

Title: 'A suitable job?': a qualitative study of becoming a nurse in the context of a globalising profession in Bangalore, India

Abstract

Background: Research on Indian nurses has focused on their participation as global migrant workers for whom opportunities abroad act as an incentive for many to migrate overseas. However, little is known about the careers of Indian nurses, or the impact of a globalised health care market on nurses who remain and on the profession itself in India.

Objectives: To explore nurses' accounts of entry into nursing in the context of the globalisation of the nursing profession in India, and the salience of 'migration' for nurses' individual careers.

Design: Qualitative interview study (n=56).

Settings and participants: The study drew on interviews with 56 nurses from six sites in Bangalore, India. These included two government hospitals, two private hospitals, a Christian mission hospital, a private outpatient clinic and two private nursing colleges. Participants were selected purposively to include nurses from Christian and Hindu backgrounds, a range of home States, ages and seniority and to deliberately over-recruit (rare) male nurses.

Methods: Interviews covered how and why nurses entered nursing, their training and career paths to date, plans for the future, their experiences of providing nursing care and attitudes towards migration. Data analysis drew on grounded theory methods.

Results: Nursing is traditionally seen as a viable career particularly for women from Christian communities in India, where it has created inter-generational 'nurse families'. In a globalising India, nursing is becoming a job 'with prospects' transcending traditional caste, class and gender boundaries. Almost all nurses interviewed who intended seeking overseas employment envisaged migration as a short term option to satisfy career objectives - increased knowledge, skills and economic rewards - that could result in long-term professional and social status gains 'back home' in

India. For others, migration was not part of their career plan: yet the increases in status that migration possibilities had brought were crucial to framing nursing as a 'suitable job' for a growing number of entrants.

Conclusions: The possibility of migration has facilitated collective social mobility for Indian nurses.

Migration possibilities were important not only for those who migrate, but for improving the status of nursing in general in India, making it a more attractive career option for a growing range of recruits.

Key words: Careers; Gender; Globalisation; India; Migration; Nurses

- **What is already known about the topic?**
- The globalisation of the health care workforce has linked individual 'career choices' to opportunities in international health care markets and Indian nurses have actively chosen to migrate.
- Incentives for migration include perceptions of higher pay structures abroad, increased possibilities for professional development and dissatisfaction with social attitudes towards nursing in India.
- Studies of migration, and the few studies of nursing in contemporary India, have largely focused on nurses from Kerala and on the implications of migration for the health workforce in low and middle income countries.
- Little is known about the impact of this globalized health care market on nurses who remain, and on the profession itself in countries such as India.

• What this paper adds?

- Nursing remains a default 'suitable job' for many women from inter-generational nurse families in India.
- Migration has important positive implications for the workforce remaining in India, including those from non-Keralite communities, and is encouraging the collective social mobility of Indian nurses.
- In a globalising India, nursing is becoming a job 'with prospects' which transcends traditional caste, class and gender boundaries

'A suitable job?': a qualitative study of becoming a nurse in the context of a globalising profession in Bangalore, India

Introduction

In 1998/9, there were 48 nursing colleges in the state of Karnataka, south India. By 2003/4 this number had risen to 145 (Government of Karnataka, 2006). This dramatic expansion of training capacity reflects the emergence of nurses as an important 'export' for India (Khadria, 2007, Thomas, 2006, Gill, 2011, Alonso-Garbayo and Maben, 2009, DiCiccio-Bloom, 2004, George, 2005, Walton-Roberts, 2012, Woodbridge and Bland, 2010). As part of a globalising health care workforce, (Kingma, 2006), Indian nurses migrate to access higher pay structures abroad, increased possibilities for professional development, to join family overseas or to escape dissatisfaction with social attitudes towards nursing in India (Hawkes et al. 2009, Khadria, 2004, Thomas, 2006).

To date, however, discussions of the motivations for and implications of this expansion in nurse migration have been based largely on the experiences of migrant Indian nurses themselves (Woodbridge et al. 2010, Thomas, 2006, George, 2005) and on the impact of the 'brain drain' from low and middle income countries on health system performance (Gill, 2011, Rao et al. 2012, Chen et al. 2004, OECD, 2010, WHO, 2006). Few empirical studies address the views of nurses who remain in India. One exception is a recent study by Nair (2012), who surveyed and interviewed nurses from Kerala who were working in Delhi. Nair notes that despite international migration having raised the visibility of nursing, it remained a job with low social status.

The current status of nursing in India relates to the intersections of religion, caste and gender through India's colonial history (Abraham, 1996, Fitzgerald, 1997, Nair and Healey, 2006). Nursing, in its modern form, can be understood as arising from the colonial expansion of medical services and education in the second half of the 19th century, with the bulk of nursing education taking place in Christian missionary hospitals. The emergence of Western style nursing in India came to be incorporated into historical social divisions in which nursing became associated with the traditional

caste based division of labour and specifically with low status work. In the Indian caste hierarchy, notions of 'purity' and 'pollution' within the body come to be signified through rituals and social practices that separate higher and lower castes in the public arena (Gupta, 1992).

With its association with menial work, nursing has traditionally been viewed as a 'polluting' occupation that presented a threat to the social identity of those from the upper Hindu castes, and thus an inappropriate choice of employment for them (Abraham, 1996, Somjee, 1991, Walton-Roberts, 2012). As the caste hierarchy was not so visible in Christianity, converts were less affected by fears of pollution and other caste constraints found in Hinduism (Abraham, 1996). However, the affiliation of low caste Hindus and Christian converts with nursing made those from higher Hindu castes reluctant to enter the profession, thus presenting a challenge to female medical missionaries working in India who sought to recruit Muslim and upper caste Indians to lift nursing's public image (Fitzgerald, 1997).

That nursing is predominantly gendered work has also been widely analysed as one important element in the relative status of nursing and its attractiveness as a career to those of high social status (Davies, 1995, Ehrenreich and English, 1973, Garmanikow, 1978). Little of this work has drawn on settings such as India, but as nursing's modern origins lie in Western systems introduced during the colonial period, and nursing continues to be a female dominated profession, these feminist analyses resonate with the Indian setting. However, in India, changing opportunities for women are reflected in a loosening of the significance of caste stratification, particularly in urban settings such as Bangalore, where cosmopolitan mixed populations diminish (to some extent) the salience of pollution rules (Beteille, 1992). New jobs in IT and the service industry are outside the boundaries of traditional work-caste arrangements and, through providing competitive salaries, Westernized work place culture and opportunities to travel for young men and women, are part of social liberalization trends that are beginning to transform previously held attitudes towards caste and gender (D'Mello and Sahay, 2007). As Chauhan (2007), Beteille (1992) and other social commentators on India argue, caste has become one signifier among many, with class and income becoming important markers for such

purposes as marriage choices or social status. In this context, there are signs that the image of nursing in public consciousness is beginning to change in that other religious groups, particularly Hindu women and men, and Muslims (although to a much smaller degree) are entering nursing (Somjee, 1991, Walton-Roberts, 2012).

Bangalore (Bengaluru¹) provides a useful setting to explore how globalisation and this rapidly changing occupational environment are shaping the profession of nursing in India. Bangalore is the state capital of Karnataka, with a population of some 8.4 million and is India's third largest city. As well as becoming synonymous with India's information technology boom, Bangalore is also a major medical hub, with a large range of research and medical facilities, from 'super-specialty' hospitals that offer high quality treatment and facilities for wealthy Indians and foreign clients, to poorly regulated private facilities and government hospitals catering to lower income patients. The growing number of medical and nursing colleges makes Bangalore a migratory destination for people from across south India, and a recruitment centre for medical professionals, including nurses (Khadria, 2004). However, a large number of recruits from its home state, Karnataka, are also trained in Bangalore and, have, to date, rarely been included in studies of nursing. This study therefore aimed to fill a gap in knowledge on the effects of globalisation on the nursing profession in India, in a rapidly changing environment for women at work.

Methods

This study draws on in-depth interviews with 56 nurses from six sites in Bangalore conducted over a 6 month period in 2008 and a month long follow-up visit in December 2009. Participants were interviewed once. However, as the lead author conducted about 20 hours of observation at the sites, conversations about nursing were held with some respondents again subsequently, particularly nurse supervisors during 'rounds', with notes recorded in the lead author's field journal. The lead author returned to Bangalore for a follow-up visit in December in order to discuss some of the emerging findings with key informants from nursing institutions and to revisit two of the sites.

Participants were recruited from a range of settings which provide employment and training: this included two government hospitals, two private hospitals, a Christian mission hospital, a private outpatient clinic and two private nursing colleges. A retired nurse and her daughter (also a nurse) were also interviewed. Within the sites, participants were selected purposively, with the aid of local gatekeepers such as hospital superintendents, to include a range of ages, seniority and to deliberately over-recruit (rare) male nurses. Age served as a proxy for the number of years the participants had worked as nurses. All nurses (except for one male nurse who entered nursing training in his late twenties) joined the labour market immediately after obtaining a 4 year BSc in Nursing or a three year diploma in General Nursing and Midwifery (GNM).

The final sample included 49 female and 7 male nurses, a range of qualifications and nurses largely from Christian and Hindu backgrounds. There are no national or regional data sets of the origins of nurses, and the intention was not to draw a statistically representative sample, but to include a purposively selected range of experiences, backgrounds and work settings, for maximum variation.

Interviews, which typically lasted 45 minutes to an hour, covered how and why nurses entered nursing, their training and career paths to date and plans for the future, their experiences of providing nursing care and attitudes towards migration. All but four interviews were conducted in English (the language of instruction in nursing colleges, but not necessarily the participant's first language) by the lead author (SJ) who, with dual Indian-British identity, had an 'insider-outsider' status (Srinivas, 1997) which is often attributed to 'Non Resident Indians'. Four interviews were conducted in a mixture of Kannada, the preferred language of these respondents, and English, by a local research assistant with the lead author present.

The approach to data analysis drew on grounded theory methods (Glaser and Strauss, 1967), with a cyclical process of data collection and analysis that involved generation of emerging theoretical categories, line by line open coding, comparisons across cases, and close analysis of 'deviant cases' (such as male nurses, or those whose first choice of career was not nursing). In addition to comparing

the accounts of nurses within and between the sites, the research findings were also compared to other studies on Indian nurses, particularly the works of George (2005), Percot (2006), Nair and Percot (2011), Nair (2012) and Walton-Roberts (2012) on nurses from Kerala.

The study was approved by the ethics committee of the London School of Hygiene and Tropical Medicine and information was submitted about the study (including consent forms) to the management of each hospital for review and to invite any questions or concerns about the research. To maintain confidentiality, pseudonyms are used in this paper, with age and home state in brackets.

This paper focuses on four themes that shed light on the changing meanings of nursing in India: how nursing comes to be a suitable career choice, particularly for women; the importance of role models and 'nursing families'; the attraction of a 'job with prospects' in the context of a globalising profession; and the role of migration in careers.

Findings

A suitable choice for women

Nursing remains closely associated with female gender, and in accounting for their 'choice' of nursing as a career, a number of nurses interviewed cited their gender as making nursing a default choice, made with little reflection. As Tara (28, Karnataka) explained:

Everybody was going into this profession only. All girls, usually they will go to this one only. And even my mother, she told 'you go to this'.

Similarly, Deepa (30, Tamil Nadu) recalls the way in which nursing was presented to her as the obvious option:

Firstly, I didn't know anything about nursing when I joined newly. My sister was doing nursing. As soon as I finished my PUC (two year pre-university course), they said 'Okay, sister is there no? You go and join.' So, without knowing I went and joined.

Those who did discuss other potential avenues of employment most often mentioned another female dominated service profession - that of teaching, also considered gender appropriate, and, as training is affordable, class appropriate. For older nurses, teaching and nursing were cited as among the few

occupations available to them at the time. Although other occupational choices may have opened up for women, many participants still reported that gendered expectations from families had closed other options, as Prabha (25, Karnataka) recalled:

Well basically I was not interested in nursing. I was interested to do law. I told my mum [...]and she told 'No, it would be suitable for boys rather than girls. I don't want you to get into law'. That's what she said... So then I was thinking 'Which other profession will I go [for]?' Then one neighbour, she had completed her nursing. She told 'it will be a good profession, you will have a good future'. So, I said 'Okay fine, I'll join.' So it was just like that. I did not have options, I don't know, I did not have any other options, so I just went for that.

However, not all women end up in nursing, and not all nurses are women. Although the female-centric history and development of nursing largely explains the overwhelming presence of women in the field, it does not fully account for why women would chose nursing over other options, in a setting such as Bangalore where a number of other avenues of employment are available to women. A first particular 'trigger', as suggested in Deepa and Prabna's accounts, above, was that of role models: other women in their networks already working as nurses. Also significant was the important role of family in the decision making process.

Considering nursing as a job for you: the importance of nurse families

What turned nursing from a candidate job for women in general into the obvious choice for an individual was often reported to be an influential role model. Responses such as '*my mother/sister/aunt is a nurse*' to the question 'why were you interested in nursing?' suggested an inevitability of following a path already made by other female friends or family members. As Ashwani (23, Kerala) explained, the decision was "*No decision. My sister was a nurse*".

A number of participants could be said to come from 'nurse families', in which a large number of female family members were also nurses. An interview with Sophie and her daughter Joy during preliminary fieldwork was a first exposure to the phenomenon of 'nursing families' in India and the influence that nurse 'role models' have on the decision of younger family members to enter nursing:

SJ: And why did you go into nursing?

Joy: Well, I think I have always been, you know, inclined to work at the hospital, the choice was between medicine and nursing and I think I went into nursing mainly because my Mum was a nurse and I sort of followed in her footsteps. We went to the same school, and nursing school, both of us were, we did exactly the same.

Such accounts were typical across the data set. Malika (25, Kerala) explained the influence of her aunts:

My mummy's sisters, both of them were nurses. I used to see them wearing the uniform when I used to go to meet them in the hospitals I would see them with the patients, with injections, trolleys and then I saw er, they went to the Gulf... So, a little bit of this was there, if I will be able to do, I will practice nursing only, like that.

Overall, twenty nurses specifically mentioned the presence of at least one other female relative who was a nurse with some, like Lakshmi, coming from large nursing 'families' where *"All of our family, all of us four sisters are in nursing only"*. This was particularly true of the nurses from Kerala, of whom ten out of sixteen nurses originally from Kerala talked about other female family members who were nurses. There has been a long history of nursing in Kerala, with patterns of recruitment traditionally among the Christian community, many of whom came from Kerala. As George (2005) notes, these communities were historically relatively more open to women working outside the home than other religious communities. Rita's (29, Kerala) account suggests the typicality of such Keralite 'nursing families':

SJ: Ah! So Kerala has lots of nurses?

Rita: Hah! Lots of nurses! In one family, at least one nurse is there.

SJ: And in your family?

Rita: In my family, total four nurses (laughs)

SJ: Who are the nurses in your family?

Rita: My elder sister and two other sisters-in-law (laughs).

Nurse role models were reported as actively encouraging an interest in nursing through persuasive discourse around the opportunities and benefits of a nursing life, an encouragement that at times was a more directive steer when young women from nurse families had other ideas:

Because really during that time I was not interested in this profession. I wanted to become a teacher. Then, one of my aunts, she is a nurse ...she told me that nurses earn so much good opportunities, because it is one of the noble professions if you finish the course you can go anywhere in India, anywhere in the world, like she told. She gave some encouragement to me. Then I changed my plan and I was joined to the nursing (Lizzie, 27, Karnataka).

Encouragement was not experienced only by female family members. Three male nurses came from 'nurse families' and two mentioned similar encouragement:

My sister is a nurse. And my cousin is working in the UK. She told like that 'go to male nurses, it is a very good chance for male nurses in the UK and other foreign countries'. (Karthik, 34, Kerala)

As social networks in India tend to be more communal and not just limited to the immediate family, the influence of 'nurse family' role models extended to the mothers and sisters of childhood friends as well as to neighbours and family acquaintances. Savitri's vivid account of the influence that her best friend's mother had on her decision to become a nurse suggests how such influences may contribute to the widening appeal of nursing beyond its Christian roots:

I belong to the Hindu religion. I have a very close friend Mary from the Christian community. We were very close friends ... So, her mother was a nurse ... So once I accompanied her to see her in X hospital. Maybe we were 15 or 14 years like that. So that time I had gone and I saw the nurses going to the wards and coming back from the wards and then going and taking the patients. We were with her mother for some time. For about half a day or something like that. It was mainly, you know, patient care touch and you know, the uniform, pure white and good, beautiful looking, like angels, big big, you know, veils and other things. It really impressed me. (Savitri, 57, Andhra Pradesh)

For those coming from non-nurse families, however, entry into nursing was not always easy. Despite being inspired by Mary's mother, Savitri's family was against her decision to enter nursing and wanted her to become a doctor. Similarly, Karishma (54, Karnataka) from a high Hindu caste reported that she was initially inspired to become a nurse when she was hospitalised with tonsillitis as a child. She saw the nurses in "full uniform" and was attracted to the idea of nursing. However, she faced

opposition from her father who wanted her to be an ayurvedic doctor or a lawyer. In addition, Karishma also had to overcome some of her own prejudices when she began her nursing training, explaining *“Because in some religions, so much dirty and all. We are hesitating to touch them. That is our mentality”*. Consequently, unlike nurses from ‘nurse families’, who are already following an accepted path, ‘first timers’, particularly from better-off families, often have to negotiate some of the public images of nursing that render it an ‘unsuitable job’.

A globalizing profession: beyond caste, class and gender barriers

What made nursing a feasible choice for recruits from outside the traditional sources in Keralite Christian communities, given the potential threats to social identity of nursing work alluded to by Karishma, above, is an important question. The majority of Hindu nurses in the sample were drawn from lower and middle castes. With caste and socio-economic status closely related in India (Dalmia, 2004, Iverson et al. 2010), this finding is indicative of the class backgrounds of nurses interviewed. Embarking upon nursing training is a costly endeavour. The average fees for a nursing student are between 70,000 Rupees (approx 1,500 USD) and 1 lakh of Rupees (approx 2,100 USD) per year for a Diploma (three years) course and a BSc course (four years) respectively. Unless a highly competitive ‘government seat’ is obtained, which pays fees and a living stipend, this excludes not only the poorest segments of Indian society, many of whom are drawn from historically marginalized castes, but also high caste yet economically poor families and low income candidates from Muslim and Christian backgrounds. Consequently, while caste trends provide a general guide to occupational segregation, caste by itself is insufficient to account for occupational choices such as nursing. Although a few respondents specifically mentioned coming from a ‘poor family’, the majority were from lower middle-class homes, with father’s or mother’s employment reportedly including farmers, shopkeepers, nurses and clerical posts in private and government institutions. Few, if any, of the nurses interviewed came from families where parents were in high-income professions such as medicine, law or finance.

Economic constraints within households emerged as being particularly important when discussing occupational choices were feasible. For most of the participants in the study, medicine would be financially out of reach unless tuition fees and living stipends were paid through obtaining a free, 'government seat'. Soraya (22, Karnataka), for instance, explains that for her family: "*Medicine was not that affordable, so we thought fine, whatever our level, let us go with those things*". The majority of nurses in this study, regardless of caste or religious background, accounted for their decision to join nursing as being primarily 'economic' and thus class based, rather than specifically related to caste. This does not mean, however, that issues of caste are no longer relevant. Indeed, being of 'high caste' was highlighted by some nurses as a reason why nursing was *not* considered to be a 'suitable job'. For this group in particular, the ongoing normative association between nursing and low caste work was particularly problematic, making nursing a deviant choice, regardless of the family's economic status. Savitri is explicit about these religious and caste associations:

The impression, especially in Andhra Pradesh, nursing is just not even 1% of the girls that will go for nursing in my state. That too, from the upper caste, I mean in the Hindu community, hardly 0.1% you will not find.

However, where such considerations could be overcome, an investment in a nursing education could bring high financial yields for nurses and their families, in that they are able to find a job relatively quickly and can contribute to family earnings, as was suggested by nurses from a range of backgrounds:

In those days we had a tough time you know, so I thought 'okay, I'll join nursing'. Because in those days, we were not that well settled. (Neelam, 53, Karnataka)

It's easy to get jobs. And if you go for a degree, and after getting one degree also people will be there without any job. So mainly we have selected because of this, it is easy to get jobs. That is the main reason we have selected this profession. (Annie, 32, Kerala)

Nurse education training as an investment that would reliably provide a salary has not only attracted women, but increasingly also men, in that economic concerns exert considerable pressure on both men and women from lower income families to engage in a vocational course that offers a

guarantee of employment. For male nurses, alternatives mentioned as attractive job options include engineering, management studies and working in the corporate sector. Alongside these, nursing reportedly now also offered a specifically 'professional' option, as Santosh (25, Kerala), who had worked as a clerk in an accountancy firm after secondary school, recalled:

My parents were not satisfied with my education as I didn't have any qualifications, just after 12th standard (18 years) I was working, but I was very happy with the job, but they wanted me to be a professional, some profession kind of thing, so they advised me to be in nursing.

Although class considerations and the need to 'find a job' also serve as an important 'push' into nursing, these alone do not explain why nursing was selected above other available employment, some of which was reportedly better paid than nursing. Rather than being 'just a job', nursing was perceived as a way to access social and economic rewards, particularly through possibilities of migrating overseas: it was therefore also seen as a job 'with prospects'.

The 'pull' of nursing: a job with 'prospects'

A key factor in the decision-making process to 'become a nurse' is the perception of nursing not just as 'a' job, but as a 'job with prospects'. These 'prospects' relate to the view of nursing as now internationally mobile. Nursing is not considered to be a well paid profession in India and the low salary of Indian nurses was frequently raised as an issue of concern. The pay of nurses in some hospitals was seen as equivalent to the pay of 'unskilled workers' and considered to be lower than that of other government employees. However, an investment in nursing education, compared with teaching, accountancy or other alternative candidate professions in India, was the possibility of overseas employment. Nurses were well aware of the international 'nursing shortage' and many were keen to secure working visas in countries such as Australia, Ireland, the United Kingdom, the United States, Canada, and the Gulf states. The perceived economic and career benefits of becoming a nurse migrant cut across age groups. A number of nurses in their forties and fifties in the sample were return migrants, or were interested in working abroad. Out of five return migrants interviewed, all were in this age group. Three now worked in senior positions in nursing education, one was the

superintendent of a private mission hospital and one was retired, where they had spent between five and ten years abroad, mainly in the Gulf, returning to India a few years earlier.

Many nurses in their twenties and thirties were keen to work overseas and, at the time of the interviews, a few had already taken their Registered Nurse (RN) and English proficiency exams required for the United States and were waiting for work visas. Reported incentives to migrate centred on the desire to 'learn more' and 'earn more'. A 'foreign salary' offered the possibility of building up savings that nurses could use to buy houses, support their families, invest in family businesses and put aside money for their 'dowries'.ⁱⁱ Consequently, many planned to return to India after a few years and 'settle'; a term typically used to refer to the prospects of a financially stable life, as Kumari (24, Karnataka) and Prabha (25, Karnataka) explain:

SJ: And why would you go abroad? For the salary?

Kumari: Yes

SJ: or the experience?

Prabha: Experience also

Kumari: Experience also

Prabha: We get to know things better, like advanced technology. Like a few things we may not come across in India which we may come across in abroad also. That is also there. After that, salary wise, it will be helpful for us.

SJ: And how many years would you want to spend there?

Kumari: Two, three or four, not more than that.

Prabha: Within five, not more than that.

Kumari: At least with that we will be settled, we will be having financial stability. We will come back here, we will have our own money to study further or something, or if we've got to get our own house or something. We'll be like, we'll have something at least.

This view of migration as primarily a short or medium term strategy enabling nurses to 'settle' was typical. Thomas (24, Kerala), for example, when asked what he planned to do in the future, replied:

Actually, for all nurses, the hidden agenda is to fly abroad. My wish is to go abroad and to well settle. After that, I will come back and I will do something for the society.

Thomas' reference to a 'hidden agenda' was not a literal reference to secrecy surrounding nurses' migration plans, but referred to the desire to migrate overseas being very common and, for some, an incentive to joining the nursing profession. Indeed the openness with which nurses discussed migration strongly suggest that plans to migrate overseas were not 'hidden' at all, nor did nurse migration constitute a touchy or sensitive topic. Nurses were very candid about their future plans to migrate and the reasons they wished to do so. Discussions with nursing superintendents, nursing principals and medical directors also touched on nurses' regular requests for time off to attend interviews and take the relevant exams for nursing overseas.

In addition to the economic potential of 'international nursing' were increased social benefits, particularly in terms of knowledge, experience and status through becoming or (crucially) having the potential to be, a 'nurse migrant' and the increased social status for returnees. Enhanced marriage prospects for women with nursing qualifications are indicative of these potential social rewards. Annie (32, Kerala) and Josephine (37, Karnataka) suggest this is particularly important for young women from Kerala where young Keralite men frequently look for nurses as their brides:

Josephine: They [Keralite nurses] can earn money for their wedding or for the future expense. Even they can construct good houses. The total life atmosphere will be changed. And even nurses, boys are also looking now. Those who have passed the IELTS (international English language testing system), that everything they see now.

SJ: So you are saying that the boys are looking for nurses?

Josephine: yeah, yeah

Annie: If you see the [matrimonial] ads you can see the difference. Earlier they used to ask for a good looking girl and things like that. Now you have the 'good looking' but also BSc, GNM, working abroad. If they are working in India, if they have passed the IELTS exam. They are giving preference to all these things (laughs).

In Kerala society, dowry payments tend to be considerable and, although negotiable, often include money, jewellery, property and/or other family assets. For young female nurses, in addition to being able to raise funds to support dowry payments, a nursing qualification is also considered an important dowry asset that can offset some of these costs and secure a suitable partner. Some

respondents from other southern Indian states highlighted that the payment of dowry was not as pervasive as in Kerala. Josephine, who did her schooling in Tamil Nadu, went on to explain:

See Malayalees (Keralites), the girls, they have to give a lot of dowry. So, one profession in which they can earn more money that is nursing. They don't wait at home without a job. They can get a job immediately. They can go abroad, earn, and take care of everything and their families. That is what has been happening. See, even from their childhood, they start keeping money, to give the dowry. But Tamilians and all, they don't.

However, the 'prospects' attached to migration possibilities are not restricted to the ability to raise dowry payments, but also signify a resultant rise in the status of nursing evidenced in the reported increased attractiveness of nurses as marriage partners. The possibility of migration therefore has resulted in status gains even for those nurses who have no intention to migrate.

'Localites' and 'Out of towners': the decision to migrate

Not all nurses planned to or expected to migrate. Those who did were typically younger, working in the private sector and were 'out of towners', that is, those from outside Karnataka, the majority of whom were from Kerala. Out of sixteen Keralite nurses interviewed, five had already migrated overseas and six expressed the intention to migrate. Of the five Keralite nurses who had no plans to go abroad, three felt that this had only been possible before marriage and they were now reluctant to leave their children. A further two Keralite nurses had been interested in migrating, but their husbands did not agree.

The accounts of career plans of Keralite nurses contrasted strikingly with the testimonies of 'localite' nurses from Karnataka who, for the most part, showed little interest in migration. Nineteen out of thirty-four nurses from Karnataka stated that they did not plan to leave India and were not interested in working overseas. Some nurses from Karnataka (n=8/34), however, did highlight an interest in seeking overseas employment and mentioned similar reasons to nurses from Kerala, particularly the desire to gain increased knowledge, skills and expertise through working in foreign hospitals and earning a higher salary than in India. Three nurses (one from Karnataka and two from

Kerala) stated that they had previously considered seeking employment overseas but as their husbands did not support this idea, they dropped these plans.

Rather than being an 'individual' and incentive driven choice, for many of the respondents the decision to migrate was influenced by contextual considerations, particularly family circumstances. The decision to migrate was typically 'communal', and emerged from individual's interrelated networks that included the overseas community diaspora, extended family and 'batch mates' of nurses who trained together. The latter acted as important sources of knowledge about available career opportunities, in Bangalore and beyond. The family and overseas networks were particularly evident in the narratives of nurses from Kerala, indicating the normalisation of migration to Malayalee (Kerala) culture (Nair, 2012, Nair and Percot, 2011, Walton-Roberts, 2012).

On the whole, the Keralites were portrayed by members of their community and by the 'localite' nurses as being culturally different to nurses coming from other states in the South, particularly with regard to their propensity to be internationally 'mobile'. During the fieldwork, various participants, both Keralites and non-Keralites, told variations of a joke: "*When man first arrived on the moon, a Keralite offered him a cup of tea*", suggesting a shared perception that Keralites are worldly, ambitious and enterprising. Whereas many people from Kerala have large networks of overseas relatives and friends, those from other Southern states do not. Aarushi, a 25 year old nurse from a rural area in Karnataka, explained:

No I am not interested to move abroad, my family would not permit me to move abroad. Sending me to Bangalore itself is a big thing, sending me abroad is far from happening.

This captures a sentiment that was frequently echoed by the 'localite' nurses interviewed - that they were on the whole more settled in Bangalore, with families and a social network rooted within the State. Nurses from Kerala, on the other hand, represent a distinct migratory community. The Keralite 'out of towners' had already migrated to Bangalore which for many of them was a stepping stone to employment abroad. This is particularly because Bangalore is home to a number of large hospitals (those of 1,000-beds and above), where employment experience at hospitals with high bed strength

is a pre-requisite for successful overseas nursing applications. For these nurses, leaving Bangalore for employment overseas therefore represented another step along the migratory chain.

Almost all nurses interviewed who intended to seek overseas employment planned to return either to Bangalore or to Kerala. For others, migration was not part of their career plan: yet the increases in status that migration possibilities had brought were perhaps crucial to framing nursing as a suitable job for a growing number of entrants.

While the benefits of migration may be directly experienced by nurses who migrate, the possibilities of a newly globalized profession also touch those nurses who choose not to leave India. They derive from the reported implications of nursing now being seen as a 'job with prospects', which contributed to the greater visibility of nursing as a globally mobile career choice. As Parvati, a 34 year old nurse from Karnataka, explained,

Nowadays I find that people are coming up. People are coming up and they are talking something good about the nursing profession. It could be because of the knowledge wise and also because of the job placement. Because they find that when you do nursing, you can earn your bread without much difficulty. Because you can get a job anywhere, in any part of the world.

While the most visible nurse migrants on the international nursing circuit may be from Kerala, the gains in visibility for nursing from migration possibilities go beyond the individual careers of migrant nurses. They are contributing to a collective status renewal of nursing as a globally mobile profession. This study found that the perceived demand of Indian nurses abroad was viewed by nurses as securing important status gains for nurses as a collective group.

Discussion

This study drew on a relatively small sample of India's nurses, from six hospitals in the private and public sectors. However, this is one of the few studies undertaken in India, rather than among Indian migrants, and it included a range of ages, qualifications and settings. Importantly, it included those from States other than Kerala who have not traditionally contributed to nurse migration and have therefore been largely ignored in recent research on nursing in India.

Other research has documented the importance of nursing as a 'life strategy' for women in India, particularly those from Kerala (Percot, 2006, Nair 2012, Nair and Percot, 2011), providing more

than simply a job. Nursing has long offered women from some social backgrounds in India opportunities to earn an independent income, and for the older generations of nurses, it was one of the few employment opportunities available. In Bangalore, where opportunities for women's employment are now expanding, nursing continues to attract new recruits, and our findings suggest that the appeal of nursing is widening beyond those with few other options.

Nair (2012), in a study of nurses from Kerala working in Delhi, identified well established female peer networks as important for women in nursing, providing not only mutual support but also information on new posts, particularly in the private sector where recruitment is typically less formal than in the public sector. Our findings echo the importance of these networks particularly for young nurses. In addition, the female centric history of nursing has led to the development of extended 'nurse families', in which nursing resembles an inherited female trade. Although these 'nurse families' were most evident in the accounts of nurses from Kerala, we also found that networks and family role models were important to nurses from other states, including those for whom migration was not an aim and for the small, but growing, number of men entering the profession.

The potential for migration is an important element in the attractiveness of nursing as a life strategy. As has been found in studies that have examined 'push' and 'pull' factors behind health worker migration (Dovlo, 2005; McCourt and Awases, 2007), low salaries, poor working conditions and a perceived lack of career opportunities at home often served as contextual factors that push Indian nurses towards employment in foreign hospitals. However, unlike in other studies, notably that of Nair (2012), the issue of the low status of nursing in India did not arise as a specific 'push' factor in the interviews in this study, although a few nurses did mention the continued low esteem in which nurses were held. The majority, though, including nurses from across the range of home states and seniority, discussed nursing as not only a career for those with few other options, as it has been traditionally portrayed, but increasingly as an attractive 'job with prospects' suitable for a growing range of Indian communities.

At the level of health systems, literature has focused largely on the implications of migration for the health care workforce of the sending countries, as out-migration contributes to the shortage of skilled health workers and shifts the burden of training costs to those health care systems which can least afford it. This study did not aim to evaluate these potential consequences of the expansion of nurse training and international migration on the provision of nursing care in Bangalore, although globalisation is likely to have had some of the negative consequences identified in the wider literature. However, we suggest that the emphasis on negative consequences for health systems has rendered less visible some of the more positive potential consequences for the nursing profession as a whole in settings such as Bangalore. Specifically, this study has identified a number of implications for nursing within a globalizing India, with indications that it may be beginning to shed its caste and gender associations with low status, 'local' work in favour of the image of a job with (international) prospects. First, the majority of those intending to migrate saw this as a short or medium term strategy only, and indeed several nurses in this study were returners, coming back to contribute to nursing, nurse management and nurse education not only with additional skills, but with the added status of having worked abroad. Second, and perhaps more importantly, we suggest that migration offers opportunities for collective social mobility because it has made nursing more visible, and more attractive as a potential career for an increasing number of young Indians from a widening range of class, caste, religious, gender and economic backgrounds.

The fact that nurses can secure jobs abroad has been a key factor in changing the image of nursing not just for those who migrate, but importantly for those who remain. Emerging opportunities for nurses through higher education and employment mobility has attracted a number of new recruits into the profession, particularly those from other religious and caste backgrounds. For those families with the financial ability to make an investment in nurse training, the investment pays off with ready employment at home in a job with improving status and the prospect of building economic capital back home in India through short term overseas employment. While nursing remains a predominantly female profession in India, the perceived employment opportunities for

male nurses has resulted in an increased demand for a nursing qualification among young men, also seen in other countries such as Jordan (Ahmed and Alasad, 2007).

For women in particular, though, international migration offers economic and social benefits as well as an escape from traditional assumptions and obligations that are an important part of the social fabric of India. Nurse migration is thus a visible example of female mobility that is important to elevating the status of women as well as to raising the profile of this female dominated profession. As such, migration is a significant social and professional strategy for nurses at both an individual and collective level.

At a more political level, therefore, migration may function as a means to develop a collective 'bargaining tool' for nurses with which to argue for important changes to their salary and employment conditions in India. This study therefore presents the relevance of a dual discourse around the phenomenon of international nurse migration from India. On one hand, the migration of Indian nurses to countries overseas reflects the 'brain drain' of skilled health workers, where a workforce 'crisis' has been reported globally, by a range of low, middle and high-income countries, including India (WHO, 2006, Rao et al, 2012). On the other, migration offers opportunities for individual and collective social mobility and thus functions as a key professionalizing strategy.

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i

Renamed Bengaluru in 2007, the city is still widely called Bangalore, and was by the participants of this study.

ii

Dowry refers to the net exchange of all cash and in-kind gifts made from the bride's household to the household of the groom at the time of marriage. Although the payment of dowry is a criminal offence in India and prohibited since the passing of the 1961 Dowry Prohibition Act, the practice is widespread among many communities across the country that observe endogamous marriage practices.