as continued hindrances to the profession (Walton-Roberts, 2012). During the initial period following liberalisation, a change in India's attitudes towards nursing began to be noticed by commentators on Indian nursing[11], which continues today. This was partly due to it becoming more acceptable for women to work outside the home particularly those from the middle classes. This was particularly true of the new urban middle classes as shown by Donner (2011), accompanied by the increase in post-school education of young women. The two incomes generated by the husband and wife and immediate family would help educate children and provide greater financial security; this discussion is taken further in Chapter Five.

The factors above helped diminish some of the social stigma of nursing in contemporary India. This period also saw an increase in nurse migration, particularly from Kerala (Walton-Roberts, 2012). As I observed from my initial fieldwork and interviews, many saw nursing as a way to secure financial security. It made good sense to pursue nursing, as it was a demanded profession in India and overseas. In Kerala, nursing is seen as an 'export commodity' (Wilson, 2011:146), and several of my respondents noted that every family has at least a nurse or two in their ranks. The key destinations for nurses began with the Gulf States and spread to the UK, US, and Australia. Nursing status in India has improved since the 1990s; many families prefer their daughters to become nurses. Nurses make good marriage prospects with the associated financial rewards and international travel (Walton-Roberts, 2012). One student at Carmel College told me that her mother was a nurse and so was her sister and nursing was 'always seen as a good job'. When I asked why, the groups of students I was talking to emphasised the point that their parents thought nursing was a good career path. It would offer 'a good job and status and security' – that is, financial security. The respondents at this college were all young, 18 or 19 years old, and all felt nursing had a good level of status. During an interview with the principal of a college of nursing, in response to a question on the motivation to nurse in India, Sister Catherine cited 'money' as a

[11] Nair, 2012; Wilson, 2011; Walton-Roberts, 2012

primary issue and ‘service’ (to others) as a secondary consideration. Sister Catherine supported the view that economic liberalisation had had a positive effect on nursing.

Figure 4: Me and Sister Catherine at the end of my visit with students and staff.

A discussion with another principal of a school of nursing, Sister Anne, revealed that, in the 1990s, the number of schools and colleges of nursing drastically increased. She attributed this to the increasing demand for diplomas in nursing. They were cheaper, and meant that more students could afford to train as a nurse. The figures from the Indian Nurses Council (INC, 2016) list 4,248 nursing colleges across India in 2012, 345 of which are in Kerala, and 287 in the Punjab where my informants are also drawn from. The figures were much lower in 2004. The total number of nursing colleges then was 871, with 81 in Kerala, and 56 in the Punjab. Salaries for nurses in India did not increase with the expansion of nurse training institutes, but

it reflected what Sister Anne described as the need ‘to train to become a nurse before they can go abroad to earn the salaries’.

Sister Anne also noted that the number of men wanting to train as a nurse had increased, and she thought this was due to the travel prospects and earning potential abroad. According to Rajiv Ghandi University of Health and Sciences, Bangalore, in 2007-2008, there were 97 male student nurses registered, compared to 276 female students. By 2011, the numbers had increased to 2454 male students and 5270 female. Further evidence of the increased number of male nurses was recorded at Maharashtra Nursing Council, where the number of male nurses rose from 597 in 2013 to 1038 in 2015 (no comparison given for female nurses has been given). The increase in the number of male nurses could also possibly contribute to the reduced levels of stigma in nursing. It is an attractive profession for men because nursing can be lucrative, and working overseas adds social as well as economic value to the profession. The gains of working abroad include social and financial capital, as well as sending money home to the family by way of remittances (I discuss this further in Chapters Three and Four). The issue of migration features strongly in the narratives of the nurses I worked with: both the male and female nurses in the UK, as well as the principals and student nurses. The mid-1970s saw the beginnings of sustained migration of nurses to the Gulf States to take up new opportunities in nursing (Percot & Rajan, 2007). The next generation of nurses saw career potential through migration to the West, with the UK becoming a prominent destination. The West offered exciting and lucrative opportunities for young nurses, ones in which family played an important part in the decision to migrate. Migration is discussed in relation to career and personal life strategies in Chapters Three and Four.

Conclusion

Reflecting on the history of India’s nursing profession is important to highlight how contemporary nursing in India has developed from one of poor status to a more acceptable profession for young middle-class women and men. In tracing the particular historical development of nursing in India, I have shown in this chapter why the profession is envisaged in different ways to those prevalent in, for example, Western Europe. While in the latter locations nursing developed around a notion of ‘care’–with which came a certain kind of

moral respectability—in India the role came to be associated more with stigma and risk of moral pollution. However, through colonial and missionary interventions in nursing in the late 19th and early 20th centuries, an alternative, more positive view was constructed through which nurses themselves and, over time, the general public could come to view the profession. The influence of overseas nurses levied on Indian nurses saw a level of hierarchy that still prevails in modern India, and seen through the division of labour, where the nurse remains subordinate to the doctor. In contemporary India, two views of nursing prevail. One shows that there remains a stigma associated with a profession that drew recruits from women on the margins of society and which dealt with bodily pollution. At the same time, nursing could also be imagined as a modern, professional role associated with high moral values. The improvement in nursing cannot be seen in isolation as I have shown. Improved status is linked to being middle class, and migration, which lends nursing a level of acceptance from not just Christians but higher caste Hindus. Migration has proved a strong draw to pull young Indians and their families to enroll in nursing courses. Despite this, an ambivalence about nursing in India still exists in some quarters, rooted in Hindu and colonial histories, and continues to influence how the profession is seen and experienced in the present, as I will explore in subsequent chapters.

Chapter Three – Why Nursing?

'One goal of each family is at least one child must become a nurse. This increases their social and economic status and this is a good motivation for them to become a nurse. In Kerala, the motivation to become a nurse was strong: it leads to a good job and to good marriage prospects for the nurses. They become attractive to people because she [the nurse] has a possibility of going to work abroad' (Sister Catherine, Nursing College principal).

Introduction

If the notion of service was what drew Indian women of particular status into nursing during the colonial era – as I explored in the previous chapter – then, in this chapter, I argue that contemporary motivations to nurse are considerably more diverse. Here, I draw from interviews and informal conversations, both with the principals of nursing colleges I met in India and with nurse migrants I worked with in the UK, to identify what those motivations are. This is important in the general sense of telling us something about the globalised context within which Indian nurses now train and work, and also in the more specific sense of helping us to understand what nursing, as a profession, means in present-day India.

In the following chapter, I begin with the reflections of four nursing college principals I interviewed back in 2010, before setting out – in subsequent sections – the *particular* motivations my engagements with Indian nurses in the UK over the last eight years brought out. In short, these relate mainly to status, religious duty and service, familial duty, and economic considerations, although – as I also demonstrate – most nurses are motivated by a mixture of all of these, and there are notable differences across gender lines. Examining these motivations in relation to nursing also enhances our understanding of how ideas about gender, pollution, and duty and status, inform life in the contemporary Indian context more generally.

The majority of the nurses I worked with did not have a firm reason for choosing the UK as a place to migrate to and in which to study, the attraction for the nurses in immigrating to the UK was due to links through family already residing in the UK. London in particular was a draw, as it has a large Indian diaspora, and many of the nurses situated themselves within it. The employment agency that the nurses used had contacts and links with the UK and in

particular with London, which further directed the nurses to the UK. Recruitment to the US has increased every year since 2004, mainly from the Northern Indian States. Migration to the UK has increased each year, with nurses mainly from Cochin (in Kerala) and Bengaluru (in the adjoining southern state of Karnataka). This is reflected in where the majority of my respondents come from. Nurses from these states also migrate to the Gulf States, and to Australia/New Zealand (Garner et al., 2015).

Reflections from Principals of colleges of nursing in Kerala

This section explores the reflections of four nursing principals from colleges in Kerala that I spent time with. The benefits of becoming a nurse that they noted included economic benefits, opportunities to travel, and improved marriage prospects. These issues were also raised by the nurses, and there are similarities between their reflections, but in some cases, they are also at odds with opinions of the nurses. The principals' opinions are valuable as they are the ones who deliver and monitor student nurse training. More importantly, the principals help steer their students to the idea of migrating for the purposes of work and career enhancement. While the benefits may not at first glance appear unique to nursing, the consequences of migration are real and have a huge impact on the profession in India. Migration contributes to the ongoing issue of poor staff to patient ratio and the 'brain drain' of nursing talent form India (Hawkes, 2009).

To begin, I recount a meeting I had with the principal of Mission College of Nursing Kerala, Sister Mary, a nun who looked as if she was in her mid-50s. She had nursed in the Gulf States, and returned to India to take up a senior position. I attended a meeting arranged by the employment agency I liaised with as part of my role for my former employers (see Chapter One). The employment agency was linked with the college in order to recruit alumni to work overseas. We met in her office at the college, and discussed what attracted her students to nursing. This room was large with a prominent dark wood desk dominating the space. On the wall next to a bookcase was a large framed print of Florence Nightingale[12]. Sister Mary sat behind the desk and I sat opposite. She had quite a brusque manner and I found it easy to imagine myself as a naughty student brought in to discuss my behaviour. We toured the college building later that morning. This was a large building with wide verandas and, like

[12] The importance of Florence Nightingale, and her influence on the Indian nursing profession, is discussed in Chapter Two.

the other building I visited, it was in need of a lick of paint. Each of the classrooms had wooden study desks; there was a small library, practice rooms (for practising fundamental nursing skills) and a teachers' office/lounge. The gardens appeared well-maintained, despite the poor state of the college building.

This particular principal stated that there is 'no care here in student nurses; it has more to do [with] status, girls think about a better job but [have] no heart', referring to the motivation to nurse. As far as she was concerned, it was all about status and financial gain for current student nurses and not about serving the sick and infirm. This is largely true when it comes to the male nurses, but the female nurses claimed also to be driven by more altruistic ideals. In addition, it became clear that we were not only dealing with individual motivations, but those of wider family networks. I met with eight student nurses at Mission College, and they all expressed the view that they had been had pushed into nursing by their respective families (I will explore this in relation to my nurse respondents later in this chapter). How decisions are made to become a nurse are important, as they show that familial thinking and negotiations are involved in a person becoming a nurse. Future planning is shown by the family who are striving for stability and economic security; actually being a nurse is secondary to what nursing can offer the individual and the family. I questioned the principal on whether she thought economic reasons were what behind the parents' decisions to push their daughters into nursing. She agreed they were, along with the possibility of finding a good marriage match. One student I spoke with, for example, had wanted to study literature, but her family had said no, because nursing would enable her to work abroad. The head of the Carmel School of Nursing, Sister Catherine, also strongly believed that 'money' motivated the students to nurse, and that 'service' was only a secondary consideration. Sister Agnes, the Principal of the Samaritan College of Nursing, expressed similar thoughts. While the sisters bemoan their students' reasons for becoming nurses, they actively encourage their ex-students to take up opportunities overseas, and they see the benefits for both the nurse and their family in doing so. Nursing as a caring profession is associated with less altruistic values. However, their opinions conflict with my findings from the female nurses I interviewed themselves, all of whom claimed that service to others was their prime reason for becoming a nurse.

Somjee's (1991) comparative study of the involvement of women in health services in Asian societies (pre-economic liberalisation) noted similar findings to the thoughts of the principals

I interviewed. The older established generation of nurses felt the new young nurses lacked the 'human care' approach. The older nurses in Somjee's study believed the younger generation's motivation was centred on materialism, because these younger nurses would move from hospital to hospital to find better wages and conditions of employment with the aim of improving their economic status. The older nurses had ideals about nursing rooted in service that were inculcated in them when they had undergone training; this may explain why the principals feel nurses in contemporary India express a different set of values. The principals of the colleges would have been from the same generation as the nurses referred to by Somjee (1991); they viewed themselves and their generation of nursing as being driven by service, which they felt was lacking in the student they taught in the current era. The principals all seemed to be viewing their motivation to nurse as being purely service driven and as an ideal for nursing. What they failed to see is that nursing is still driven by service, as my respondents suggest.

Somjee's (1991) research revealed that the older generation of nurses felt that the new nurses were more interested in therapeutic intervention, such as antibiotic therapy, rather than interaction and displaying care to the patient. This hands-on/physical element of nursing had been considered polluting in the past, and removing or reducing contact has led to a corresponding reduction of some of the stigma associated with the work of a nurse. This is somewhat observed with my own respondents, as many expressed a desire to come to the UK because of the new technologies and advances in medical care available. There is something about advancing their practice that is attractive to the nurses; it implies modernity, superior practice, and a higher status profession. Many of the nurses in my study felt this was lacking in the hospitals in India. This is probably true for some hospitals, and there has been a lack of investment in many privately-run hospitals (Reddy, 2015), although India has numerous high-tech hospitals in larger cities such as Delhi. These generational differences are evident in the principals' narratives; they began their careers during a very different time. Nursing was viewed in a different light: one associated with ritual pollution and the accompanying poor status. Opportunities to work overseas began to develop, but this was not widespread. The principals' attachment to service is a way of legitimising their career choice in two ways: to mitigate against the poor status of nursing but also fulfilling the obligations of their faith and beliefs. The status of nursing in India is not driven by care delivery; today, opportunities for travel, overseas work, and overseas education form the backbone of contemporary nursing, which further highlights these generational differences.

Sister Catherine reflected that families would say 'my daughter is a nurse in the UK, in turn they would say to friends and family and friends that you had a son or daughter living and working abroad'. Sister Catherine highlighted, as did many other respondents, that a nurse is 'a demanded person in the marriage field, a nurse in the family who goes overseas is seen as a draw for potential suitors and marriage'. This applied to both male and female nurses, as indicated by the nurses' experiences, thus creating another attractive factor behind becoming a nurse.

Sister Catherine indicated that:

> …one goal of each family is at least one child must become a nurse. This increases their social and economic status and this is a good motivation for them to become a nurse. In Kerala the motivation to become a nurse was strong it leads to a good job and to good marriage prospects for the nurses as they become attractive to people because she [the nurse] has a possibility of going to work abroad.

Sister Agnes, Principal of Holy Name College, also reported similar factors influencing the decision to nurse to those already discussed. She reflected that nursing was not seen as a good choice for marriage prospects 15-20 years ago. However, she has observed changes in society over the same timeframe, including the greater acceptance of women working outside the family home, and a more positive attitude to the profession because of its prospects (migration and income). These meant that it had become very popular in terms of promoting a positive match in marriage; marrying a nurse offered greater prospects for travel overseas, and the potential to earn a good stable income outside India. The overriding opinion of the four principals of the nursing colleges that I interviewed was that families push their children to become nurses. The discussion above leads into the next section, where the improvement in nursing image is explored further from the nurse's view point. Nursing has changed in the way it is delivered, and this has coincided with the improved status.

Nursing image, gender roles and status rewards

As I have indicated in Chapter Two, the image and status of nursing has been gradually changing in India, in part because of actual changes in the ways nursing is done: the potentially polluting management of bodily fluids has moved increasingly over to the realm of orderlies or unqualified auxiliary nurses (Van Dongen & Elema, 2001; Nair & Healey,

2006). This has created opportunities for young men and women to enter a profession that can offer job security and a steady income. Seeing nursing in India in this context shows how it has developed and changed, giving the profession a salient and prominent position in the employment field for career aspirations. The rise in popularity of nursing as a profession for both genders has been accompanied by a reimagining of gender roles; this reimagining is unique to nursing. We see men entering a female-dominated world of work, something that is unusual in India, where it is more commonly the other way round. Fuller & Narasimhan (2007), for example, showed that amongst software workers in Chennai, around 25% were women which has had a significant influence on their social development as part of the middle classes. These young women have reaped the rewards of an ever-expanding industry, and have been afforded many more advantages than their mothers received, such as higher education and career development. In this section, I will first discuss the rise in the status of nursing from the viewpoint of the nurses, and then consider gender roles within nursing. This provides a picture of how contemporary nurses themselves view the nursing profession: what is to be gained by being a nurse; how this impacts on the social status of the nurses and their families; and how the nurses view the world and where nursing fits in with this.

All initial interviews with the nurses in my study were undertaken in the UK, the exception being Jey and Minu, with whom I spent time in India prior to and after their weddings. I will begin with 22-year old Ranjit, an unmarried, female Hindu nurse from the Punjab, and her view of nursing and its changing status. Ranjit's parents were initially sceptical about her taking up nursing because of the poor image of nursing in the Punjab where she is from:

> Up to ten years ago, [the general public] felt not good [about] the nursing profession. However, the times are changing; technological changes make people see nursing as a better profession. Everybody is doing study and putting their daughters in the nursing profession.

Ranjit felt that nursing is now 'good, and they know it is a respected field now, especially to educated people'. Ranjit believed 'educated people' could see past the stigma[13] and view nursing as a profession suitable for men as well as for women in a more positive light, one with financial and job security, thus reflecting the change in the image of nursing and acceptance of nursing and women working outside the home. This has led to less demarcation

[13] Stigma is discussed in Chapters One and Two; in this chapter, it is linked to the decision to become a nurse, and not the historical context.

between male and female roles within the family. What Ranjit eludes to is the rise in the technical element of nursing that ensure the nurse has less hands-on physical contact with the patient. The popularity of the nursing population has also served to increase the status of the profession, as Ranjit indicated that it is the wish of the family to have at least one nurse.

Preeti, a female nurse from the Punjab, and a classmate of Ranjit's, was also concerned about the image of nursing in India. 'There's not like respect for the profession in India, people don't think like they, they don't even, they don't want anybody going in the nursing profession, I don't know why'. She explained that, despite this general view, her parents were happy with her choosing nursing. Preeti reiterated Ranjit's belief: it was the level of education that influenced what people thought of nursing. 'It depends, like the educated people don't think [that nursing is a problem], the illiterate people think that nurses are not good, [that] the nursing profession is not good'. Ranjit expressed what many of the other nurses believed: that education signifies progress and breeds forward-thinking minds.

The parents of Manju[14], another of Ranjit's female classmates, are in agriculture, and she described her mother as a 'homemaker'. She talked about the image of nursing:

> Because people in my village are also Sikh, they like this profession [nursing]. However, Indian people not from my community, not Sikh, such as Hindus, or Christians and there are also other castes, they think that nursing profession is not good because the profession of nurses is not good in India. They look down upon the nurses, they think they do not have any degree, they do not study, and they have become nurses. In older times, the nursing profession was just training and they become nurses with no study. There was not too much hard study. Now they [nurses] study, they gain degrees; there are different levels of nursing. Different courses of nursing, the specialties are there, but they think that the nursing is the same as old profession and their thinking is, they think that nurses are not good... or something else like I cannot say.

Manju, Preeti, and Ranjit's views contrast with those of the nurses I worked with from Kerala, who believed that nursing had a more positive image. The difference in the perception of nursing between Kerala and Punjab is closely linked to the historical

[14] Manju was a classmate of Ranjit's from the Punjab. Like Ranjit, she was 22 and unmarried when I met her.

development of nursing. Kerala, as indicated in Chapter Two, has a long history of nursing, whereas the nursing profession in the Punjab is less developed. Views of the society are changing, but there is still more stigma attached to nursing in the Punjab than there is in Kerala (Healey, 2013; Somjee, 1991). The association between nursing and Christianity is somewhat removed from caste denigrations, and partially explains the beliefs of the nurses from Kerala. Osella and Osella (2000:41), through their research with Izhavas in Kerala, argued that both men and women could participate in professional work and still maintain status. They showed that low status work, in particular, was gendered when directed at women, and this would reflect less favourably on them and their families. Osella and Osella (2000) saw professional work, such as that of teacher or doctor, as being gender-neutral, hence the perceived higher status. The financial status and benefits of these professional roles negate the idea of low status. Unskilled jobs, such as labourer, confer less status and are reflected, in part, by limited financial benefits. If we regard nursing as a profession with skilled practitioners, as discussed by Manju and Preeti, the Osella and Osella's (2000) findings help justify the nurses' view of nursing. Pockets of low status being associated with nursing still exist, but as more and more of Indian society understands what nursing is and its benefits, this low status has mostly dissipated.

The question arose while talking to the male nurses about whether nursing is an acceptable profession for men, given that it is traditionally a female-dominated profession with various associations, such as one linked to motherhood. Luke[15], for example, initially felt nursing was not suitable for men, but he experienced peer-pressure from his classmates and contemporaries in and out of school which directed him to take up nursing. 'My friends were also forcing me to go for this course and then we...went for a course in West Bengal. At that time I felt it is so difficult [going to study nursing] that I did not do well'. Luke was worried about men being nurses and the image of a man being a nurse. He felt that female patients would refuse care from a man. **'**I think people will like [to have] ladies' care. Because, ladies are normally nurses.' Luke became a mental health nurse, as did many of his male peers. He felt that it was more acceptable for men as dealing with mental health patients was seen as not suitable for women, since mental health nursing work could be physically demanding and the patients potentially volatile and violent. In Luke's opinion, this meant that mental health nursing lent itself more to masculine attributes of strength and courage.

[15] Luke was 24 when I met him. He came from Kerala, and is a Syrian Catholic.

I spoke with Luke, Jey, and their housemates further about why it is now deemed acceptable for men to become nurses in ways it had not in the past. As always, Jey was the main spokesperson for the group, but the rest of 'the boys' agreed with his comments. He stated that it had become acceptable for boys (as they described themselves) to take up nursing in the early 1990s in line with economic liberalisation and globalisation in India (see Chapter Four for an explanation of liberalisation). Nursing is considered a good profession in Kerala, according to Luke, Jey, and the other male nurses from the region. They rationalised this because people in Kerala were, they said, more open and educated than in other parts of India and therefore respected nursing. This was a sentiment was echoed by the female nurses from Kerala and by some of the nurses from the Punjab, such has Ranjit and Manju.

The principals of the nursing colleges estimated that about 25% of students in nursing colleges were, or had been, male. Prasheri (2012), reporting in the *Times of India* that male nursing numbers had increased, noted that Rajiv Ghandi University of Health Sciences (Karnataka, India) enrolled 97 men and 276 women on their undergraduate nursing programme in 2007-2008 and this number increased to 2,454 men and 5,279 women in the 2010-2011 intake. However, the increase in the numbers of male nurses has now started to subside, according both to Jey and the principals of the colleges that I met. Their reason for this is that nursing is not in vogue anymore. This is due to general degrees in electrical engineering and computer engineering becoming more popular, largely because they now attract higher salaries in India. Up to the time that Jey and the other male nurses trained, the potential to earn a good salary as a nurse tutor in India or a nurse abroad was a huge driving force for men to join the profession, in which they could earn more than they could by being an engineer. According to Jey, there 'was a boom then, now people are thinking why come to the UK to earn the same money that they can as a computer/electrical engineer in India, the cost of living is much higher in the UK too'. He also questioned why one would come to the UK now if you could not get a Post Study Work visa (PSW). This allowed the nurses to stay in the UK, work for two years, and then apply for leave to remain if they met the requirements for this. The majority of the successful nurses did do just that. Without the PSW, it made the prospect of travel to the UK more costly and less appealing. I discussed with Jey the popularity of nursing; in his opinion, Indian nationals:

> Are good at being adaptable [a practical approach to career prospects] to different situations when there was a boom in nursing or one in engineering men are attracted

> to whichever one is booming (at the time) and which one will give them a better income or job security.

In my discussions with Jey, he felt nursing became fashionable for a time because it was easier to get into than engineering; there were lower fees, and nursing was perceived to have greater rewards. Jey completed a physics degree before going into nursing. His first degree was chosen by his parents, which he was happy to undertake. Once he finished the physics degree, he wanted a more career-orientated profession and qualifications. His parents had both retired. His father was a head teacher in a high school, and his mother was also a teacher. Jey reflected that, because of their high social standing and status within their family and village, they pushed him to do a general and what was deemed at the time, a more respected degree, which is what he considers a physics degree to be. They had a high status and respect within the village. Jey finished his physics degree in 2004, spent a year at home not working, and initially thought about doing a postgraduate course in hospital administration. Jey then realised that the demand for nurses was quite high and the demand for nurses from aboard was even higher, and this in turn would improve his marriage prospects and his social status. Initially, his family were sceptical of his transition into nursing. They thought nursing was not a suitable job for a member of the family due to their high social status. Jey's parents believed nursing was a difficult job and, as they came from a family of teachers, they wished Jey to follow suit. Jey's aunt by marriage was a nurse; she is married to Jey's paternal uncle, and this was seen as a step up for her, as she was from what they defined as a low-class family. The opinion of nursing by Jey's generation differs from that of his parents, and he had different expectations of his career. He saw the benefits of nursing that his parents had yet to realise. However, they did allow his sister to go into nursing because his parents thought it was a good job for women. Jey, who was 28 when we first met, talked about the cultural expectations of having to stay in India and look after his parents. I visited him and his housemates at their shared house in Southall. At the time, his father was 74 and his mother was 64. For Jey, his choice to become a nurse was due to his wanting to forge a good career path, in order to enable him to look after his parents financially and in a caring sense in the future. Being male, Jey reasoned he was able to make the career change and choose which path he wished to take. He wanted to make his own choices about his career even if it went against his parents' wishes. Jey was the most singular minded of the nurses that I interviewed. However, he too felt a keen sense of loyalty to his parents and saw a career in nursing as a way of being able to support his parents in the future

through the financial rewards of nursing and the care skills he would develop. When I met his parents in Kerala for Jey's wedding, they were very proud of him and his career choice. This was expressed to me by his parents. Jey translated, as they spoke very little English; their main language was Malayalam.

A child living, working, and studying abroad has a positive impact on the family and the individual's status. There was prestige at stake if the family had a child living and working abroad. The male nurses view being a nurse as one of the easiest ways to do this, as the entry criteria are lower than for other courses; nursing was therefore more accessible to them. The lure of migration was a key driver to take up nursing, and the concept of migration in order to nurse is an established trend. The male nurses viewed nursing as more marketable because of the global shortage of nurses (Senior, 2010), plus nursing has greater transferable skills specific to nursing that would enable them to work in any part of the world.

There is a certain stigma associated with nursing because it brings its practitioners into contact with ritual pollution. This is at odds with the impact the income has had on the positive status of nurses. This is a consequence of the belief of the Kerala nurses that nursing has a positive status, and in Kerala, nursing is regarded more highly than it is in other states. The opportunities nursing offers has had a positive impact on the the social standing of the nurse's family, class being more associated with income, education and wealth, and caste with purity and status. The nurses I worked with (for the most part) position themselves in relation to class rather than caste (although the two are of course interrelated), hence why they feel the status of the profession is gaining strength.

Gender

In the previous section, I showed that the nurse's view of the profession was that it was ungendered: women and men equally carry out their nursing roles with positive effect on themselves and their families. There was a slight differences in opinion between the nurses from the Punjab and Kerala, but I gained no sense from any of the nurses, bar Luke, that nursing was purely a feminine pursuit. This resonates well with Osella and Osella's (2000) work in Kerala, where nursing is now seen as a professional job where the work is not purely associated with gender. This view of nursing, however, contrasts strongly with Busby's (2000) exploration of gendered work in Kerala, where the families of Catholic fishermen continue to show clear distinctions between gender roles within a community. Busby (2000)

proposed that a wife and husband were one unit with clearly identified roles that they both fulfilled. The man was the fisherman and went out to work; the women stayed at home and raised the children, but were tasked with selling the fish in the market, which was deemed the female domain. An exception to this might be if the wife were ill; men could be seen helping with the household chores.

At first glance, a nurse, whether male or female, has the same role; it is essentially to care for the sick. This would be the same situation for nurse couples. There is limited demarcation between their roles, as opposed to the strong demarcations between male and female roles identified by Busby (2000). What we see, however, are clear differences as noted through the male nurses' narratives who sought different rewards from nursing as compared to their female counterparts. These nurses show that different aspirations around nursing can be gendered. The male nurse's career aspirations for the most part involved wanting to be in charge, to be tutors, the educators of the future nurses. They wanted to be dominant in the nursing profession. This sets the male nurses apart from the female nurses, whom they felt would remain ward-based nurses. In Busby's (2000: 203) work she showed that the identity of her male respondents depended on their role and links with the seam and this gave them their fisherman identity. Each of the nurses at first glance is a nurse and this forms their identity in society. On closer inspection the differences between male and female nurses arise because the female nurses take on a caring role and this is how they define themselves in the profession. In contrast the male nurses strive to set themselves apart from the feminine side through their career aspirations described above. What the male nurses indicate and enact in their nursing aspirations is to be the breadwinner for their families thus maintaining a level of masculinity and fulfilling what was expected of them.

I gained the sense that to discuss money was not acceptable amongst the female nurses I worked with, as opposed to the male nurses who could reflect their masculinity and role as breadwinner in discussions about money. The male nurses offer different perspectives on nursing, one that personifies masculinity, stability through steady income, education, and the prestige of working and learning overseas. By doing this, they legitimise their career choice in what has traditionally been seen, in India as elsewhere, as a female arena. The male nurse's view represents how they believe society expects them to behave and this is the same for the female nurse. Both genders are conforming to an expectation of Indian society in the way they answered my questions and presented their views of nursing.

Masculinity in Kerala was investigated by Percot (2012). Her work revealed the popularity of men marrying nurses; this was at odds with traditional values of masculinity, ones where the man leads the family into the modern world, but marrying a nurse can see the nurse fulfilling this role. This is in stark contrast to Busby's work with married couples. She highlighted how men in Kerala were mocked in films, in the press, and in books for being dependant on the women to sustain the family. This is not the case with the male nurses in my study, but an element of this role-reversal is evident in the case of Minu and Madan (an electrical engineer), where Minu is the main breadwinner, as is Naya, Jey's wife. De Neve (2011) described the different ways of 'being' masculine, which the nurses certainly show. Despite Jey and Madan not being the breadwinners, they remained in charge of managing the family finances. These examples show how gender identities are altered or adapted in the UK to fit with a new social world. According to Sarwal (2015), who presented narratives of immigrant men from South Asia in Australia, he showed that men living in the diaspora can be marginalised as the relationship between gender changes. Men can find themselves marginalised through their qualifications or work experiences not being substantive enough to meet the changing demands of the Australian work arena and immigration rules. Madan, Minu's husband, certainly experienced this. He is a qualified mechanical engineer but works in retail as he is unable to secure work as an engineer due to differing requirements of the role in the UK. This experience in the diaspora is not one I associated with the male nurses I worked with, as they are in their UK under their own merits and qualifications.

For the male nurses, the pull into nursing and any association with low status and stigma is not an obstacle to them. Their views of nursing also help preserve the positive of image of nurses as seen through their eyes. Busby (2002) saw male and female roles being intertwined for women to do well. They needed their husbands to be a good fisherman so that she had fish to sell; the wife's status was dependant on her husband's in that sense. In nursing, we can see that female nurses have a level of status in their own right, and that men and their family seek to align with it, due to the nature and positive impact nursing could have on marriage prospects (as I discussed in detail in Chapter Five). Both Rennu and Suki remain unmarried and are able to support themselves financially by being nurses. This section has addressed issues related to status, gender, and the way nurses view the profession and how its reputation is improving. Acts of service are considered next. This was a prominent factor for why the female respondents became nurses. I have also highlighted the male nurses' views and scope for career development which is lacking in the anthropological literature.

Religion and doing service as motivations to nurse

In this section, I explore how religion and notions of service have influenced the female nurses in particular to want to be nurses, as well as doing service for the wider community. This notion of service is in stark contrast to how the male nurses (bar Somm) felt drove them to nursing. The male nurses were more motivated by economic factors and the status nursing could bestowed on them as a demanded profession one with good prospects. This comes as concurrent them through this thesis. Some of the student nurses at Mission College spoke of the motivation to nurse in terms such as 'God's love made me choose nursing, [it is] also more exciting than many other careers'. The quote is from Christian students studying at a Catholic college, and her classmates replicated her view. These trainee nurses were all from Christian families and continued to worship in church when they moved to the nursing hostel attached to the college. The students, who were all girls, also reported that this was a 'safe' career choice as it had job security and opportunities to expand and sustain long careers. 'God's love' implies a link with religion and nursing, something that has long been observed by commentators on nursing, in many parts of the world. In India, nursing and the medical profession have also been considered as integral to early charitable acts, such as helping a sick neighbour, a family member, or the member of their congregation (Lundmark, 2007). Some of the female nurses voiced honouring their religion as a motivational factor to nurse.

Lundmark (2007) considered the use of theology-based theories of nursing as a means to explain what motivates someone to become a nurse. He argued that 'God's love' enacts a value system that should underpin the act of nursing, as opposed to scientific advancements. This view poses a dichotomy with my own work and the reflections from the nurses. Many of the female nurses saw service, based on their religious values, and technological advances, as being in balance with their motivation to nurse. A Christian tradition emerged, with those pursuing nursing as a vocation or honouring God (Bradshaw, 1994), and a few of the nurses expressed this. As I explored in the previous chapter, Florence Nightingale, through her efforts of reform, had seen the emergence of nursing with a strong Christian ethos; one of subservience, sacrifice, and submission in the service of their patients and medical staff. Further to this, the image of nursing as a 'noble profession' began to emerge, emphasising pureness where nursing was viewed as a calling. These beliefs pervaded into mission nursing and became a prime focus behind nursing work in India (Healey, 2013: 36). The TNAI promoted these ideals of nursing, emphasising sacrifice through service. This idea of service,

as observed by Healey (2013), was supported by the strong affiliation that nurse leaders in India felt towards Florence Nightingale. These ideas of service resonate with Somjee's (1991) work and the reflections of the principals of the colleges that I met.

As I have shown, Christianity has had a profound effect on the development of nursing in India, and has a long association with the profession. The nurses expressed that the desire to become nurses was articulated through religious beliefs, but also to support society and honour their parents' wishes. The sense of duty and service in nursing were expressed by most of the female nurses. White (2002:286) explored the notion of nursing as a vocation, and proposed that nurses do in public what mothers do in private and made a personal choice to nurse which lends itself to being a vocational profession. White (2002) suggests that nursing can be viewed as the 'professionalization of the domestic.' The image of nursing as that of mother and feminised is problematic, considering my nurse respondents were of equal number for both male and females. This may account for the male nurses expressing different forms of motivation to become a nurse. There is also the implication that to be a good nurse one has to possess a certain level of morality and that nurses strive to do the best for their patients (White, 2002).

Contemporary nursing in India has seen a shift in this identity to one which includes Sikh, Hindu, and Muslim nurses of both sexes. Vocation linked to Christianity has waned, but service-based motives are still relevant to the female nurses. Suki, Ranjit, Preeti, Minu, and Melki all talk of giving 'good care'; Manju sees nursing as 'service to humanity', and Suki felt it is 'nice to care for sick people'. Each of these reflections highlight that nursing for the female nurses is vocational in nature. Motivational factors that influence vocation include the act of caring, the development of relationships with patients and care delivery (White, 2002:283). These mirror the motivational factors expressed by the female nurses. While White's review of vocation and nursing is a general analysis, it correlates with the work of Somjee (1991) and Healey's (2013) work on Indian nursing, and how it is viewed in Indian society. Nursing is still a role, job, or profession, but it moves beyond this. It gives nurses an identity, one which ascribes to certain values, norms and ideals that underpin nursing (White, 2002).

The female nurses did not use the word 'vocation' in our interviews, but they used similar language, which suggests that service was a large part of the rationale behind becoming a nurse. Preeti is one such example: she did not use the word vocation or duty, but she expressed a desire to care for people, which is another reason why she became a nurse. I would interpret this as a 'vocation'. The difficulty with using the word vocation is that it has a different meaning in the Indian context to the Western interpretation of the word. According to Somm[16] and Devorah, vocational work in India is assigned to someone who does a short course, such as hairdressing or becoming a mechanic, and leads to a job with security. In the UK, similar vocational training is undertaken through apprenticeship programmes. Somm and Devorah further explained that vocational training is much cheaper, and therefore those from lower classes and with low incomes may be more likely to choose this form of education. Vocational training is a much quicker way to learn skills and develop a career, and thus be able to contribute to the family's finances. However, White (2002) sees vocation and nursing as a way of understanding the motivation to nurse.

Let me give some ethnographic examples of nurses who motives might be considered 'vocational'. First, Manju was motivated by service and her religious beliefs. She explained further, why she became a nurse:

> I became a nurse because I think it is a lovely profession, it is a service to humanity, and we know that the service of humanity is the service of God. Yes, the reason is that I was interested in this profession. In my religion (she is Sikh) we love to serve humanity because it supports our religion and our guru. Seiji is our Guru and we respect him. In addition, it is written that the guru and Seiji that we have to serve humanity, we have to share, and we have work with other people, we have to serve humanity. If we want to love God, then we have to serve humanity.

Manju, like many of the female nurses from the Punjab, was vocal about her religious motives. The Punjabi nurses expressed this desire to honour their religion through service to others. This demonstrated the link with nursing and religion.

[16] Somm and Devorah are a married couple from Kerala; both work as nurses in the UK. They are Pentecostal Christians. They are very committed to their church and spend much of their spare time with the congregation of their local church in the UK.

Melki[17] echoed some of Manju's thoughts:

> Nursing is good social work and to give a good nursing care to the patients, because in the end there is so many poor people, they have no knowledge about their diseases and about living standards. Nurses play important role to giving a good care to the patient.

An American news item published by a Lutheran Church, from a Missouri Synod, while anecdotal (Plummer-Krull, 2012), illustrated that vocational training linked to Christianity and service is still evident in India. This report highlighted 17 Indian nurses who undertook parish (community) nursing and theological training as part of an initiative by the church to address shortfalls in care in India and to spread the ministry of the church under the term 'vocation of mercy'. Somjee (1991) and Percot and Rajan (2007) noted that, in the early 19th century, many nurses were trained through churches in similar programmes to this, where they received their training, cared for the sick and, in turn, they spread the word of God. In Kerala, Christian nurses have dominated the profession for many years pre- and post-independence. This helped maintain the low status of nursing because Christians were perceived as low caste converts by Hindu society, when, in reality, many of the nurses, having come from long-established Christian families, were not converts, which the nurses were proud of. Jey and his housemates explained to me the history of Christianity in Kerala, which is notably different to that of other parts of India, as they understood it. St Thomas, an apostle of Jesus, was said to have come to Kerala after Christ's death in AD52 (Reddy, 2015) and 'brought' Christianity to the State. Throughout the 16th and 17th centuries, Roman Catholic missionaries settled in Kerala, and Christianity spread. However, it was not until the beginning of the 19th century that medical missions arrived and nursing began to develop (Reddy, 2015). Jey's understanding of Christianity and nursing is somewhat polarised: while nursing definitely developed and spread through the influence of Kerala nurses, other areas of Indian have long-established Christian roots. For example, Mosse (1994) discussed how parts of Tamil Nadu experienced conversion of Hindus by Syrian Christians in the late 17th century, as well as newer conversions through American missionaries (to other Christian denominations) in the 1940s. However, it still remains the case that Kerala took the lead in the development of nursing through the pre- and post-colonial era (Healey, 2013).

[17] Melki is a female Hindu nurse from the Punjab.

Service as a motivational factor is a prominent feature for the female nurses. Somm was a notable exception amongst the male nurses: he directly expressed a desire to serve the sick and needy. He started his training to be an Ayurvedic doctor, but disliked the Hindu doctrine that came with the training (he is a Pentecostal Christian), and opted to transfer to a nursing course instead. In his Ayurvedic training, the students were expected to wear traditional clothing, another aspect that Somm did not like, as he felt more comfortable in Western-style clothes. Somm had wanted to care and give service to the sick and had the aptitude to train as an Ayurvedic doctor, so nursing to him was not a step down but, he felt, a sensible choice and a way to continue to care for the needs of the sick in a way that was more aligned to his own beliefs and values. Once settled into their careers, religion and faith is something that many of the nurses I worked with—both male and female—believed sustained them. For many, especially the male nurses, the ideas of service and helping others were not directly articulated by them. However, faith was a motivation once they became a nurse and they wanted to care and serve their patients well by being good nurses. This is the case with my interviews and discussions with the male nurses. They are still nurses, but the language used to describe what motivated them to take up nursing is fundamentally different from that of the female nurses.

Notions of duty towards the family

This section explores how the female nurses decided on a career in nursing through a joint family discussion, in which a collective decision was made to become a nurse. This was regardless of whether the nurse had chosen the profession or their family had chosen for them. In the case of the latter, the nurse's motivation to nurse was to respect the family's wishes, even if they felt a little 'pushed'. The opportunities that nursing offers are linked with issues related to image and stigma which the family negotiate to form a new life strategy, where previously nursing was not an acceptable profession. For the female nurses, they wanted to respect their parents' influence on their lives and careers, and did not feel they needed to challenge their parents' decision, as they were doing the best for them and their wider family. The female nurses also articulated a sense of obligation to follow their parents' wishes, something that resonates with Van Wessel (2011) in her work with young people in Baroda, India. She identified feelings of obligation and obedience with her female respondents, namely, students at the local university. This came from a sense of honour towards their parents who helped them to grow and flourish. A similar sentiment was

expressed by most of the nurses I worked with. This was not a feature of the male nurses' motivations, who were pulled into nursing through other motivations, including economic ones, as discussed in the next section.

Suki, who is a Hindu from Delhi, and was 28 when I first met her, who to date remains unmarried, felt she was 'pushed' into nursing by her family. On my first meeting with her, we had lunch at the house where she rented a room. The house was owned by a Sri Lankan family, and she called her landlady 'aunty'. Suki (a classmate of Jinu and Preeti) summed up the reasons why she began to nurse and came to the UK. Suki has two sisters, both nurses, and, whilst growing up, she realised what nursing entailed and that it was an easy way to establish a career with prospects. She decided to come to the UK because she had wanted to experience a new culture and a new way of living. Suki is the only nurse to have openly expressed this desire to embrace a new culture. As I came to know Suki, it became clear to me that this motivation comes from a curiosity to embrace new experiences and the ways in which they influenced her life course. She felt 'a little bit changed' by her time in the UK. Even though Suki felt her sisters 'sort of pushed' her to enter nursing. Suki's reflections show that she wants recognition for doing good work and servicing the sick, which helps legitimise her role as a nurse.

Further reflections of the nurses showed similar patterns as Suki in their route into nursing. I met with Preeti, interviewed, and chatted with her at the shared house in London where she was living with a family and two of her classmates, Melki and Manju. They occupied one room in which they ate, slept, and relaxed, and Preeti had a room to herself. They had use of the kitchen and bathroom in the house as well. Preeti was the first one I interviewed. We also chatted as a group about nursing, their families, and life in the UK. We both sat on her bed in the room. Preeti had made a vegetable curry that she insisted I eat while we talked; Preeti said she would eat later. Preeti's[18] reasons as to why she became a nurse resonated with many of the female nurses, and offers similar insights into motivation to nurse.

Her views also reflect part of what the principals of the college observed. She came to the UK after her diploma in nursing to upgrade her education standard, and for the opportunity to

[18] Preeti studied a top-up degree. She was 26 at the time, and from the Punjab near Chandigarh. She is Hindu.

develop her financial prospects, by either working in the UK or moving back to India where degree nurses received a higher salary.

Preeti recalled:

> We [her and her family] know there is a very good scope of nursing and my elder sister was in the nursing profession and she motivates me to do the nursing and other people, and that is good. Now I am in London and I am upgrading my study and they [her parents] are very happy that I am in this profession and making a good...future. When I was in school, I want to become a doctor. However, I did not clear the test of doctor ship and this when I came to the nursing profession. Actually, my eldest sister is also a nurse and she always motivates me to the good...

She explained that although she was interested in the medical profession she had opted for nursing instead. 'So if I didn't take a seat as a doctor, then I take a nursing qualification.' Preeti's reason to come to the UK to study was that she was 'interested in doing studies, and during my job I thought that if I do only job, I will not gain the knowledge and the skills – so that I – I want to upgrade my study'. She had wanted to do this in India but her parents 'wanted me to do that, to go abroad and do good study and for like the Master'. Preeti's parents felt nursing and education of nurses received higher status in the UK. She planned to complete her BSc top-up, and then study for a Master's degree[19]. Preeti said that her parents had a strong influence over her, probably because she was unmarried, and, when asked if she must follow her parents' instructions, she said: 'Yes we have, I have to'. Manju (another housemate of Preeti and Melki's), like Preeti, had initially wanted to be a doctor, but this dream had not materialised. She explained that her parents did not have the money to invest in her training for be a doctor, but nurse training was more reasonable in price. As indicated, less money is invested in educating female children, and this is one reason why nursing is dominated by women (Percot, 2012: 75). Manju explained:

> Before adopting this profession [nursing] I also tried for exam, like, an entrance exam for a PMT, to become a doctor, but because of my family problem, I couldn't do this because of economic problems and financial problems to become a doctor because it is very, very expensive. My sisters were encouraging me to become a nurse.

[19] Preeti did, in fact, return home to India, as she did not achieve a high enough score in her IELTS test to enable her to undertake her adaptation course.

> However, I wanted to do BSc nursing, but the financial cost was too much to study at BSc degree level. The diploma was cheaper but I have still become a nurse.

Manju and Preeti are the only two female nurses who had an initial desire to become doctors. Being a doctor offered similar travel prospects as nursing but awarded the individual and their families much greater prestige and greater financial awards than nursing. Preeti did not gain the grades to enter medical training and, as Manju highlighted, her family could not afford the course fees. In the colonial and post-colonial era, doctors' power and influence increased; they became more even more respected and valued than nurses (Reddy, 2015). One of the reasons for this was that trainee doctors had access to high quality training institutes and became well-respected figures in society. Some of the status came from the investment into medical training institutes by politicians with their own and state finances who could gain political capital in favouring the medical profession this way. This was in contrast to the under-investment and lack of interest in the nursing service by policy makers, which also served to increase the power and dominance of doctors in healthcare (Reddy, 2015). Both Preeti and Manju came from the Punjab where several of the nurses still thought that nursing, while its status was improving, had a lower status in society. Becoming a doctor could have given their family greater prestige.

Preeti and most of her classmates were in their early 20s; they too felt their parents had levied considerable control over their lives. The nurses and their families displayed ways of doing where collectively as a family the decision was made that their daughters would become nurses. None of the female respondents resented their parents 'pushing' or guiding them into nursing, with the exception of Jinu. De Neve (2011: 79) explored the influence of family relations on career choice and development amongst middle class industrial families. One example cited is of a young man undecided on whether he would study abroad who, with the aid of an elder brother, made the decision to study in Edinburgh. This individual indicated a shared family decision in which it was decided he would return to India after his studies and join the family business. Like De Neve's (2011) example, these female nurses respected their parents' opinions and many felt that because they were indecisive about what to do after school, their parents guiding them into nursing was a positive step. Nursing helped them attain a secure career, as well as prospects for the future for them and their families.
Sonija, a Christian from Kerala, was heavily influenced by her mother to become a nurse, but not 'pushed' in the same way as Suki, and Manju. Sonija recalled:

> My mother, she was a nurse, and when I said I want to go for nursing, she was like, Look and try something else, there are lots of other careers,' but I really got inspired from my mother. She doesn't know that but like when we came back to India, [from the Middle East] so many people around us and all that and they used to come to her when they have any mild, like any pain or anything, they know that she's a nurse, so they would just come to the house. I was small then and I did not know it was a simple thing, but still it got into my head that I wanted to be a nurse. My mother was working as a nurse, so it was okay to choose nursing.

Sonija's mother, however, was initially opposed to her studying nursing, as she knew how demanding physically and mentally taxing nursing could be on the nurse:

> She is a nurse, the problem is that nurses have to stand for a long time and she has this arthritis and I still remember when she goes for duty, she goes wearing her shoes. When she comes back, she'll be having her shoes in her hand because her legs just won't fit into her shoes, her legs will be swollen after the long standing. So she did not want me to go through all that, it was painful. So she said 'Okay, but you've have to study something else after nursing, you have to go on, I don't want you to stop your studies just with nursing, BSc nurse, I don't want that.' So I said, even I want to study. I mean in this time if we don't study, the more we study even – after MSc I feel I'm not, still I feel I need to go more.

Sonija talked over her career choice and they agreed it was the right option for her; her mother felt that Sonija had the right personal qualities to be a nurse. This included a caring nature and the stamina required to be able to cope with a profession that could be both physically and mentally draining at times. One's personal motivation to become a nurse is not a new concept in nursing; it can be the looking after a sick relative that brings people to nursing (Reddy, 2015).

Family supporting the nurse to take up the profession has emerged as a theme, in nursing work for both male and female nurses. This is not unusual in middle-class families (Donner, 2011). Consequently, family support is crucial to the success of a young person in developing their professional aspirations. Familial association with nursing was also expressed by several of the female nurses, as part of how they were guided into nursing as a career with prospects and a future. Walton-Roberts (2012: 183) has termed this route into nursing the 'nurse

relative, nursing vocation', when a nurse joins the profession by following a family member, often a sibling, into the profession. This has been seen to be a very common phenomenon amongst Christians, but less so for other religions. Johnson et al. (2014: 737) have also identified this phenomenon, and highlighted the importance of nurse families in promoting the professional as a career option for their kin. Up to 75% of Christian nurses had a relative who was a nurse, compared with around 40% of Hindu nurses. This was due to the colonial influence on nursing which meant nursing became a career option in some Christian families, as my respondents demonstrated (Reddy, 2015). The draw into nursing, as I have observed, is becoming an element of motivation to nurse outside the Christian religion; both Minu, a Sikh (whose mother is a nurse) and Suki, a Hindu (who has two sisters who are nurses) and others demonstrate this. This section has explored duty and respecting parents' wishes as being more prominent in the female nurses' reflections of their path into nursing. The next section deals with economic factors which, while not discussed overtly by the female nurses themselves, was a factor in the choice of career by their families.

Economic motivation and better employment conditions

Economic gain and stability were primary concerns in my conversation with the male nurses. Most of my conversation with them revolved around being financially stable and providing for their families and their futures. This sets the male nurse apart from the female nurse as to why they believe they came into nursing. In my discussions with the male nurses, they show limited obligations to their parents, and highlight their own personal advancement through nursing. However, what they did indicate that by being a nurse they could not only benefit themselves but their children and own parents in the future. For women, it is the financial stability that nursing offers, and which attracts them to the field; this can be achieved through migration. In the 1970s and 1980s, opportunities for migration became more available. It is the subsequent generations of would-be nurses that have seen and taken greater advantage of the opportunities to migrate. However, Somjee (1991), reflecting on the historical context of nursing in India, noted that historically many women also came into nursing as a means of securing economic freedom from the early part of the 20th century. This was true of those who were widows or orphans, or had no other means of financial security, so economic gain is not a new concept in motivating one to become a nurse. This is a view point supported by Reddy (2015:4) who noted that only families in dire need of money would permit women to nurse. This added to further the stigma attached to the role as well as women who undertook

nursing, as that profession was seen to damage their menfolk's masculinity by assuming the role of breadwinner in some cases (Reddy, 2015:4).

Jinu was the only female nurse to explicitly highlight economic factors influencing her route into the profession. She demonstrates how family influence is a factor that relates to choice of career, but also the future and earning power of the nurse. Nursing would offer Jinu economic security when raising a family. Jinu[20], a friend and classmate of the nurses doing the BSc top-up degree (Manju and Preeti), felt very strongly that her parents had forced her into nursing. Her reflections contrast with the other female nurses who felt guided into the profession but did not feel pushed.

> I come from a small village near Cochin that is in India, and, you know, when I finished my Plus 2 that means 12th class, I told how to go for any professional studies [nursing]. Then my mother told me I had to go for nursing because, you know, at that time, it was difficult [financially]. Actually, our family was poor at the time. Therefore, they told that I just had to go for professional studies [nursing]. Therefore, I told it is better to get job and I told to go for nursing. In addition, how to make some money, just money as my mother's reason why I should be a nurse. Because my family also told that, you have to support our family. So but to go for, you know, nursing studies so that I can support my family.

Jinu reasoned why her parents 'pushed' (her word) her towards nursing: 'Because I know so many nurses are there in their family, they go abroad and make money at the time'. However, nursing held no interest for Jinu:

> I was not at all interested in that because like in Plus 2 I got 85% [final school examinations]. Therefore, I told my parents that I want to go for other studies, not nursing. Actually, they did not have enough money to send me for engineering studies. In addition, nursing compared to other studies, it is cheap. So they told – actually... *[Jinu becomes very emotional at this point]*. Actually, you know, in our place I think I was not interested at that time because I feel that I got this much marks

[20] Jinu is from Kerala; she is married with two children. Her family and husband remained in India while she studied.

> and on the other hand, in our place[21], they don't think nursing is an honourable profession. In our place somebody will say that, 'I don't want to marry a nurse' but now it's alright for me because I could support my family and now I've got a very good family and made a good marriage my husband supports me too much.

Jinu's initial view of nursing contrasts with the male nurses from Kerala who all believed nursing was a good profession. Financial matters are handled by male members of their families, as many of the female nurses reported that their husbands of the future would look after the family budget and so on. The women's role in a family does not, for the most part, involve dealing with money (Osella & Osella, 2000: 46). However, Busby (2000) found that the wives of fishermen managed the family finances, in contrast to Osella and Osella's (2000) work. This suggests that gender roles can be fluid and adapt to specific social settings. Many female nurses showed little interest in money *per se*, but knew that nursing did offer financial security, and that in the UK they were more likely to earn better salaries. Another reason why Preeti came to the UK was due to the poor pay and conditions experienced by nurses across India. She believed it would be sensible to stay and work in the UK after her course finished 'Because there are good facilities and there is good wages also'. The prospect of better wages and working conditions was important to Preeti. 'In India there is very much work hard… workload is high, but the pay is less'. She earned about 5000 rupees a month (approximately £50, or £600 per annum) in India. Newly qualified wages in the UK (which the nurses would start on once they have undertaken the adaptation course) is approximately £21,000 per annum.

Many of the nurses, male and female, worked in private faith-run hospitals in India, where the pay was less than government-run institutes. There are some large international hospitals in major cities across India, but none of the nurses, male or female, had sought work in them. Employment in private faith-run institutes, where most of them worked, was much easier to come by. In government hospitals, a policy of positive discrimination was applied, which offers a percentage of jobs to nurses from Scheduled Castes (Healey, 2013 & Thomas, 2006). Jey and his flatmates saw these policies to be giving a helping hand to the less educated and lower classes. Each of my respondents – Christian, Hindu, or Sikh – felt there was little or no chance

[21] By her 'place', Jinu means her village near Cochin in Kerala. She enjoys nursing and performs the job to the best of her abilities, despite her initial reluctance.

of promotion or career if they worked in government hospitals; this is based on their personal experiences and their interpretation of the reservation policy which showed some bias towards government employment policies. To obtain government jobs, connections are important: vacancies are located through networking and personal referrals (Thomas, 2006). Most of the nurses did not have these connections, with the exception of Minu whose father was a civil servant. The nurses were, by their own accounts, all middle or upper castes. Many chose to work in the private sector, but again, because the salaries are much lower, this became a motivational factor to seek work abroad or pursue education opportunities overseas. Manju recognised economic factors, such as pay disparities, that may explain why many Indian nurses move overseas:

> Because, that is because the system of India is changing now but hospitals and nursing homes are not giving good pay to the nurses, but the government is doing good pay [in Government sponsored hospitals]. However, it is hard to get a government job in India. Yes, in government hospital, they are more salaries, but in the private nursing – workload is more, but the salary is less.

Nurses that work in the private faith-based sector of healthcare are more inclined to migrate because of poor promotional prospects, pay, and conditions, which shows a strategy of future planning and expectations for their careers. Thomas (2006:280) identified that 78% of her respondents in the private sector intended to migrate, compared to 41% in the Government sector. The nurses, bar Suki[22], worked in the private sector and, for the male nurses, this was cited as a factor in their decision to migrate. Jey and his housemates were keen to transition into management roles that were better paid. They felt they stood a better chance of succeeding in these roles if they had an MSc degree from overseas because there was stiff competition for them. This would add more prestige to their qualification and help them stand out from the numerous applicants that went for senior roles. Some of the male nurses were keen to go into teaching for similar reasons. Jey and Abin felt that it was better for male nurses to be in management with better pay so they could be the main earner in the family when they married.

[22] Suki was a Hindu who worked in Delhi at a government hospital. She was a member of the BSc top-up degree cohort along with Jinu and classmates.

Aava was the only nurse I was aware of who sent money home during her course. Jey and his housemates told me they were not expected to send money while they were studying. She saved up from her wages as a Health Care Assistant[23] (HCA). Aava believed she had no choice as she felt her father made poor financial choices with money so she sent home cash to help support her sister and mother. She did not trust her father to do so. Remittance payments are long established in Kerala and a commonplace activity (Osella and Osella, 2000:132). Indeed, remittances have been a key factor in the economic prosperity of Kerala. Such payments are more commonly made by men, although none of the other nurses sent money home while studying and working as HCAs. This raises the issue of different expectations of male and female offspring. Families want the children to do well and earn a good income, hence they pushed them to go overseas. The male nurses once they completed their studies and were working; were expected to send money home to support their families.

The principals of two of the colleges of nursing felt positive discrimination and poor working conditions/pay were major factors in driving nurses abroad. It is not difficult to see why remuneration is a motivating factor; even with the higher cost of living in the UK, most of the nurses reported being in a much stronger financial position working in the UK. Preeti and the other nurses are displaying elements of life politics, as described by Giddens (1991), where they are shaping their own futures, seeking out ways to develop themselves and their careers through better working conditions, salaries and education. This is not just for personal gain but to ensure the status of her family and the family into which he or she marries. Economic gain from nursing is important to each of the nurses. For the female nurses, it centres on job security; for the male nurses, it is for status and prestige and the chance to prove themselves as the breadwinners of the family

Other considerations

There are two other factors that are worth noting as I conclude this chapter: one, the relative status of the nurse's social position due to being middle class; and two, the promising marriage prospects afforded to the nurse. Improved marriage prospects are an important motivational factor which I briefly highlight here, and take the argument further when discussing my experience at two weddings I attend in India (see Chapter Five). Both Reddy (2013) and Somjee (1991) identified this aspect of nursing in their own research, and how it made nursing an attractive profession to pursue. Other factors may be contributing to

[23] HCAs are unqualified members of health teams that support nurses with fundamental patient care.

improved marriage prospects, such as the more diverse demographic background of nurses. There are more men taking up the profession, greater numbers of middle class nurses, as well as members of religions other than Christianity taking up the profession (Walton-Roberts, 2012). The nurses themselves (male and female) recognised that they could make a good match in marriage if they were nurses. This was only briefly talked about by the nurses, but seemed a significant contributory factor in their parents' motivation for them to become nurses. At Jey and Minu's weddings, nursing was considered an attractive profession by their relatives because of the travel prospects, as opposed to caring for patients, the sick and the vulnerable. The status the family derived from having family members who were studying abroad was also a key factor in the drive to have a nurse or nurses in the family. The nurses and my other respondents also believed that nursing had become more attractive to higher social status people, i.e., the middle classes. Suki talked about the fact that becoming a nurse would improve her marriage prospects and increase her income. She was certain of this because she had seen both her sisters make good marriages. To date, Suki is 36 years old and unmarried. This is unusual in her community. I consider marriage and nurses, as well as middle classness, in detail in Chapter Five.

Conclusion

This chapter has explored the context of the decision-making process to become a nurse for both the male and female nurses, examining the differences between the genders. Nursing itself has clearly changed: there are different ways of performing nursing in contemporary India which have led in part to the reduction of stigma associated with nursing. This is a key factor behind all the nurses' reasons to nurse. Both the male and female nurses and their families have taken advantage of this improved status. Nursing is associated with much more positive prospects in terms of career, travel, and earning potential. This has attracted more men to the profession and led to more non-Christian nurses taking up the profession.

Through my ethnographic work, I have shown clear differences and contrasting views between the motivation to nurse and career aspirations of the male and female nurses. At first glance, nursing appears ungendered, as with other professional roles. However, both men and women show how gender can be fluid and adaptable within nursing. Nursing as service is dominant in the female nurses' narratives; it is a way to express the feminine which is linked

to motherhood and caring. In contrast, the male nurse is driven by economic and career development. The male nurses use these elements to express and support their masculinity and offer a different aspect of nursing that is not seen as much in the female nurse. The discussion with the nurses demonstrates how they fulfil they gender roles, but also offer insights as to how nursing can support changes in gender roles, such as the women becoming the main breadwinner and more financially secure.

Migration, as I go on to explore in the next chapter, both motivated those I worked with to become nurses in the first place, and also helps them – in different ways – to achieve the other motivations outlined in this chapter.

Chapter Four – Migration of nurses from India

'I choose the agency… because they advertise quite a lot about this programme through newspapers, and they were arranging the skype interview in my home town... Yes, they charged a lot from us... actually they were telling the [pre-departure] programme which they called the ASM is conducting by the University... and they were telling the fees as a whole bundle... they were cheat... (they cheated us)' (Jey reflecting on the agency he and the other nurses used to come to the UK and enrol in either the BSc top-up or the MSc in Nursing.)

Introduction

Nurses travel for work. It is a well-known fact within the nursing world that nurses' core skills in providing care are transferable to most parts of the world. Nurses migrate in search of new opportunities, better pay, and conditions (Healy, 2013 & Reddy, 2015). It is perhaps not a surprise, therefore, that Indian nurses migrate. This chapter discusses migration and the journey of the nurses I worked with to the UK, how they prepared to come to the UK, and their initial experience as migratory nurses. In Chapter Three, I examined the motivation to nurse, identifying that migration is a key element in the nurse's career choice for both the male and female nurses I worked with. How nurses migrate and what their initial experiences of the UK have barely been documented. Migration forms a key life strategy for Indian nurses and their families, helping to raise their social profile and gain prestige. The opportunity to migrate has also helped to elevate the position of the nursing profession in much of society in India. It has helped change public perception of nursing for the better, demonstrating all the options nursing can offer. The concept of migration is highlighted in anthropological writing about the new middle classes in India. This chapter extends the knowledge and examines the experience of the nurses as a unique group of young Indians: one in which both men and women are attracted to a profession that offers the access, not only to migrate, but to better education and social improvement opportunities. This chapter will explore the sacrifices that families make to give their children these opportunities to migrate for education and work.

This chapter also continues to explore the identity of the nurses I worked with, not just in terms of demographics but in relation to who they are as individuals, the journey they had to take to migrate to the UK, as well as who they are as a group of Indian nurses. Little is known

about the characteristics of a typical Indian nurse who comes to the UK, despite their making up a significant proportion of the overseas nursing work force. In this chapter, I examine the process of decision-making undertaken by the nurses and families in making the final decision to migrate. By doing this, I demonstrate some of the sacrifices families of nurses make in order to send their child overseas, and therefore the importance for the nurses of succeeding once in the UK. This is fundamental to helping them maintain their middle-class status, with claims such as 'My child is studying in the UK at a prestigious university' being commonplace among parents of nurses I encountered in the course of this study.

For the nurse, the experience of the process to enable them to migrate, good or bad, has an impact on how they settle into life in the UK. Osella & Osella (2000:45) and Nair (2012) have discussed the migration of nurses, but this is largely to the Gulf States or within India. My work thus offers a unique perspective on Indian nurses migrating to the UK. The nurses draw on their middle-class status by utilising the service of others in the form of employment agencies who secure the correct visa, university places, accommodation in the UK, and so on. This does leave the nurses vulnerable to exploitation, as young migrants, which they have experienced as they prepare to come to the UK, and when they first arrived. I will also highlight the initial experience of the nurses when they arrive in the UK, how this impacts on how they settle into life in the UK, and how they adapt to a new educational setting. Migration has a dual purpose: to improve the education of the nurses themselves, and to improve their status by adding to the cultural capital of the nurse and their families. This is cemented by working in the UK. For these middle-class nurses, education and study overseas are a driving force behind migration.

Migration and Indian nurses

The migration of nurses has dominated the discourse on contemporary nursing in India since the 1990s. During initial fieldwork in India in June 2010, I visited four schools/colleges of nursing in Kerala. Each one of the schools or colleges of nursing was a Christian faith-based institute; three were Latin Catholic and one was Presbyterian. Each of the principals of the colleges was female and they had all become nurses through what they described as a vocational calling; that is, to serve the sick and needy. All of the principals of the colleges and schools of nursing were well educated to at least a Master's degree or above. For the

most part, they had extensive experience of teaching and nursing in India and abroad. Recruitment of nurses who wish to migrate has, in recent years, focused on Delhi, Bangalore, and Cochin (Khadria, 2007), the latter being where most of my respondents were recruited. Nursing offers so many opportunities for young women, in particular, and it was my observation that the principals wanted their students to have the advantages of working abroad, financial security, and experience. The sustained 'brain drain' of good quality nurses from India has left the profession exposed to staff shortages that are not always able to keep up with demands of the role adequately to address the needs of the patient (Bach, 2007 & Hawkes et al., 2009). Table 1 shows the poor ratio of nurses to 10,000 population. While a deficit may exist in nursing numbers within India, some India migrants do return home to fill these vacancies after training or working overseas. Many of my respondents initially reported that they planned to work in the UK for about 10 years, then to return home to care for family members, and so on. However, Minu, Sonija, Somm, Jey, and Devorah all wanted to settle in the UK permanently after working for two years in the country. The return of quality nurses to India cannot therefore be guaranteed.

Osella & Osella (2000:45) observed economic migration by nurses from Kerala, nurses who initially went to the Gulf States, and later to the UK and further afield. Migration of nurses in significant numbers started in the 1970s, with the Gulf States being a primary option (Percot & Rajan, 2007). Indeed, this was the period when the principals I spoke to migrated, and more individuals began joining the nursing profession specifically in order to travel. There were no shortages of nursing jobs in India at the time; however, pay and conditions in India were poor. During this time, more Hindu and Muslim nurses joined the profession (which had previously been dominated by Christians), partly for the opportunities of working abroad and the social benefits nursing offers. The UK, the US, and Australia have become more popular as destinations because of a range of factors, one being that they can buy homes and retire in these countries; this was not possible in the Gulf States. Many used nursing in the Gulf States as a stepping-stone to the UK or further afield. Several adaptation nurses I met had done this. In other instances, hospital managers have collaborated with nursing agencies by actively encouraging nurses to work abroad. It was through such collaboration that I was introduced to the principals of the colleges.

Donner & De Neve (2011) noted that Kerala in general has strong trade links with the Gulf States. This had driven the migration of skilled and unskilled workers from Kerala. Over two

million migrants to the Gulf States are from Kerala, and 16% of these are women (Percot & Rajan, 2007). Migration has improved the economy of Kerala, from where most of the migrant nurses originate (Willson, 2011). Percot & Rajan (2007) concluded in their study that 90% of nurses were from Kerala and that they were Christian. Percot is a French anthropologist, and Rajan is a professor for the Overseas Indian Affairs Unit in Thiruvananthapuram, Kerala. They explored migration data and conducted an anthropological study of the migration of nurses form Kerala. The largest proportion of nurses from Kerala were from the Kottayam district, with Ernakulum second. The majority of my respondents also came from these districts of Kerala. Walton-Roberts (2012) proposed that the migration of nurses is different from other female, non-skilled migrant jobs (women often migrate to take up domestic roles), as nurses have professional qualifications and credentials and tend to be employed by institutes and not private individuals. These conclusions were also drawn by Percot and Rajan (2007) and Larsen et al. (2005), who explored the notion that female migrants to the Gulf States were better educated than their male counterparts, who may take up labouring or unskilled work in construction. The nurses I worked with exemplify this, and indicate that this is still the trend. What this also highlights is the prominence of women as migrants and shows a shift in visibility of women working outside the home, and the ability of a nurse to make a good career with favourable financial rewards. International migration has enhanced the status of nurses; it has also attracted more men to the profession (Walton-Roberts, 2012). Although there are no published figures recording the number of male nurses in comparison to female nurses, half the nurses in my study are men. This supports my notion that men are drawn to nursing by the attraction of better salaries overseas, as discussed in Chapter Three.

The initial period of sustained nurse migration from India was for work purposes. The lines between work and study are now blurred, as one cannot be achieved without the other, but the nurses demonstrate that there are different strategies used to enter the employment market in healthcare delivery. Undertaking nurse education is therefore an attractive portal into the world of nursing in the UK. In the case of the nurses in this study, work was the primary goal, which was facilitated by undertaking programmes of study. To be able to work as a qualified nurse in the UK, the nurses had to complete the Overseas Nurse Programme (ONP) which requires three months of study and 3-6 months of assessed clinical practice. Both must be passed in order to be admitted to the NMC register of nurses. For the nurses doing the top- up degree and the MSc in Nursing, the ONP was an optional part of the course which not all

undertook. The nurses' visas allowed them to work while studying, but also after their coursework was completed. Most of the nurses did work as HCAs while they were studying which is part of the work world of nursing. Interestingly, many of the male nurses did not pursue the ONP, preferring to continue working as an HCA. They were either not willing or not motivated enough to study for the required IELTS score (7 in all categories). The male nurses, as discussed in Chapter Three were more motivated by financial gain; even though remuneration as an HCA is considerably less than as a qualified nurse in the UK, it is much higher than the salary of a nurse in India. As far as their families were concerned, they were working in the nursing field, as discussed later on. The female nurses were much more proactive on the whole, and this in part is due to motivation but also giving themselves a degree of career and financial freedom which higher earning potential working as a qualified nurse could offer them.

Thomas (2006: 279) collected data on migration from 448 nurses based in Delhi. Her findings are representative of the demographics of the group of nurses I worked with. According to Thomas (2006), 81% of the nurses in the age bracket 20-29 expressed a desire and intention to migrate, compared with 45% of the higher age group. In her study, 73% of the migrating nurses were Christians, compared with 48% who were Hindu nurses (Thomas, 2006). The majority of nurses surveyed who intended to migrate were Malayalam speakers (Keralan language), as were my respondents. Thomas (2006) concluded that, although migration is economically favourable, it does lead to a reduction in the number of nurses needed to resource healthcare in India due to the large numbers of nurses migrating. Health policy makers have not considered this fact, and this is something she felt would adversely affect the target of increasing the ratio of nurses to patients in India, as suggested by the WHO. The low ratio of nurses to patient's stands at 17.1 nurses per 10,000 population, compared with the 88 nurses needed per 10,000 population proposed as the ideal number by the WHO, if migration continues (WHO, 2015). The WHO figures are based on an ideal ratio of nurses to patients, which is not always attainable. Despite the deficit in nurses, only one of the principals for a college of nursing felt it was a shame that the 'good nurses' are the ones that go (abroad to work) but some do come back to India, as she had done herself, and bring back new skills and ideas to nursing.

Collectively, the nurses did not see their migration as problematic or detrimental to nursing in India. The nurses focussed on their own career development and saw migration as a positive

option, something they had all strived towards. The female nurses from the Punjab all considered nursing in the UK had a better image and that this would be transferred to them and their families. Some of the Punjabi nurses experienced negative reactions towards their chosen career. While the nurses were improving their own lives through migration, the profession in India is suffering as indicated by the numbers of nurse to patient ratio. Little consideration is given to nurses. This is not a surprise as migration is actively encouraged by nurse educators, including the principals that I met. The idea of migration is planted early in their training and continues through until graduation. Many worked for the required year before applying to migrate. The 'good' nurses are the high achievers and, together with family support, migration is made possible (financial and personal).

Remittance and migration

Economic benefits of migration are not the only factor in the decision to migrate, as shown in Chapter Three. However, migration has been responsible for improving the financial stability of Kerala, in particular. Remittances have contributed to this on a large scale (Wilson, 2011; Osella & Osella, 2000). The common feature of all migrants' work experience, skilled or unskilled, has been the flow of remittances back to Kerala (Osella & Osella, 2000). Reddy (2015) describes how female nurses often move or migrate to other states and beyond to seek economic stability. While nurses and doctors are prominent in the migration discourse, unskilled workers, such as labourers, domestics, and drivers, are also among those that migrate. It is not surprising, then, that nurses have migrated to take advantage of better wages and working conditions.

A large proportion of migrants from Kerala to the Gulf States have been Christians (Osella & Osella, 2000), and nurses, as noted previously, make up a significant proportion of migrants. Osella and Osella's work concentrated on young male migrants, while observers of nursing, such as Healey (2013) and Reddy (2015), focused on female nurses. My work takes a step further, and discusses the role of the male nurses in the migration phenomenon. There are some parallels that can be drawn, in terms of improved status and the greater wealth of the migrant, as well as better marriage prospects experienced by migrants, skilled and unskilled. The differences lie in the fact that my female nurse respondents were not expected to send remittance payments. This differed from their male counterparts. Female nurses such as Sonija, felt they were obliged to send payment, but it was not expected of them. Nursing in

India is characterised as a profession that is under-resourced, and there is little to no unemployment. Nursing offers a steady, regular income, albeit a limited one in terms of salary enhancement. The male nurses in Walton-Roberts's study (2012) sent remittances home, and some have helped support a sibling through education, while increasing the cash reserves of their families.

Recruitment of the nurses

There are established employment agents who assist nurses with migration and with finding education institutes in which to study or undertake the adaptation courses in the UK. As a representative of my former HEI employer, I liaised with one particular agency (NRcol) based in Ernakulum, Kerala. NRcol was responsible for advertising recruitment days where a colleague and I would interview candidates. Each of the nurses who undertook the BSc top-up and the MSc in Nursing enrolled with this agency. For successful nurses, they ran a month-long cultural awareness programme of classes to prepare the nurses for life and study in the UK. This included elements of academic work, such as Harvard Referencing, academic language, and information on life in the UK and how to budget for daily life such as utility bills, food, and sundries. I provided most of the information for this programme, but the agency billed the nurses for it. The agency also booked the nurses' flights to the UK, arranged visas, and found them accommodation near the university.

The purpose of my visits to NRcol was to interview and select nurses to undertake a top-up degree or an MSc in Nursing. The adaptation course was available for those who were eligible. Otherwise, the adaptation nurses I worked with used other agents or applied independently for the course. In this part of the discussion, I explore the experience and give a sense of the exploitation of nurses, in addition to how the recruitment process demonstrates aspects of being middle class. The nurse's route to migration is similar to many other migrants, but there is one main difference: many nurses to the UK migrate for education, as well as work. This co-dependency of education and work sets the nurses apart from unskilled workers.

The use of an agency is common practice for those wishing to migrate for education and work, and delegation of these sorts of task is an everyday occurrence. The agencies have

proliferated in number as trans-national migration has increased. The nurses are a captive audience for employment agencies as they have a strong drive to work overseas. I asked Jey and his housemates why they used the agency. Jey's reply echoes that of the others:

> I choose the agency… because they advertise quite a lot about this program through newspapers, and they were arranging the skype interview in my hometown... Yes, they charged a lot from us... actually they were telling the program (pre-departure programme) which they called the ASM is conducting by the University... and they were telling the fees as a whole bundle... they were cheat... [They cheated us]

It was not until I met with Jey and his housemates, about a year after their arrival in the UK, that we discussed the agency. Being in the UK with some distance from NRcol, gives another lens through which to make sense of the use of agents. It is not just about exploitation of the nurses: it is way of life for migratory Indians. I discovered that NRcol had charged the nurses for their services the same amount as the University fees for a full year of tuition. I questioned Jey and his housemates about what they thought about this. The answer was 'well this is what happens in India'; 'India is corrupt'; 'this is the Indian way'. 'It's the system'. I challenged them about their acceptance of being financially exploited and I asked what they meant by the 'Indian way.' Jey and his housemates further explained that the consensus was that it was an everyday occurrence in India to have someone do the work for them and that it was too much hassle to have to do the application process themselves and arrange travel and so on. As Jey stated, 'The agency did the work and it saves us time, there is too much paperwork and this is the price we must pay, it's the system, we have the money'. When Jey said 'we have the money', I took this to mean that the nurses did have the funds, and the access to disposable wealth was part of their being middle class. However, as I discovered with the more nurses I interviewed, this was not always the case. Around eight (out of 30) of the MSc nurse's families had taken out education loans (offered by many banks in India with government backing), to be paid back when the nurses had completed their courses. Aava was the only student who sent home money to India while still doing her course. Jasom's family had taken out an education loan but they did not expect him to pay it back even when he failed his course. When I met Jasom in India at Jey's wedding, he was planning to come back to the UK to do the adaptation course, which his parents were funding through another

loan. What the nurses describe is not exploitation in their eyes but a means to an end; an easy way to navigate the bureaucracy of the migration process. The rewards of a place on one of the courses was high; therefore, the nurses were willing to overlook or ignore the process which was seemingly exploitative.

An article in the UK *Nursing Times* (Harrison, 2004) highlighted the exploitation of Pakistani overseas adaptation nurses by recruitment agencies. The Pakistani Nurses Association was to make a concerted effort to stop the practice of agencies charging exorbitant fees for adaptation courses far beyond what the courses cost. Much of this stemmed from lack of knowledge of how the adaptation process works and, as for my respondents, agencies are used in order to make the process easy. However some have accused agencies of employing forceful tactics to bring a steady stream of Indian nurses to the UK. Several adaptation nurses I taught had paid very high fees – up to £6,000 for the visa service and introduction to a care home that would employ them through their course. Many had to sign an agreement to work for the care home after the course for 1-2 years. This is very similar to the bond nurses must adhere to in India, which means they must work for a set number of years in the hospital they trained in. In Suki's first experience of coming to the UK, she paid around £4,000 and, while she was undertaking the ONP, she was not supported in her placement with the clinical proficiencies she needed to achieve and was, therefore, unable to complete the course. Suki returned home to India and applied to do the top-up degree, again. Jose (2011) identified the issue of migration and use of agency's among his respondents and found that it could take a considerable amount of time and money. Many of the nurses I worked with took on average nine months to reach the UK. This proved costly as most would give notice on their jobs, and consequently they were without a salary for a number of months. Parents supported those students who adopted that route. For the nurse who was not successful in passing the entry criteria for the respective courses, this was a double blow, as the agency would still charge fees for the process to get them to the application point.

I met many of the nurses at interviews in person for a place on the courses, and a few by Skype. My first impression of the nurses was that they were ill-prepared and did not have the requisite English language skills to be accepted into the various courses. This was when I was in Chandigarh in Punjab to conduct interviews. It was obvious that nurses had been coached

prior to the interviews, as several offered the same answers to a range of questions. The day before the interviews, the NRcol office manager offered to photocopy our paperwork for the interviews, and it is at this point, one might guess, that they took note of the questions in order to prepare the nurses. My colleague and I realised quite quickly that the interviewees had been coached. This was problematic because we posed scenarios and problem-solving questions related to nursing practice as part of the interview process, and good English comprehension was needed to answer the scenarios and for the course for which they were applying. We changed the interview questions after about six or seven candidates. The issue of coaching was less obvious in Cochin and Bangalore, but we also noted that the nurses were much more confident with their English language skills. I got the impression that the women working with the potential students in Chandigarh wanted them to do well and this is why they helped prepare them fully for the interviews. Applicant's success at interview was also a success for the agency, generating income. However, the lack of appropriate preparation by the agency and the applicants' lack of appropriate skill caused them to be unsuccessful through the application process.

The importance of being accepted onto a course of study in the UK was emphasised to me by the emotional reactions of a few of the unsuccessful applicants. One female applicant was quite distressed at failing the interview and, consequently, was not accepted onto the programme. The applicant offered very poor answers to the questions posed and had a limited comprehension of English. My colleague and I were having a quick break between interviews when this particular applicant stormed back into the agency offices very angry and quite distressed. She burst into the room we were in, and was very aggressive. She was gesticulating and banging her hands on the table. We tried to calm her down explaining why she was not successful and that she could try again for the next cohort in six months. This did not appease her, and she would not believe we would not take her. She did not understand the reasoning; she felt she had a right to be accepted because she had the requisite English language qualifications and that she was a nurse and had been nursing for several years. The applicant would not listen to us, and became even more agitated. She blocked our exit from the room. The agency's security guard was summoned and he had to remove her from the building. This nurse's family would have already invested a lot of time and money in working with NScol to get to the point of interview and this would have been wasted. Because of her behaviour post-interview, we refused to interview her again.

While this applicant's reaction was initially a shock to my colleague and myself, what I did not appreciate at the time was how much was invested in terms of time and gaining the English language qualification, and how much money the family would have invested. There were also longer-term issues at stake, such as the fact that working abroad would also improve her marriage prospects, and *not* succeeding in the interview could thus be seen as changing her life trajectory more generally. A few other nurses were disappointed not to be successful at interview, and several pleaded to be accepted onto the course because this would greatly enhance their career prospects. What is more, not coming to the UK was then letting themselves and their parents down. After our time in the office in Chandigarh, my colleague and I came to the conclusion that the support the agency staff had given applicants prior to interview offered them no advantages and, for some, had raised their expectations of being successful too high. The particular problem with coaching and other forms of preparation conducted by NRcol was that it made it difficult for some of the applicants to engage independently with learning and engagement in class once in the UK.

Getting ready to go

This section considers the nurses' preparation to come to the UK and their expectations that were not always met when they arrived. I met many of the nurses at the different offices of the agency, but I spent more time with the MSc nurses prior to their departure to the UK. Overall, they were excited and looking forward to coming to the UK and they asked lots of questions of me. They were concerned about the food, transport, and daily life. The 'bad' English weather was a prominent feature of all discussions with the nurses from Kerala and Bangalore. A few of the nurses were concerned about the right clothes for the UK weather. Very few, two or three, asked about university and the course they were undertaking.

As mentioned earlier, the nurses undertook a month long, pre-departure course facilitated by the agency. The contents of this included academic development centred on writing style, referencing, and reflection. These topics were included as they formed the backbone of the courses they were undertaking. This was particularly problematic, as the agency staff did not fully understand themselves what was expected of the nurses once they were in the UK and studying at a UK HEI establishment. This created a mismatch with what the nurses were expecting and what actually happened in the UK (as discussed in Chapter Six: Learning and

Education), and how this affected the nurses' experience of higher education. Some of the nurses that passed at interview did not succeed on their courses in the UK.

The first group of nurses I taught were the top-up degree students. These included Preeti, Manju, Jinu, and Luke. Preeti and Manju were selected in Chandigarh, Jinu and Luke in Cochin. The group of eight from Chandigarh all struggled with English comprehension, in terms of speaking and writing. Only two of the Chandigarh group had learned English at school. Instead, they had learned at nursing colleges, but many had not used English outside the classroom, as their patients did not speak English. They were less familiar with everyday use of English and it did take several months for them to reach an appropriate level of English academic work. By speaking and using English every day, their proficiency developed well. Jinu, Luke, and Suki had all learned English at school and were very much more used to using it in everyday life. All three were able to follow lessons well and contributed in class. The entire group had additional academic classes to improve academic writing and academic English. Jinu and Suki did well and achieved an upper second and lower second class respectively. All the other students passed and gained third class honours degrees. Luke, despite his prior experience with using English, struggled with assignments and, much later, I found out from him that his difficulties were due to him preferring to socialise and drink alcohol rather than to study.

What proved to be key here were the preparation and interventions the student nurses had from the NRcol; these proved to be fundamental in how they adapted to academic work in the UK. For those with a good grasp of English prior to engaging with the NRcol, their chance of success was higher and this was borne out in their results. These students took less time to adapt to UK education regimes, while for the others it was almost like 'trying to see in the dark' because of their poor English comprehension. I provided information about the university, the courses, and the expectations of them in terms of academic development. This pre-departure course did not prepare them for the realities of studying in the UK. Most did not realise the amount of academic work expected of them on a weekly basis and the preparation they had to do for each of their subjects prior to classroom activities. Those studying the MSc had a large amount of independent study which entailed their navigating the University library and becoming familiar with online learning, which many found very

challenging. I discuss this in more detail in Chapter Six, but it is important to emphasise here that this did present immediate problems, as the pace of the course was fast and most of the nurses initially wanted to complete the course in a year.

In the end, they all took the 18-month option, which meant they undertook their dissertations in that last six months. This, in turn, would cost them and their families more money. This did create some tensions within the MSc group as they felt the agency had 'sold' the course to them as a one-year programme, not to mention adding to the financial burden on their families. The agency discussed the course guidelines, including the 18-month option of the programme, with the students before commencement of the course. I also discussed this at the start of the course. I had anticipated that 18 months would be required to allow for adaptation to a UK style education. While their visas were for 18 months and the course fees covered the potential of an extra six months, many had not budgeted for the extra six months' living costs. This did cause some hardship for a few individuals and many needed to work the full 20 hours their visa allowed them to work to support themselves. In terms of other issues related to the course, they felt they knew their role and how the course would work, but many had not taken on-board the huge commitment they would need to make. Further implications of the reality of undertaking the course are discussed in Chapters Six and Seven.

The preparation programme included an element about daily life and the cost of living in the UK. The nurses from Kerala were particularly worried about the UK climate. They were accustomed to warm temperatures; the Punjabi nurses were not as concerned, because they lived much further north, and were accustomed to fluctuations in temperature. I found myself advising them on what clothes to pack and explaining how the seasons work. The Malayali's found it difficult to find winter clothes in India and many had to buy clothes when they came to the UK. I advised them on the cheap clothing retailers to purchase warmer clothes. This ate into their budgets for being in the UK. I used an estimate from the UKBA and various university web sites which gave information on how much students had to live on in the UK. From this I estimated £635 a month for rent (in shared accommodation), food, travel, phone and so on. Many did not have the suggested funds and relied on getting a part-time job as a Health Care Assistant (HCA) to fund their living costs.

Most did find work quite easily, but found the work hard and challenging and were often too tired to study in-between shifts and university days. Several nurses wore hats and gloves in the classroom from the onset of their courses (September) and looked thoroughly miserable. Jinu found the weather particularly harsh; she bought a warm coat but only had a thin blanket on her bed. She lived on a very tight budget, which she derived from her HCA work. Jinu worked very hard on her studies and was a diligent student, but seemed very unhappy all the time. I discuss her situation in Chapters Five and Seven, but mention her reactions here as an example of how the climate had a much more profound effect on the nurses in terms of personal comfort than other factors.

First steps in the UK

The MSc students arrived in the UK about a month after I had met with them at the agency in Cochin. There were 30 nurses in the cohort: 28 from Kerala, one from Chandigarh (Minu), and one (Anil) from Bangalore. A colleague and I met the nurses at Heathrow Airport and dispatched them in groups by taxi to their new homes. Most of the female nurses went to share homes with families in the Southall and Hayes area. Eight of the male nurses, including Jey and Abin, were accommodated in one house in Southall. On Monday morning, in a break from their induction to the university, Jey and Jib came to me in quite a distressed state saying that their accommodation was awful. I looked at photographs on their mobile phones showing exposed electric wires, threadbare carpets, and cramped rooms. They had moved into a house already inhabited and the numbers swelled to 14 in a three-bedroom house. There was only one bathroom and toilet for 14 people, and no electricity in the upstairs of the property. The front door did not lock so they had to keep all their valuables such as passports, laptops with them. This shocked me; I had heard of slum property owners in the area of Southall from news reports, but did not expect this to be the experience of the students. Jib joked, ‘we are from India and this is a slum!’ They were being charged £350 a month for their space in the house, which they felt was extortionate for what they were getting. It was obvious that they could not stay in the property but this was not something the University or I could get involved with. The agreement with the University was that the agency would take responsibility of securing their accommodation. Jey had telephoned the agency in India explaining their situation. The boys were all angry that the accommodation had not been vetted and that they were expected to live in such conditions. NScol offered to find them alternative accommodation, even though they said their present accommodation was good for

the price. Through family connections, Jey and Jib found their own house for the eight of them in Southall. Jinu and Luke (who were taking the BSc top-up degree) moved in with them. They were all friends or relatives from Kerala.

Jey and his housemates' second house was a large semi-detached that was definitely in need of some refurbishment as described in Chapter One. Jey and his housemates were very happy in their second house; each time I popped round, various other members of the MSc cohort were present. This was 'home from home' for many of them, as they called it, and it was also known as 'the party house', where they celebrated Indian festivals, such as Diwali, as well as Christmas and birthdays. Their house was the focal point for the group settling into life in the UK. Jey and Jib, in particular, were the patriarchs of the group and there to help, if needed. This included helping with academic assignments, or when someone was feeling homesick they would try to cheer the person up. The initial experience of Jey and his housemates had positive repercussions; they bonded well as a group and became the support mechanism for the whole group of MSc students, male and female. This had a positive impact on the academic development of the nurses; the more able assisted these who were struggling with transition to study in the UK. For most of the students, a common bond emerged, in that many knew each other, either through attending the same nursing college or as relatives. Being nurses and studying in the UK also helped establish relationships; the two nurses from outside Kerala were embraced by the rest of the MSc group.

The nurses, both male and female, lived in Southall or Hayes when they first came to the UK. The notable exception was Somm and Devorah who choose to live in High Wycombe, away from the Indian diaspora. The nurses lived in rather encapsulated lives in the Southall area where the familiar was evident, from hearing Indian languages being spoken, to clothes shops selling Indian style and made clothes, to restaurants serving familiar Indian dishes, to supermarkets selling food stuffs, spices and other familiar items from home. Jey and his housemates particularly enjoyed the environment of Southall and felt very quickly at home there. Bauman (1996) explored the social world and lived experiences of people living in Southall. Many of his respondents at the time two decades earlier voiced a desire to move away from the area, reason being the area was unkempt and grubby. Others were eager to distance themselves from the diaspora and the rules of Indian society, much as the female

nurses I worked with cited as their reasons for leaving Southall. By moving out of the area they could distance themselves from the diaspora and the enforcement of what some saw as restrictive practices, not conducive with their modern lives in the UK. I explore in Chapter Seven why some of the female nurses moved away from what the felt were prying eyes, from members of their social worlds in India, in the form of family friends or relatives. They took advantage of being able to escape undue criticism and lead a less monitored life. Bauman (1996) examined the ideas amongst his respondents that moving away from Southall to a more favourable area, in essence less Indian; this change could also aid social advancement. Moving out of Southall gave people an opportunity to meet and engage with those from outside Indian society, very much something the female nurses relished (see Chapter Seven). Missing from Bauman's narratives is the Christian Indian aspect, which the majority of the nurses were, but it's the encapsulation and the lived experiences of Southall that are reminiscent of the Christian nurses' experiences. Bauman did show that, amongst the different groups of Indian nationals (Sikhs, Punjabis, and Muslims), there was little engagement between the different religious. Luke, one of the male nurses, found it hard to converse with the Punjabi men he first shared a house with. They spoke a different language and came from a different culture, as Luke saw it. There was little common ground. In this respect, some of the nurses do differ from Bauman's respondents. The Hindu, Sikh and Christian nurses of the MSc group did engage with each other. But the division within the BSc top-up group was very evident; Hindu nurses from the Punjab did stick together, and the Christian Nurses from Kerala did the same. The nurses that did continue to live in Southall found that the geographical distance from home offered some advantages; for example, previous work as an HCA meant that they could pass off the role as doing nursing and did not a have to reveal that this was an unqualified role. The financial incentives were such that the nurses and family could overlook the lower status of HCA work.

This section has identified how in some cases the nurses were ill-prepared by themselves and by the agency. Their expectations of the interview process did not match the reality and this left some nurses very disappointed and their families at a financial loss. The investment of time and money can be considerable for the nurse and their family and can have an impact of the nurse's social world, their marriage and career prospects. Much is riding on them being successful.

The world of nursing in the UK

It is important to highlight key aspects of the world of nursing in the UK to add context because the nurses come to the UK and enter the nursing world that has been characterised not only by hierarchy but also social divisions in relation to class, gender, and race of the nurse. A brief look at the history of nursing in the UK sets the scene for what the Indian nurses experienced when they came to the UK. Florence Nightingale set about developing nursing in the UK, which then filtered to other areas of the Empire. As I have shown, nursing in India was, and still is, shaped by the interventions of Nightingale. She attracted and recruited upper middle-class women who were unmarried. This shaped a respectable nursing service, but with an underlying current of class stratification. This class status was also played out in terms of nursing position. The upper-middle class occupied the prestigious matron or ward manager's position, and the lower classes, the general carer who did the more menial tasks, such as personal care and feeding. Parallels can be seen in the current UK nursing climate where the role of the HCA encompasses personal care and feeding. The type of hospital a nurse worked in could also strengthen the class divide. The voluntary sector hospital supported by the upper middle classes held a much higher position than a poor law hospital in the UK in late 19th and early 20th centuries. During this period, a process of nurse training developed in the prestigious voluntary hospitals; one that would fulfil all positions in nursing, from the matron to what was termed the 'bedside nurse'. This would be irrespective of which type of hospital they worked in (Smith and Mackintosh, 2006). Carpenter (1997) argues that this gave respectability to nursing, despite its perception as a lowly profession, because the upper classes occupied the leadership roles and supported the training of prospective nurses.

The development of a hierarchical nursing service in the UK and India went hand-in-hand with stratification of hospitals based on their specialities. The prestigious voluntary hospitals of the 19th century were associated with acute medicine and care, while in the UK, asylums were seen as on the periphery of healthcare, in a similar way to how care homes are seen today. The middle and upper-class nurses were associated with the former, and working-class women with the latter (Smith and Mackintosh, 2006). This trend in UK nursing continued into the start of the 20th century (Davies, 1980). The hierarchy in which hospitals were classified also shaped the position of the nurse, which was influenced by class, gender, and ethnic background. The more elite positions were still held by upper middle-class, white

women (Carpenter, 1997). During the 20th century, nursing in the UK continued to have an elitist structure, where a two-tier system existed until 1980s. This consisted of State Registered Nurses (SRNs) and, below them, State Enrolled Nurses (SENs), who carried out what were seen as the menial aspects of nursing, i.e., direct patient care. These were replaced by auxiliary nurses, the fore-runners to the HCAs.

Nursing diplomas and degrees were introduced (all nurses have to obtain a degree now), and this cemented the division in nursing even further. The HCA occupies the very bottom end of the nursing hierarchy (Smith and Mackintosh, 2006). For the nurses coming to the UK, this is their only choice of nurse-related work until they successfully passed the adaption course. This, as I discuss, can be an uphill struggle for many nurses. It follows that they enter on the bottom 'rung' of nursing, as well as work in a marginalised area of healthcare. However, this element of healthcare, the care of the elderly and vulnerable, is a valuable and vital part of nursing; sadly, it still earns little recognition and status in the UK. Many of the nurses felt that the status of nursing had improved in India but, nevertheless, they came to the UK and found themselves in a low status position.

When the nurses arrived in the UK, they found it relatively easy to find employment as an HCA within the private sector. This form is employment is characterised by a high turnover of staff. Staff turnover, particularly of HCAs, is due to poor pay and conditions, but also due, as Jey called it, to 'heavy nursing'. It is labour-intensive, involving personal care, moving and handling of patients, as well as engaging with patients with challenging behaviours, such as dementia. HCAs do not require specific training; it is mostly on-the-job. Typical shift patterns are 12.5 hours, which the nurses found particularly difficult to begin with. In India, they were used to an 8-hour shift pattern. Jey and three of his housemates worked in a care home owned by one of his aunts. The nurses felt they were treated quite well, but they found it very tiring doing a few shifts a week, travelling to and from the care home, and trying to keep up with their studies. In India, none of the nurses worked part-time whilst studying. This meant that they had not developed strategies yet to cope with competing pressures. This theme is discussed further in Chapter Seven.

When I visited Jey and his housemates the first time, we discussed how they had settled into life in the UK. The conversation turned to discussing their part time jobs in care homes. They felt the work was quite hard and demanding. The role of an HCA[24] does not exist in India, nor were they exposed to work in care homes. Smith and Mackintosh's (2006) case study review of nursing homes in the UK suggested that migration of nurses from overseas reinforced a division of labour and the drawbacks of nursing in the UK. The drawbacks related to the nurse's class, gender, race, and ethnicity, and noted that ethnic minorities are over-represented in nursing homes. The study focussed on employment in care homes because this is a place of nursing in practice that attracts and offers employment to overseas nurses. All of the nurses who were working, bar Minu (who worked in a fast food restaurant initially), worked in care homes. The majority of the overseas adaptation nurses I taught also worked in care homes. The nurses took on the role of the HCA that are located at the bottom end of the nursing hierarchy (Smith and Mackintosh, 2006). Many took on this role because the work was similar to nursing practice; they would be working alongside nurses and this was a prime way to familiarise themselves with UK nursing practice. The work of an HCA is, however, characterised by low pay, being largely placed in the private sector. Working in the NHS offers greater job security, and better pay and conditions. The nurses also would not have been used to doing physical or hands-on care with the patient, such as personal care. In India, auxiliaries or relatives undertook this intimate work. Many of the nurses took a while to adjust to this, and were behind in what they called the heavy nature of the work.

The hierarchy in nursing manifests itself in affording certain disciplines in nursing more status. Critical care nursing is one example of a nursing discipline occupying a higher position than care home nursing (Smith and Mackintosh, 2006). They argue that the continued migration of nurses to the UK has strengthened the hierarchical structure of nursing in the UK. Overseas-trained nurses, as noted, take up positions in care homes and similar HCA positions in the NHS. In the late 1960s, there was a steady increase in interest shown by nurses in India about coming to work in the UK. There was a degree of prejudice aimed at these nurses, in that they were less competent in their use of English. They were not able to carry out duties to the required standards, while nurses from Australia and New

Zealand were considered superior and much more favourable immigrants. However, nursing shortages were common and the Indian nurses continued to flow into the UK, with numbers increasing from 1970s to the current day (Healey, 2013). The nurses were recruited into the lowest paid roles in nursing care with the lowest status. They were not aware of this prior to being in the UK. This helped them maintain the illusion they were doing well in what was the respected field of nursing here in the UK. The nurses were either not aware or chose to ignore the reality of nursing in the UK, and that they were occupying the lowliest position. Despite this, the pay was more than that of a qualified nurse in India, which prompted many to embrace their roles, as it still helped to accumulate status because of the money and because of being employed in the UK. They did not feel the need to explain the type of nursing support work they were doing as they continued to refer to the HCA role as nursing. HCA work would be considered as polluting within an Indian context, but by being in the UK, the nurses took advantages of the geographical distance with India. The nurses did not see the need to explain the role as the pay was good in comparison with India. The nurses were also distanced from the gaze of their families and their communities, therefore the demeaning qualities of HCA work diminished in the UK. The reality was the nurses were doing work that was close to the original roles in nursing in India before it gained professional status and what had given nursing the stigma attached to it. This had reaffirmed for me that the motivation of male nurses was not to be a nurse *per se*, but to take advantage of overseas travel as they had done, but not pursue a nursing career any further.

In order to practise as nurses in the UK, overseas nurses must undergo an adaptation programme that typically lasts 3-6 months (this programme has now changed in structure and process). To be eligible for an adaptation programme, the nurse had to gain a 7 in all four domains of the International English Language Testing System (IELTS) test (NMC, 2008). This can be an extremely high goal to attain. Minu took the test 4 times; Aava, 7 times. To enter the BSc top-up degree, they needed a 5.5 overall, and 6 overall for the MSc. None of the BSc and MSc nurses arrived in the UK with the requisite IELTS scores for the adaptation. They studied for this once in the UK, as did most of the adaptation nurses I met. Less than a third of my respondents gained the requisite IELTS score for adaptation courses, even after studying at BSc and MSc levels. Many are still practising as HCAs, despite having a nursing degree and an MSc in Nursing. More of the female nurses managed to get the IELTS score. Jey and Naya, when they returned to the UK after their wedding, talked me through their plan

to get Naya through the IELTS test, and to undertake an adaptation course. She did indeed do this and now practises as a registered nurse in Jey's aunt's care home; Jey has still to take the ILETS test some two and half years later. Jey and Naya show how gender roles can be reassigned: Naya is the main breadwinner in the UK, but the roles more likely would have been reversed in India. Jey looks after their one-year-old child.

Like Jey and Naya, Minu and Madan presented as a cohesive couple where they perform in the world of work for the good of the couple and family. When Minu's new husband (Madan) came to the UK, he took a position as a sales assistant in a petrol station. He is a qualified mechanical engineer. I asked Minu about Mani's choice of job, Minu explained that 'we need any job'. Employment would bring in cash and help him gain his confidence with English. He is still working in retail. It has proved very difficult to find work in his profession. It is not like nursing, where the core principles are the same. There is no adaptation course for mechanical engineering, and he may have to retrain. One thing of note that each of these nurses said when they spoke of their plans was that they used 'we'. For example, Jey said 'we will get Naya through her IELTS and adaptation, we concentrate on this first'. He then explained he would follow suit after she started working as a nurse. Minu reflected, 'we do not mind, it is good he (Madan) gets any type of job'. Discussions with Minu before her wedding gave me the strong impression that she liked to be in control of her future and subsequently, Minu wanted to continue to work as a nurse after the wedding and wanted to invest her and Madan's time into this. His career would follow later. It was very much a similar situation with Sonija and Jib. These couples presented as a united team, where their goals were as one. These goals were closely aligned with that of their respective families. Most of the nurses would discuss their goal but would also link this to that of the family as a whole. Jey would also talk in terms of 'us', which meant his parents and wider family, and not just Jey and Naya. This type of collective decision has influenced the nurses from their choice of career through to the decision to migrate, with the family in the wider sense being very much part of the decision-making process (Johnson et al., 2014).

Reviewing the experiences of the nurses, there is some correlation to Marriott's (1991), Roland's (1988), as well as Dumont's (1970) exploration of the dividual versus the individual, certainly in the career choice of the nurses and the decision to migrate. The former

is relational, and the latter autonomous. What the nurses act out is the emotional and social connections within their main family group and outside with caste or local community. In the relational world, exchanges between people create a level of symmetry that rubs off on the members or on the group. This creates cohesion and a way of being and doing (Marriot, 1991). The nurses and their family present as a compound unit rather than a group of individuals, within which the 'we-ness' of the decision-making process is played out. According to Roland (1988), a psychoanalyst, Indian persons will rarely see themselves as independent thinkers exhibiting the 'I-ness' separate from the family influence. In my initial conversations with the nurses, I felt the 'we-ness', the close bond with family, and the being as one entity came through strongly. The nurse's views were valuable, but the overarching decision about their futures was certainly made together with their parents. The nurses are part of their social groups: they are active participants in the choice of career, guided by their parents, but their opinions also matter. The dividual in post-liberalisation India has seen more of an impact of the individual on the dividual (Wordlaw, 2006). He argued that the Christian propensity for consumerism and paid employment creates a more autonomous way of living. This is more evident in the Christian nurses, where financial remuneration for the male nurses and the drive to travel aids them living more autonomous lives in the UK. The female nurses, in particular, relish the autonomy, and are able to distance themselves from the more traditional aspects of their social world. The female nurses in India were restricted in access to the public world which is invariably facilitated by a male relative. As I show with Minu and Aava, they strove and attained a level of independence they felt would be hard to achieve in India (see Chapter Seven). Being both a nurse and a member of the middle class has challenged the split between the individual and the dividual in its original sense and the relational aspects of their lives.

Roland's' (1988) argument is, however, somewhat over-stated, as I noted upon scrutiny of the nurses' lives. I observed that the nurses used a combination of 'I' and 'we' when discussing their lives both in India, and much more in the case of the UK. Jey is a prime example. When he left school, he undertook a degree in physics at his parents' suggestion; there was some talk of him being a teacher like them. He did not enjoy it and could not see a future for himself in that field, so he researched other courses and settled on nursing for the benefits of the job, especially the travel overseas. His parents were initially reluctant to support him financially but he stuck to his resolution, demonstrating independent thinking

and actions. His parents did eventually say yes, after agreeing that Jey could see a future for himself as he wanted it to be, exhibiting what Roland calls 'I-ness', a concept that Roland argued was at odds with how Indian people experienced themselves. The 'we-ness' was distorted when they moved to the UK, in some of the nurses' cases. Some of the female nurses began to develop a sense of control over their lives. For example, Minu claimed she had gained 'independence' in the UK. On an everyday level, she felt the freedom to go for a coffee with a friend or drink in a bar after work. In India, she had never been permitted to do such things. On a life-course level, she refused to get married until she had finished her ONP course and had started her nursing career. She was happy to get married but, as she put it, she wanted a bit more time to herself before settling down and getting married. This is something, as she said, she would never experience in India. I contend that the nurses are able to do both: have the independence and the collective family experience. Appuhamilage (2017) contended that the notion of the individual and collective can exist together to influence a person's daily life and decisions they make. The nurses act in this way taking up the chances of independence and autonomy that exist in the UK to meet their needs. The nurses I worked with are driven by both their individual wishes and the needs of their families. They are motivated to achieve as a nurse, but also to improve their family status by working and being educated in the UK.

What the nurses have done in the UK is to have embraced their new lives, including the sense of support and collective action that came from their friends and course mates. As Jey summed up, they became each other's family, replicating some of the structures that guided their day-to-day lives back in India. In a sense, they acted as moral guides in the different world of the UK diaspora. They displayed a different sort of 'we-ness' and reaped the benefits of this. I discuss further the nurse's experience of being in Chapter Seven. My study of nurses' experiences in the UK shows their own way of being in the diaspora and their experiences, which manifest themselves in a way to demonstrate how two sets of habitus find ways of co-existing productively, creating ways of being that are neither stereotypically Indian or Western, but which are distinctive in their own right to a particular diaspora.

Conclusion

International migration has enhanced the status of nurses formerly considered a low status profession (Walton-Roberts, 2012). With this increased status, however, comes the

considerable pressure levied on the nurse to migrate. Much rests on the nurse's ability to succeed in the migration field and be a migrant who travels to the UK for work and study. Family status and prestige is at stake. For some nurses who fail at the interview this can be a devastating blow as their family would have already invested time and money to get the nurse to the first phase of the migration process, the interview. Also for the nurse and family, there is the added factor that remittance will not be forthcoming, something that is important to the family finances. The process of migration is carried out through engaging an employment agency. The idea that this is an exploitative process is a Western concept. While costly, the agency is fundamental in helping the nurse navigate through the laborious process of applying to UK colleges, obtaining the correct visa, and so on. This is a common practice in India, and tends to work very successfully for the nurse. Once in the UK, there is a definite settling-in period, as the nurse adapts to life in the diaspora. The nurses find their own way of doing just that, and they negotiate work and study to best fit their needs. The MSc group, in particular, developed their own micro-community within the diaspora of Southall to cope with the challenges of being in the UK. None of these particular nurses would have been able to migrate if they had not been members of the middle class, with the income to either pay agency fees or the means to obtain education loans to do the same. In the next chapter, I explore what it mean to be middle class for the nurses, and why migration is one of the key factors in maintaining and improving their status. The data I have gathered can help not only educators, but also employers of Indian nurses to select appropriate induction, and work-based learning programmes that will help the nurses adapt to living and studying in the UK. Such programmes could also be adapted for overseas nurses from other countries.

Figure 5: MSc Nursing Students in the agency office in Cochin prior to their departure to the UK. They were about to start on the pre departure course and had come into the office to meet me.

Chapter Five - Being middle class: A matter of identity

'Girls can upgrade their status from lower caste or higher social status [by] marrying in to a higher family. This often can be the case of girls who are nurses because of economic benefits and the prospects of travel of nursing' (Jey summing up middle class status and improvements in social standing).

Introduction – what is middle class in contemporary India?

Through the use of ethnographic data, I will show how each of the qualified nurses I worked with in this study identified themselves and their families as middle class. This chapter will discuss what being middle class means to those nurses, extending the discussion from Chapter Four. Some comparison will be drawn with the nurses' narratives and experiences through analysis of the literature on the middle classes in contemporary India. How the nurses construct the idea of being middle class, and its influence on their sense of identity, is also discussed in this chapter. Being middle class, I argue, is the main feature of the nurses' social status and is a fundamental component of their identity. For the nurses, being middle class made them who they are. Class, rather than caste, for the Christian respondents was, in their opinion, the key to their social standing in their communities (this is discussed later on). The nurses from the Punjab who were either Hindu or Sikh saw their caste as part of their identity, but class and religion featured more prominently in my conversation and interviews with them. The way the nurses place themselves in the middle classes is not dissimilar to other young Indians from comparable socio-economic backgrounds, as I will show, but with some key differences. Religious background and the region of India they came from also dominated the conversations I had with the nurses around identity and belonging (discussed in Chapter Seven). The Christian nurses felt distant from caste but their lives have been very much shaped by the region they have grown up in, as well as by the influence of the state, as I discuss later in this chapter.

What is the 'new' middle class? The Indian perspective

Discussion on the 'new' middle classes in India is evident in recent ethnographic literature. Saavala (2003), for example, studied the urban middle classes in Hyderabad, focussing on a

group who were previously from a low caste background, and who had to prove their worth to maintain their new status. Saavala tries to describe who the new middle classes in India are: in short, groups of nationals whose economic and social position have been elevated following economic liberalisation, and because of India entering global markets (2003: 234). She argues that visibility of women working outside the home is a prominent characteristic of the new middle classes. This follows the improvement in women's prospects in terms of education and career development. The female nurses I worked with exemplify this, as many are the first in their families to work outside the home, whether they be Christian or non-Christian. The term 'coming forward' was a popular phrase used by the middle-class respondents in Gangly-Scrase and Scrase study, who were studied in West Bengal at the end of the 1990s (2009:82). This related to greater opportunities available for both women and men. A common belief amongst the middle-class people Gangly-Scrase and Scrase (2009) worked with was that it was backward to prevent women from working outside the home and from accessing education. This argument sits well with the nurses since, as I will show, education is a defining feature of their middle classness. Saavala (2003:235) proposed that her respondents saw themselves as neither poor nor part of the 'elite', but as a third, distinct class. The nurses, too, were clear and resolute that they were middle class; they were comfortably well-off in financial terms and their families were financially secure. The one noticeable exception was Jinu who described herself as middle class, but came from a poor family. Jinu saw her family as middle class because they were educated post-school, including her parents.

For the most part, the nurses in my study described their middle-class status as being well-established, one with history, and, in that sense, the nurses did not see themselves as part of the 'new' middle classes, as described by Saavala (2003). However, there was little evidence that their families held the middle-class position before their parents' generation, so this status could be considered relatively new. Many of their parents were the first to be educated and hold positions in commerce or industry, which, Saavala (2003) noted, was where many of the new middle classes who emerged in the 1990s were employed. I have difficulty, however, in aligning the nurses I encountered with Saavala's (2003) other claims about new middle classes, in particular her respondents' lack of confidence in their social position because they were the first generation to be classed as middle class. The nurses did not

indicate this was the case for their families: indeed, they were very confident and convinced they held a strong position in their communities through their middle classness.

Saavala's (2003) respondents had their roots in the former backward or untouchable castes; by contrast, many of the nurses I worked with – and particularly those from Kerala – classified themselves as 'general caste' or outside caste boundaries. A few of the nurses from the Punjab were Sikh or Hindu, but they did not come from the lower castes. Minu, for example, was a Jat Sikh (high caste). Her family history revealed their high status in her community; they were land and property owners in a rural village, and her father had been the first to move to an urban environment. It was this move and her father's employment for the Government that elevated their class status. Minu's class may have changed but her caste status had not. The commonality between the nurses is their potential for social mobility through their career as a nurse who could work abroad with increased earning potential. This group of nurses believe in both partners working in the marriage to further improve the future of their children and maintain their middle-class status. Key factors that maintain and develop social mobility such as education post-school, financial stability, and overseas travel/work are discussed and will be further developed in this chapter. They support the reasoning by the nurses as to what it means to be a middle-class Indian.

What does it mean to be a nurse and middle class?

What makes a person middle class? This was a question I posed to all the nurses. This elicited similar responses from both the Christian and the non-Christian nurses. The most in-depth conversation about middle-classness was one I had with Jey and his housemates when I visited them at home in Southall. This took place over several of my visits. I also spoke about this with Jey and two of his cousins when I visited his family home in Kerala for his wedding. The overriding theme that emerged was that their middle-class status was due to their fathers' profession and their family's corresponding high standing in their community. Common high-status professions highlighted by the nurses were teachers, managers of some sort (such as a bank or a factory), senior engineers, or businessmen. As well as the father's profession, the family or families being landowners or landlords was also an important component of being middle-class. The nurses from Kerala mainly indicated this to be the case where most families had plots of land growing rubber, ranging from a few trees to a small farm. The nurses saw those that rented or tended the land were lower class, as they had

neither education nor financial stability. Further education post-school for both male and female children (typically a BSc or MSc in India or overseas) was a fundamental element of the nurses classifying themselves as middle class. This would not be for just themselves but for their siblings and cousins as well. Studying in an English-medium school and speaking a good level of English was something most of the nurses felt gave their family and themselves additional status and strengthened their middle-class position in their communities. Working or studying overseas, which the nurses I worked with very much associated with the nursing profession, contributed to their social mobility, in particular through the acquisition of wealth that overseas travel made possible. This was further supported by the capacity of the nurses' families to enable overseas travel to take place, and the knowledge of where to migrate to for the best opportunities. A final point was relative wealth (compared with other members of the community) or being financially comfortable; that is, having spare or disposable income/pension funds. Minu (from the Punjab) and Suki (from Delhi) were was the only nurses to discuss caste and the position this gave their families in the community in any detail. I shall return to this later in the chapter.

Some of the characteristics the nurses used to categorise themselves as middle class resonate with Fuller and Narasimhan's (2007) findings in relation to their research with Information Technology (IT) professionals and the new middle classes in the south Indian city of Chennai, predominantly made up of Tamil Brahmins. Fuller and Narasimhan's (2014) later work clarifies and describes how Tamil Brahmins have undergone a reinvention of their image from an elite, high caste, rural situated group to one that displays modernity and middle classness in an urban setting. Education is of primary concern for themselves and their children, as well as having professional employment. Tamil Brahmins occupy many roles in professional and manager classifications. Consumerism and disposable income feature in the discussions, and, while this was less important to the nurses I worked with, it was a topic that was discussed. Among Tamil Brahmins, the education of women has also been seen to be widespread and has been beneficial in developing women's roles in the workplace (Fuller and Narasimhan, 2014). This is similar to where the nurses, in particular those from Kerala, position themselves. As with the Tamil Brahmins, the link between status and improving class is a developing one where key components begin to emerge.

Migration is an aspiration for many of the young Tamil Brahmins[25] that Fuller and Narasimhan describe, as it is with the nurses. This can be problematic for the Tamil Brahmins/ IT workers who want to embrace the modern but still maintain traditional norms and values. This manifests itself in concerns regarding their children's development and assimilation into American culture. America was the prime destination for migration. For their respondents. The option to return home after a period of work abroad is seen as a way to instil traditions in their children (Fuller and Narasimhan, 2014). A further prominent pull to return to India is caring for and supporting parents in old age, and returning home from working aboard to care for them was important to the IT workers. Parental occupations were relatively unimportant for the IT workers because their status came in part from their achievements, and in part from their pre-existing, high caste status as Brahmins. In my own work, the nurses' fathers' occupation was, by contrast, an important factor in defining their identity as middle class. The uniformity of opinion from the nurses could be due to an element of being told they are middle class by their families, along with their experience of being in a middle-class world with advantages such as opportunities to travel and work overseas. The nurses' families were able to strengthen the assertion they were middle class by having children who were nurses and had the realistic potential to working overseas. The nurses did not question their status, rather they took it as a given that they were middle class. The elements of middle-class identity highlighted by the nurses were presented in an interconnected way, where their role as a nurse exemplified their middle-class status, and where education, English language teaching, financial stability, their fathers' professional identity, and work/study overseas came together, as shown below.

Many of the nurses believed that, because they were middle class *before* they were nurses, they passed on a level of status and respectability to the nursing profession. The middle-class status also enabled the nurse families to be able to send them overseas for study and work. Nurses who are not part of the middle classes would find it hard to be able to have access to the opportunities of going overseas offer. They may not have had access to English-medium teaching which could be another obstacle. It is also acceptable to nurse if you are middle class, from Kerala, in particular, and Christian. An explanation for this can be seen in Fuller's (1976) exploration of Kerala Christians and caste. He put forward the argument that

[25] The US is a popular destination, especially in the field of IT.

Christians do not have the same notions of ritual pollution in terms of interacting with bodies and bodily fluids, as those held by Hindus and Muslims. This adds to the premise that Christianity and nursing has such a strong link[26]. Fuller's (1976) argument points to the fact that historically Christians would practise 'distance' pollution, as did the Hindus, for whom touch was not the only way for pollution to be passed between individuals (it could travel in the air if there were great differentiation between castes) (Fuller, 1976:63). He noted differentials similar to caste amongst different groups of Christians (this will be explored further later), where Syrian Christians were considered to have a higher status than Latin Catholics (in second position) and, lastly, Christian converts. Syrian Christians were deemed capable of neutralising pollution by high caste Hindus (Fuller, 1976:63). Fuller (1976 :63-64) cites an example in which, if a low caste individual passed an object to a Syrian Christian, they would absorb the pollution and if they then passed the object to a high caste member, the latter would not become polluted. If there was no Syrian Christian acting as the middle person, the high caste member would be polluted. Fuller uses this example to show how Hindu practice and enactment of pollution could be shaped and reformed. In the section below, I continue the discussion of class and caste showing the relationship between the two and the impact on the nurses.

Caste and class

Caste and social class can be viewed as instruments of social positioning. For the Christian nurse, caste was not the determiner of their social position, but class was. I will begin with an explanation of caste. In a general sense, caste has its roots in a closed social system where admission to a certain caste is by birth and perpetuated through marrying within the ascribed caste. From a historical perspective, each caste was different and unique. In contemporary India, caste still has an important role to play in society. However, some of the key elements of caste have eroded or altered, as explored by Srinivas (1995). One occupation could support which caste a person belonged to; however, as new professional roles have merged, its influence is less prominent. Examples given are pilots, factory staff, or doctors, for whom there is no particular caste (Srinivas, 1995). Likewise, the nurse does not have a caste classification. This is now enforced by the nurses, in particular the Christian ones, who see caste as having little influence on their social status and position. Hereditary influences

[26] Nursing also has a strong link through missionaries and the Christian sense of service, although Hindus also have a strong notion of service.

between the castes is still somewhat observed as it remains common for people to marry within their caste. The Christian nurses—while they do not do this actively—continue to marry within their religion. Marrying outside one's religion is seen in a very negative light by the nurses I worked with. Although the hierarchy between castes is still evident, lower castes are not as dependent on the higher caste for employment as in the past (Donner, 2011).

Liberalisation has seen education and employment opportunities open for all Indians, and has led to less demarcation between some persons. For the most part, the Christian nurses I worked with skimmed over the notion of caste and its impact on them when I asked about it. The only prominent observations from my conversations with them was their dismissive attitude to the reservation policy and equality in the workplace. This they felt had a negative impact on their career development. Caste is remarked upon a few times in my conversations with the nurses in the following sections, but it certainly is not their primary concern for social advancement and career development.

Bourdieu (1984) explored the notion of distinction in relation to class. He argued that economic, cultural, and social factors all added to social position as defined by the dominant class. The middle classes could improve their economic capital through income and employment which gave them cultural legitimacy and superiority. Economic, educational, and social capital were used by middle classes to distinguish them from classes below them. Expression of contemporary class ideals see people linked by a shared position through consumption and production of their social position (Bayly, 1999: 343). Similarly, respondents gave much attention to strengthening this middle-class position through consumption practices. Donner (2011) argued that, in India, in the last 20 years, a change has occurred in how economic capital is used, and the education of children is paramount to that change. The nurses exemplify this, as their families are prime consumers of higher education in India or overseas. This new overt consumption of how and what money is spent on is a key feature of the middles classes in India today. The nurses are just one reflection of modernity in India seen through English-medium teaching and professional employment.

The nurses demonstrate that there is diversity within their identification with being middle class. For example, Jinu considered her family to be poor but they were still able to facilitate her higher education. The broad classification of middle class is not unique to India. White &

Rogers (2003) explored the concept of middle classness and noted that socio-economic disparities existed between those who identify as middle class. Also amongst the female nurses from the Punjab, most of them, bar Minu, were the first females to be educated in their family. The nurses from Kerala, by contrast, had experienced their mothers receiving an education post-school. There also seems to be a difference between material position and cultural understanding of employment. The nurses working as HCAs, which is a very menial role, believe themselves to be middle class. They position the role of HCA as being an important part of the nursing world. It is convenient for them to give this impression of HCA work, as this has implications for their status as much of it is derived from being a nurse. This way the family can keep up the perception that their child is *nursing* in the UK.

The new middle classes, with respect to India, is a broad term that is based on affluence, English speakers who have taken opportunities of new technologies and globalisation to strengthen their social position. Fernandes (2006) view liberalisation as the key to the emergence of the new middle classes. For example they are upwardly mobile, have entrepreneurial drive, and aspirational consumer practices. The middle classes in modern India can be the same but different. The nurses are perhaps less entrepreneurial but high consumers of educational and English-speaking aspirations. The nurses feel that they are born into their middle-class position and learn to embody this, whilst their parents promote the family as middle class because their child is a nurse and is being educated and working overseas. The nurses have grown up with the promotion of achievements in education and English teaching with an affiliation with the nursing profession pushed by most of the parents. They are less likely to see themselves as anything but middle class. When the nurse described what it means to be middle class, it is portrayed as socially normal and historical, as they do not see a time before being middle class. Being Christian as well as being middle class gives them a distinct identity outside caste. Fernandes (2006) does not see middle classness in India as a new concept; there was social and structural changes prior to liberalisation through both caste and class, but is now more direct in its links to liberalisation.

As a topic of conversation, class was more widely spoken of than caste by the nurses. Minu[27] and Suki[28] were the only nurses to equate their status and identity with caste *and* class. Minu and I had several conversations about her life and that of her family in the days leading up to her wedding in India. We would be chatting after breakfast (which was usually chapattis and curd) and, on one occasion, Minu explained why she classed herself both as Jat Sikh (high caste) and upper middle class. This status she reasoned was related to her grandparent's high social standing in their community.

> I'll tell you, the reason is like my caste, my grandparents, that generation were landlords, they own properties, huge parts of lands and in their times they used to be the heads of the villages, you know. So they were, the grandparents, they used to be in a good positions in the villages or any part where they were living. My grandfather was designated Sarpanch through the religion (Sikh). It is like the head of the village. Yes the basic reason is like that my caste people, identity will be like we should own some property, the land – agriculture land basically. So that is my identity, like I'm from this caste [Jat Sikh: a high Caste, likened by Minu to Brahmins].

Her family's high status in terms of caste and class meant that, like Jey's family, they did not tend the land. The act of labouring on the land was for the lower castes and not Minu's family. In order to preserve their status, this practice continued from her grandparents' generation to the current family members:

> Yes we do have land. That grandparents' land will be divided in their sons. So my dad also got some share from my grandparents. So that will be now passed on to my brother. So this is how it goes. The land is passed from male heir to male heir. Yes we give it, like my grandparents will not go and do agriculture. But they will give it for rent, the whole land, and they will, the crop will be there and they will just scatter all the profit and everything. Therefore, that's how we do...pay someone else to do the work.

Minu discussed with me her social standing and being a nurse; she felt it was acceptable to gain a profession and not just get married and be a 'home' wife. She reasoned that this meant 'more and more women' were working and this improved not only the financial position of

[27] A Jat Sikh
[28] A Hindu

their families but meant it was more acceptable for women to work. As I have indicated, amongst the middle classes, this is indeed the case, and one supported by most of the nurses. However, according to Jeffrey and Jeffrey (2001), Jat's preference in marriage is for educated women such as Minu, but it is not for women who work outside the home. This would help preserve their social standing. Minu asserted, however, that her family were more forward-thinking in their attitude to women working; this stems from Minu's mother working as a nurse and being the first in her village to be educated beyond school. Minu's desire to keep working after marriage is because she wanted to protect the career she was developing in the UK. Minu had informed Madan (her fiancé) that she would still be working when they married and that she did not want to start a family for a few years (more on this conversation is detailed in Chapter Seven: Being in the UK). I questioned Minu further about her class status and she believed her family were 'Upper middle class'. She explained what she meant by this:

> Upper middle class like I say with both parents are working, like monthly income is good, and they spent, like my sister is abroad, they afforded to send her abroad, three of us [this includes her brother]– we had a well education and everything, so our basic things are being satisfied, you know. Property and luxuries make up class too.

Minu further explained that her family were also high caste Jat Sikh and, as well as securing them a good financial position and education post-school, this also contributed to their higher status and being upper middle class. The combination of land ownership, income and education, as well as their high caste position, created the family's upper middle-class status.

A division of opinions regarding the importance of one's caste or class was evident between those from Kerala and those from the Punjab or other states. The Christian Keralan nurses did not associate their social status with caste; it was brushed aside as not being relevant to them. Caste was, however, an important issue in that the Christian nurses saw it hindering their progression at work. This division within the group was not a strong one but opinions did vary on which gave them a higher social standing, whether it was class or caste. The nurses from Kerala and elsewhere did not see a link between being middle class and their caste. The way the nurses used class as a means of expressing their identity resonates with the shift in Indian society where class has become a more significant social differentiation, with the notion of caste becoming less dominant (Fuller, 2007). As Indian society has changed over

time, so has the notion of class. Liberalisation helped shape the modern explanation of class as seen through the eyes of the nurses. Jey and housemates felt that discussing caste is not a significant topic of conversation in modern society; class is much more in vogue, interesting, and more important. This sentiment was shared by the two Hindu male nurses.

However, while caste may not be a popular topic of conversation for the Malayalis, in reality, caste is still a prominent feature of social and work life in contemporary India. Affirmative action, as discussed above, is one of the State's measures to influence the social status, access to education and employment opportunities of the people ((Donner & De Neve, 2011). The reservation system, in which education places are divided by quota, afford scheduled castes (formerly 'untouchables' or, to use the current preferred term, Dalits) more places. The nurses cannot distance themselves totally from caste as they appeared to in their conversation with me. Aava and Luke both had to leave Kerala to study in other states, as there were not enough places available at colleges in Kerala. Unlike the other nurses, the Christians ones in particular, Minu does see caste as part of her identity, due to the history of her high caste status going back generations in her family. The nurses from Kerala have used class and the fact that they are middle class as a means of placing themselves in a stronger position in the social world than they had previously occupied with caste classifications.

Suki, a Hindu from Delhi, was the most vocal respondent when it came to discussions on caste, but also only briefly talked about it. When she did, it was to do with her obligations to those less fortunate that herself. Suki considered herself middle caste. She did not reveal her caste other than it was middle caste. I am not sure if she was embarrassed by it or did not consider it important as part of her identity. Suki talked very little about her class status as well. I have concluded that Suki was more influenced by what she did with her life than what status she held. In this way, she was very different from most of the other nurses who defined themselves by their social status, be it from class, caste, or both. Suki did not believe that money was important to her family. One of her sisters had married a wealthy man and improved her financially stability in doing so, but Suki did not feel pressured by her parents to do the same.

Suki, like many of the others, felt education would lead to a good job and security, as well as pleasing and honouring her parents. Suki believed in affirmative action, where 'scheduled castes' (and other 'backward castes', as classified by the state) were positively discriminated in terms of education opportunities, in order to acquire better paid jobs and greater career opportunities. This goes against the middle-class ethos, where rewards are through personal achievement and dedication to studies. In terms of nursing, as previously discussed, the scheduled castes are treated favourably in terms of promotion in Government hospitals. The Mandal Report (published in 1980) began this process of change (Donner & De Neve, 2011). Suki talked in depth about the lot of poorer people and the need of society to support them, even though this had affected her chance for promotion in the government hospital in Delhi, where she worked. This prompted her move to study in the UK, with the aim of raising her prospects at work.

Caste, as I have indicated, is not something that I explored in any detail with the nurses. As previously mentioned, the majority of my respondents are Christians or from Kerala where these nurses believed the discourse about caste was less important to them because they do not have a caste. They were very different from, for example, Andhra Pradesh Christian converts that Staples (2014) describes, who continued to be identified by their former Hindu castes as well as their class. For this particular group of nurses, the strict classification of caste was unimportant. A further point argued by Fuller (1976) is the notion of pollution, not evident in discussions of the Christian social world. This contributes to why the nurses feel removed from notions of caste and do not believe that it affects them in their day-to-day lives. For the Christian nurses, identifying themselves as being middle class was an important way for the nurses to attach themselves to a higher social status. They felt 'general caste' status assigned to Christians would mean they would be much lower down the pecking order, as they saw it, particularly in terms of promotion in government-run hospitals, as discussed earlier. This may account for the nurses seeing caste as having less influence on their lives. Arenn and Vin were Hindu but from Kerala, and they too felt more akin with their middle-class status than the boundaries that may have been attributed to them by caste. Further similarities have been explored between class and caste. The attributes and explanations of being middle class given by the nurses resonate with caste nuances described by Srinivas (1995): namely, land-ownership, family ties, high place in the social hierarchy for the family, Western education (English-medium), and government jobs. However, the latter point was

not as pertinent to the case of nurses. Minu illustrated this by reasoning that, unlike class, her family's high caste status would remain even if they lost their land and relative wealth. Both caste and class are hierarchical in their structures. Similarly, Bourdieu (1984) argues that social class would remain after gaining an education, for example, even if wealth diminishes. The Christian nurses gave the impression that they felt distant from the 'general' caste that was ascribed to them and it had little effect on them. Donner & De Neve (2011) argue that caste exists in different forms throughout India, and has varying social impact.

Financial stability, wealth, land ownership and social mobility

In this section, I discuss the interplay between financial stability, wealth, and how their families—through their fathers' professions, landownership and their future careers--achieved this. A recurrent theme that I noted, which several of the nurses discussed, was the obligation they felt towards their parents for funding their education and travels. This also highlighted the nurses' expectations of themselves, in addition to what they felt their families expected of them in terms of gender roles. Many of the nurses (when I interviewed them or chatted with them in groups) discussed that being middle class did not necessarily mean a family was wealthy or had a disposable income. Financial wealth or being comfortable was less important to some of the nurses, such as Jinu, whose family, as she emphasised several times, are middle class; her father was a head teacher, but she described her family as poor and not financially comfortable. Jinu felt her family were poor, in relative terms. The family's finances were stretched, as her brother also had been supported through university, but education was still of prime importance to her family. Both her parents had pensions from work, affording them some financial security for the future. However, they still needed both Jinu and her brother to work to supplement their incomes and build up their savings again after paying for university fees. As Jinu explained, this was the main reason why she became a nurse: to help support her family in the future as they had supported her through her education. For Jinu, further education was an important feature of their middle-class status, even though her parents had little disposable income.

> Okay,... and I come from a small village in Kerala and, you know, when I , when I finished my Plus 2, that means 12th class, I was told how to go for any professional studies. Then my mother told that to go for nursing because, you know, at that time, you know, it was really difficult [financially]. Actually our family was really poor at

> the time. So they told that I just had to go for professional studies. So I told it's better to get job and I told to go for nursing. And... how to make some money. Yes, just money, sure for the main reason I became a nurse. Because my family also told that you have to support our family. So but to go for, you know, professional studies so that I can support my family.

This obligation to her family that Jinu felt can be linked to the discussion in Chapter Three regarding honouring her parents' wishes and putting the family first in her choice of career, a definite form of future planning.

For some of the nurses, their families may have been middle class but they still needed to take out education loans in order for them to pursue education post-school in India or overseas. This was the case with most of the nurses from the Punjab (bar Minu) and for Jasom and Vin (two of the nurses from Kerala undertaking an MSc). Donner and De Neve (2006) identified the relationship between varying levels of financial security and being middle class. This highlighted how the middle classes in India acted out their roles in society, with various factors in play. These included education, profession, money, and conspicuous and inconspicuous consumption. Financial stability was not always a given amongst the middle classes. Education and a subsequent professional job could sustain the middle-class status; the use of and purchase of goods and services were also a factor. Being able to afford the trappings of the modern world were as important. This contrasts with what Fuller and Narasimhan (2007) described when they identified entrepreneurs or professionals working in the private sector as the new middle class, for whom financial gain was a strong factor in their status. Jinu's family circumstances illustrate this suggestion well. The pressure to send her and her brother for further education was a priority for this family as a means to preserve their middle-class status. However, the high cost of fees to study engineering (her preferred career choice) meant that Jinu was not able to pursue her personal choice of career. The fees for nursing were much lower than engineering, and nursing was seen as offering greater job security. Jinu accepted this, as she wanted to respect and honour her parents' wishes, in particular those of her father.

Sonija also described herself as middle class. However, her upbringing was slightly different to that of her classmates in that she felt she was spoiled and felt favoured by both parents. I visited Sonija at her home in Banbury which she shared with two other nurses from the care home where she worked. In contrast to most of the other homes I visited, their dwelling was bright and well-maintained and there was no mould evident on the walls. As we sat at the kitchen table Sonija explained that she was no cook, and she made me a cup of tea and offered me biscuits from a packet. She was taking cooking instructions from her mother over Skype. She had not learned to cook when growing up at home as many of her contemporaries had. Sonija did not say she needed to cook because it was expected of her as a woman, but rather because she wanted to be more self-sufficient. Sonija and I talked about how she was enjoying living in the UK and we discussed her family circumstances. Sonija explained why her family were middle class, and similarities can be seen with Jinu's discussions of financial stability and wanting to honour her parents. Sonija demonstrated this in her desire to work and contribute to the family income, but also in her intention of paying them back for funding her education. Sonija's father had worked in the Middle East as an engineer for a number of years. This, she believed, gave her family financial stability, and both she and her brother had been able to go onto further education after school.

> The family, we're okay, we are never financially down or anything, my dad was able to afford everything for us. And we never had any issues like that, but now we are starting to because now it's been a long time, and it's high time that I start working. My brother is working anyway, he's looking after the house now, so it's high time I started working.

Sonija's brother had gone to university to study computer engineering and now works in Bangalore. He sends money home to the family now that their father has retired.

Sonija felt that her family:

> Do not expect me to contribute [financially] to the family, but I feel I should because they have done a lot for me and I do have a responsibility to do something for them as well, so I should, so I'm just waiting for this... to get finish, work for some time, do something for them before I get married.

Sonija raised the issues of expectations and obligations, of male and female children respectively. In her social world in Kerala, there is less emphasis on dowry payments (this is not always the case in Kerala; payments can be steep) which meant she was not expected to contribute to the family income or savings. Dowry payments are discussed later in this chapter in relation to Jey's and Minu's weddings. For male children, it is a different case; they are expected to put back some of their income into the family finances (remittance is discussed in relation to migration in Chapter Four). Jey's plan was to work in the UK for six years, then return to India and support his parents in their old age. He reasoned that this is how he will fulfil the expectation both to support his parents as the only son in the family and as part of his adult life, a point illustrated by Fuller and Narasimhan (2014) earlier in this chapter. Jinu's situation differs from most of the other female nurses because she felt obliged to contribute to the family finances, due to her family being in a weaker financial position compared to that of her contemporaries' families, and also because of the cost of sending her to the UK to study. Her husband had an office job but was not well paid. While she was studying in the UK, she sent a small amount of money home to her family. Jinu's wages as a part-time HCA in the UK proved sufficient for her to live on, albeit frugally, and to send money to help her husband with the cost of bringing up their two children. Despite no expectations to do so, Jinu still felt obligated to send remittances home to India.

Sonija's family, like many of the others, also owned a small plot of land that was used to farm rubber. This was the same for most of the nurses from Kerala. Arenn's father is a 'farmer who owns a rubber plantation, this earns good status [for his family] in our part of Kerala'. The status Arenn talked about is related to the disposable income generated by the additional cash, as well as the prestige of being a landowner. Most of the nurses' families own small rubber farms, providing a major crop in the Kerala region. Their parents may be teachers or managers, but it seems to improve a family's social standing if they own land as well. Fuller (1976) argued a similar point: that amongst Christians in Kerala, land ownership was a way to acquire status, and the land was often cultivated by farmers employed from the Punjab region. This was the case for Jey's father who had rubber and pineapples being cultivated on a small farm adjacent to their property which were managed by a family from near Chandigarh in the Punjab. These farmers received a wage and accommodation to maintain and cultivate the land. In contrast to Fuller's findings (1976), each of Jey's three uncles and his brother-in-law all owned rubber farms but they farmed the land themselves.

Although there is insufficient data to support the argument that this was a specific trend, it was certainly the case that many of the nurses that I worked with were part of landowning families that also tended their own land. Osella and Osella (2000:147) showed that landownership also provided their respondents with status. However, the land was mostly used to cultivate rice, which is a staple of Malayali's' diets. Most used the rice for their family's own consumption. Many believed that cultivating their own rice produced a healthier crop than one that was bought externally. The nurses' families are an illustration of the ideas described by both Fuller (1976) and Osella & Osella (2000) about land ownership. The economic motivations behind rubber cultivation is the drive behind the nurses' families to buy land. However, the acquisition of land and the status of landownership helps affirm the status of being middle class in all three cases.

Figure 6: Rubber drying in Jey's parents' garden a symbol of prosperity and welcome additional income

Figure 7: Jey's brother-in-law demonstrating how you cut rubber trees to extract the sap

The contribution of English-medium teaching and education to being middle class

The nurses felt strongly that they were contributing to their family's middle-class status because they were being educated. In this section I discuss education, further exploring the benefits of being taught in English which enhances the chances of studying and working in the UK. Bertaux and Bertaux-Wiame's (Bertaux & Thompson, 1997) study of French society and established links between social status/standing of the individual and their family, and how this informed their identity as being middle class**.** Status is derived from a number of factors: wealth, disposable income, education attainment, marriage to those of a similar status, not to mention the father's occupation. The experiences of the nurses certainly showed these characteristics. The nurses' status is linked to their family's status and vice versa. Improving their status helps the family maintain their position in society. If a family has a good social standing in their community, the nurses strived to maintain or improve it. The pursuit of further education was how the nurses would contribute to the family's status. All the nurses talked about the importance of education and upward social mobility. Benei (2010) has shown this is not unique to India. Likewise, education and being middle class are

intertwined. For the whole of India the highest levels of literacy can be found in Kerala, a statistic of which all the Kerala nurses were proud, whether Hindu or Christian.

Benei (2010) observed that while education could be fundamental to improving a family's socio-economic status, the medium in which it was taught offered greater elevation to a person's position. The nurses also reflected that the language being taught in schools and colleges was important, with the 'better' institutes teaching in English. The majority of the nurses had attended English-medium schools and all had attended English-speaking nursing colleges. In Kerala most of the schools were English-medium, but in the Punjab many of the nurses' families had paid for them to attend private schools that taught in English. English-medium teaching afforded the nurses and family greater status than education in state-level languages, Hindu and Punjabi in the case of the nurses from the Punjab.

For many of the nurses, their parents made conscious decisions to send them to English-speaking schools. Even in their childhood, it seemed that their futures were being planned for. Speaking English and being educated in English is another dimension of being middle class. Minu's parents sent her to an English-medium school, as they wanted her to progress and be successful in any chosen career. Likewise, the family's servant, who was lower class, worked two jobs in order for her to send her children to an English-medium school, with a view to helping get on in life and improve their social standing.

Commentators on social mobility, such as Busby (2000), also identified the importance of English language teaching. Her work centred on a fishing village in Kerala where receiving English language tuition and being able to speak good English afforded the family high status and could lead to a respectable job. Osella & Osella (2000), in their work on social mobility in Kerala, further observed that having English-educated children who were confident enough to speak English in everyday life, as well as formally, added to the social and cultural capital of the family and showed the family in a prestigious light to the outside world. English is also considered as *the* language and thus a fundamental element of being middle class (Fuller & Narasimhan, 2014); Chapter Six on education and learning explores in greater detail the value and importance of being taught in English.

A further advantage of being taught in English, particularly at the post-school level, was that this could provide advantages in terms of job opportunities for the nurses. Apart from the UK, many Indian nurses migrate to Australia and North America. Donner (2011) noted that part of being middle class was the investment in education of children, and adopting education-enhancing strategies. While she asserted that the middle-class parent may not automatically assume education was followed by good job prospects, it would, however, reflect well on a family and enhance their social status. The tangible returns from education may be slow to materialise, but the rewards of the qualification can be great, in terms of enhancing a person's and family's middle-class status, and, in turn, improve marriage prospects (George, 2005), a view that Minu, Jey, and many of the other nurses shared.

Fuller and Narasimhan (2007) have highlighted similar observations from their study with IT professionals in Chennai. Scrase and Ganguly-Scrase (2011) likewise observed the expansion of the middle classes following economic liberalisation across many echelons of society in India. Their work centred on middle classes in Kolkata and Siliguri in West Bengal. One measure of improvement in social standing of the middle classes was the acquisition of education, as well as English language skills which became important as a mark of being middle class. English was seen as an international language by some of Scrase and Ganguly-Scrase's (2011) respondents, and my respondents and their families also see English as an important element of middle-class identity. Astra (1997) identified education as a means of developing cultural capital and thus improving status. However, for the nurses, their parents could reasonably assume they would have future job security as nurses because in India and overseas there is always a shortage of nurses (Simon, 2009). My respondents stressed that nursing is a 'demanded' profession, that is, there is always a need for a nurse. This further highlights the premise that international migration has increased the importance of being a nurse and has had a positive impact on it being an acceptable profession for the middle class (Fuller & Narasimhan, 2006). This may have influenced the improved status of nurses and increased its acceptability to the middle classes in contemporary India, a view strongly supported by my respondents. When I attended Jey's wedding, I was given the impression by Jey, and by his immediate and extended family, that education was also extremely important and an entitlement of being middle class. Education was as important as financial security and disposable income. In contrast, the wealth of Minu's family seemed to have been given a

slightly higher priority than education. However, they were very proud of her achievements. The theme of education is discussed in greater depth in Chapter Six.

Being a Malayali[29] *; a matter of identity*

A powerful theme, that of being a Malayali, emerged from nurses from Kerala; they had pride in their identity and expressed it as a means to support their middle-class assertions. In some conversations with the nurses, they came across with a slight sense of superiority to others from outside the state. This was in reference to how religious they were, as well as the high literacy rates in Kerala, and they also considered those outside the state as less well educated beyond school, and that the outsiders had rejected traditional ways in favour of modernity. Personal wealth for many of the Kerala nurses was important, but displaying this wealth was seen as slightly crass and was related, in their everyday discourse, to other regional identities. Punjabis, for example, were sometimes described as vulgar because of the particular ways they were seen as displaying their wealth. For my Malayali informants, by contrast, it was more acceptable for wealth to be shown through spending on education of the children in the family; having a comfortable house was important but being able to send children abroad for education was crucial. For the nurses from Kerala, prolonged migration has been a pivotal factor in both the robust economic development of the state of Kerala and changes in class status. This has also significantly reduced poverty and has led to 50% of the population considering themselves middle class (Wilson, 2011). In the context of the nurses' social world, this has affirmed why the nurses are adamant that they have a good social status and expectations about positive futures. This move away from Kerala for work has seen many from Kerala migrate to English-speaking nations and the Gulf States (as Sonija and Somm's fathers did), where there have been significant opportunities to improve economic status (Osella & Osella, 2000). Most of the nurses hail from Kerala. Through their families they have links in the UK, primarily in London, with many already working in nursing. This is an important factor as to why they chose London as their migratory destination: a support network was already in place for them. While the Punjab has to a lesser extent been involved in nurse migration, they too had links from family and friends from home. These may not necessarily have been nurses, but still people known to their families through social connections, from the same town or community.

[29] The nurses called themselves Malayali's.

George (2005) believes nurses are the most prominent and most successful migrants from Kerala; indeed, 90% of the nurses from India in the Gulf States are from Kerala. They are part of what Wilson (2011) calls 'export commoditisation', where their skills/profession are viewed as a lucrative commodity with potential to reap great economic benefits. This, in essence, is how most of the nurses from Kerala see the nursing profession: as a means to develop and sustain financial stability for them and their families. This has led me to believe that nursing is indeed a commodity that can be exploited for financial gain and status. Migration in Kerala is regarded by Malayali as the fundamental route to social mobility, and the nurses exemplify this. Christian nurses have traditionally dominated nursing, but the profession is now seeing other faiths such as Hindus from Kerala (respondents Vinn and Abin) taking advantage of the benefits of migration (George, 2005). For many of the nurses, being part of this migration phenomenon has aided their sense of individuality and social identity, and they have taken advantage of the opportunities of social mobility. Migration and education have enabled the nurses to acquire cultural capital through the improvements in their status and that of the family, as well as their financial status, while securing educational capital (Beteille, 2002). Migration from the Punjab to the UK has also been significant since the 1940s although nursing is not a dominant profession as rather more manual or business persons migrated (Chanda and Ghosh, 2013).

Being middle class and life choices

Jey and his contemporaries acknowledged that they were in a privileged position being middle class. Jey felt he had more choice over what he did with his life than those in the lower classes. There was no immediate need for him to contribute to the family finances. He demonstrated this by choosing nursing, even though he had completed a physics degree. The term 'choice of career' was not always the case when considering Jinu's situation, or one or two of the others', such as Jasom, who were 'forced' into nursing. The aim of their parents by choosing their career path was to give the nurses financial security and assure their futures. Along with the improvements in economic status, liberalisation has also created opportunities for independence for young women who are able to work more outside the home. There is recognition amongst the nurses that when both the husband and wife work, the two incomes combined secure their futures, and their children's education. Two incomes mean that both

male and female children could be educated and they did not have to decide who was sent onto further education after school.

For the female nurse, being middle-class improved their status, gave them a greater chance for social mobility and, in many instances, more control over their lives. In Minu and Sonija's cases, they both delayed their weddings to develop their careers and secure jobs in the UK. Devorah delayed having her first child so she could undertake the adaptation course and secure a job in the UK. Devorah commented that if she was living in India with her in-laws they would have exerted a lot of pressure on her to have a child in the first year of marriage. To date, Suki remains unmarried and has looked to secure her future by buying property in Delhi. She purchased two, one-bedroom flats, and has rented them out. Many nurses felt that the opportunities to study abroad post-liberalisation offered them career stability, afforded prestige to them and their families, through travelling and working abroad.

Minu's mother was a role model for her and, in some respects, a pioneer who paved the way for other women to work outside the home. She was the first woman in her family's village to take up a career as a nurse and move away from the traditional role of being a housewife; other women followed afterwards. Minu felt her grandmother was an inspiration to her as well. She was the one to push her mother into nursing. Her grandmother felt that Minu's mother would benefit from the independence of having a career. This would also help the financial stability of the family. This role of family members in shaping the lives of younger family members has been investigated by Thompson (1997) who observed that fathers, mothers, grandparents, older siblings, aunts, and uncles can all play a part in influencing and developing the career of children in the family. Many of the nurses reflected that the reason they chose nursing could be attributed to suggestions and career direction by family members. However, most did not feel they were forced into being nurses; more of them felt that they were guided.

Religion, marriage and being middle class

In this last section, I will show how middle classness is played out by highlighting how some of the factors already discussed influence marriages and the positive impact being a nurse has on the attraction for marriage. This will be done by using my observations and experiences gained from attending two weddings in India. A wedding signifies the making of a new

relationship, extending the social network in a way that can promote the middle-class status of both the bride and groom's families and, as such, warrants exploration and consideration (Mand, 2002). A marriage offers families a way to demonstrate and affirm their middle-class status through the process of how the wedding is enacted, including decisions such as who is invited and what is offered at the wedding feast. These points are discussed and analysed in this section.

The Christian nurses I worked with distanced themselves from caste, but the Christian society has elements of hierarchy that influence whom one would marry, for example. Dumont (1970) suggested that Christians do divide into sub-sections which are similar to caste, but only in a very general way. The classifications are not rigid. Fuller (1976) disputes this and suggests that the sub-divisions in class do strongly resemble those of caste. Fuller (1976) identified the influence of class as being important to a person's status but did note strong similarities with caste stratification. He studied Keralan Christians and identified a hierarchical society with many links to caste. Class is a mechanism for exerting power. The practice of Christian religions in Kerala enacts elements of power and hierarchy. Fuller (1976) contended that there exists a caste structure amongst Christians, where Syrian Christians are at the top of the hierarchy, followed by Latin Catholics, with New Christians such as Pentecostal or Presbyterian faith at the bottom of the hierarchy. He also noted that a person cannot change their status by joining a Syrian or Latin Church; if their status was low, then it remained so. There may be social mobility in class, but religious status can act like caste and can hold back improving one's status. The majority of the Kerala nurses were Latin Catholics. Luke was a Syrian. Somm, Devorah and Aava belonged to Pentecostal churches. I did not sense from Somm or Devorah that they felt they were anything but middle class, and their religion did not affect their perceived sense of status. Indeed, none of the nurses identified or mentioned a link with status and their religion. This may be their youth and lack of awareness or simply something that neither I nor the nurses identified at the time of my study. I also met with the nurses outside their normal context and social groups. They identify as nurses studying together, and being in the UK may have softened the divisions of their Christian faiths. Similarities do emerge with Fuller's work, however, where marriage is concerned (1976:56). He showed that Christians would not marry outside their groupings. Syrian Christians would only marry other Syrians, and Latin Catholics would marry Latin Catholics, while the newer religions would also only marry within their group.

The Christian nurses' patterns of marriage mirror those Fuller sets out. To them, an important aspect of maintaining a middle-class status was marrying within one's own religion and to those of the same class. The nurses felt a certain amount of pressure, even with the feelings of more choice about their lives, to conform to traditions, such as arranged marriage and following their particular religious values. Fuller and Narasimhan (2014) also observed this, as did De Neve (2011), who noted that amongst the young and educated middle classes traditional values and practices were still enacted. Jey stated that 'the family would only accept someone who was also middle class as a prospective bride for him. However, Jey and his housemates agreed that:

> Girls can upgrade their status from lower caste or higher social status married to a higher family this often can be the case of girls who are nurses because of economic benefits and the prospects of travel of nursing.

This was the case for Jey's uncle. His father's middle brother had married his wife, a nurse, who was from a lower-class family but a Latin Catholic, as were Jey's family. However, for Jey and his contemporaries (Abin, Arenn, and Vanesh), they felt it was more important to marry someone on an equal footing to them. The prospective spouse would be more likely to be matched in terms of education and financial status. This did not seem to be about just status, but also practicalities and the future. They stressed that the cost of living was becoming more expensive in India. Consequently, education and financial security were paramount for securing a good future for them. However, for the Sikh and Hindu nurses, such as Minu and Suki, marrying within their caste and education were primary concerns, along with the importance of their prospective partner being middle class. The wealth of the marriage prospect's family was less significant.

What Jey and his contemporaries have described above is companionate marriage. Fuller & Narasimhan (2014) observed this amongst their respondents, namely middle-class Tamil Brahmins. This modern approach to marriage sees the bride and groom matched in class status and in education, with young men preferring graduate wives. Working overseas was also an attractive prospect for future spouses. The attractiveness of education helped facilitate the improvement in female education. They noted that women would often marry straight after their higher education was completed. This was not the case for most of the female nurses I worked with. They may have completed an MSc or BSc top-up degree, but this alone

did not enhance their marriage prospects. Those that did marry did so after they had completed ONP and had found a secure job as a nurse in the UK. Fuller and Narasimhan (2014) noted that, in a modern marriage, the prospective brides and grooms were more involved in the decisions made about whom they would marry. This is obviously more difficult if the person is abroad. Jey's wife, Naya, was found through a local marriage agency and his father, two cousins, and uncle met her and her family on several occasions and deemed her a suitable match. Jey had previously asked that his wife be educated to masters level as he was, but other than that he let his family choose his bride. Jey arrived in India several weeks before his wedding and was able to meet with Naya and get to know her.

Minu was more involved in her choice of husband. Her 'uncle', a family friend, knew Madan's family and suggested him as a prospective groom. Several months before the wedding, Minu made a week-long trip home to India in order to meet Madan. She would not say yes to this potential husband until she had met him and had time to think about it. As she told me, she made the family wait five days before she said yes to the proposal. One of the conditions was that Madan came to live in the UK with her, which he agreed to. She did not want to relinquish her nursing career. More of Minu's reponses to being married are discussed in Chapter Seven. Minu was able to exercise the power she had over the particulars of her marriage; she was in a strong position being a nurse, as this gave her status and bargaining power to achieve what she wanted from her upcoming nuptials. Her career as a nurse is very important to her, and she enjoyed life in the UK and did not want to reliqinquish it. Moore (1998) argued that women who migrate first can bring much to marriage and can help raise the couple's status. Minu was certainly able to do this, being a nurse. Minu and Madan's marriage indicates how migration of women has been influential in the marriage arena. Marriage for social mobilty and women's involvement in migration are factors that Palriwala and Uberai (2008) explored in research on gender issues and migration in South Asia. Migration and employment would have increased Minu's value in the marriage arena, in turn increasing her scope for selecting a partner. In essence, she occupied a strong bargaining position. Madan still had to be acceptable to Minu's family and had to match her background, which he did. He was a Jat Sikh, educated at masters level as a mechanical engineer, and middle class. For both Jey and Minu, being a nurse improved their chances of making a good marriage, accepted by both the respective bride's and groom's families.

The adverts below demonstrate how nursing is a popular career choice when choosing one's prospective wife for resident and non-resident Indian men.

Figure 8: Matrimonial Advert

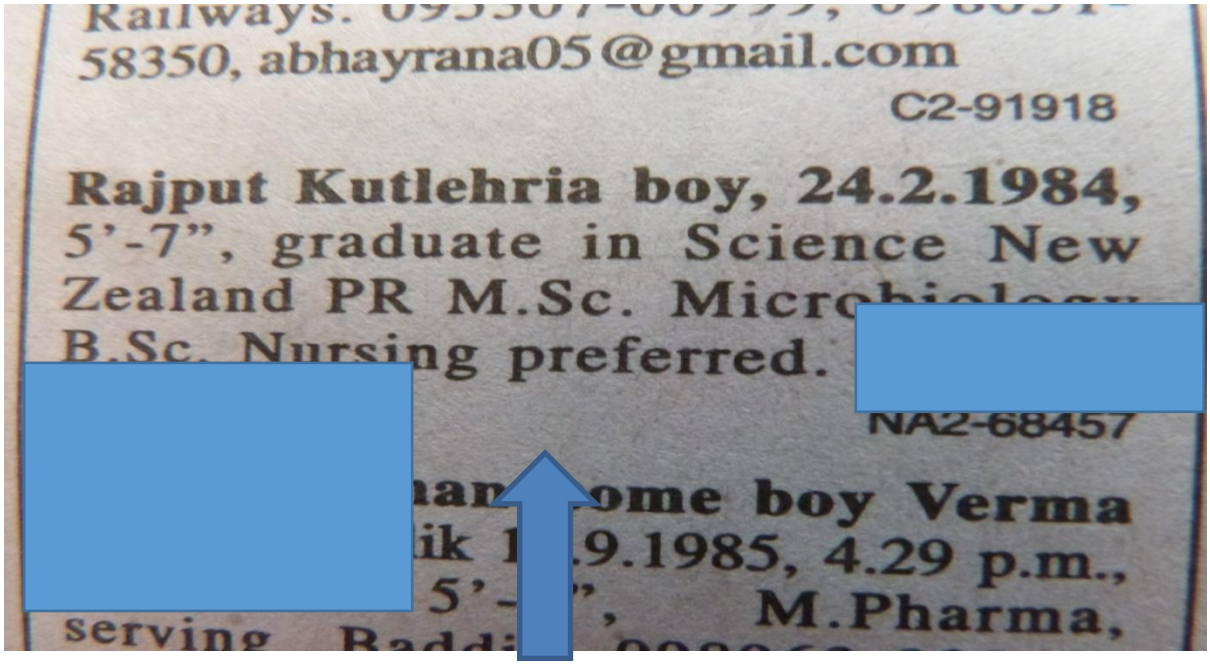
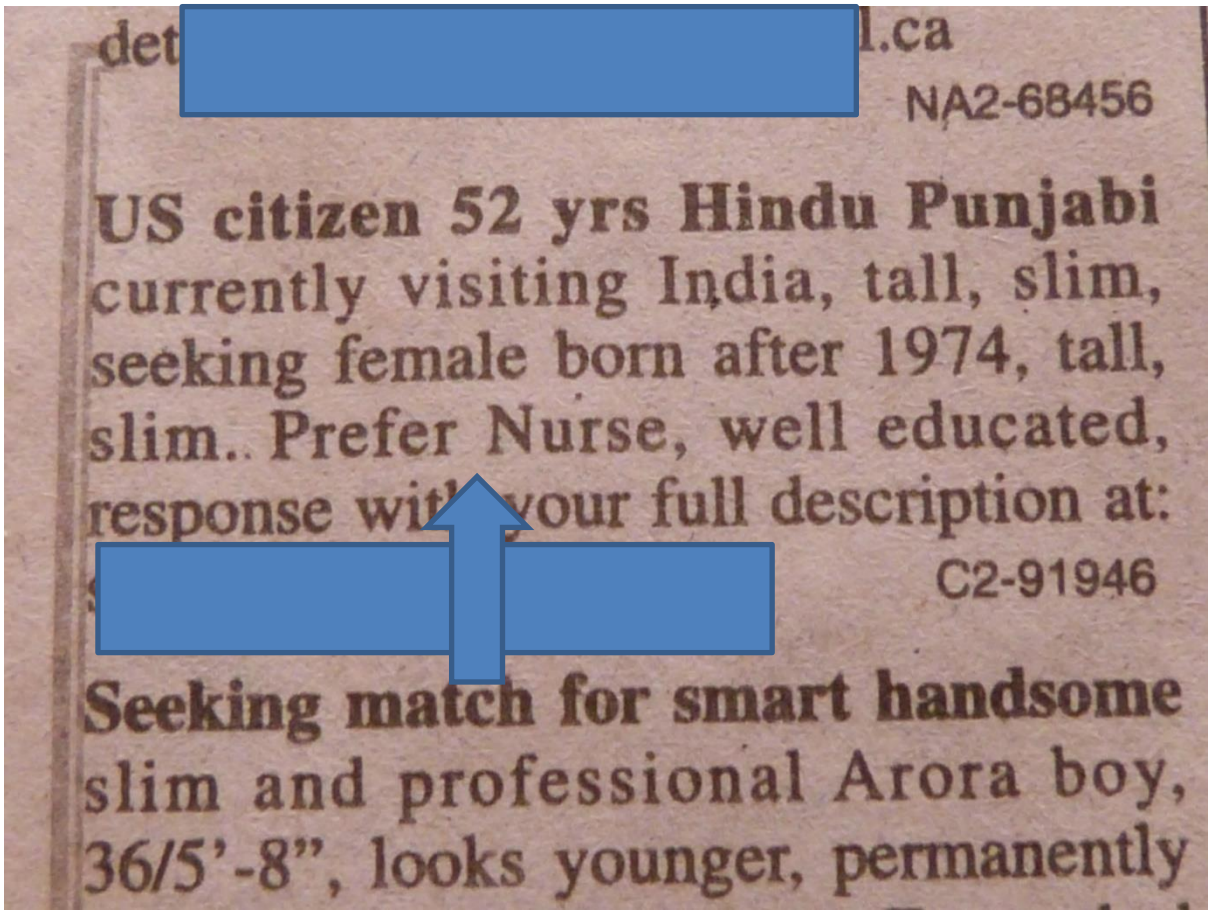


Figure 9: Matrimonial Advert

Figure 10: Matrimonial Advert



An important aspect of marriage is the dowry payments and gifts. A dowry is a payment given to the groom's family as a condition of marriage (Wilson, 2011). Dowry payment through to the 1990s could be high in Kerala; nurse migration, particularly to the Gulf States where wages were higher, offered a way for nurses to contribute to this payment (Wilson, 2011). Marrying someone of the same middle-class status could inflate the dowry price (Healey, 2003). The families of both Minu, and Jey's new wife, Naya, paid dowry to the husbands' families. Minu's father bemoaned the dowry price; he did not reveal how much he spent in total. He purchased items of gold jewellery for five members of Madan's (her fiancé's) family, plus cash for the newly married couple instead of a car as they were going to the UK. Minu informed me that her father would have also bought a car for the newlyweds but, because they were to live and work in the UK, he gave them cash instead. This was the accepted dowry price in their community. Mand (2002: 235) showed the importance of gift giving from the bride's family; gifts were a means of showing the importance of the family to the family accepting the bride. Gifts from the groom's family are also given, in the form of

clothes, a wedding ring, and a gold necklace. Minu received four new outfits from Madan's family to wear when visiting the family after the wedding. Jey's new wife, Naya, arrived at his parents' house three days after the wedding with several items of cookware, a large metal wardrobe, and a picture of Christ's Last Supper. I also witnessed a large wooden wardrobe being delivered to one of Jey's cousin's house after he had married. The wardrobe was more a symbolic than a costly item. The picture of Christ's Last Supper was well-received by Jey's family, and hung above the dining table. Religious objects were a sign of respect towards Jey's family and a common wedding gift between Christians, as a sign of their faith.

Spending time at Jey and Minu's respective weddings with them and their families allowed me to make sense of what being middle class meant to the nurses. Jey's family were financially secure enough that he was able to take six months off from work after the wedding. This enabled him to settle into married life before coming back to the UK and resuming work. Jey chose nursing because he wanted to improve his financial status, as already mentioned in another chapter. His parents being financially secure meant that he could take advantage of this to continue his education in the UK. Education is incredibly important to this particular family, in terms of their position in society and their community. Jey's father was the eldest of three brothers, and he had been a head teacher. He had more disposable income than other members of the family and was able to help other members of the family by assisting with post-school education costs. Each of Jey's cousins, uncles, aunts and other family members were introduced to me by their highest education achievement (discussed in more detail in Chapter Six). Each spoke English and wanted to practise this with me. As Jey explained, this was the family's way of indicating their importance: through education and through speaking English. They were demonstrating their education to their peers and to the rest of the family, by showing how advanced they were with their use of English.

The importance of education for middle-class families was also evident when I attended the two weddings. Both sets of family members showed considerable pride in the fact that Jey's and Minu's professor (as I was called) from the UK had attended both the weddings. This represented affirmation of education status and a display of middle-classness. At Jey's wedding in particular, it seemed that everyone wished to speak to me and everyone wanted to

comment about life in the UK and how nursing is a good profession in the UK. While there was less direct conversation about education amongst Minu's family, they were proud of her studying in the UK, and of the fact that another daughter lived and worked in Dublin as a nurse, a direct result of her overseas education. Following the wedding party, one uncle engaged me in conversation about the merits of being a nurse in the UK, and how it was a good job with high status and that Madan, her new husband, had made a good match with Minu, reinforcing what was discussed earlier. Most of Minu's younger relatives and friends spoke some English and were more curious about life in the UK than Jey's family had been. One cousin wanted me to get her a place at the university I worked at so she could continue her education. Other than that, little mention was made about education. Much talk was about how lavish the wedding was, and what a good match it was for both families.

One aspect of how Jey's parents reinforced their middle-class status was offering a variety of plentiful foods. They displayed their hospitality by doing this each day during the wedding celebrations. Whilst this is not uncommon at wedding ceremonies amongst all classes, Jey stressed that this was more lavish than the lower classes could offer. This was a particular way his family demonstrated they had disposable income, as well as the number of people fed at the various wedding parties. There were around 600 guests at the wedding and the feast that followed; everyone connected to both sides of the family (Jey's and Naya's) was invited to the celebrations. The feast included beef and fish curries plus an assortment of side dishes and rice. Around 70 of Jey's close family members were entertained at Jey's parents' house the night before the wedding and the morning of the wedding. Jey suggested that part of being middle class and maintaining a good image was being generous and displaying the fact that they had disposable income through their generosity. This was not in terms of physical luxuries such as cars and gold jewellery (as I observed with Minu's family), but more to do with who attended the wedding. This meant that each family member, even distant relatives, were invited to the wedding, to avoid potential insult. This is what Mand (2002) highlighted as important to the status of the family and the wedding; inviting both rich and poor relatives was a way of including all, but also showing generosity. This could be detrimental to the families' high status. Many of the nurses spoke of this happening within their families. What did not matter was the financial stability or the status of relatives; all were welcome.

In contrast to Jey's wedding, Donner (2011) has commented that feasts have become less elaborate in Kolkata. This, she argued, was a factor in urban weddings of the middle classes, where some western food and consumables such as branded soft drinks are consumed. Jey's wedding contrasts with this, but Osella & Osella's (2000) description of a Christian wedding, also in Kerala, fits well with what I observed. A wedding venue such as a village hall is hired, outside caterers are used, and traditional food is served.

Figure 11: Part of the celebrations after the wedding ceremony was for Jey and Naya cutting the cake in front of their guests and this began the wedding celebrations.

Figure 12: The feast at Jey's wedding, held in the village hall. There was around 500 guests at the feast all catered for and there were left overs which we enjoyed at Jey's home the day after the wedding.

Figure 13: At the reception, Naya is now in her red wedding sari a gift from Jey.Jasom is to the far left of the photo in the purple shirt, and Arun is next to him.

Minu's wedding was in a wedding palace, which is normal practice amongst her family and social group. A wedding palace is a venue used by families to celebrate a marriages. Since a wedding can be typically be for 500-1000 guests the place is able to cater for this amount of guests and provide entertainment. Two buffets were served during the day; Minu's father told me that they were of the traditional Sikh diet which is all vegetarian food. The noticeable difference in the two weddings was the consumption of alcohol by the male guests at Minu's wedding. They drank whisky. Her father told me this was a status symbol and an expectation at a Sikh wedding; it also had to be the best whisky. He said: 'Have you not seen here in the Punjab? You see rows of shops, one is a sweet shop, one a drug store and the next a liquor store'. These three types of shops were repeated along the streets in the city and town. I did observe this when we visited Chandigarh.

I was much more involved in the build-up to Minu's wedding and was able to be part of all the preparations that took place. I arrived a week before Minu's wedding; she had only arrived two days previously and there was still a lot to do in terms of planning. Unlike Jey's wedding, I saw very little of the preparation but I was involved in choosing Minu's wedding outfit, jewellery and shoes, accompanied her on trips to the beauty parlour, and participated in the henna session where all the females members of the family and friends were decorated with henna.

Figure 14: Henna application, the day before the wedding. A fun-filled afternoon, replete with gossip and laughter. Minu is to the far right, wearing a green T-shirt. The henna was applied by and man and two assistants.

I met various family members as they arrived at Minu's home prior to the wedding. There was much excitement amongst the women of the family and one evening the women engaged in traditional dancing. Minu's father was the most prosperous in his family, and Minu

explained that many of her cousins were from the country and had less wealth but were all well-educated, possessing bachelor degrees in commerce and teaching. Minu's mother was very much in the background during the preparation outside the home. It was her father, fiancé, and brother who accompanied me and Minu to choose the wedding outfit, jewellery, and so on. Minu's mother also stayed behind when we went on a trip to the Golden Temple in Amritsar, the Sikhs' most holy place to give thanks for a good marriage. I went with Minu, her father and 'uncle', who was actually her father's closest friend.

Figure 15: 'Uncle', Minu's father, centre, and Minu at the Golden Temple where prayers were offered for the success of Minu's upcoming marriage.

Minu's mother did not come along on this trip, as Minu stated 'she had too much to do at home [in preparation for the wedding and guests staying at the house].' This seemed unusual to me, but Mand (2002), in exploring Sikh weddings, described women as being very much

involved in the home preparations, greeting visitors and gatherings of female relatives. Outside the home was the domain of the man, in this case, Minu's father and brother. Minu's father was also the one who handled the money; he arranged and paid for the gifts, and the wedding venue, explaining why he was involved in the public-facing aspects of the wedding.

On the day of Minu's wedding, she spent four hours being dressed in the lavish bridal outfit with accompanying jewellery. Her best friend and neighbour went to the beauty parlour with her for the preparation. The first time the rest of the wedding party saw Minu was at the wedding palace. Minu's family were gathered there once she was in the building while some of the female relatives and I formed a receiving party for Madan. He was accompanied up the drive of the palace by drummers and bagpipes and the members of his family. It was very loud and a bit raucous. He was then accepted over the threshold of the palace. Minu thought this important as it recognised tradition being honoured in how the wedding was played out. Mand (2002) noted the use of traditions and how they would be enacted were an important aspect of Sikh weddings, which I know Minu wanted to respect, as she lived in a contemporary world but still desired to uphold tradition and embrace it. Once inside, Minu and Madan were hurried upstairs by the photographer's assistant and many pictures were taken over a period of two hours. Minu and Madan had not been alone together or physically touched before this point, and they were both visibly shaking.

Figure 16: Minu and Madan posing for photos prior to the wedding ceremony. This took place over a period of two hours. Once the photographs were taking a small party

The wedding ceremony took place after the photographs in a small Gujrat (Temple) in the town. This was a small affair with only about 30 people in attendance. This was the most formal part of the wedding and lasted about 45 minutes. Afterwards we arrived back at the wedding palace where Minu and Madan were escorted to a stage by the wedding guests to receive gifts and good wishes. Minu's wedding had about 800 guests in attendance; there was music and dancing, and a lot of whisky drinking by the men. The ceremony lasted until about 7 pm in the evening. At Minu's wedding feast, while the men danced on the makeshift dance floor (see picture below), beggars entered the grounds. They scrambled for low denomination notes that the men flicked in the air and discarded as they danced. There were about six individuals, all male, the youngest looked about eleven and the eldest in his thirties. When I spotted the gang, I questioned one of Minu's cousins who they were. She explained that gangs of beggars, usually all men, went from wedding to wedding, collecting up the money that was thrown to the ground. It was my understanding from her that this was very normal practice, but to me, as an outsider, it seemed somewhat intrusive and a bit unusual, as the gang leader stood and watched and collected the money. I asked Minu about this practice. She said it was very common in the wedding season (which runs in the winter months). I told her my initial thoughts about what I saw. She admitted that it was sad but in a way a form of employment and it was another way in which the family could be seen to display their wealth, as the cash was seen as disposable income and therefore not important. In contrast, at Jey's wedding, the ceremony took about four hours and was officiated over by four priests. The wedding banquet was served, but there was no music or dancing and once the food was eaten, the guests left. A few family members came back to Jey's parents' house afterwards, where they chatted and sat for a few hours then left, marking the end of the wedding.

Figure 17: The wedding ceremony in the Gujrat (Temple) this was attended by about 30 wedding guests made up of close family and friends.

Figure 18:The male family members dancing at Minus' wedding feast. The women joined the men later on the dance floer

Figure 19: The newlyweds sitting on the stage receiving gifts which consisted of mostly money.

Figure 20: Posing for a photo at the wedding feast with Minu's cousins. My outfit and shoes were chosen by Minu's father.

Conclusion

What this chapter has shown is why the nurses all believe they are middle class. Derne (2008) and Fernandes (2006) explored the notion of the so-called 'new' middle classes. While their work centred on consumerism, their discussions on social mobility, education attainment, and identity linked to language, religion, region, and caste highlight the experiences and reflections of the nurses. The fundamental difference with this view and the nurses is that they do not position themselves with the 'new' middle classes, as they all felt they had a family history of being middle class. Because the nurses are middle classes, they have an established social status which becoming a nurse helps them bolster and sustain. This is due to the many benefits such status can afford them, such as post-school education, overseas work, and travel. The middle-class status also acts as a motivation to become a nurse as they

can, in theory, sustain this status for them and their family through being a nurse. Education attainment is important to all of the nurses. For the nurses from Kerala, English-medium teaching was a given and adds further merit to their social status. In contrast, some of the parents of the Punjabi nurses sought English-medium teaching to help raise their child's social profile. Caste and class co-exist for most of the nurses. However, what is clear is that class is a more significant indicator of social status for this group. For the Christian nurses, this may account for why class is more prominent in their discussion on social status. Attending two weddings—one Sikh and one Christian—has afforded me a view into how middle-class status might be demonstrated through the major life-cycle rituals for these young middle-class nurses. I take the theme of education further in Chapter Six, and explore and examine the impacts of learning in both India and the UK.

Chapter Six Learning – From the mouth of the teacher

'Learning and teaching was from the mouth of the teacher that is the education system in India. This means that the student learns from what is coming from the mouth of the teacher, students always depend on the teacher for ideas. A student is not expecting to challenge a teacher or what he is teaching. In the Indian education system the teacher is a God'-: reflections from Jey.

Introduction

This chapter continues the theme of education raised in Chapter Five. Education, and teaching and learning, are considered. The nurses' experiences of formal learning and teaching in the UK will be explored, as well as their reflections on their learning journeys in India. The narrative concentrates primarily on their formal learning, but aspects of the nurses' informal learning has had some influence on their experiences in the UK. The nurses' experiences in the classroom in the UK and India form an integral part of living and being in the UK. I will show that the nurses' motivation to learn and their identity as nurses are shaped by experiences of learning to be a nurse. This learning journey takes a very different format in the UK compared with that experienced in India. This can pose a challenge for the nurses if considering the requirements of UK registered nurses for continuing education through their whole careers. The challenge for Indian nurses is twofold. It is not just about the clinical/practical application of nursing skills which the Overseas Nurse Programme (ONP) prepares the nurses for, but also about the academic aspect of nursing which is an integral part of nurse education. Indeed, student nurses must complete an equal amount of theory hours to clinical hours (NMC, 2018).

Pelissier (1991:75) proposed that 'Learning and teaching are fundamental, implicitly or explicitly, to human adaptation, socialization, culture change, and, at the broadest level, the production and reproduction of culture and society'. This is a good basis from which to explore notions of learning. 'Formal learning', as defined by Pelissier (1991:87), is dedicated teaching and learning through a course of study, and has a formal language and discipline attached to it, and it is in this sense that I apply the phrase here. 'Informal learning', by contrast, tends to be activity-centred and takes place in a person's social world. Each of the

nurses I worked with had gone through a process of adjusting to a different style of teaching and adopted a different approach to learning in the UK versus their experience in India. For some, this was a relatively straightforward process yielding academic success. Unfortunately, for a number of the nurses, this was a much more difficult experience that has led to failure or not achieving in the way they expected or anticipated.

The concepts of situated learning as proposed by Lave and Wenger (1991) offer an interesting dimension in relation to the nurse's experiences of education and learning. Central to their argument was that learning cannot be viewed purely as cognition. But it is also rooted in social context and cultural processes. Following on from this communities of practice see the learner closely linked with the community where the learning takes place. Lave and Wenger (1991) describe 'old timers' being an integral part of teaching apprentices or 'newcomers' to be socialised into a particular community. The student or nurse (in my study) may be on the periphery of nursing or the academic social world to start but will gradually be integrated into the community of practice through teaching and practice experience with patients. Teaching student nurses and qualified nurses are very much delivered in this vein where the experienced 'old timers' engage with the 'newcomers' to enter the community of nursing. The student nurse begins as a novice and through situated learning which straddles cognitive, social and cultural knowledge they themselves can become the 'old timers'.

Nursing education and fieldwork in India

Each of the nurses in my study had to achieve a certain level of education in order to enter nursing programmes in India. For example, to enter the Carmelite School of Nursing near Cochin in Kerala, and many other schools of nursing, the students must achieve a 50% pass rate in the 12th grade examinations (end of school examinations at 18). This was typical of the other colleges I visited. The fees for nursing are lower than many other post-school courses; many of the middle-class families took out a study loan from the bank. These loans were promoted by the government as a means of increasing post-school studies. These families could usually afford to pay back the loans and interest. A few of the nurses I met in India and in the UK had taken out study loans, either to help with initial nurse training or to fund their studies abroad. The principal of Mission College stated there were very few students from lower classes attending her college. This has been observed by Mehta (2006), where

scheduled castes, other backward castes, and Muslims, were markedly underrepresented in the student bodies of Indian colleges. Mehta (2006) found this could be largely attributed to poor secondary school education and lack of preparation for further study and university. This may explain why from my own research I came across no Muslim nurses or nurses who identified themselves as lower-class. It may also be one of the reasons why policymakers in India have been trying to address this issue in uptake of university places and loans (Mehta, 2006), and also through the reservation policy in the workplace (discussed in Chapter Three). What this shows is a contrast between what the nurses felt about being disadvantaged by the reservations policy and the reality that they were in a privileged position because of their social background in terms of education and opportunities to work/study overseas.

To prepare myself for my study, I needed to consider what learning is in terms of Indian nurse education. I carried out interviews and observations of classroom teaching at five schools/colleges of nursing during initial fieldwork in India in May/June 2010. Learning is concerned with the development of feelings, reflection, and thinking, as well as doing (Kolb, 1984). Learning styles develop from engagement with learning activities, preferred ways of learning, and how the student interacts with their environment when learning occurs (Yamazaki, 2005). What was evident from my observations was that Indian student nurses have a different approach to learning than UK-taught students, but not dissimilar to other overseas nurses and have developed preferences for learning styles. The locations of this part of my fieldwork were in the southern district of Kerala, South West India.

The insight I gained into nurse education in India helped me make sense of the nurses' education and learning journey in the UK, which did not always seem to match their expectations of nurse education in the UK. The classroom observations in India showed that the style of teaching was repetitive, and could be considered didactic in nature. This type of teaching is what I had expected to observe from reviewing education literature on India (Clarke, 2010; Donner, 2006; Niles, 1995; Osella & Osella, 2000). Initially, this made me think that the Indian-style education was detrimental to the nurses' learning; however, this was not the case, and each of the nurses I met had a good foundation of nursing knowledge, which they were able to apply clinically. For me, reading the literature alone did not give enough of an understanding into the variation in learning styles, teaching methods, and a set

of norms and values associated with education that differed from the ones I am familiar with. As Yamazaki (2005) has proposed, this is brought about by cultural influences on learning and socialisation, which lead to preferred ways of learning within a particular context. Thus, the nurses' learning styles are shaped by their experience and the culture of education in India.

Carmelite School of Nursing, respect and deference to the teacher

I observed several teaching sessions at the Carmelite School of Nursing, Kerala. I have chosen to reflect on one particular session with a class of second year student nurses who were being lectured in medical nursing theory to highlight the nature of rote learning and how student nurses learn. As I entered the classroom, I was introduced to the students by the tutor. There were 25 students in the room, all female in their late teens and early 20s. They were all dressed in their nurse uniforms: long lilac dresses with white medical coats over the top of them, and open-toed shoes, ready and prepared for when they would go on to the wards after the class. The room was much like the rest of the school and hospital; it was drab, the plaster was chipped away in places, and the room would have benefited from a good lick of paint. Each student sat on a wooden study style chair, each with a notebook in front of her. I was positioned in a seat at the front of the room across from the tutor. I was told the topic of the session was epilepsy.

The session was delivered very much on a 'chalk and talk' basis, and by rote learning[30] and memorisation**.** The room was deathly quiet, apart from a fan rattling above our heads, until the tutor began the session. The class was taught in English, and the students responded to the tutor's questions in English. I was later informed that if the students spoke in Malayalam[31] they would be fined one rupee and it would be recorded in a book of misdemeanours (see the rules the students had to subscribe to below).

[31] Malayalam is the 1st language of Kerala

The session started with the tutor asking a series of questions about the aetiology[32] of epilepsy. The students all answered in unison, as if reading from a script. For example, at one point the tutor asked: 'How are messages carried to the brain?' They responded 'Neuro pathways', with no deviation from the script by either the tutor or the students. This pattern was repeated several times concerning different aspects of epilepsy care, and the tutor would ask after each learning point things, like 'clear for you?' Or 'you want any more?' These were rhetorical questions and each time the students gave the expected answer, again in unison. The tutor repeated this type of questioning again through the session; for example, she would say: 'I think you all understand?' Each student would say 'yes' and the class would move onto the next section. The means by which the tutor phrased the closed questions served to shut down any possibilities for queries to be raised, rather than encouraging students' questions. There were no opportunities for deeper discussions on the subject matter, or for clarification of queries if there were any. I did wonder at the time what would have happened if they had said something was not clear or that they wanted more information, but this did not occur.

During most of the session the tutor spoke rapidly, reiterating facts and statements. The classroom became quite noisy and it felt slightly frenetic as the students regurgitated answers at the tutor, to the extent that I abandoned my note-taking for a while until the class calmed down a bit. At the same time, the students were also busy scribbling away in their notebooks. The tutor would repeat the section of care that had just been covered and when doing so she would select one student to stand up and summarise what had just been said. In fact, what the student was doing was repeating what the class had previously just spoken about, and not delivering a summary of the information. At the points when the students were repeating back to the tutor, she would interject throughout the conversations, in essence answering the questions she had asked of the students. As the session progressed, each time an important point was made the students were instructed by their tutor to 'underline / highlight, underline/ highlight. This will be in your examination'. The observations in this classroom session illustrated teacher-led learning which is commonly associated with rote learning, where the role of the examinations is the end point to demonstrate academic achievement. Despite my initial scepticism of the success of this approach to nurse teaching in India, it was very clear

[32] Aetiology – study of the causes of a disease

as the lesson continued that the students had sound theoretical knowledge of this area of nursing practice as I assessed through my professional knowledge of the epilepsy.; this method of teaching had enabled them to build on previous knowledge, as the afternoons were spent in the clinical setting on a ward of the hospital located next to the college.

Figure 21: 'From the mouth of the teacher' lesson on epilepsy.

Academic success is seen as desirable and the teacher is a respected figure (Ninnes et al., 1999). The nurses I worked with in the UK all experienced this type of coaching in their nurse education; even so, the nurses still needed to have an in-depth knowledge of the curriculum. They were generally told what information to include in their written case studies or the specifics of what would be in the content of the examinations. Somm (from Kerala) recalled that

> The colleges [nursing] tend to try and ensure that all their students pass the exams so that their reputation does not fall. The case studies that have to be done are straight forward and not challenging.

Jey, my informant from Kerala, reflected on his experience of being taught nursing:

> Learning and teaching from the mouth of the teacher that is the education system in India. This means that the student learns from what is coming from the mouth of the teacher, students always depend on the teacher for ideas. A student is not expecting to challenge a teacher or what he is teaching. In the Indian education system the teacher is a God.

Jey's words reflect how the student nurses I observed acted towards the teacher. There was a level of deference to her; not one of the students questioned her, and they all looked at the teacher for the entirety of the lesson. When I discussed this with the Indian nurses in the UK, many felt their teachers deserved respect as they were imparting knowledge to them; their teachers were the true experts in the field of nursing. Teachers in their social groups and families were seen maybe not quite as Gods, as Jey put it, but certainly as respected figures with a high social standing. This I observed for myself when I was referred to as Jey or Minu's 'professor' at their weddings, and when many of the guests sought me out to converse with me on all sorts of matters, from their educational aspirations, to life and nursing in the UK. At one point in the evening before Jey's wedding, I was summoned to sit down next to and speak with the senior priest of the area (a guest at the pre-wedding party). This, I was told, was a huge honour, as his time and conversation was precious. I also took this as a sign of my status as a 'professor'. This hierarchy and high status of teachers is important as this further helps support the view of the nurses that post-school education will bring them and their families' status and enhance their social standing.

Guru's and their role in teaching and learning

I have likened the respect given to teachers to the caste status of teachers, or to the high social standing of individuals, such as gurus, who are highly regarded as purveyors of knowledge. Guru is a Sanskrit word, and identifies a person who is a teacher as well as a person who is

respected, and who can in turn support the spiritual development of the learner (Pandya, 2016:205). The role of gurus in India has had an impact on how people relate to teaching in other contexts, such as the student nurses I observed and the deference they gave their teachers. This can offer insights into how nurses view education through to how they were taught and the respect given to such teachers/tutors.

Gurus have been noted in India texts going around 4500 years (Saha,2007). Gurus were still evident in literature in the 1950s and in contemporary India literature, gurus were still seen as imparters of knowledge and spiritual leaders, looked up to, and revered. Teachers are also imparters of knowledge. Gurus had personal contact with the students, and hence could develop an individual's belief and influence their life path. This reference to teachers as gurus was prominent in Kale's work (1970). The teachers have a value judgement in their role, and this is in part formulated from their own views, supported by history and tradition imparting high status on teachers. Kale's research (1970) centred on secondary school teachers. Undertaken in 1968, and therefore dated, it nevertheless offers some insight into the high status given to teachers, and some parallels can be drawn with nurse tutors. The teachers were adamant that the teacher commanded respect and had prime authority over the students he worked with, not to mention their learning (Kale, 1970:372). This was in much the same way the nurse tutors interacted with their students. Gurus in contemporary India are observed working in transnational institutions funded by their devotees. Often the followers of gurus have come from the educated middle classes and from urban environments. The style of the gurus ranges from well-dressed business type personas to wild traditionally-dressed purveyors of spiritual reasoning. What they offer varies from addressing spiritual needs to teaching techniques to alleviate stress, such as meditation and relaxation methods (Warrier, 2003). Gurus are viewed as spiritual leaders who have mystical powers, which followers can reach out to in order to help heal themselves in a spiritual way. The middle classes may move from one guru to another to find which one fits their needs. What is certain is that the follower will align himself or herself with a guru and give themselves up to him or her. In this sense, the guru has high status and is seen as an individual that can influence and control a person's destiny (Warrier, 2003).

Gurus and teachers do bear similarities to each other, in that they both impart knowledge. Gurus, however, do not seem to have the level of authority they did in the past: individuals will move from guru to guru until they find one that fits with their beliefs and needs (Warrier, 2003). This differs from the nurse teacher, as the student has no say on how and what they are taught. As I have shown, they are often forced or pushed into nursing and have little control over the career they have chosen. The key element of spirituality which is foremost in the rhetoric of gurus is not present with the nurses, but most of the nurses are Christians. In the case of Hindu nurses, they were taught at Christian colleges where some indoctrination would have been present.

Apprentice Learning

The anthropological work on apprenticeships is also useful here, for looking at and considering learning and teaching of a practical profession in relation to my own work and the nature of nursing clinical work. Marchand (2008), in anthropological research on apprenticeships in Yemen, Mali, and London, found that that being an apprentice involves deep engagement with learning, leading to becoming a skilled individual. The apprentice develops a sense of belonging to a particular trade that involves social development and moral code. In the same way, becoming a nurse has similar properties and characteristics. The nature of apprenticeship learning can be seen in the nurse-tutor and student-nurse relationship. The tutor is an experienced nurse, passing on knowledge to the novice.

Chaikin and Lave (1996: 37) work is also relevant to apprentice learning. They studied Liberian tailor apprentices and observed that became part of the community of Tailors through a shared language and implicit norms much as happened in nursing and provides the identity of a nurse. Learning occurs through not just transmission of knowledge by educators but how takes place with others interacts, learning outcomes are socially constructed and this will help bridge the theory-practice gap to help apply academic knowledge to practice which is very much a part of developing as a nurse (Lave & Wenger, 1991). Korthagen (2010) supports the arguments by Lave and Wenger and explain how situated learning with its embodied social learning and cogitative learning characteristics of knowledge development can both can take place in harmony to bridge the theory-practice gap as exemplified by nurse education.

Simpson's (2006) ethnographic fieldwork amongst apprentices in shipyards in the state of Gujarat noted that learning was framed by hierarchy and respect. Learning was often repeating activities gained through watching a master at work. In Simpson's case, humiliation was another key teaching strategy, where one would hope not to repeat a mistake for fear of being humiliated. Much of the student nurses' learning is carried out in a similar way through observation and practical application of a skill as well as being able to breakdown a skill into its component parts, although I did not observe any habitual humiliation. Simpson (2006) argues that the use of one's mind to understand fiscal matters and accounts was seen as 'brain' work and much harder, and the domain of ship owners or merchants (Simpson, 2006), while the manual labour of the ship workers' work was seen as 'easy' work. High status was afforded to the work of the mind and less to labour of the body in the manual work. Nursing straddles the two domains by being classified as physical work, with caring and nursing patients, and theoretical knowledge associated with disease and illness, i.e., the science of nursing. Lave (1997), in her work on apprentice tailors in Liberia, suggested the notion that school education contrasts strongly with how apprentices learn their trade. School, however, does prepare the apprentice for cognitive thinking and problem solving in the context of being a tailor.

Continued links can be seen with Simpson's work in the area of the relationship between the master and the apprentice, where deference is shown by the apprentices, along with a willingness to follow the rules and boundaries of the relationship. This is seen in what I describe in my observations of classroom activities and the nursing students and their teacher. The aggregate knowledge that the apprentice gains narrows the gap between the student and the master, in terms of skills and knowledge, and this is seen in the student nurses as they successfully register as a practitioner. A further area that Simpson (2006) emphasises is that, despite the apprentices' disadvantaged social backgrounds (that of low status), they can be improved by mastering their art which may lead to them becoming merchants or ship owners. A range of possibilities may be open to them through learning a craft. Similarly, as I have discussed in previous chapters, nursing can lead to increased social status and a change in fortunes. Interestingly, nursing in the UK has now begun to develop nurse apprenticeships as a way to become a nurse while being employed. The nurse apprentice is employed by a hospital trust, and sponsored by the trust, allowing them to avoid costly fees and taking out student loans (NMC, 2017).

Style and delivery of teaching

Apprentice and guru learning commands not just respect for the teacher, but also allows for the acquisition of practical skills or ways of being, and offers insights into how the nurses view and embrace teaching and learning. The practical application of nursing theory, as taught in the classroom sessions in Kerala, and the experience of my respondents, are still relevant to nursing in India today. The nurses I engaged with believe that nursing is a practical profession within which one 'does' something to the patient to make them better or to feel more comfortable. As Suki reflected, 'In India nursing is based on practice and improving skills for the better. In India we practise and then attend the classes which helps to improve the skills'. Therefore, the application of effective, practical-orientated skills is why many nurses enter the profession, as discussed by Ramburuth (2000). The learning that takes place in both the classroom and the clinical setting of nursing bears some similarities to apprenticeships. Apprentice skills that are developed and learned are enacted in the workplace (Lave, 1977). The student nurses I observed being taught went to the clinical areas (ward in the hospital next to the college) after their theory lessons to practise what they had learned. Similarly, apprentices are subject to structure and discipline in the process of learning in nursing. Lave (1977) studied apprentice tailors who moved through different stages of learning advancing skills as they developed into masters in their field. The practical activities enabled the apprentice to develop their skills to a high standard. This approach is what Bourdieu and Passeron (1990) termed the 'scaffolding' approach, where the learner carries out tasks in a bid to eventually be unassisted in the learning activity. Benner's (2000) seminal work on acquisition of nursing skills/practices reinforces the terminology coined by Bourdieu and Passeron: she noted that student nurses progress along a continuum from novice to expert. Nurses who changed roles and worked in a new area of practice would start on the continuum again and progress until they were expert in the new area of nursing.

As identified, there is discipline in learning, as Lave (1982) noted in her work. The apprentices she observed used a curriculum of sorts which was identical and often followed a similar sequence. Likewise, in nursing there is a standard nurse curriculum laid out by the Indian Nurses Council (INC) that all student nurses must follow. There may be some reordering of learning, but essentially all student nurses throughout India follow the same

course content to achieve qualified nurse status. There is a difference here to Lave's (1982) observations on apprentices, in that nursing does have the formal classroom-based learning. Therefore, learning in the classroom setting and in a practice/clinical setting reinforce the notion of the 'on-the-job' nature of apprentice training applying to nursing students, too.

Teachers have positions of power and influence, but such power is emulated through their social standing, nursing experience, and knowledge of the nursing curriculum. There is an element of power over the lives of the students: ultimately, they will mark and pass/fail their academic work or clinical practice. Thus, the teacher decides if the student will become a qualified nurse. Caste and the role of Brahmins or higher castes as teachers could also be used to explain why teachers have high status amongst my respondents and in my observations. Many of the Kerala nurses are Christian and, as I explain in Chapter Five, they do not feel the constraints of caste, and distance themselves from it. This may be unique to the Kerala nurses; many other Christians and non-Hindus throughout India do feel the influence of caste in their private and social lives (Osella & Osella, 2000). What I suggest, and what my research supports, is that the high status the nurses afforded to their teachers is initially articulated in the high status given to education, which is one element of their middle classness. By affording their teachers a high status, they continue to improve their status as they are educated. The nurses would also speak of the university in the UK in which they were enrolled as one of the most prestigious in the UK. This served to perpetuate the image of education as a high-status attribute. Pelissier (1991) argues that learning and teaching are intertwined and encompass elements of socialisation and cultural change, which in turn serve to enact culture and society. Teaching is a noble profession; therefore, being educated means you are pursuing knowledge and improving yourself. The nurses use their educational journey and the role of the teacher as a way of affirming their middle-class status. This element of life is an important part of their identity and negotiation in the social world. It is education that brought most of the nurses to the UK, and will ultimately determine where their career and futures develop.

I now return to my classroom observation. As the class continued, each time the tutor asked one of the class to feedback material, she would wave her hand at the individual, gesturing for them to stand up, and, with a wave of her hand, indicate for them to sit down in a way that

seemed quite dismissive. The students did not seem to react in a negative way to the tutor's attitude. This was because they expected this response from her. Both Minu and Rennu[33] recall how most of their teachers were strict and unapproachable and, although Rennu remembers the occasional tutor who was 'sociable and friendly', the norm was a tutor who was detached and unapproachable[34]. As she reflected,

> When I was [a] student some teachers are strict and I was afraid of them but I learned more quickly and some were less strict and I relax and learn comfortably but slowly. In India nursing is based on practice and improving skills.

Rennu's reference to nursing in India being based on nursing practice is discussed later in terms of why some of the nurses struggled with their theory-only MSc and BSc courses that they undertook in the UK. Many of the nurses said they were sometimes afraid of upsetting their tutors and were keen to follow their direction. The curriculum in India has a heavy emphasis on learning skills and academic attainments. The classes would typically be long; eight hours a day with homework each night. Discipline and dedication were needed to succeed. Discipline was important to the students I encountered. They were extremely dedicated to their studies, but the stakes were high in terms of successful educational attainment, and a certificate in nursing, either by degree or diploma, was the end goal.

Rules & regulations; Hostel and classroom at Carmelite School of Nursing

- The student should speak in English amongst themselves and also the ward.
- There will be a fine for each Malayalam word (Rs.1/ Malayalam word).
- Nursing students are not allowed to go out of the institution without permission.
- All nursing students should submit out passes to the hostel warden on the previous day.
- Students are allowed to go shopping one day a month during the visiting day along with their parents.

The hostel rules listed above represent one element of this, but also the role the teacher took in the classroom was one of authority and superiority over the students. The nurses faced the

[33] Rennu was 27 years old when I met her and , from Kerala she was an MSc Student

notion of authority in their working lives; a strict hierarchy exists in hospitals in India, and their studies prepare them for this. The hostel rules applied to the whole institute. In Chapter Two, I highlighted the strict rules that nurses face when undertaking their training; some of this is due to protecting the nurses from potential violence, while also protecting the reputation of the nursing establishment. Nurse education is not only about the knowledge and skills gained to deliver quality patient care, but also about strict rules of conduct, and codes of practice and behaviour. Nurses in India, as in most countries, have to abide by a code of conduct laid down by nursing councils (TNAI, 2016). This bears a strong resemblance to student nurses in the UK who must behave in a disciplined and professional manner and work toward adhering to the nursing code as set down by the NMC (2015).

The students at Carmelite were being socialised into discipline of the mind, not only in terms of their education and learning, but also regarding the person and the body and how to behave in the world of nursing. An element of this involved adopting the cultural norms, values, and beliefs of the profession (Pelissier, 1991). The long-term aim of such rules and restrictions plus those that govern nursing practice are imposed on them to protect the patient and themselves in terms of the knowledge they gain and how this is translated into safe patient care. This is what Halsey (1997:529) referred to as the imposed curriculum, where an element of control was levied on the student. Often at state level, this helps to mould action; in the case of nurses, the practice of care and also the curriculum influence how the student makes sense of the world they enter and their subsequent behaviour. In the UK classroom setting, I imposed strict time-keeping; this was not just to avoid disruption to my teaching but also to mimic clinical practice where one would not be allowed to be late for a shift.

All of the classes I observed in India were single-sex, like the one I described above. Single-sex classrooms are a common feature of Asian education (Ninnes et al., 1999) this may not necessarily be the case in contemporary India but is and a common feature of nurse education; all of my respondents were taught in single-sex classrooms at nursing college. Single-sex education may be preferred as it may be seen to offer a more productive and achievement-led classroom environment (Shah & Conchur, 2009). Until 20 years ago, nursing in India was dominated by women. This has gradually changed, with more men taking up the profession (Healey, 2013). However, single-sex classrooms remain preferred.

Faith and religious preferences may also be exercised when choosing single-sex education and schooling, but these particular the preferences when choosing courses (Weiner, 1994) may be stronger determinants than whether the education was single-sex.

A study of students at colleges in Haryana found that co-education was favoured by many of the respondents, but their parents preferred single-sex female education. My respondents saw single-sex education as the norm for nursing, but if they had studied engineering or computer science, they would have expected co-education classes. In India, it was observed that girls and boys would be educated separately up until the mid-19th century. The consensus of opinion was that boys' education was steered to the business world and public careers. Girls' education, by contrast, steered them towards marriage and the domestic and the less public world (Shah & Conchur, 2009). The latter could be still true in some respects in India. Even with many women working outside the home, nursing is still viewed largely as a feminine pursuit. When I spoke to Jey and one of his uncles about career choices, they felt strongly that nursing or teaching a professional course, such as becoming a computer science tutor, were more acceptable pursuits for females, especially when they had children.

The idea that rote and repetitive learning, as observed, is the norm when applied to Asian and Indian education contexts is not new; for example, Ninnes et al. (1999) explored the experience of teaching and learning amongst undergraduate Indian students attending university in Australia. The study highlighted the respondents' experiences of rote learning methods in primary education in South East Asia. I discussed teaching styles in India with the office manager in Bangalore on my initial field trip; he was an agent used by the UK University I worked for to select candidates for the BSc and MSc course.

> 'It is rote learning in India,' as he explained. 'That is, the student is told what to do on the board and then they go home and they learn it … [there is] very little time or opportunity for them to be freethinkers and to think independently when studying.'

Ninnes (1999) argued that rote learning could be seen as being teacher-centred, with the student reproducing material through repetition, and the student being dependent on the teacher for their learning and success in education attainment. The lack of resources, nursing

journals and text books is also a key feature of the experience the nurses had of learning in India. Ninnes (1991) proposed that under such regimes there is little scope for analytical or critical application of material taught. This difference in the perception of the depth of teaching does not mean the Indian way of teaching nursing through rote learning is necessarily backward, or the UK method is superior, rote learning is simply the norm within the Indian classroom and social context. Patients' needs are still catered for, and the nurses still have a vast knowledge of systems of the body and disease. This they have learned through rote and repetition.

Implications of the style of teaching, learning and discipline in India

At the time of my initial fieldwork in India, I did not see the significance of the style and content of teaching, until I was teaching the nurses myself in the UK. The experience of this style of teaching, where students only spoke in class when asked or directed to do so, may help explain why, initially when in class in UK undertaking the various courses when asked to express their opinions, many of the nurses were mute. Or, if they were asked if they had any questions the answer was 'no', even though many would have quizzical or blank expressions on their faces, giving the impression they had not understood something. The discipline instilled in the Indian classroom teaching, as indicated above, was to speak when spoken to and not to question the teacher; being asked to give an opinion, their own opinion, was a challenge to many of my respondents whilst in their student role.[35]

The rote and memorisation style of learning was enacted in nurse education in the UK for a number of years until the reform of nurse education at the end of the 1980s. Ramprogus (1988) called it 'rote discovery learning', where the student is asked to memorise material and to solve problems or deliver patient care in formulaic ways without the knowledge to understand what they are doing, and why they are doing it. Ninnes et al. (1999), Ramburuth (2000), and Niles (1995) challenged these assumptions and stereotypes that Indian students were all rote learners, and that rote learning was necessarily detrimental to their education experience overseas. However, Ramburuth (2000) did note that the approach to learning and

learning behaviours between home students (Australian) and Asian students could be quite different. This included the motivation to learn through social approval, with the need for competition and eventual success also being important; it was not just about how they were taught in their home country. Ramburuth (2000) believed one should avoid generalisations in terms of how students learn and achieve success in their studies overseas. Ramburuth's (2000) findings resonate with the nurses. Their school and college education was based on repetition and memorisation, but many were able to achieve academic success in the UK through adapting to a *new* style and way of teaching and learning. Pelissier (1991:76) has termed the criticism of non-Western education as the 'them' and 'us' differentiation, where the 'us' is Western, male-orientated education of the middle classes seen as superior, and 'them' is other forms of education systems. This leads to value judgements and questioning of whether individuals from other cultures possess differing capabilities and learn in different ways.

This rote style of teaching delivery and engagement with students is in direct contrast to my own teaching style, and that of many of my colleagues. The technique that I and my colleagues adopt involves using a PowerPoint presentation as the medium to outline basic points and elaborate facts from our own experience or knowledge of subject matter using case studies, research articles, and so on. Group work and class discussions are used to confirm and elaborate on learning points, and justify their answers to questions. This method of teaching we employ in the UK setting made it initially difficult for many of the Indian nurses to adapt to the style of teaching and learning. From my observations in India, and from discussing teaching and learning with the nurses, this was due to the void between how they had learned in India and the UK style of teaching, and not necessarily due to less ability. The nurses were studying at a different academic level, either BSc or MSc, and this can be problematic for all students even if exposed to Western education, as there are different expectations of them, as well as learning at a higher academic level. Each time the nurses answered a question about applying theory to a nursing scenario I would ask 'why?' rather than just letting the nurse in a student role give the textbook answer. I was asking them to form their own opinion, not just from the literature but from their extensive clinical nursing experiences. This went again the social norm they had experienced in the Indian classroom setting. Nonetheless, many of the students were silent for weeks, despite encouragement from me and my colleagues. If questioned directly, some looked genuinely scared and appeared

like a ‘rabbit caught in headlights’; they remained non-communicative and avoided my gaze. After several weeks, most of the nurses would anticipate me asking ‘why?’ when they raised a point and try to give a more holistic answer, or would turn it back on me and ask ‘why?’ if I gave a bland statement.

The UK approach to teaching and learning is certainly not without its problems and criticisms. This can be seen in the reform of nurse education which has had criticisms both in the nursing press and wider afield. Nurse education is now all degree-based and has high entry requirements, which means that, in some quarters, student nurses are seen to be less interested in caring for the patient in favour of theoretical/technical care and academic success. The phrase ‘too posh to wash’ was attached to the new modern nurses, implying that they were above giving personal care, and favoured undertaking procedures and managing the ward area (Graham, 2009 & Young, 2004).

The approach to teaching in the UK, however, implies collaboration between the nurse and the teaching staff at the HEI, as well as a need for the nurses to be active learners. Gibson (1998) argued that such approach needs input from both the teacher and the student, and a willingness of both parties be active in the learning relationship. Considering this, both the nurse and the HEI teaching staff need to adapt to both learning and also teaching delivery. Clevehas (2012) described similar experiences of Saudi Nurses being educated in Australia in a Master’s programme, who had to juggle life outside university, as well as adapting to a different style of learning and teaching. A close relationship with teaching staff was one way of supporting their academic success. I would say this is paramount in my experience of teaching overseas nurses, not just from India, but from other non-Western counties. While the nurses demonstrated some of the stereotypes associated with rote learning, as identified by Ninnes et al. (1999), some were not able to bridge the gap in different learning styles. Other nurses, such as Jey, Nithin, Sanju, Sonija, Minu, Rennu, Somm, and Jinu, were able to develop the critical thinking and problem-solving skills expected of them. These nurses did build up closer relationships with the teaching staff through seeking assistance in learning in the form of one-to-one tutorials; they expressed that they were motivated by a sense of duty to succeed for their parents, but also for themselves and their future careers. Ramburuth

(2000) found this type of motivation was strong and influential on his respondents' learning tactics and results.

The other aspect of learning and teaching in the UK that many of the nurses found difficult was the concept of independent study, a point illustrated by Harris (1997). Self-directed learning and independent study have become the backbone of nurse education in recent years. The student must seek to diagnose their own learning needs and find the materials to help them achieve academic success (Fisher et al., 2001). Several of the nurses had difficulty with homework and research tasks, such as using electronic materials or going to the university's library. A small number of the female nurses had to have their hands held (in a literal sense) and had to be physically escorted to the library because they were scared of doing so by themselves. They were so familiar with being given the answers to their academic work by their tutors in India that this really took them out of their comfort zone.

Engagement with independent learning is also problematic in UK nursing courses. This is especially the case for those who have not studied for a number of years, at both the BSc and MSc levels. Sonija, Rennu, and Minu all recalled that women did not perform any activities in India by themselves; they were always escorted by their father or brothers. The only exception was going to the shop close to home, but even this would be with a girlfriend. When undertaking their nurse training in India, they were never alone, were escorted to and from their nursing hostel to the hospital for placement by a tutor, and, as set out in the hostel rules I outlined above, were not permitted to leave the college premises without an escort. In the UK, this newfound freedom, in terms of their education and managing their own time, was daunting for some of the girls. In this sense, they were socialised to perform in a certain way when being taught in a formal setting. Additionally, activities outside the classroom, such as going to the library, were also problematic. Chapter Seven details the experience of the nurses being in the UK beyond the classroom setting.

Joy and Kolb (2009) noted, as described above, that, in general, students from across Asia may appear timid and introverted in an American classroom setting, where student participation in classroom discussion was expected to be high. This is mirrored by the

reaction of some of my respondents in class in the UK. The nurses, as mentioned previously, nuance of UK education that the nurses, in particular some of the female nurses, had to get used to. Minu explained that 'some are shy, it is too difficult for them'; she meant that some of the girls found it hard to speak in class due to being introverted and not being used to being with boys in the classroom. Sonija had many male friends at home in India, so she felt quite comfortable in class, asking questions and joining in discussions. For the shy ones, however, it did mean that they perhaps missed out on opportunities to engage with and clarify material in the classroom, which may in turn have been detrimental to their academic results.

Lave and Wenger (1991) focussed on classroom learning where learning problems can occur as was seen in how the nurses adapted or did not to the UK learning and teaching style. They were all successful in the fact they had registered as nurses in India and been part of a local level COP and a more widespread COP joining other nurses in India. The MSc and BSc (top up) nurses were focussed on purely theoretical learning and they were situated in the Health Sciences COP at the HEI. The first group of MSc students, in particular, became the 'teacher' or the 'old timer' the student that followed helping them adapt to studying in the UK and move from the periphery to an integral part of the academic work at the HEI. The nurses became part of the academic world that exist with a level of inclusiveness and shared values and goals (to pass their respective courses). Even after the course, many, like Rennu when commenting on her MSc course, said with some bitterness that 'in India I had practical sessions which I lacked in UK' despite the fact they had signed up for a 'theory-only' course. This I can now reflect was caused by the way the MSc and BSc top-up courses were marketed to the nurses when they were recruited in India: that is, they would experience all the modern nursing techniques and most believed that clinical practice would be included in this. These observations seemed to resonate with Minu[36] as she reflected on learning during her nurse training and education:

> It was difficult in the start… because back home… we are dependent on teachers. It's like spoon-feeding rather, I can say, because they give us notes, everything will be in our hands. Okay, we have to go home and just learn the things and you have to just

> write down in the exam. Everything will be there. We have no need to search in computer or anything; we have books and libraries, that's how we are restricted.

Jey has similar recollections of his nurse education:

> In India the nursing teaching field is almost in the hands of women. Sad to say that, many of them still prefer the old-style teaching... That is the teacher thinks [does all the background work for a subject] and the student learns what they think [teach].. Many of the teachers prepared themselves the notes according to the university syllabus by referring the books and they give these notes to the students during the teaching hours. The students will write it in to books and cram it all for the exams. Sad to say that many of the students even don't have the idea about their syllabus because they always depend on the teacher's notes to study so they don't bother to refer any books… if you are not referring any books you don't need any syllabus.

Minu also summed up her expectations of what she was expecting in the UK:

> Until I went to the academy[37], so from there I got an idea like this is how it happens. But yes, it's more flexible also here, like, you know, if I consider the job hard, sometimes – when I came in here I got a small job to work in some shop, in chicken shop or something. After college I can work. But if I was back home it's not – if you are studying you have to do whole studies, if you are working, you have to do work. That was a big difference.

Minu and the other nurses, male or female, were not allowed to have part-time jobs when they were undertaking their nurse training in India. Their focus had to be on their studies and nothing else. They had very little spare or leisure time. This was an experience that resonated with Somm:

> The workload was high. It could be tiring for students, sometimes they became mentally frustrated. Staying away from home, living in hostels, mobiles phones were not allowed

[37] This is the pseudonym given for the agent and the academy they owned, which many of the respondents used in order to apply for their BSc or MSc courses.

(so no communication outside the college) and no time off because of a heavy theory and clinical workload.

In the UK, by contrast, Minu and many of the other nurses had the freedom to study when and as often as they wanted and could take on part-time work to support themselves. Some were disciplined, and balanced study time with their part-time work, but others worked as many hours as their visas permitted (20 hours per week). For some, this left little time for study or they were too tired from working in care homes, and the travel to and from their shifts. Vin and Abin complained about this. They were concerned with earning as much money as possible to support themselves in the UK so that their families did not have to send much money to them. This applied to several of the male nurses. They had to factor into their time household chores and cooking which they did not have to do in India. This is something none of the students would have done in their student hostels whilst training to be a nurse. However, Suki did not work, preferring to 'give all my time to study, make my parents proud' (by passing her BSc top-up, which she did). The added stressors that the nurses experienced would have been influential in how they engaged with their studies, and, for some, impacted on their academic success.

The motivation to learn is important in terms of the experience of the UK education for the nurses. We cannot take this as being present in all students. It is worth noting that a few of the nurses neither liked nor enjoyed studying nursing as a subject matter. One boldly told me: 'I do not like reading, I do not like writing.' My response was, 'Well, why are you here?' This was the case for Jasom who did not want to be a nurse but wanted to be a long-distance truck driver. 'My parents made me take nursing. I hate it,' Jasom explained why he subsequently failed his MSc: 'I am lazy. I do not like it'. Jasom was disappointed in himself as, despite the fact that he had extremely good comprehension and written English skills, he had no interest in nursing and no motivation to learn about it. I was able to catch up with him in India at Jey's wedding in Kerala after he had failed the MSc. He felt 'shamed' at this point as he had not worked hard and tried to gain his MSc. At the time of Jey's wedding he was in the process of coming back to the UK to do the ONP, as he realised that nursing would offer job security and a career path, even though he did not enjoy it. Jasom pursued a career in

nursing purely to please his parents and express his respect for them. Family and kinship influence is explored in Chapter Five.

Only a few of the nurses had considered in any great depth how the challenges of a different style in teaching delivery in the UK might affect their learning. Preeti[38], when considering the style of teaching in the UK, articulated that she enjoyed the different approach to teaching and her own learning:

> Style is very different and I think it's a good difference from India because in India there is only like one way of learning... but in the UK, we increase in our knowledge by reading from different books, by doing literature review, we increase our knowledge. It was good. We learnt from previous experience, it was good and we think about, about our previous, like previous experience and it was good.

Preeti[39] felt 'exams are very boring' and the assignments are 'interesting and good'. When asked about how she felt about putting her own thoughts into an assignment and doing reflective work, Preeti seemed very positive. Despite never having used reflection, she found it easy to grasp. Her comment that 'we remember all the experience' refers to her nursing clinical experience from India, which she was able to apply to the theory she was learning in the UK.

At interview (in India to join the course), some of the applicants asked about the different learning styles in the UK, but very few were aware of the differences and what they meant when questioned about this. For the majority of my respondents, gaining an education was very important, but they had given very little thought to how they would *actually achieve* educational success. Education and learning was a means to an end. This I have attributed to their ages; most were in their early to mid-twenties at the time I met them, and had little insight into their own learning styles or how achieving or not in their studies would influence

their futures. Most were eager to please their parents and follow their parents' guidance on their career path, as much as they were happy to be led. Jey and Somm are the only respondents who stood out as being independent (choosing nursing on their own) and were aware of their own strengths and weaknesses academically. They were both close to thirty years of age when I met them, and had gained life experience and some maturity.

Each of the respondents believed themselves to be academically strong due to their experiences of education in India. They were high achievers, gaining marks of 70% or 80% and above in their school and nursing examinations. The style of teaching and assessment of achievement in the UK was a complete shock to the system for several of the respondents. Many had unrealistic expectations of what their academic achievements in the UK would be. This was particularly so amongst those doing the MSc course, and the males nurses within the group. For some, it felt extremely humiliating and they were 'depressed' to receive marks of 40 to 50%, even though these were pass marks. They did not seem to understand the academic implications of the leap from undertaking a BSc to doing an MSc. However, they also had little appreciation of the different ways in which they would be taught, the high amount of independent study, the different assessment strategies (reports, assignments), and the level at which the work would be marked in the UK. This is certainly a drawback of the UK approach to teaching and learning, and shows a mismatch between how the curriculum was delivered and what the nurses' previous education experiences were. I contend that being better prepared by NRcol, and by the university itself, could have aided more of the nurses to develop their academic skills.

In India, the nurses were assessed by end-of-year examinations, which were a mixture of short-answer and multiple-choice questions. In the UK, the work was based on written assignments submitted at the end of each module. It is worth noting that examination tends to yield higher marks. Jey and his housemates reflected after they completed the MSc: they thought by joining the programme they would attend a 'few classes', write 'some assignments' and pass the course. This is what they experienced in India and also what they were told would happen in the UK by their agents in India. For the most part, the nurses assumed that if they were taught, they would learn. Few had considered how to be self-learners, a definite requirement of MSc-style teaching and learning. Young (2010)

investigated learning styles and the relevance to the categorisation of learning. What he highlighted was the experience of learner-centric education; this educational category is a move away from what the teacher wants the learner to learn, and focusses more on what the learner thinks about the material that is being presented to them. The learner interprets the material given to them, in order to make it their own; this is very much what was expected of the MSc students, but it was a style of learning that they had never experienced. In the 'taught' element of the UK course, the nurses would only be provided with snippets of information on the main points of an argument or learning point derived from the theory, leaving it very much up to the respondents to research that theory and apply it in academic assignments. The nurses had given little thought to the issues of studying in English and did not feel prepared for studying in the UK. None of them realised how hard it would be, nor had they considered the amount of study they would have to undertake at home or outside the classroom. In hindsight, the mismatch between expectations and reality is something both the agency and the HEI could have better prepared the nurses for, and possibly could have resulted in better results for some of the nurses who failed their courses. Several of the nurses also reflected on what their friends' experiences of studying an MSc were in India. Jey's friend had told him that taking out their tutors for dinner or buying them gifts would ensure they passed the MSc (Jey was quick to point out he was not saying any of the students had bribed their way through their nursing courses!). Jey and Sanju, in particular, realised quite quickly that the onus was on them and their achievements, on their own understanding of the material, and how they would interpret it in the assignments and examination within their MSc course of study.

Adapting to teaching and learning in the UK

The nurses undertaking the BSc and MSc top-ups supported each other through the first assignment and continued to do so throughout their studies. Despite coming from a competitive education background, I noticed that most of the academically adept nurses were willing to help the weaker ones with their assignment preparation. The nurses inevitably drew comparisons between studying in the UK and India, and many regard the UK methods favourably. Melki[40] enjoyed the different style of teaching, but found it hard to adjust because of her experience of education in India.

[40] Melki was studying the BSc.

> Because in India we do a study about the heart (discussing the Cardiac care module she took), but they are not so many deeply and critical analysis about the heart and about the medicines for treating heart conditions. So it's a good time from us to learning new good things about the study of the heart.

She initially struggled:

> Because it is a totally different subject from India. In India the subject is not, not talked to during the study, because we only learn from books. They give us one subject, one topic, and one book with it and we give our test to the, to the...

In the UK, Melki felt they were exposed to much more depth about the subjects they studied through books and extensive supportive literature. In her eyes, the material they utilised was more up-to-date and related to current best practices.

> Yes, for the critical analysis, we read many type of books, journals written by many different authors and so there are different views for us to explore and it's a good time to learn more.

Melki is referring to critical thinking and analysis about learning about the heart, in terms of more than just its functions, as she did in India, but also about how to prevent disease and care for heart conditions. The material used to teach the subject was drawn from many different academic sources, including journals, online forums, and books, and not just one textbook as she was used to in India. Limited bibliographic aids and resources are other common features of rote learning regimes (Ninnes et al., 1999). Indeed, this is something I noticed during my observations in India. The libraries I visited on my first field trip were poorly stocked with limited and outdated text books, with few academic journals, and each subject area, for example, 'cardiac nursing', had only one textbook assigned to it. This was due to the limited availability of resources and finances for equipment, including books at the privately-run colleges. Many of the schools of nursing are charity-run and rely on donations.

Part of the adaptation process was learning to cope with different assessment regimes. The respondents found they coped better with the assignments if they had prior knowledge of certain aspects of the curriculum, and this gave them confidence to learn. For example, the

cardiac module of the BSc course and the public health module of the MSc both cover major health concerns in India, not to mention aspects that the respondents had practical experience of as a nurse, as well as some academic teaching on the subject matter.

As seen in Donna's reflection on her experience a few months into the course:

> Sometimes I felt homesickness, but my aim is that I want to complete my course, I want to take and complete my BSc, because here the education is very different compared to India, quite different because of the different way of writing for essays. But after I came here I have made improvements... the lecturer told me there was much improvement in my essays.

This positive feedback was a motivating factor for Donna to continue with her course, even though she found life in the UK hard:

> I'm just feeling it is good, that's the main thing. It is hard (studying in the UK) but if, we work hard, then we lead to success. That's the number one thing. The education being different, but, you know, cardiac classes is quite interesting because we've got previous knowledge and the teacher see that and we learn new things which is... really nice and we are doing leadership and management also. So that's a new subject because we didn't learn that. It was also good and interesting.

Despite Donna's positive reflection about the leadership and management module, all of the respondents struggled with the concepts of 'leadership and management' and had problems engaging with the subject matter. This is largely attributed to the fact that nurses on the whole neither lead nor manage nursing care in India. There are, of course, exceptions and one such case was Sonija[41]. But on the whole, the nurses in India follow the doctor's orders; the care plans were written by the doctors and the nurse followed any change in the patient's care dictated by the doctor (Somjee, 1991). The ONP students coped much better with the material they studied because their course was 50% theory and 50% practice. Each lesson was based on nursing experience and they could directly apply their experience from India to adapting to working as a nurse in the UK. This course had an almost 100% pass rate (including second

[41] She worked on an innovative project where nurses form part of a team and lead certain aspects of care.

submissions). The nurses undertaking the course were highly motivated, as within 6 months if the passed the ONP they would be able to practice as a nurse in the UK and take advantage of the rewards of earning a nurse's salary and added status to them and their families.

The perceived barriers for being educated in the UK.

For some, barriers presented themselves not only in the teaching style but also in practical issues such as classes being taught in English, and the nurses not fully understanding what was being said to them. This was a problem noted by Brown (2007) in her exploration of international Master's students' academic development. The nurses noted the different regional/country dialects, and the speed/tone of voice of the lecturers teaching the Indian nurses. Preeti remarked at their graduation ceremony 'see we're talking now, we understand everything you say'. She talked about how they felt comfortable with English, felt able to converse easily in English and that they would ask questions now. This contrasts with their initial feelings of embarrassment about asking questions if they did not understand what was said to them. This was because their own country's educational experience did not accommodate interruptions of what the teacher was saying.

Preeti did struggle initially with being taught in English and the accents of some of the lecturers who taught her:

> It's hard. Some days we can't understand. Now it's good like for three whole months we've managed. But in the first or second day it was very...hard

Preeti's comprehension of English improved the longer she was in the UK through having to converse in it at university and in her part-time job (as an HCA[42]). Preeti learned English at school, but was taught in a mixture of English and Punjabi during her nurse education.

Melki was taught in English at her nursing college in the Punjab, but being taught in English in England was, as she put it, 'quite different. I have no problems in doing the study'. She did not find the assignments too difficult to comprehend. However, being taught in English and the variety of accents were a challenge. The tutors on her BSc top-up were English, Irish,

Turkish, and Palestinian, which provided a variety of different English accents for her to adjust to.

> English is just more difficult because our mother tongue is Punjabi, so at that beginning of the course I had so many problems. But at the present time I have no problems. I can now understand the teachers.

Sonija also felt quite positive at being taught in English as she had attended English-medium schools and been taught English at a nursing college in Kerala. She had also taken her IELTS[43] and achieved a 7 across the board, which is a good score. This level is required to apply to be a nurse in the UK. After she completed and passed her MSc, Sonija successfully passed the ONP. She thought 'I was okay, I didn't find any problem actually*';* she did fail one element of the examination: 'that exam, the exam was the one. I was scared, but it was okay, I managed somehow*'* (She passed on her second attempt). Luke[44] had a similar experience to Sonija. He had learnt English at a Church school:

> 'I think when I was doing my fifth standard, I started to learn English and I was studying my common language (Malayalam) as well... but we got English education from our fifth standard.'

Even with this in mind, the biggest challenge Luke felt was *'*I think its education the system, the way they offer education'. Luke found the style and delivery difficult even though he had a good level of English; he too felt the challenge of being taught in English in England. As mentioned earlier, the MSc nurses found the exam particularly challenging, and for many it was their least favourite part of the course. All of the nurses from Kerala were taught in English-medium schools and colleges or schools of nursing, which meant they had greater English comprehension skills that gave them an advantage in the early stages of their courses.

D'Amore et al. (2012) proposed that educators should be aware of students' different learning styles and that demographic factors can contribute to a student's learning style. This certainly rings true with my observations and experience of teaching the nurses. The lecturers involved in teaching were experienced in teaching international nurse students but felt they needed to

[43] Passing the IELTS is a requirement for all overseas students who wish to study in England.
[44] Luke took the BSc.

adapt their delivery and teaching style for the Indian nurses. This was because, while having taught international nurses from different countries in one class, we had never had a large cohort straight from their country of origin. They had time to habituate to the UK and found it easier to adapt to university life. Formative work was used extensively in all three programmes of study and helped the learners bridge the gap between their past experience and what was expected from them in the UK.

Conclusion

This chapter offers insights into how education facilitates learning for the large pool of nurses from India in the UK; some of these challenges are relevant to other overseas nurses not educated in the UK. Considering the concepts of situated learning can be applied to the nurses while they studied at an HEI in the UK. Initially they were outsiders performing simple tasks or in academic work formative assignments. As they gained a deeper and broader knowledge base they will become part of the COP and develop a social identity as well as relevant skills. The nurses' journey sees them on the periphery of the HEI community until they began to engage with their learning and understand the differences with being a student in the UK as opposed to India. Where expectations of independent study and learning are promoted as a central ethos of the teaching and learning.

Education is fundamental to sustaining the nurse's middle-class status. In order to achieve a good education, the nurses must negotiate a new way of learning, one that contrasts strongly with their educational experience in India. According to this group of nurses, learning success depends on the following factors and the degree to which each was given importance or was achievable: past experience and success in education; motivation to succeed on a social and personal level; confidence and personal drive; English language skill; social and peer support; and career aspirations, both their own and their parents'. For the majority of my respondents, the style of teaching in the UK and at university presented them with initial problems, some of which were related to being taught in English. Few of my respondents really considered their learning style, their English aptitude, and the possibility of failing their courses. Some certainly did not see the correlation between these things or their own application to their academic work, and the link between teaching styles and their own success or failure. This can be partly attributed to poor preparation and lack of clear information about the structure

of the course including how it was to be taught, both of which was the responsibility of the NRcol and the HEI. Rote and didactic learning does exist in India, but, according to Clarke (2010), the situation is changing in primary education where less didactic approaches are being used in some areas. However, each one of the nurses did experience this style of teaching and learning in nursing before coming to the UK. Having said that, whether they passed or failed, each nurse had to adapt to some degree to the different modes/style of teaching delivery when they had come to study in the UK. Some found this a more onerous challenge. Other nurses rose to this challenge, coped well and achieved academic success, completing and passing their BSc, MSc, or adaptation programme. The nurses' experience of their learning journey in the UK is one aspect of how they adapted to a new way of living. In chapter Seven, I look further at the other factors that contribute to the nursing lived experience of being in the UK.

Chapter Seven - Being in the United Kingdom

'I'm living my life here in a sense, like how I want to live. But if I was back home, I can't because it's different' (Minu).

Introduction

This chapter explores and examines the reality of the nurses being in the UK, developing the discussion from them being migratory nurses and how they perform in the UK by negotiating change in their personal and social worlds. To address this, I will explore how the nurses for the most part developed independence and control over their futures through to how they settled into life in the UK, and the role of the distance created between their Indian social worlds and those in the UK. Work as an HCA or as a nurse is part of this experience, but it is the nurses' wider social world that determines how successful they are at adapting to life in the UK. This forms part of their identity of being an Indian nurse in the UK, and may also influence how long they stay in the UK. I will examine case studies of nurses who have embraced life in the UK by adopting new practices and forging friendships, both outside the diaspora and with fellow Indians who are from different regional backgrounds to themselves. The Indian diaspora and enactment of cultural space have developed worldwide, including the Gulf States, the US, and the UK. Economic liberalization has rapidly expanded migration and settlement in countries outside South Asia. Primarily unskilled migrants gravitated to the UK, but since 2002, Indian nationals have become the largest group of skilled migrants to the UK (Raghuram, 2008). Students have also contributed to this growing diaspora. Between 1995 and 2004, there was a 30% increase in the number of women migrating from India, and a large proportion of these were nurses recruited to the NHS. Migration is considered in more detail in Chapter Four.

Autonomy

As we have already seen, the nurses are part a distinctive part of a middle-class group of Indians in the UK. For both the female and male nurses I worked with, their time in the UK has been one of change and adaptation. Nelson & Rafferty (2010) made an interesting and important point that nurses travelling and migrating to seek greater autonomy and free

themselves from social ties is not a new phenomenon. She reviewed the case of nurses joining the colonial nursing service (CNS) where middle-class British nurses between 1896 and 1966 sought adventure and freedom by taking up nursing roles across the Empire, India being one of the destinations. Factors that drew nurses into migrating were family connections in a colony such as India, as well as the expectation of a better life and new experiences. It could also increase marriage prospects, as there were many single men of a comparable middle class or higher background working in the colonies. While I am exploring the migration of Indian nurses to the UK, Rafferty's work pinpoints similar sentiments to those verbalised by my respondents. Many have found life in the UK has offered opportunities they would not have had in India, in both personal and professional terms.

A common theme amongst the female nurses in particular is the quest for autonomy, once they realised this was possible in the UK. The nurses then actively sought out some distance between them and their broader family and diaspora as I will show. For a few nurses, however, the experience has been less than positive. The nurses gained a level of autonomy they previously did not experience in India through employing upward mobility strategies as well as taking advantage of financial gains in nurse employment. For the most part, in my conversations with the nurses the lived experience of being in the UK led them to recognise the possibility of autonomy over their lives. This is not something that the nurses envisage when seeking to migrate; it was improving social status and financial gains that motivated them. The notable exception was Aava, who I discuss later; she had already begun a journey to develop her sense of autonomy and freedom.

In order to illustrate the points above, in the following section, I relay a number of case studies. These are primarily based on the female nurses who were not only more vocal on their time in the UK, but have also felt a greater level of independence and more opportunities than the male nurses. An important aspect of the experience in the UK was building a support network through their colleagues in the classroom; this helped many of them adapt to life in the UK, and gave them a number of shared experiences.

Freedom and independence

A common theme that was echoed by the majority of the female nurses I worked with was that they gained more control over their lives, as well as enjoyed more personal choice in the decisions they made since coming to live and study in the UK. This was either explicitly or indirectly, and in comparison to their perceived lack of 'freedom' that they experienced in India. A few nurses directly used the English word freedom; others described how the constraints they felt in India were, somehow, diminished once they came to the UK, allowing them to attain a level of independence they had not experienced before. The use of the word freedom, I should note here, is problematic: it implies the nurses were restrained or imprisoned in their lives in India. When the nurses talked of 'freedom' they expressed different things: they spoke of freedom from family ties or strict rules about how they lived their lives, freedom in how they performed at work or how they dressed, or freedom from seeing poverty and deprivation in India on a daily basis. The freedom the female nurses identified comes from the different expectations between being in India and being in the UK. In India, the unmarried nurses either lived with their parents or in a female nurses' hostel for qualified staff. The nurses' movements were restricted and they were for the most part not allowed out of their dwellings unless accompanied by a male member of the family. The only experience the nurses had of living away from home was living in the student nurse hostel where their movements had also been restricted.

In this chapter, I will show how some of the nurses have relocated themselves and moved away from areas with a high Indian population such as Southall, London, with the aim of lessening the influence of the Indian diaspora and gained all important freedom in their lives. In the diaspora, we can see the ways of doing things in India and living one's life replicated, and sometimes enforced, in Indian communities outside India.. In the diaspora, nationalism and pride in all things associated with India can become stronger and more visible (Raghuram, 2008). For most of the nurses, freedom is a positive effect of being in the UK, but for some, such as Sadhika and Supinder, it has had negative implications which are discussed in later sections of this chapter.

The UK is attractive to nurses because Indian nursing is strongly influenced by the UK model of nursing. The UK therefore offers something familiar in terms of the nursing profession and

English language. As indicated in Chapter Two, many of the nurses are from Kerala and speak English. A few of the nurses I met also had family in the UK and this influenced their decision to come to the UK. The nurses contributed to and were inevitably affected by their diaspora and the enactment of Indian beliefs and norms in the UK. However, nursing can offer the nurses a level of freedom as they control their working lives and have fewer restrictions placed on them than in India. The increase in skilled workers has also seen the rise of Indian middle classes migrating to the UK who may enter the British education and work systems (Robinson, 1988). The nurses are representative of this phenomenon. Dicico-Bloom's (2004) work reflects the experiences of Indian nurses living and working in the United States. One of her respondent's key experiences was that of racism; the differences between Indian and US working culture and inequalities experienced at work. These contrast with the experience of my nurse respondents, who did not discuss racism or the experience of inequalities at work. From conversations I have had with them, I have inferred that the nurses did not discuss racism because they did not experience racism. Both Saju Somm and Minu have achieved senior positions in their workplace and had not experienced inequalities at work. Work for these Indian nurses in the UK tends to be seen in a much more favourable light.

The ONP proved very effective at helping the nurses adapt to working in different healthcare settings, such as care homes. The nurses who did ONP and those who worked as HCAs did so where they were most needed. As I pointed out in Chapter Four, staff numbers in care homes fluctuate and staff shortages are common. While the nurses found the work strenuous, they did not voice a poor experience in the work setting. Many of the staff they worked with were from India or Eastern Europe, and as such were all adapting to life and work in the UK. Dicico-Bloom's (2004) research highlighted that Indian nurses were different from other Indian migrants, as it was often the female nurse that made the decision to migrate and the profession gave them the choice to do that. This was whether they were married or not, and those that were married found that their husbands would often take on unskilled work as they were not able to find an equivalent career in the US. Minu and her husband Manju are one such example amongst my interocutors. Several of the nurses in Dicico-Bloom's (2004) study married once they were working in the US, as did many of my nurse respondents. The nurses settled into careers in the UK first; this increased their marriageability and made them more attractive in the marriage market.

Case Studies

In the following case studies, which make up the majority of this chapter, I offer comparisons with the nurses' experience in India. The comparison offers a means to highlight and explore the significant changes in some of the nurses' lives, as they experience a new way in which to live. I will use their voices and reflections to explain what being in the UK and experiencing greater freedom/independence means to the nurses, and how they expressed themselves as they developed their own agency and control over their lives. All but one or two of the female informants had, by their own admission, experienced strict rules of behaviour and lifestyle imposed on them by their families and local communities as they were growing up. This continued when they left home and studied to be nurses in India. The female student nurses I encountered and my female informants had similar experiences when they were students: they lived in women-only hostels, attached to the schools or colleges of nursing which were very often in the same grounds as the hospital they worked or trained in. If the hospital or college was not on the same site, they were escorted or driven to them. As students, the female nurses were not allowed to leave their hostel, except for one day a week or in some cases, only one day a month. In order to do so, they had to seek permission from the college and they could only leave the premises with a relative. Several of my informants had this experience after they qualified as nurses and lived in hospital accommodation. These types of rules and restrictions did not apply to my male informants.

Minu

Minu was 23 when I met her. She is from the Punjab and a Jat Sikh. She has been the most vocal of the female nurses in respect to what freedom means to her. Minu's experience mirrors that of many of the other female nurses. Minu studied at a Christian college of nursing in the Punjab. She lived in a student nurse hostel near the hospital where she did the practical element of her nurse training. Minu recalled that, according to the hostel rules, she was only permitted to leave the premises on a Sunday, and only if a male member of her family was present. This was often an uncle who lived nearby and occasionally her mother accompanied by her father. Minu recalled her training fondly, despite the restrictions on her movements. She forged close female friendships, and enjoyed listening to music and watching television in her free time.

Minu discussed restrictions on her behaviour and movement during her nurse training in India, but enjoyed it nonetheless. As she recalled one day when we were talking over lunch in the UK:

> I did my training from ...a School of Nursing, in the Punjab. It's quite far away from my home. I enjoy my training a lot, seriously. Because of my friends were good and my group and when, my tutors are not North Indians, they belonged to South India, and they were quite hard, but my group was really good and I enjoyed a lot. Even I missed here and I don't have like that group, and I will not get it in future, that group. We had lots of leisure times, and in vacations we friends went to ... to spend one or two days together and even our college organised short trips and in Punjab, they were organised in Punjab, not outside of Punjab.

Minu did not feel she was restricted at the time of her training. It was only when she came to the UK that she felt she could live her life differently. She began to think of notions of freedom and being in control of the decisions that affected her life and what this meant for her. She felt she has 'complete freedom' in the UK:

> I'm living my life here in a sense, like how I want to live. But if I was back home, I can't because it's different. You are in a society (India), so there you can't think of going out after six o'clock, but here I go, I go for late night out. In the last week I've been to London, I went for my friend's birthday and we went for movies and we went for drink and to a club. My parents don't know. They think I come home each night after college/work and do not know I drink alcohol. I do like cocktails! My dad drinks, but very occasionally. He drinks like when he has his own office parties, but we can't judge him, 'Oh he's drunk and he's coming home.' It's not like this. So in our family it's not been done much, you know. But he will not have accepted that like his girls drink.

A couple of the heads of nursing schools and a few of the female nurses explained the restrictions. A prominent reason was so that the female nurses were protected from the outside world, as well protected from being exploited or experiencing violence at the hands

of men who may prey on their youth and inexperience. The restrictions imposed on her as a student nurse were welcome. They made Minu feel safe. This, in turn, would also protect the reputation of the college or hospital as being somewhere that safeguarded the nurses in training. There has been a history of attacks on nurses in India, such as rape and assaults, with many from the 1970s onwards gaining notoriety (Healey, 2013). Healey (2013) reported that there was little regard for the safety of nurses by the authorities. Some measures were introduced at this time, such as better security in hospital, nurses wearing less feminine work clothing, especially in the community (public health nurses). However, in 2005 (Healey, 2013:159) a report on public health nurses' safety revealed that little had changed and the nurses frequently felt unsafe. Nurses also faced verbal and physical abuse from patients in hospital, and little has been done to alleviate these problems (Healey, 2013:187). The notable exception has been the lobbying and protests against nurse attacks by the Delhi Government Nurses Union (DGNU). They have raised public awareness of the violence against nurses, making it more visible and less acceptable.

As above, violence against women in India has been widespread and recent high-impact cases have been reported widely across India. The reporting of the gang rape of a physiotherapist in Delhi in 2012 prompted the debate on violence to become more widely talked about and disputed. This led to an increase in convictions for sexual assault (Oxfam, 2013). Despite this, Minu still felt that the incidence of violence against women was high in India, with many of the episodes of violence unreported or not making the papers due to the frequency of attacks. An additional barrier was the perception of the general populous that the police and authorities were lethargic when it came to protecting women from violence and prosecuting the perpetrators. Oxfam (2013) investigated the violence against women and they report revealed 15% of rape cases went to trial and, of this number, only 24.2 % resulted in a conviction. In 98% of cases of rape, a family member or someone known to the victim was the accused. I discuss domestic violence later.

Minu felt much safer in the UK and when reviewing the figures, it is not surprising. The threat of violence against women in India is a real phenomenon in Minu's and the other nurses' eyes. This is borne out of the stories she heard of violence against women outside and within the home. Her parents and tutors at colleges also reminded her frequently about the

dangers of being out alone or going out after dark. Despite her perception that the UK was much safer, she was a little fearful when she first came to the UK. However, now through her own experiences of being out by herself, Minu believed the police were more effective and that violence against women, though still happening, was nowhere near as prevalent as in India. Minu based this belief on her and her parents being told by the employment agency that the UK was safe for women. Minu said she found this to be the case for her and her female friends; they could walk home from work alone, go shopping, meet friends for drinks and feel safe. She had done all this without incident. Many of the female nurses used the word 'comfortable' to describe how they felt being in the UK. They used this in reference to travelling to and from the university, visiting the shops and their friends. By the way they used the word I have taken this to mean they felt safe, as Minu did; they did not feel threatened or uneasy when out in public. This feeling, however, took some time and was referred to by the nurses only after they had been in the country between six months and a year, when they felt settled in the UK. Minu's life in the UK has been one of more choice and control over her than in India. She has been able to assimilate both worlds together by accepting an arranged marriage but by instigating a different way of living in her marriage, one in which she felt she had more freedom and was on a more equal footing with her husband. Minu and Madan are also a prime example of gender rules changing through Minu becoming the main breadwinner in the marriage.

Sadhika

Violence against women is not only carried out in the public world but also in the private space of the home. Sadhika's case shows that freedom can come at a cost. Sadhika was an MSc student who went on to do ONP, also from the Punjab, who had experienced domestic violence, which resulted in her taking out a restraining order against her husband a few months after arriving in the UK. Sadhika held developed beliefs about freedom and on how she should be treated as a wife and woman in the UK. Her beliefs had caused her great pain and hardship. When I first met her, she was outgoing and very motivated to achieve in her studies. She had already completed a top-up degree in the UK at another university and had been in the UK over two years. Over a period of a few months, she became withdrawn and disinterested in class. I met with her one weekend and, as we had coffee, she told me why. She had become a victim of domestic violence perpetrated by her husband. In India, she believed she would have tolerated the violence in which her husband physically and

psychologically abused her, as ‘normal’ or not out of the ordinary, nor would she even as classed it as a violent act. However, she ‘knew’, as she put it, that in the UK this was not acceptable. Sadhika went to the police to report the attacks as they became more frequent and violent. Her husband’s passport had been seized and Sadhika had taken out a restraining order against him. This should have made life easier for her but her 15-month-old baby was living with her husband’s family in India while she studied and the family threatened to never allow her to see her child again. Her sister tried to intervene but she was still not permitted to see the child. I suggest that in order for Sadhika to navigate her way as a nurse in a new cultural context she had changed her expectations of her relationship with her husband, thus articulating a way in which she wished to be treated in their private world. Rejecting domestic violence was possibly due to the fact that she saw her rights as a woman being easier to uphold in the UK.

Sadhika’s belief in her rights as a woman and mother extend to her relationship with her in-laws in India. Sadhika had to make a trip to India where she took her in-laws to court, and won custody of her child, who she then placed with her sister before returning to the UK to complete her studies. However, Sadhika was never able to apply herself and concentrate on her academic work. She carried on until the end of her course but did not pass and returned to India. I unfortunately lost touch with her after that. Sadhika’s life up to when I met her had been full of tragedy and hardship. Her first husband had drowned in a river in front of her. She remarried against her parents’ wishes as they wished her to take on the role of a widow (being Hindu, this was expected by her family but not, according to Sadhika, by the wider society) but, as she said to me, ‘how can I survive? I am only a nurse ...I need money, security’. She met her second husband and all seemed well between them until the second year of study, which is when I met her. Sadhika’s husband was in the UK with her and he became jealous of her studying, insinuating she was being selfish and she should be at home looking after him and the house. Sadhika told me he was resentful of having given up a business in India to come with her to the UK where he could only find work as a cleaner. Sadhika was realising her expectations of the UK, but her husband was not; this is where the difficulties began. Sadhika’s interpretation of her wish to study was very different to that of her husband. Sadhika wanted to better herself for the good of her family through raising her academic profile, which would enable her to gain a promotion in India or the UK. She was very much practising Roland’s (1988) ‘we-ness’ in her relationship with her husband, as I

discussed in Chapter Four. Sadhika's husband's behaviour suggests he considered that Sadhika was just thinking of herself, and that by becoming the main breadwinner she was challenging his masculinity as head of the household. This reversal of traditional roles had, however, been successful in the cases of Jey and Naya and of Minu and Madan, so I am not, to be clear, suggesting that Sadhika's experiences had been inevitable.

Sadhika's case is not unusual in terms of being a victim of domestic violence; being a migrant nurse, she had very much taken on the role of provider for the family. Her wages as a qualified nurse when she completed her adaptation after her MSc course would far outstrip her husband's. Busby (2000:37) explored the relationship between domestic violence, power within relationships, and gender dynamics in India. One explanation offered by Busby (2000) for violence perpetrated by men against their wives was the display of masculinity and, as such, it was an inevitable part of married life. The dominant view in Indian society that Busby studied stresses that both parties are responsible for the violence. The manifestation of violence, Busby (2000) believes, is diminishing but with this rhetoric, it is not surprising that Sadhika saw domestic violence as a part of life in India. The counter view to the inevitable is that violence can be avoided and challenges to the male's dominant role can be used. This has arisen from women's reactions to the violence and political awareness of violence *per se* in India. Support from the state has sought to address the problem, through strengthening of laws governing the sale of alcohol is believed to be a common cause of violence. However, as Busby argues, blaming alcohol for men's violence serves to take away responsibility from them as perpetrators of that violence. As such, the men are not considered to be in control of their actions due to the external factor of alcohol consumption which alters their nature (Busby, 2000:212). Many of the women Busby (2000) worked with did not see the violence as the man's fault, leading her to surmise the hurt and pain experienced by the women were like a passing storm; it happens, and then you 'get on with it'. Unlike Busby's informants, Sadhika knew because of her experiences in the UK that the responsibility for her husband's violence rested with him and not with her. She received some support from the police and had access to counselling through the university student centre. Due to confidentiality, I do not know if she took up the counselling or not; I was able to refer her, but that is where my knowledge ends.

Majumdar's (2004) study with final year nursing students and fifth year medical students in India revealed the attitudes of the students to the violence experienced by women in India. Interestingly, the female medical students believed largely that women did not benefit from being beaten, while the views of male student doctors and nursing students were inclined to think there could be some benefit to domestic violence, in that women could alter their behaviours for the better as a result of it. One view discussed by Busby (2000) was that many of her respondents felt women/wives could improve their behaviour if they experienced abuse. One rationale for the violence is that women are viewed as the lesser being to men and as a drain on finances, as well as a liability in terms of social standing (Mujumdar, 2004:355). What I find contentious is the attitude of the student nurses in Majumdar's study; they are the ones who give primary care and support to women who have experienced violence. The study brought to light both a deficit in knowledge and entrenched attitudes towards violence. The nurse students had been selected from two different colleges and the study revealed that neither of the nursing courses prepared the students for dealing with and supporting victims of violence. Neither Sadhika nor Minu mentioned receiving any training about violence against women, although Minu had a strong belief that it was not acceptable and Sadhika developed the belief as her knowledge on the subject matter increased. Sadhika's situation was unfortunate and eventually led to her leaving the UK before her original intention.

Supinder

Supinder is a female nurse who undertook the ONP. She did not encounter violence throughout her marriage as Sadhika did, but suffered negative effects from trying to improve her career prospects. Similar to Sadhika, Supinder was acting from a sense of 'we-ness' (Roland, 1988). A couple of weeks before the end of her course, her husband left her and her 16-month-old baby, citing her selfishness for studying as the reason for leaving (as did Sadhika's husband)**.** The course she was doing would enable her to work in the UK and thus increase the family's income by earning a better salary. Her motivation, as for Sadhika, was to improve the lives of her family and provide financial security, an act of 'we-ness', and not 'I-ness', as her husband believed. Both Supinder and Sadhika were devastated by the end of their respective marriages because of the shame this would cause them and their families, but were also frustrated, since their actions were intended to better themselves for their families' benefit. Both husbands displayed anger and disdain (as reported by both women) at their wives' actions, and could not see the benefits of an educated wife. Both had still maintained

the house, cooked and looked after their husbands, but had spent time on themselves studying, and this is where the conflicts seem to have arisen. By adapting and negotiating their way as nurses in the UK, Sadhika and Supinder had stepped out of the gender roles expected of them in India and had suffered the consequences.

Supinder initially felt isolated and alone after the sudden and the abrupt departure of her husband. She also felt shame and questioned whether she had done the right thing doing the ONP course and coming to the UK. Her mother came over to help her look after her child while she finished her studies. She was granted an extension which enabled her to successfully complete the ONP. Supinder now practices as a nurse in a private hospital and is doing well. She feels very secure in her career and her life.

Challenges: Agency, Social Behaviour and independence

At Minu's wedding feast in the Punjab, I was talking with her best friend and one of her female cousins and I remarked that I needed a drink. They both looked horrified and said, 'women do not drink!' I had actually meant a non-alcoholic drink as it was very hot and I was thirsty. This incident highlighted how women drinking alcohol was frowned upon by society , and by these middle-class individuals in particular, since alcohol misuse is associated with lower socio-economic groups, and with loose morals (Chari et al., 2011:138). Despite the negative association with alcohol consumption, Minu did not see she was doing anything wrong by occasionally drinking alcoholic drinks, now that she was living in the UK. Minu believed she was adapting to UK culture and enjoying the social side of life in the UK. Minu did not tell her parents for fear of being chastised and perhaps being forced to come home to India. She also did not want to disappoint them as they were proud of her and her achievements, but nevertheless, in her opinion, Minu needed her own life and independence. Minu was the only one of the female nurses to use the word 'independence', which she did on several occasions, and the concept was extremely important for her. For Minu, independence was expressed in terms of her expectations about how to live her life with newfound freedom, and she was concerned about marriage in the next stage of her life. When Minu completed her MSc, her parents were beginning to look for a suitable match for her. Minu would have liked to marry an Indian man who was living or had been brought up in the UK. Minu's

concern was if she did marry someone from India, the new husband might not understand her social activities and restrict her movements.

> They (Minu's parents) have been told my preference what I want, I told them I was looking, I told them it's better if somebody is living here who is exposed to the culture here, lifestyle, who can't question me, like 'Why are you late?' and all that stuff. So I, that was my suggestion to them.

Minu's parents would be happy for her to find and meet a UK based/born Indian, but this was proving to be difficult: 'They will give me that freedom, but I can't find one'.

> But (her parents) being there in home (India), sitting back home, they can't trust a guy who's here. So that's their problem, you know, so I don't know how I'm going to persuade them. So for me it's hard to marry a person who has been educated there (India). It might be he will react different when they come abroad, you know. Some find it easy to adjust, some they don't get interested with the things, with the lifestyle, with the food and all. So it depends, you know, so I don't know, you know, I'm not confident – if I go home and marry a person and it will be a big responsibility for me, you know, to bring a person here...

Minu's concern was that she had made friends in the UK at her workplace with Filipino, English, and Polish nationals, as well as Indian colleagues. Sometimes, as she recalled, she went for coffee after work or to the pub for someone's birthday. Minu was not staying out late every night but liked to socialise and mix with new people. In India, she very seldom went anywhere without a male relative, usually her brother or father, unless she just went into her local town to the tailor's, or the other shop five minutes from her home. Even on these occasions she would have a female friend with her. Minu's explanation for this was to protect her reputation and, in turn, that of her family. In her community the unwritten rule was: women should not be seen out alone or expose themselves to exploitation and potential danger (as discussed above). Minu further explained the expectations of an Indian husband, which she felt would be that she should come home to cook every night. But after working a 12-hour shift at the nursing home, she said this would be 'too difficult'. In support of this issue of fulfilling gender expectations (Busby, 2000), Minu stated that she could not cope with the idea of being a 'home' wife all the time, as she valued the idea of developing her career in nursing.

Minu could not envisage living her life as her mother had: working full-time as a nurse and also fulfilling all of the domestic duties in the house. Minu did not want to limit her social life to just close family and friends/neighbours as her mother did. Minu felt she could still respect her parents' opinions and their feelings whilst being in the UK. This she demonstrated by accepting an arranged marriage with a man from India. Madan was 27 and also a Jat Sikh from a middle-class family. Madan had just completed an MSc in mechanical engineering, and thus matched Minu in academic qualifications. Companionate marriage is discussed in Chapter Five. Minu met him on a short ten-day trip to India three months before the wedding, and she thought he was a good match in terms of his status and education. She thought he was quite attractive, something she personally looked for in a potential suitor. The thought of an arranged marriage caused Minu to experience internal conflict with what she wanted to do and what she felt she should do. This conflict and unease Minu felt was where, as she described it, because her two worlds – that of India and the UK – were overlapping, in terms of the modern or new ways of living and her experiences in the UK, and how she was expected to behave in India. Minu's life in the UK, like that of many of the nurses I worked with, is about straddling the two worlds, and she is trying to find her identity in the midst of this. Fuller and Narasimhan (2014) see this as part of the dichotomy facing the new middle classes, where they seek to keep the traditional values in place and they work alongside the ways of doing in the modern world, let alone a new cultural context of the UK (as in the case of the nurses). The female nurses also expressed this desire for changes in their life and this is what makes the nurses stand out from other ethnographies of Indian women: namely, that they are caught between the two worlds, as Minu felt. How they negotiate this or not is down to their experience.

Santosh, one of the female nurses from the Punjab, was cohabitating with her Indian boyfriend she had known for five years. Both sets of parents were aware of the relationship but not of their living arrangements. Santosh said she knew that neither sets of parents would approve, but she justified her situation, stating 'this happens in big cities in India like Delhi, where it is normal'. Santosh enjoyed the control over her lifestyle in the UK and did not feel any pull to return to India. To date, she is living with her boyfriend, now husband, in the south of England.

I met with Minu in Banbury one day, six weeks before her wedding was due to take place in India. At the time, she said she was 'suffering anxiety' and not sleeping well due to pre-wedding nerves. On a positive note, Minu reflected that she had been getting to know her fiancé Madan by Skype and had started informing him about life in the UK and, more importantly, how she lived her life. She also said that she would not bring Madan over to the UK (he was being supported on her visa) for a period after the wedding so she could get used to the idea of being married. Madan did not come to the UK until four months after they married. Minu also wanted that time to enjoy her freedom and independence for a bit longer and have more time to 'educate' Madan to UK ways. Minu was trying to set boundaries in her relationship with her fiancé. Minu had a strong sense of agency and control over her daily life by being able to think and do 'her own thing' (her words) in the UK. This meant choosing when to socialise, go shopping and choosing her own clothes, as well as how she was able to control her life for when Madan came over to the UK. At home in India before the wedding, she felt pulled in all directions to 'do this, do that'. The feeling of control was something Minu fiercely wanted to protect. She felt her parents' influence might change her back to carrying out female roles. However, as Minu reflected, 'I have changed and am less accepting of these things', in other words, what had been acceptable to her mother but was not to her. Minu's desire for her life conflicts with the lived experience of Busby's (2000) informants who were closely aligned with the parent of the same gender; mothers and daughters reflected each other's expectations and beliefs, fathers and sons, likewise. They were extensions of each other. Minu is forging a new path for herself, one that has been more possible with being in the UK where she felt less constrained and judged by ideals about her behaviours.

I witnessed Minu's challenges first hand when I stayed with her family for her wedding. What Minu had craved at home in India and experienced on arriving in the UK was the freedom of movement: the idea of choosing what she wanted to do on her day off rather than following what her parents suggested, to be independent, as she put it, and to be able to think for herself. In India, this had played on her mind but she did not believe a sense of independence could be achieved in India. She was worried this would be taken away from her. I could see her point. I had expected Minu's mother and best friend to accompany us on various pre-wedding shopping and social trips but it was her father, her fiancé, and her brother that came on the trip. I expressed surprise at this to Minu but she said this was the

normal practice in her family as 'mummy' (Minu's mother) would be at home getting ready for family guests to arrive. I went with her to choose her Lenga (dress) for her wedding but her mother did not accompany her, nor did her female friends. Instead she was accompanied by her father, brother, and fiancé (Madan[45]) with the same thing happening when choosing the shoes and jewellery for the wedding. Minu still maintained some control over the proceedings. Her father was very keen on the traditional red Lenga but Minu wanted something more 'modern' and she tried on a cream and red Lenga which she eventually chose. Her father was not keen on this but, with my support, Minu got her way and this one was chosen. Her mother played no part in the wedding preparations. My wedding outfit and shoes were chosen by her father and given to me as a gift. Later, on discussing this with Minu, she explained that it was her father that would pay for the wedding outfit, so it was normal practice amongst her friends and family for the father to be present as he was the one who controlled the finances.

Minu reflected on what she saw as the drudgery of the women's world, as demonstrated by her family. She said to me one morning as we ate breakfast: 'see what I mean, I cannot live like this' (in reference to a conversation about a women's life in India the day before). I immediately saw what Minu meant about freedom. She continued explaining that her mother had worked all her life as a nurse, had come home every night, cooked all evening and all weekends and, during the wedding period, her mother was the one making the tea and bringing out snacks. She never seemed to sit down, and she looked tired. She was younger by nine years than my own mother but looked ten years older[46]. Minu did not feel that her father was a bad man who forced her mother to 'work' at home as she did, but it was more a matter of this being expected of her mother to act in this way. Her mother also expected to behave this way. This expectation held by more than one party was what Minu was challenging and questioning. She did not want this for herself. Her mother was also excluded from a pre-wedding trip to the Golden Temple at Amritsar[47] as she had too much to do at home. Minu hoped this would not be her experience of married life 'It will change ... for me'. Minu had a plan how to achieve this.

[46] This was despite employing a servant
[47] The Golden Temple is widely considered the most holy place for Sikhs.

The revelations from Minu and some of my other female respondents who talked of the women's life in India, combined with spending time with Minu and her female friends and relatives, gave me a much clearer idea of what they meant by a woman's life and lack of freedom.

Part of Minu's bid to protect her freedom and independence was to move away from Southall and the Indian diaspora with its restrictions she felt imposed on her by this re-enactment of the Indian social world. In Minu's opinion, this was enacted through the sensation that she was constantly being observed in her every day aspects of life: shopping, going to and from university, and her part-time work. She had a male cousin living in Southall and she believed he might report home to her family if she did anything out of the ordinary or began to 'act more English' in her behaviour (as described above). Minu had had the opportunity to move from Southall around 18 months after coming to the UK, when she found a work placement for her adaptation course in Banbury and moved there along with Sonija[48]. Minu and Sonija supported each other in their new surroundings and, for both of their families, they felt it offered security having a friend with them, showing that social support is very much a part of the nurses new lives in the UK as it would have been at home. Both girls liked the atmosphere of Banbury; it felt less busy and they both felt more relaxed there, as the community was more ethnically diverse.

Somm and Devorah

Somm and Devorah are a married couple; they are from Kerala, are Pentecostal Christians, and both had completed the ONP. They chose to live away from Southall by moving to High Wycombe, as they felt there was too much influence there from home (India) and they both wanted to be free of this. They had similar feelings about being in the diaspora as did Minu and Sonija, and wanted to be free of its influence. Both Somm and Devorah felt they were being observed all the time and wanted to experience living 'away from India'. They felt, as did Jey and housemates that Southall was just like India, both in terms of how people lived, and being able to find all the same foodstuffs from India. They did not feel like they were living anywhere different. Somm and Devorah wanted to experience life in the UK away from the diaspora, and living in High Wycombe gave them that experience. They lived in a

[48] Sonija is 24, a Christian from Kerala and a MSc classmate of Minu's.

two-bedroom flat (they have since bought a house in High Wycombe), and did not want to share with any other Indian friends.

Devorah felt that she and Somm could have a more equal relationship and more freedom to make the necessary shared decisions about all aspects of their married lives, without family or relatives 'spying' on them or reporting back to family in India. Devorah felt the long-held concepts of expectations on her as a wife, such as bearing children and following the instruction of her husband's parents, especially the mother's (Kline et al, 2012), burdensome and a little intrusive. The long-held family belief of her as wife and mother, and Somm as the breadwinner and the main earner, was a particular challenge to Devorah. Both Devorah and Somm work full-time in the same nursing home and they would both share the household chores; it was not just Devorah's domain alone. This was a break with tradition for their families, where the male members would not engage in so-called 'women's' work. Devorah felt it was 'nice to be away from her in-laws' whom they had lived with as newlyweds: 'they were always there'. She further explained her in-laws also listened into conversations, they ate every meal with them and she felt there was no time to get to know each other properly until she and Somm came to the UK. Jeffrey's(1979:132) describes in her work on Indian women in Purdah, who were subject to being judged by the family they had married into, in respect to marriage and to being a mother. Living in the in-laws' house, as Devorah did, meant she had to adapt to the way the house was run, how food was prepared, how clean the house was, and so on. The daily routine of the house would have to be followed by the new wife. There was no sense she could change aspects of the household; she had to follow the existing pattern of work, behaviours, and routines (Jeffrey's, 1979). While Jeffrey's (1979) work is somewhat dated, it nonetheless reflects how Devorah felt her life had been and would continue to be if she and Somm had stayed in India. She was worried about the restrictions that would be levied on her, as did Jeffrey's respondents.

Devorah embraced and appreciated the privacy she felt was lacking while living in India. Devorah also felt that living in the UK gave her freedom from seeing poverty on a daily basis in Kerala. This is something that Suki also noted about life in Delhi where there were 'too, too many poor people'. Devorah said 'I can walk around High Wycombe and feel free' (from the burden of poverty). She also felt she could 'think on her own' (that is think for herself and

make her own decisions), as Minu did. A major decision that Devorah and Somm debated was whether to have a child or for her to do the adaptation course. Devorah was worried that her family and in-laws were expecting her to have a baby as she was in her second year of marriage. Devorah and Somm decided to delay having a baby, and Devorah also took further control of her future by doing the adaptation course. Devorah explained to both her family and her in-laws that both incomes (hers and Somm's) were needed in order to save to be able to afford a child in the UK. She also wanted her career but did not explain this to the family in India as this would be considered 'selfish' for considering her needs first. Jefferies's study (1979) observed this expectation, that once a couple were married a child would follow; it was not a question of if, but when. There was no discussion or debate with the young couple; a child was inevitable. Devorah and Somm felt this pressure, but being away from the family gave them the choice. Devorah and Somm did have a baby in 2015 when, as Devorah put it, 'we are ready'. She was working as a nurse and would receive maternity pay aligned to this. Another major milestone for Somm and Devorah was to buy their own house, a three-bedroom property. They have firmly settled into a permanent life in the UK. They are both very active within their church and attend many gatherings and have trips around the UK with their church. Somm has excelled in his career which began as an ONP nurse and then a staff nurse before becoming a deputy manager of a care home. He is now the manager of the same care home, and the home under his management has received an outstanding award from the Quality Care Commission (QCC). This is a very important achievement, as very few of these awards have been given to care homes. It also shows that, despite Somm working in a care home which is on the fringes of nursing in the UK, as described in Chapter One, he has shown a level of autonomy over his role and been able to shape care through his influences.

Somm and Devorah show that life in the UK can offer a balance between two worlds (India and the UK) and within the relationship between husband and wife. Devorah firmly believes that she and Somm have an equal marriage, which would have been much more difficult to achieve in India, mainly due to living with her in-laws, and the expectation of the couple to start a family as soon as possible after the marriage. The couple have continued to practice their Christian faith, and this has become an important support network in the UK with being so far away from family.

Rennu

Rennu was a former MSc student, aged 26, from Kerala, who experienced the impact of being in the UK on a very personal and physical level. She was an earnest and hardworking student who took her coursework very seriously and did not engage with the others in her class, apart from Aava. She had a quiet determination to succeed. I discussed with Rennu her plans post studies, including that of getting her IELTS[49] to level 7 and undertake the ONP. I asked whether she would consider going home to India. Rennu did not see this as an option as she would be ridiculed or shunned 'back home'. Rennu explained that, because of her illness (endometriosis), she was 'tainted' and it had made her 'not perfect'. She said that people would talk about her and she would not make a good marriage. We talked about her diagnosis and what she believed others in her family and community would think about her. From a biomedical perspective, endometriosis is a relatively easy condition to treat and manage, and I questioned why this would cause such stigma. Endometriosis is a common condition in which small pieces of the womb lining (the endometrium) are found outside the womb. Endometriosis is a long-term (chronic) condition that causes painful or heavy periods. It may also lead to lack of energy, depression and fertility problems (NHS Choices, 2013). Rennu believes that 'they' (the family of any prospective husband) would know she may not be able have children once they knew about her condition and they would reject her. She did not want people talking about her. Family and reproduction are very important to her family in India, and her role as a woman and a wife would be to produce children, as observed by Kline (2012). Much like Jeffries's (1979) respondents, there was an expectation of Rennu, as an unmarried woman, to accept that she was expected to get married. Her grandmother, to whom she was close, was pressuring her to come home and get married, but Rennu was fearful of the type of man she may have to accept, such as an older man or a widow who already had children.

Rennu was adamant that she would settle and stay in the UK, as the perception of her condition in the UK is very different from that held in India, and it would not hinder her life in the same way. Contemporary reproductive technology available in the UK would make it very possible for her to conceive (NHS Choices, 2013). Rennu was also open to marrying

someone from outside Indian society. Freedom for Rennu was not being judged or made to feel inferior; she was happy to lead a quiet life and 'stays alone' in a house, renting a room from a family. She worked three days a week in a care home and socialised very little. Rennu, like Sonija and Minu, has moved away from Southall because it was her belief that if 'Indian people' living there found out about her condition they would have negative perceptions about her. Rennu appeared a little unhappy when we met up as she has 'no one to talk to, no one at all'. She had shut herself off from people as she was ashamed about her condition, but has been slowly making friends as she realises that it is not a stigmatised illness in the UK. Rennu did eventually return to India to live with her family as she felt quite lonely and was finding it financially hard to survive in the UK. Rennu has been in Victoria, Australia since 2016, working as a staff nurse, a job she very much enjoys. She has a made a few friends, remains unmarried and, due to the geographical distance, she does not feel under any undue pressure to marry. Rennu demonstrates how she is able to live content a life outside India, free from the social stigma of her disease. She has been able to fulfil her career ambitions, albeit in Australia, and she can look forward to a long career in nursing.

Aava – exerting one's identity

Aava, Rennu's classmate and, at that time, her only friend, was raised as a Pentecostal Christian in a very strict family. Money was a constant source of pressure and stress in her family when she was growing up. In her words, 'my parents do not believe in hard work, they believe in God and that prayer will save them'. Aava does not share their views. Aava's uncle had in recent years given money to her parents to clear their debts, but much of it they had given away to the church. Even though Aava only worked part time as an HCA, she was expected to send money home each week to her mother to pay her parents' debts. Neither her father nor her mother worked so she was their main source of support. Aava sending money home is not an unusual phenomenon. Indian remittances are the largest in the world and a regular occurrence for Indian Diasporas (Singh, 2006). Aava had, since qualifying as a nurse, always contributed to the family finances and, on moving to work and live in the UK, this arrangement had continued. It is one way that Aava and her family negotiated the shifting arrangements of care and responsibility within the family. It had been more usual for men to send home money, but increasingly women like Aava are doing so. Singh (2006) argues that women have been deemed more reliable at sending money home. Aava felt her parents were

very poor at managing money, and she believed that it was her duty to continue to support them.

Aava said that she did not have good childhood memories. She recalled how her mother had 'psychologically abused' her (Aava's words) as a child and much of this had started as Aava showed signs of not being conventional and following her parents' religious beliefs. Aava did not begin to feel this until she had left home to study nursing in the Punjab. Her mother would threaten her that God was watching and would punish her. She was also picked on by her mother and sister because her darker skin differed from theirs, which was quite fair. Fairer skin is seen as more desirable and gives a person greater status. In the UK, Aava felt free of their remarks, but her parents, and mother in particular, had a strong hold over her. Aava felt her religion had made her 'insufficient' and not confident when dealing with the outside world. Because of the competition for nurse training places in Kerala, Aava had studied in the Punjab. Aava recalled that she felt closer to the 'culture' in the Punjab than she did to the culture in Kerala because it was more 'modern and sophisticated'. Aava discovered fashion and makeup as a way to express herself while studying in the Punjab and she continued to do so in the UK. Aava continued to dress in a modern fashion when she returned home after her nurse training. Aava had also had a boyfriend for five years whom she met in Goa while on holiday. He was 'high class' from a wealthy family. Her family were aware of him, but his parents were not of her. He was living in London as well.

Aava's relationship with her parents was quite strained and her way of life, expressed through how she dressed/presented herself, had led to further divisions. De Neve (2011:109) shows that some younger people are challenging their parents in terms of lifestyle choices. Aava was certainly doing this. She did not want to follow the religion as laid down by her parents. Her mother and sister shunned make up and adornments such as jewellery to align themselves with Pentecostal teachings. Coming to the UK has allowed Aava to express herself in terms of how she dresses, wears her hair, and wears make up. When I met Aava for the first time (at interviews in Chandigarh) I got the impression that she was from the Punjab (before I knew she had trained there) where Minu is from, as she was dressed in Western clothes, wore fashionable jewellery, and was fully made up. Devorah and Somm were also Pentecostal but, unlike Aava, they found the religion a supportive one and have made many friends in the UK

through the church, even though Devorah did reject the notion of wearing ‘no ornaments’ and wore some jewellery and a little makeup.

This freedom of expression did come with a price, as all of Aava’s classmates, bar Rennu, chastised and ostracised her and called her ‘loose’ because of her appearance. This was from both the male and female classmates; they would stare at her, mutter comments under their breath, or simply ignore her. Aava reasoned that they were all from Kerala like her, but they were not ‘modern’ and were more traditional in their ways of thinking, which is why they reacted to her in the way they did. This criticism by her peers about what was acceptable, in terms of dress and behaviour, was quite hard for Aava. However, she tried to ignore them and worked hard on her studies. Interestingly, Aava and Rennu were the only ones in their group of nine who passed their course and received an MSc in Nursing. Minu believed that people from Kerala were more traditional, as did Linoy and Shaju (young men from Kerala), who reflected that ‘girls are reserved in families, ways of dressing and are religious’. Aava would have appeared very modern and a bit out of place compared with her other female classmates, all from Kerala.

I lost touch with Aava but bumped into her in summer 2015. She was working at a care home where I visit student nurses on clinical placement. She appeared very happy and had passed her ONP course and was working as a qualified nurse. She had taken on the role of dementia advisor in the home. She was sharing a house with two girls: one from Poland and one from the Philippines. She has developed a large circle of friends from diverse backgrounds through her work. Aava has also travelled in Europe and she has been home to India to see her parents. She felt the relationship with her mother was easier, suggesting that maybe she was quite wilful and opinionated when she was younger. Aava and her longstanding boyfriend are no longer together and Aava is using dating websites and, as she said, ‘having fun’.

Collectively, the case studies show how life in the UK has affected the lives of the nurses. What we see in that freedom in the form of independence and life choices is a key element of successful living in a new social world. Aava, in particular, has embraced this element of UK living. However, social support is still as important as it was in India. Somm and Devorah

have their church network; Sonija and Minu have developed a supportive friendship. Most have realised their expectations of life in the UK. However, what the cases of Supinder and Sadhika show is that both parties in the marriage need to be able to see the benefits of their studying in order to improve the family status and create good opportunities for the future.

Friendship

Friendship with people from different regions of India was something some of the nurses considered a key result of coming to the UK. Jey and his housemates were a mixed group of Christian religions and Hindus, and they had been friends for years, having met at nursing college. They knew about each other's religions before, and would celebrate main festivals and holidays together in the UK and, to some extent, at home. This was not the same for the female nurses, with the exception of Minu. Minu had experienced a friendship outside her faith; her closest friend in India was her Hindu neighbour, a girl the same age as Minu. She also trained in a Christian nursing college and met other students from outside her faith. Minu's mother was good friends with her neighbour's mother. Minu, Sonija, and Aava formed strong friendships while studying in the UK and this has continued after they finished their MSc studies. They believed they would never have been friends unless they had come to the UK because they came from different regions of India, Kerala and the Punjab, respectively. They were thrown together in class admittedly but, as girls growing up in India, they did not mix with people outside their main family, class, and faith-based circles at home. The common aim and goal of the nurses working together in class, as well as how they negotiated their settling into UK life, has elements of how friendships are formed, as described by Froerer (2013), where bonds are formed between individuals. The nurses' friendships are a result of choice and mutual need, and are not dictated by society. This is demonstrated in the freedom of Sonija, Minu, and Aava to forge friendships which have been beneficial to them as they supported each other academically and on a personal level. This blurring of boundaries between groups is an element of being middle class that Fernandes (2006) has also observed, where employment or education could expose individuals to different groups of people from different religions and regions. The nurses exemplify this, especially Jey and his housemates. They were friends before coming to the UK, but have extended their friendship group and supported the rest of their MSc group, as well as some of the BSc top-up nurses, such as Jinu and Luke. When the MSc classes began, Minu sat with a

male nurse from Bangalore and a female nurse from Delhi, as they felt they did not fit in with their classmates who were all from Kerala.

As the classes progressed and they did group work and so on, Minu and Aava's friendship developed. Minu and Sonija took the overseas adaptation programme together and initially worked in the same care home. This gave them time to cement their friendship which continues today, thus showing that the nurse's nearness in a physical and emotional sense is a common way that friendships develop in adulthood (Froerer 2013:147). The common aim for all to pass their course helped sustain their friendships as they were all working towards the same goal. There have also been two marriages within the group, between Sonija and Jib, and between Luke and an MSc student, Ada, all of whom developed their relationships as a direct result of undertaking the MSc together. The two couples are Christian and believed in marrying within their religion and class as a way of honouring the traditional in their very contemporary world.

The male nurses' experience

In respect to independence and freedom, the majority of the male nurses supported Jey's assertion that 'nothing is different for men' in the UK. There were, though, a few perceived advantages to being in the UK. All the male nurses, bar Shaju, Linoy, and Somm, lived in Southall which they enjoyed. It was, they said, like being at home in India. They always joked when I visited them that I was the tourist in Southall. One example Luke and Jey gave was that Luke liked to drink beer – 'a lot of beer'— and was sometimes drunk. The housemates all saw this as funny or as a bit of a joke, but if one of the female nurses had started drinking alcohol in front of them they would inform their families back home in India. Sonija and Minu both liked the odd cocktail, but would never drink in front of their classmates for that reason. This demonstrated imposition of the social rules of India in the diaspora.

On one particular day when I visited Jey and his housemates, we took a walk around Southall and the food and clothing shops they frequented. These male nurses enjoyed the fact that they could buy the same food as in India and liked hearing Indian voices. It helped them not to get homesick too often. Some factors of life in the UK gave them greater choice. They felt better

able to delay their weddings as they waited to complete their studies and find a good job. Luke (a BSc top-up student) and Jib married two girls from the MSc group. Their families had approved their love matches, which in essence meant they had chosen their partners. As Luke suggested, if he had been at home in India, his parents would most likely have chosen his wife.

Jey and his housemates' house was the party house; they liked to have people over and they would invite all the other members of their MSc group when they started, for birthdays and Christmas. They invited male and female, Christian or Hindu. Jey and Abin reflected that this sort of party would not have happened in India. The female nurses would not have been able to attend on their own; they would have to be accompanied by their husbands or a male relative. Jey, Jib, and Arun, in particular, the bright achievers, became tutors to the weaker members of the group. They always knew what is going on with all their classmates. They had become family, as they said, and the three boys were like the elders. They enjoyed cooking for their classmates. Each time I went to visit I had food, which they say would have been wrong not to offer in their fathers' homes, so they felt they would carry on with this hospitality. Their shared background of being Indian in the UK contributed to this group becoming very close, cohesive, and supportive of each other. These nurses are displaying what has been termed as transnationalism, where they develop a sense of moral community linked to being overseas and with home (India, in this case) (Vertovec, 2007). They negotiate their belonging in the UK through utilising their experiences of growing up and living in the social world in India. Throughout this process there is some adaptation to life in the UK that can be seen by these mixed parties and dressing in Western-style clothes for the Kerala female nurses.

Conclusion

Being in the UK offers the nurses' different life choices from what many see as restrictive social practices in India. They conduct their lives in the UK in different ways, much of which is down to new opportunities, but also due to the physical distance from India. For the majority of the nurses, being in the UK has given them a sense of independence and choice on how to live their lives, either by delaying marriage and/or starting a family. Some have developed their career by seizing opportunities and embracing new ways of working. The

nurses have not lived in a silo of just friends from home; they have developed and sustained relationships with individuals they may not have encountered in their social or work world in India. This has led to new knowledge and respect for India and people from different regions, namely the Punjab and Kerala that previously they had had little contact with. There are some aspects of life in the diaspora which would see news filtering home and for that reason nurses such as Aava, Minu, Aava, Devorah, and Somm purposely situated themselves outside the diaspora. They do not want admonishment for socialising, drinking, and so on, that could be passed onto their families through diasporic links. They also want privacy from family prying eyes. Most of the male nurses have remained living in the diaspora and life has not changed that much for them. The male nurses like the similarity of Southall to home as it makes them feel comfortable, which demonstrates different life strategies acted out by the male and females nurses. However, the male nurses have altered some of their practices such as delaying their weddings until they were settled in a career. There have also been two 'love' marriages from within the MSc group and while they still needed to be approved by both families, the nurses have chosen their partners. The male nurses use Skype to contact home on a frequent basis and this helped keep the ties with home close. As I have shown, some of the female nurses have changed how they live, such as Minu socialising and drinking alcohol. They seized opportunities to change while they were in the UK. Aava is the noticeable exception: she had started down a path of change before she came to the UK through how she dressed and how she was influenced by her time in the Punjab during her nurse training. The female nurses have much more to gain by being in the UK: while I show this in a few case studies, it has been very much the same for the remainder of the female nurses. Some of the motivation to come to the UK was centred on better working conditions and a fear of violence at work. Consequently, the female nurses have felt safer in the UK, knowing that violence against women, at work and in private, is not tolerated.

Chapter Eight: Conclusions

In this thesis, I set out to explore closely the lives of a group of nurses whose primary and nurse education was in India. They all migrated to the UK for education and/or work purposes. Migration, as I have discovered, was the end goal for the nurses I worked with and for their families. Migration is seen by them as a way to cement their position as part of the Indian middle classes and, as I have shown throughout the thesis, to improve their lot in life—within a culturally-specific context of a globalising India—in a variety of ways.

Key themes have emerged and have been explored in this thesis, namely: migration, gender, being middle class, learning and education, and autonomy. The themes all interlock and are articulated through how nursing is defined in contemporary India, thus giving a voice to the Indian nurses I worked with.

Gender

During my fieldwork and time spent with the nurses, a clear difference emerged in how male and female nurses expressed themselves as nurses in society. Nursing in the UK has enabled these Indian nurses to develop their careers, but also their roles within their relationships with husbands and their own families. In the UK, it is possible for the female nurses, in particular, to take the role of primary breadwinner, as Minu and Sonija have done. This challenges typical stereotypes that form part of their social world in India: their fathers and grandfathers were the main earners in the family. This change has been accepted as the new norm within the nurses' relationships, the notable exceptions being Sadhika and Supinder (see their case studies in Chapter Seven). The female nurses have been able to negotiate with their families regarding when they get married, with some even delaying getting married or having children. As I show, the female nurses are in a strong position to steer how their lives develop through being a practising nurse in the UK. The female nurses have situated themselves in a career that offers prospects and stability in terms of a career with good remuneration and longevity. This is a result of careful planning and looking forward with their families. There is no sense that the nurses knew they would challenge gender roles, but they have embraced the control over their own lives; in the end, this has impacted on their lived experience in the UK.

The female nurses have been more proactive in undertaking the overseas nurse programme (ONP) in order to practice as a qualified nurse in the UK. The female nurses, in some circumstances, value their careers as nurses more than their male counterparts, taking advantage of the status they can earn themselves and their families through being a nurse in the UK. The male nurses that have completed the ONP have expressed career projections that differ from those of the female nurses. Here, we see traditional gender boundaries being acted out, as women dominate in numbers, but men seek to dominate the profession. The male nurses see themselves as managers or leaders in nursing; working in care homes in the UK makes this very possible. Nurses in such contexts have more autonomy and control over patient care on a day-to-day basis, as care is largely nurse-led. For example, both Somm and Linoy have achieved management roles in their respective workplaces, adding to their social statuses and those of their families. The female nurses position themselves as caregivers where the care takes place at the bedside and directly with the patients. Many of the male nurses that have continued to practice in the UK in the field of nursing—be it an HCAs or as registered nurses—need more than economic motivation to sustain their working lives. Nursing can be a difficult and often challenging profession, even more so in care homes, as Jey and Abin have articulated (Smith & Macintosh, 2007). That being said, I find it difficult to believe that the male nurses do not have some altruistic motivation to work in care homes, and thereby derive some enjoyment out of the work, as Jasom put it. It would be difficult to sustain such a career without some other motivating factors.

The male nurses who have remained as HCAs feel obligated to verbalize their notion that all nursing and support roles has a more stable and respected image in the UK, emphasising that they are working in the field of nursing, even though they occupy the lower echelons of UK nursing. By doing so, they are able to manipulate their families' understanding of their HCA roles, and thus can continue to add to the good status of their family. The families of these male nurses can then boast that they have a son working in the UK in the field of nursing. A key finding of my thesis is that these nurses do not feel the need to explain to outsiders about how UK nursing works.

Migration

Migration, as I have shown, is planned for by nurses' families, long before the nurses are qualified in the profession. Migration should not be seen in isolation, as it is dependent on a

number of factors, from the nurse already being middle class, to overseas work and higher education. By becoming a migratory nurse, they secure their futures and those of their families. This strategy is based on the nurses' success in passing their respective programmes of study in the UK, many of whom did not, and had to return to India. Returning to India without the academic qualification would have had a negative impact on their social status, as well as financial loss for the families. The significance of studying the migration of Indian nurses is that, while migration features in the narratives of other middle-class families (Donner & De Neve 2011), the migration of female and male nurses is unique, in that both genders are migrating for the same profession; this is not replicated by other professions from India in the current literature. The focus of previous research has been on female nurses migrating to the Middle East, particularly from the state of Kerala, where most of the nurses in my study originate from (Reddy, 2015; Percot & Rajan, 2007). This omission in the literature needed addressing because the Indian nurse is part of a newer wave of migrants to the UK. They comprise the highest number of overseas nurses registered with the Nursing and Midwifery Council of the UK (NMC, 2017).

Motivation

Examining the reasons why nurses migrate from India to the UK has opened up previously unknown or undocumented motivations to nurse, from both male and female perspectives. By exploring migration, I have shown that migration is fundamental to the motivation to nurse: a life strategy exploited by the nurses and their families. Gender is key to how the nurses articulated their motivation to be a nurse. On first glance, the nursing motivation for women is linked to the service of others, a more altruistic approach to their careers. For men, the financial reward and work overseas play a key part in why they join the profession. Linked to both male and female motivations is the underpinning desire to maintain and even improve their social status that studying and working in the UK can offer. Being in the UK has given the nurses geographical distance from the pockets of negative connotations levied on nursing based on ritual purity and pollution beliefs that are still evident in some sections of Indian society.

Class

I have examined the literature on the 'new middle class' in India, where one's status is defined more by one's profession than by one's caste. The nurses that I described in this

thesis definitely fulfil the aspects of what makes up the 'new' middle classes, such as post-secondary education, financial security, and migration prospects (Donner & De Neve,2011)

A difference occurs when we view nursing as an old profession, with a long and sometimes difficult history that has reimaged itself into a profession for the contemporary young Indian. Nursing was seen as a highly polluting profession in a ritual sense, and thus a career that was shunned by higher caste Hindu families (Somjee, 1991). The poor image of the profession associated with this ritual purity and pollution has all but dissipated, apart from some isolated pockets of resistance to the new improved status of nursing. Improved social enhancement prospects and the sustenance of a middle-class status has made nursing a fashionable and popular profession as I have argued in this thesis.

Migration, as noted above, is made possible by the nurses' middle-class status. They have the knowledge and the means to know how to seek the opportunities to work and study overseas. Exploring how the nurses define and act out their middle-class status has added to the literature on middle-class Indian persons. Nursing in India attracts middle-class young men and women, as exemplified by the nurses in this study. The nurses already have middle-class status through their families' high standing in their communities. Being middle class has enabled the nurses to transfer some of their social status to the profession. This, in turn, legitimises the nurses' attraction to the career, in particular, the male nurses, who reason that this improved status makes it acceptable for men to take up a female-orientated profession. This is boosted by the nurses undertaking higher education, the potential to study or work overseas, and English language proficiency.

Education and Learning

Education and learning are spects of being middle class that the nurses demonstrate. Education is so important to them and their families, and parallels can be drawn with other middle-class Indians. The unique nature of my longitudinal research has enabled me to observe and examine how the nurses negotiate between their experience of education in India and their experience in the UK academic setting. What is clear is that programmes of study need to be adaptable to the diverse nature of learning. I believe that my work is useful and relevant to anyone training and educating nurses who did not undertake their primary nurse

education in the host country. My findings contribute to the body of literature on the anthropology of education, and, in particular, to that of the nurse whose profession continues to grow. Indian educators should consider learning outside of India if they continue to promote migration to such a high extent. I offer relevant insights about Indian nurses who have joined a profession with increasing status and career prospects through migration. I show how their education in India has had an impact on how they learn in higher education in the UK. About half of the nurses I worked with were able to adapt to UK education regimes and were highly motivated to succeed.

Higher education and learning are key factors to the understanding of the nurse's journey to work and live in the UK. The clinical skills associated with nursing are adaptable in the global arena of nursing practice. In the UK, however, contextual education and learning proved to be more problematic for the nurses. On arrival in the UK, the nurses were confronted with a distinctly different style of education, and thus, different expectations on the learning process. The nurses also encountered situations in class, where social boundaries were blurred. For the female nurses, they were not used to co-educational classes, having only experienced single-sex classes at their nursing colleges. In an Indian context, education is built on a foundation of memorisation, and didactic and rote learning. In the UK, the approach to learning is one that is centred on the nurses working with pedagogic and independent approaches to learning. The focus is thus on students directly engaged with the material, and they are more in control of their own learning. For some, this methodological shift proved unsuccessful, and they failed their respective courses; they were never quite able to bridge the gap between the two styles of education.

Living in the Diaspora

Through the eyes of the nurses I worked with, I have been able to examine the reality of being a migratory nurse in the UK. Of primary interest is how the nurses are able to enact levels of autonomy and independence in their everyday lives—something the female nurses, in particular, found to be difficult when growing up in India. Moving away from the diaspora has given the female nurses even more control over their lives; I show how the diaspora can be somewhat limiting and restrictive in a social sense, stifling the nurses' desire to live in a different way to that commonly found in India. The diaspora is viewed as restrictive by many of the female nurses, whereas outside the diaspora, the possibilities are endless, as shown in

some of my case studies in Chapter Seven. Living outside the diaspora has expanded the nurses' experiences, and also allowed them to make friends with people outside their normal social circle. The female nurses I observed have adapted to life in the UK by the way they socialise and mix with friends at work, how they shop, and even how they prepare meals with a more European flavour. For example, Aava has embraced these new opportunities in order to travel around Europe by herself, something she would not have contemplated when she was living in India. Many nurses, such as Minu, have managed to bridge the gap between the two social worlds: the UK and India. Minu consented to an arranged marriage, but took her time saying yes to the match. Minu has adjusted to married and domestic life, while still maintaining the elements she sees as freeing, such as meeting friends for shopping or drinks. The female nurses show that young Indian people can live outside the diaspora and still maintain family ties with home.

Areas for further research

Below are some areas that require further exploration, and build on the questions and conclusions raised by my study. The nurses' career development requires further scrutiny; it would be interesting to know and explore whether the male nurses enacted their masculine aspirations for being a nurse—that is, did they become managers and achieve leadership roles? We know from Jey's experience that he did not, but Somm, Linoy, and Jasom are developing towards those roles.

A further aspect of the nurse's social world worth examining would be whether their social status is sustained or indeed enhanced through being educated in the UK and working in the world of nursing, even as an HCA.

Of relevance to investigate would be the nurses' attitudes to working with older people in care homes. This type of nursing is something that none of the nurses had experienced in India; therefore, this type of nursing challenges Indian societal norms, where older people are typically cared for by their families.

An important part of nursing in the UK is continuing education, such as taking courses linked to their area of practice. Exploring how and if the Indian nurses have done this would further help flesh out the picture of how they adapt to the profession of nursing in the UK long-term.

For the married couples, such as Jib and Sonija, Minu and Manju, and Somm and Devorah, it would be add another dimension to being middle class o explore their relationships living in the UK. Do they have a more equal partnership within marriage as Devorah and the other female nurses have alluded to?

An additional topic of research would be investigating the experiences of the nurses that have returned to India after successfully completing their respective courses. Have these nurses changed their practice, and do they have different expectations for their careers. For the nurses that became teachers, has this influenced how they prepare themselves for teaching? Has their style of delivery altered from being in the UK?

These questions are beyond the scope of this thesis, but do point the way towards further research.

The themes explored in this thesis contribute specifically to the knowledge around the anthropology of India in particular being middle class and migration. Limited contemporary literature exist around nursing in India and the nurse as a migrant and how important it is to sustaining a middle class identity. This runs as a theme throughout this thesis as detailed below. Understanding Nursing is important in so many ways in contemporary India as I have shown. It is of prime importance to UK nursing as Indian nurses remain the highest number of overseas registered nurses in the UK. Gaining insights into who they are and importantly their learning experiences and needs will help with the develop of continuing develop of nurse which is key to being a registered nurse in the UK.

Epilogue: Where are they now?

In closing, I offer an update on some of the nurses I worked with, which continues on from Chapter Seven.

Suki and Jinu

There exists a mismatch between expectation and reality for some of the nurses. The dream of a new and improved nursing career was not always realised, and some nurses failed in academic work and had to return to India. For some, like Suki and Jinu, their UK qualifications were not recognised in India. Suki returned to India with her BSc in Nursing,

and expected to be able to advance her career in the government hospital in Delhi. However, the Delhi nursing council did not recognise her UK degree, and she initially found herself working on a dermatology ward, which she saw as punishment for spending a year in the UK. Suki now works in Theatres and is much happier with this aspect of nursing. She remains unmarried and lives with her parents. To ensure her future with the financial support of her parents, she has purchased two flats for rental in a good suburb of Delhi. Jinu discovered on her return to India that none of her local hospitals in Kerala would accept her degree. Jinu enrolled in a distance learning course from a college in Bangalore to achieve a degree qualification acceptable in India, allowing her to advance her career and earn a higher salary. Jinu did not enjoy her time in the UK, and she was homesick most of the time. She missed her husband and children considerably, but she is now fulfilled in both her home life and work.

Sonija and Minu

Sonija and Minu undertook the ONP together, and both initially worked in the care home that had supported them the during their adaptation process. Minu remained there until 2015, and now works in a private hospital in the Banbury area as a theatre practitioner. She is pregnant and is due to have her first child in the autumn of 2018. Like Minu, Sonija took up a position in theatres in another private hospital in the Oxford area. She has just had her first child with Jib, and is now on maternity leave. Both Minu and Sonija delayed having their first child until their careers were well established. This meant that they can take maternity leave, and then return to work and continue their professional development. A similar strategy was employed by Devorah as a way to help secure their child's future and keep two incomes, bolstering the family finances. It is interesting that Suki, Sonija, and Minu all work in theatres, an area where there is limited intimate contact with patients; they do not carry out personal care, for example, thus distancing themselves even further from notions of pollution. They view their roles as more technical and advanced, which helps create a better image for their family of the work they do.

Abin

Abin is now in Canada, awaiting his registration to work there as a nurse. He reflected 'it was a long journey for me… was working back in India (Kerala) since I left the UK (in 2015)'. Abin is not married, but his parents plan to arrange this once he is working as a nurse in Canada. Abin, like Jey and Jib, did not pass his IELTS examination to a high-enough standard to undertake the ONP. The female nurses, such as Aava, Sonija, and Minu, were more motivated as they all wanted a career in nursing. The male nurse differs here as income is a prime concern, and the ONP process takes a long time; as Jey put it, he is not patient. Also for Jey, Manju, and Jib, their respective wives completed the ONP, which adds stability to the family, in terms of social status and economic gain. Within their marriages, they act as one, and if one of them is a registered nurse, then both benefit. As discussed in Chapter Three, the male nurses, bar Somm, came into nursing for the opportunity to travel for work and education, which being a nurse in India allowed them to do. The image they relay to their families is one of working in the nursing field in the UK, even as an HCA. This adds to their social status and provides a steady income without the responsibility of being a registered nurse.

Jasom

Jasom, who professed laziness when he undertook the MSc, is now working as a nurse in a dementia home which he finds challenging but also enjoyable and fulfilling. He has a very different attitude towards nursing from when I first met him, when he told me his parents had 'forced' him to be a nurse. He initially 'did not like' nursing. Jasom lives near Birmingham, visits Vin and Jey once a month, and chats with Jib and Sonija often. The MSc group have, for the most part, remained good friends, and have developed close personal relationships. They see these relationships as being part of a 'family', and a support network while away from India. The nurses have developed their sense of community within and outside the diaspora. The initial divide between the nurses from the Punjab and Kerala has dissipated, and they now identify as a group in terms of their shared experience of higher education in the UK, and in the world of work. For the most part, the nurses feel like a family and they are there to support each other where needed.

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