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**Who cares? Indian nurses 'on the
move' and how their transnational
migration for care work shapes
their multigenerational
relationships of familial care over
time**

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Declaration of Original Work

I hereby confirm that I have composed this thesis and that this thesis is all my own work. I also declare that this work has not been submitted for any other degree or professional qualification.

Nikki Dunne

Edinburgh, 30 January 2018

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Abstract

This thesis explores how migration for care work shapes Indian nurses' multigenerational relationships of familial care over time. Using qualitative research methods, it interrogates the intertwining of economic and non-economic factors underpinning the entry and continued participation of this group of women and men in the nursing field and international nursing labour markets. The thesis is broadly informed by a relational approach to care. More specifically, the thesis draws on feminist theories on care as a lens for analysing the migration of nurses from poorer regions to wealthier regions, as well as a transnational care framework to analyse the care relations that nurses maintain and sustain in the context of their migration. In paying attention to changes over the life course and participants' constructions of their future, a focus on the temporal adds to existing frameworks for theorising. Through an analysis of the nurses' personal accounts, this project examines the connections between undertaking the care of patients in British hospitals and nursing homes at the same time as caring for their own families, both in India and the UK.

Drawing on in-depth qualitative interviews with 25 Indian women and men working as nurses and carers in the UK, the thesis demonstrates how nurse migration is underpinned by 1) the structural and gendered inequalities that drive migration and caregiving, as well as 2) the moral values that sustain multigenerational care between family members that 3) change over time. Firstly, the thesis highlights how the socioeconomic conditions in India, the structural demands for nurses in the British health care system, gender and racial hierarchies within the nursing field, and the colonial relationship between India and the UK create the conditions that have enabled Indian nurses to enter the British labour market. This reveals how a complex array of intersecting policy contexts on labour, migration and healthcare shape the practices of reciprocal care in the nurses' resident and transnational families. The transnational care practices that emerge out of these contexts are entangled with the nurses' insertion into the global labour market. Secondly, the thesis reveals how

multidirectional and asymmetrical reciprocal care relationships between nurses and their families also underpin this form of migration. The analysis finds that culturally informed values regarding care for family is a central factor in stimulating and reproducing nurse migration. The nurses' consistently present accounts of decision-making regarding past and imagined future migrations and work in terms of caregiving and care-receiving, with familial care duties and obligations frequently mapping onto the migration opportunities engendered by nursing. This care in turn circulates between different family members, in different locations, to differing degrees, over the life course. Lastly, by drawing attention to the changes that occur over personal, migration and family life courses, temporality is identified as a central dimension of nurse migration and transnational family life. Aspirations and hopes reveal the importance of imagined futures for reproducing nurse migration and transnational family care.

Focusing on this complex intersection through the personal accounts of the nurses, I argue in this thesis that migration for care work both shapes and is shaped by multigenerational relationships of familial care over time. In doing so, the analysis draws attention to the mediating factors that impact upon the ways in which this care has been exchanged over time, paying special attention to (re)negotiations of childcare and eldercare over time. By focusing on the creative and innovative ways in which the nurses navigate the obstacles to caring for family in the context of migration, the thesis contributes to the growing body of literature that questions representations of victimhood often imposed on migrant women from the global south. Examining the family care dimension of nurse migration and its changes over the life course is essential for better understanding the broader dynamics of the overseas nursing workforce and the factors influencing their arrival, settlement or departure from the UK, as well as how family relationships shape and are shaped by international migration for care work. Overall, the thesis contributes to the empirical basis for a revaluing of care that takes place within and across borders.

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Abbreviations

DH	Department of Health (UK)
GCC	Global Care Chain
GNCC	Global Nursing Care Chain
ICTs	Information and Communication Technologies
ILR	Indefinite Leave to Remain
IELTS	International English Language Testing System
MAC	Migration Advisory Committee
NHS	National Health Service
NMC	Nursing and Midwifery Council (UK)
ONP	Overseas Nurses Programme
PIN	Professional Identification Number
PR	Permanent Residency
RCN	Royal College of Nursing (UK)
UK	United Kingdom
US	United States

Chapter 1 Introduction

It is more than likely that whenever we have been in need of care, or will require it in the future, it will be provided in some part by migrant and minoritized workers. These caregivers deliver our children, tend to our parents and grandparents, cook our food, clean our hospitals and bear witness to our naked emotional distress (Gunaratnam, 2013, p. 14).

I first met Pushpa¹, a fifty-year-old nurse from India at a Malayalee² Cultural Association meeting in a northern English city. Introduced to me by her daughter, who had organised for a lawyer to come to give informal employment advice to the twenty-or-so nurses present at the meeting, Pushpa was keen to talk and we arranged to meet the following weekend. She reflected on a career that began when she trained as a nurse in her homeland after completing her secondary school education, that brought her from the southern state of Kerala in India to other states in India, to Saudi Arabia and the United Kingdom (UK). During her time in Saudi Arabia, she married and had two children, returning to live in India six months after the birth of her first child. She heard from friends that the UK was recruiting nurses and she and her husband decided she should apply, thinking about the benefits of a British education for their children, the better status of nursing in the UK compared to India where it is perceived as a low status job, and the money that could support their parents, siblings and other extended family members. After migrating to the UK she worked as a care assistant in a nursing home, eventually making her way into the National Health Service (NHS) as a registered nurse.

At the time of our meeting, Pushpa was working in a supervisory role in the NHS, and spoke with pride of her accomplishments in the British nursing labour market, but also recalled the difficulties she faced as she adjusted to life in the UK. Her

¹ Pushpa is a pseudonym. Other identifying features have been omitted to ensure anonymity as far as is possible. See Chapter 3 for a full account of the steps taken to safeguard respondents' anonymity. Pushpa's story is based on our interview which took place on 04 August 2014.

² Malayalee, Malayali or Keralite is the term used since Indian Independence to describe natives of the South Indian state of Kerala, where the nurses in this study are all originally from. The reason for this focus is explained later in this chapter and Chapter 3.

credentials and professional experience did not automatically transfer to the UK. She worked long hours, performing backbreaking and unpleasant work and found it difficult to care for her children under these circumstances. She often felt like she did not belong amongst her colleagues, and suffered multiple indignities in her daily working life. She spoke about the important role of family and friends who helped and supported her, and how she in turn helped them in multiple ways. She emphasised the importance of her family at every stage of her career, from the aunt who influenced her initial decisions to enter nursing, to the desire to 'care for' family in India by sending money to them earned from working abroad. Whilst working abroad, her extended family have supported her with childcare, by visiting the UK for lengthy periods as well as looking after the children in India. She spoke about her desire to care for herself, her husband and elderly mother-in-law in the future, and her plans for early retirement which involved an ambivalent return to India, interspersed by frequent trips to the UK, or wherever her daughters settled after their marriages, to look after her much hoped-for grandchildren. Throughout this story, Pushpa illustrated how her nursing career has been and continues to be inextricably bound to both migration and family. This thesis is about women and men like Pushpa who migrate from India as nurses. It foregrounds their experiences of migration, and traces the changing care exchanges between family members that take place amidst the backdrop of their entry into the nursing labour market in the UK, which has historically been a 'nurse-importing' country.

Since the inception of the NHS in 1948 the British healthcare sector has relied on skilled workers who have trained overseas to fill recurring labour shortages. The crisis in nursing recruitment and the recourse to international nurses in many parts of the global north means that nursing increasingly operates in a global market, where countries like the UK, US and Ireland are important importing countries, whilst India and the Philippines are dominant suppliers of nursing labour (Yeates, 2009). Moreover, given that the nursing profession has been historically designated 'woman's work' and continues to be overwhelmingly feminised (Brush and Vasuparam, 2006), it is not surprising that the majority of the overseas nurses are

women (Kingma, 2006), although nursing is increasingly becoming an attractive option for men in developing countries due the opportunities for international migration associated with the profession (Connell, 2009). Nurse migration is hence increasingly recognised as a form of transnational feminised migration for work and a response to the growing demands for nursing care labour³ (Yeates, 2004, 2009; Kofman and Raghuram, 2006; Isaksen, 2012). Feminist scholars refer to this movement of migrant care workers from poorer regions to wealthier regions as indicative of a changing international division of care labour, whereby global inequalities are (re)produced through the redistribution of care resources (Parreñas, 2001; Hochschild, 2002; Yeates, 2009).

However, overseas nurses, and migrating people in general, are not just a labour force. The women and men who cross the globe to undertake the care of patients in British hospitals and nursing homes are also simultaneously embedded in relations of care with their own families, both in India and the UK. But when migration separates family members geographically from one another, how can care and support be provided and received? How does moving to care for patients in the UK shape caring for family members in the context of said migration? Pushpa's story relates to the dynamics of women's labour migration, but simultaneously points to some of the ways that multigenerational care is important to transnational families (and the gendered dimensions of this care also). For instance, Pushpa recalls how her mother carefully allocated Pushpa's remittances to the extended family, by building a new home for the joint family, paying for the education of Pushpa's siblings, and putting aside money for the healthcare of Pushpa's grandparents. Her mother-in-law looked after her daughter on the two occasions Pushpa worked overseas alone, assisting Pushpa's husband with childcare, cooking and cleaning whilst they waited for

³ I use the words 'work' and 'labour' interchangeably throughout the thesis, although I am aware of their different connotations. However, whilst work is often used to refer to productive labour, feminists have gone to a lot of effort to point out that childcare and housework is a particular type of labour, even when unpaid. This is typically called social reproductive labour (see Chapter 2 for further discussion). Similar to the reproductive labour women perform in the private spaces of the home, nursing labour is feminised, historically unpaid or under-paid, and invisible work that women have done to reproduce the productive male labourer (Henry, 2014).

reunification; Pushpa sent money to India to support this also. The money Pushpa sent to India whilst she was in Saudi Arabia and the UK was not simply an economic exchange, but was imbued with the love, obligation, duty, and emotional connections existing between Pushpa and her multiple family members remaining in India. Now that her mother-in-law is elderly and frail, Pushpa hopes that her return to India will facilitate the hands-on care that she feels like her mother-in-law deserves according to traditional Indian cultural values.

Pushpa's desire to return to India post-retirement connects to the call for more research on those nurses who choose to return home after a period of time working abroad (Kingma, 2006; McElmurry, Solheim, *et al.*, 2006). Return and 'stepwise' migration, whereby migrants sequentially work in several countries as transit points or stepping stones until they reach their most preferred and final destination, is known to be significant, even among migrants who have received permanent residence (Kingma, 2006; Matsuno, 2009; Carlos, 2014). The International Organisation for Migration believes that given the choice, many migrants would prefer to be 'circular' rather than permanent migrants (Kingma, 2006). Although there is very little data on return migration, the Centre for Nurse Migration outlines that return migration is more likely to take place if family members are left behind in the source country (Haour-Knipe and Davies, 2008). Haour-Knipe and Davies (2008) found in their study of return nurse migration that the primary factors that contributed to the decision to return home were non-economic and often related to family concerns. Return migration often involves family or life cycle factors such as finding a spouse, having one's children educated 'at home' and in one's native language, or retiring. Migrants, not infrequently, return home to look after ageing or ailing parents, sometimes earlier than they had expected. Other non-economic factors for returning home include a love of homeland, family and friend ties, climate factors, lifestyle and lack of the discrimination or prejudice that the nurses have faced in their destination country (Gmelch, 1980). This suggests that care obligations and duties as well as experiences in the labour market are significant factors in the future-orientation of overseas nurses and their plans to return to their country of

origin. This thesis aims to shed light on these issues, while contributing to the broader literature on labour mobility and transnational families.

In order to better understand this intersection between migration, familial caregiving and nursing care work, the thesis explores the experiences of overseas nurses who undertake the care of patients in British hospitals and nursing homes at the same time as caring for their own family, both in India and the UK. At its core, it is a story of transnational family life, but one that extends the analysis beyond nuclear families, moving outward from relations between mothers and children to focus on extended family relations and multigenerational networks of care. Through the personal accounts of the women and men participating in this study, the thesis illustrates how practices of unpaid care (familial) are related to paid care work (nursing), and how both these spheres intersect with migration and change over the life course. Examining these intersections, which are woven through each empirical chapter, is essential for better understanding the broader dynamics of the overseas nursing workforce and the factors influencing their arrival, settlement or departure from the UK, as well as how family relationships shape and are shaped by transnational migration for care work.

To study these intersections, I draw on the feminist theoretical framework of the 'global care chain', which identifies systematic relationships of production and consumption starting in source countries as producers of 'care' labour that end in destination countries as recipients of care. I also draw on the transnational care literature to surface the care relations between the migrant nurse and her resident and transnational family that both shape and are shaped by migration for care work. These conceptual frameworks are discussed in more detail in the following chapter. For now, the important point to note is that nurse migration reflects both global inequalities as well as shaping and being shaped by a form of familial caregiving that transcends national borders. Before outlining the research questions guiding this study, I place the migrations undertaken by the nurses in this study in context since

historicising these trends, however briefly, helps situate the origins and development of nurse migration patterns. I do this by looking at both the Indian and British contexts.

1.1 Indian Nurse Migration to the UK: Histories and Geographies

This section provides a temporal outline of nurse migration from India and nurse migration to the UK, the site of this study. Choy (2003, 2010), in her analysis of Filipina nurse migration to the US, argues for the importance of such historical contextualisation. In the absence of these histories, she says, assumptions can be drawn that international nurse migration is a contemporary phenomenon devoid of a substantive past and simply a spontaneous and rational response to labour shortages in the global north. Paying attention to the historical context instead illustrates the continuities between the colonial era, that effectively created an imperial market in nursing labour, and the current prevalence of international nurse recruitment.

Nurse Migration in the Indian Context

The history of nurse migration in India is intertwined with British colonialism, American imperialism and the Christian missionary movements of the nineteenth century (Walton-Roberts, 2012; Reddy, 2015). Both Reddy and Walton-Roberts explain the origins of the low social status of nursing in India as resulting from a patriarchal and caste-based culture that stigmatised nursing as polluting and very close to that of servant castes considered untouchable. Nursing was thus commonly seen to be taken up by Christian communities and low-caste converts since, despite its own elitism and patriarchal norms, it operated outside strict Hindu caste restrictions. The south-western state of Kerala has a long history of Christianity, from before the 1400s, which distinguishes the state from most of the Indian subcontinent (Reddy, 2015). Reddy describes how, in the nineteenth century with India under colonial rules, Protestant missionaries 'flooded' the region. Many of these missionaries had medical training, operating along strict gender divisions, with

nursing closely associated with the female domain, whilst doctors were predominately men (although Reddy points to notable exceptions). The women's missionary movement aligned itself with the civilising mission of the colonial project, and training Indian women as female nurses came to be seen as an exemplar of women's liberation from Hindu traditions. Nursing in the colonial period thus became an attractive career predominantly for Christian converts from communities considered untouchable under the caste system. Social prejudices against this group reinforced the perception of nursing as 'dirty' and low status work (Healey, 2013). However several authors point to the positive transformations in the status of nursing as a profession due to its association with international migration (George, 2005; Percot, 2006; Nair, 2012; Johnson, Green and Maben, 2014).

Nursing in India, in its modern form, can thus be understood as arising from the colonial expansion of medical services and education in the second half of the nineteenth century, with the bulk of nursing education taking place in Christian missionary hospitals in the south of India. This historical context meant that nursing in India became closely associated with Christianity, particularly in the state of Kerala. Kerala became the first state to host these British-led nursing schools and Walton-Roberts (2012) describes how the underlying message replicated the ideology of total superiority over that of the native culture's concepts and practices and health care. Besides putting India on the path to a professionalised model of nurse training, British colonialism also created an infrastructure that established the grounds for international nurse migration (Solano and Rafferty, 2007; Walton-Roberts, 2012). In response to the wartime shortage of nurses in the UK, the British government established the nursing assistant position via the 1943 Nurses' Act (Solano and Rafferty, 2007). The nurse assistant was expected to perform 'less intellectually challenging nursing tasks' (Walton-Roberts, 2012, p. 180). This Act maintained the distinction between British and foreign nurses, instilling 'a professional hierarchy that favoured British nurses' and 'reinforcing assumptions based on race, class and social background', whilst also laying the foundations for a supply of trained nurses to the British domestic market which was experiencing a

nurse shortage due to World War II (Solano and Rafferty, 2007, p. 1059). Assessing the impact of colonialism on the nursing profession in India, Walton-Roberts adds:

Colonialism, therefore, created and reinforced a relationship of inequality both at home and overseas within the Indian nursing profession. This relationship extended into the post-colonial period in the development of a nursing education model that was inappropriate to India's public health needs, and in the subjugation of Indian trained immigrant nurses who entered the British health system in the post-independence period (2012, pp. 180–81).

Whilst reflecting on the historical context illustrates how British colonialism established the foundations of post-colonial nurse migration from India to the UK, Reddy argues that the Keralan context is particularly important. In the 1970s, Kerala embarked on a trajectory of modernisation, in which poor economic growth coexisted with high social indicators in health and literacy. This form of development was referred to in a worldwide discussion on its replicability as the 'Kerala Model' (Devika, 2012). However, this model of development also gave rise to mass out-migration from the state, including that of nurses who 'bore the stamp of a society that valued women in particular (and thus its high social indicators), even as their departure signalled its inability to retain key sectors of its workforce' (Reddy, 2015, p. 16). The migrant nurse from Kerala thus became an embodiment of the contradictions of this model, and it is argued that the migration of such nurses trained in the global south to the global north constitutes not only a 'brain drain', but is a 'perverse subsidy' from poor to rich country services (Yeates, 2009b, p. 184). Kerala is thus clearly an important site to explore nurse migration, historically standing in contrast to India as a whole, which has generally been perceived as a non-sending region when it comes to female migrants (Walton-Roberts, 2010).

In recent times, overseas nurses recruited from India tend to go to the UK, the US, Ireland, Singapore, New Zealand and Australia and the Gulf countries (Khadria, 2007), and the government of India sees the increased opportunities for nurses abroad as a positive factor, rather than viewing it in terms of a loss of valuable

healthcare resources. As the National Commission on Macroeconomics and Health mentions:

In fact, with the large number of opportunities opening up for employment in foreign countries, particularly for nurses, it would be to India's advantage to focus on expanding the number of colleges and nursing schools alongside efforts to ensure good quality to make them employable (cited from Gill, 2011, p. 56).

The Indian state thus appears to be focused on creating a 'nurse production' industry, with healthcare experts and entrepreneurs urging India to promote nurse exportation. Some healthcare experts have also warned India not to lose out to the Philippines, a country that is fast becoming a 'leading human resource bank for nursing staff to the world healthcare sector next only to Kerala' (Yeates, 2009, p. 89). Educating nurses for emigration has thus become a growth area for the private sector due to the large profits involved; the numbers of private training institutions, for example, have mushroomed since the 1990s (Nair and Rajan, 2017). Whilst liberalisation policies adopted in India have led to a 'mindless expansion' of the number of nursing schools, the supply of nurses has not been proportionate to regional demands, with the demand for nursing courses depending on inflated estimates of the requirement of nurses in international labour markets (Walton-Roberts, 2010; Nair and Rajan, 2017). At the same time, employment in the domestic market is unattractive to the majority of potential nurses because of the poor working conditions associated with the profession (Gill, 2011; Nair, 2012). Against this context, India is experiencing a scarcity of nurses, where only 40 per cent of the total nursing workforce in the country is believed to be active because of low recruitment, migration, attrition and drop-out due to poor working conditions (Gill, 2011). The loss of qualified staff can severely impact the functioning of health systems; the migration of skilled health personnel has led to the virtual collapse of health systems in some sub-Saharan countries. This reinforces Yeates' point that this movement represents a 'perverse subsidy' that can be traced to historical and colonial linkages.

Two central points emerge from this discussion. Firstly, the specificities of colonialism and Christianity in Kerala and the model of development followed in the state accounts for the predominance of women from Kerala in the nursing sector in India as well as their outmigration. Contextualising Indian nurse migration within the British colonial project of the nineteenth and early twentieth century, highlights how colonialism set the historical precedent for facilitating an international nurse migration based on divisions of gender, class, race and ethnicity. In this thesis, I address the migration of nurses from this particular region since the image of the 'Kerala Christian nurse' remains the archetype of the Indian migrant nurse⁴ and the 'phenomenon of the nursing boom in Kerala' is the subject of much attention, although there is limited attention to the documentation of nurses' lives (although see, for example, George, 2005; Percot, 2006; Nair and Percot, 2007; Nair, 2012, for notable exceptions). Secondly, this section historicises the migration of nurses from the global south to the global north, which challenges the tendency to see such migration as based upon individual decision-making. Rather, it illustrates that nurse migration from Kerala is embedded in a broader historical culture of migration. Embedding contemporary nurse migration within this context means seeing nurse migration from India to the UK as resting on a history of global inequalities and colonialism, rather than viewing it as simply a matter of individuals responding to the demand for labour.

Nurse Migration in the UK Context

The UK has a long history of *active* international recruitment. Within twelve months of the establishment of the National Health Service in 1948, there were severe labour shortages. From 1949 onwards, a number of initiatives have been introduced specifically to bring staff into the NHS from abroad (Buchan and Rafferty, 2004; Solano and Rafferty, 2007), although as argued in the earlier section, the colonial period arguably set the historical precedent for facilitating international nurse migration (Choy, 2003; Solano and Rafferty, 2007; Walton-Roberts, 2012; Reddy,

⁴ There are no accessible records of the regional and religious breakdown of nurse emigrants from India (Reddy, 2015, p. 15) so it is difficult to ascertain exactly where nurse migrants from India are actually coming from.

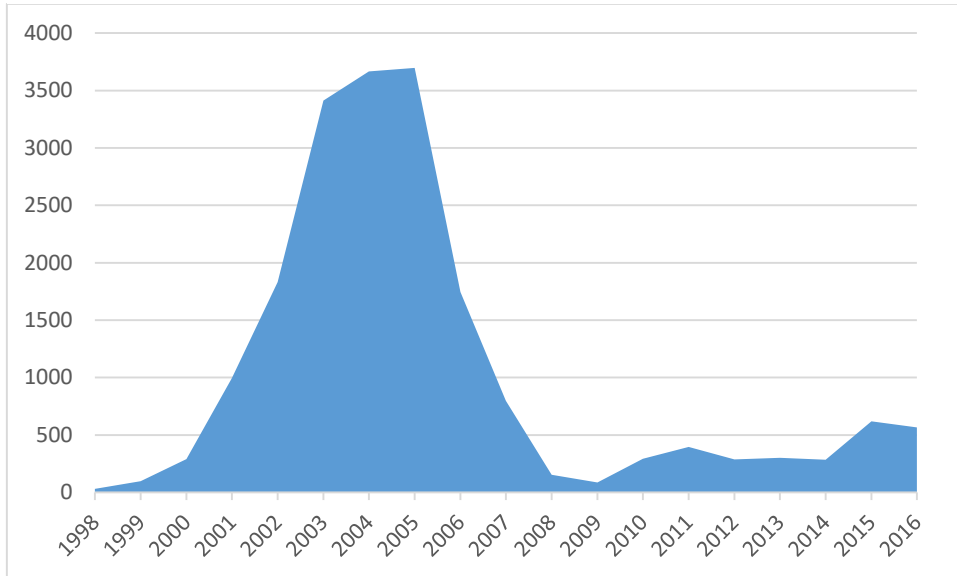
2015). Since then, successive British governments have used nurse migration as a response to labour shortages. Fluctuating trends emerge over time as the levels of reliance on international nurses have changed in response to both the domestic demand and supply, as well as cycles associated with economic, political and social circumstances (Buchan, 2003; Buchan and Seccombe, 2006, 2012; Smith and Mackintosh, 2007). Of central relevance to this thesis is the recourse to international nurse recruitment as a means to fill labour shortages in the early 2000s (Simpson, Esmail, *et al.*, 2010). This occurred after the British state, responding to neoliberal attempts to reduce the costs of social reproduction, reduced their investment in the numbers trained as nurses in the 1990s, leading to severe labour shortages in healthcare, whilst simultaneously introducing immigration regulations that led to a drop in migrants in this sector (Kofman, 2007). In response to the resulting labour shortages, policy makers and health organisations considered migration as the solution to these labour shortages, and, during the period between the late 1990s and the mid-2000s, the UK actively recruited nurses from a broad range of countries, including India, the Philippines and many countries in Sub-Saharan Africa (Henry, 2007; Alonso-Garbayo and Maben, 2009; Grigulis, 2010).

Whilst precise data on how many international nurses were recruited to the UK between 1998 and 2006 is limited, the Nursing and Midwifery Council (NMC) recorded 100,000 new non-UK registrations⁵ across that period from over fifty countries (Nichols and Campbell, 2010; Buchan and Seccombe, 2012). Over a third of nurses registering with the NMC during this time were trained overseas. India became one of the top source countries of nurses during that time; the proportion of Indian nurses went up from one per cent of the total overseas input to the NMC registry in 1998/99 to over 40 per cent by 2005 (Alonso-Garbayo, 2007, pp. 22–3). There were 30 applications from Indian nurses for UK registration, compared to 3,696 in 2005 (Buchan and Dovlo, 2004; Personal Communication with NMC Media

⁵ This is because registration with the NMC registers intent to work in the UK rather than the actuality of working. Furthermore, it records an intention to nurse in other countries, but does not necessarily record an actual geographical move.

Manager, 17 February 2014). Over 14,000 nurses trained in India joined the NMC register during this active period of recruitment⁶ (see Figure 1-1).

Figure 1-1 Number of nurses and midwives trained in India who joined the UK Nurse Register (1998-2016)



Source: Buchan and Dovlo (2004); Personal Communication with NMC Media Manager (17 February 2014).

This period of active recruitment and significant inflows of overseas nurses was followed by a rapid decline after 2006. There are several reasons for this decline. Firstly, the UK invested money into pre-registration training for nurses during the late 1990s and early part of the last decade, which saw an increase in UK-trained nurses ready to enter employment. This meant that there was a reduced demand for the recruitment of overseas nurses. Secondly, the active recruitment drive raised criticisms that UK employers were 'poaching' health workers from poor regions of the world (Nelson, 2004). In response to such concerns, the Department of Health introduced an ethical recruitment policy, represented by a Code of Practice, which effectively stopped the recruitment of health workers from developing countries. Subsequent shifts in immigration policy also contributed to the decline in the numbers of non-EU nurses entering the UK (Bach, 2010; Cuban, 2010; Adhikari and

⁶ Personal communication with NMC Media Manager, 17th February 2014.

Grigulis, 2013). Lastly, the NMC introduced a number of new measures that made it more difficult for non-EU nurses to enter the UK. During the earlier period of recruitment, non-EU nurses had to undergo a period of adaptation training before registering as the NMC. This training was available in the NHS or in private-sector healthcare institutions where there was an NMC-recognised and qualified mentor who could supervise, support and assess an overseas nurse and recommend them for full registration with the NMC, which then allowed them to practice as a registered nurse (Adhikari, 2011). In 2006, the NMC changed the regulation and the training was renamed the Overseas Nurses Programme (ONP), which was offered by higher education authorities in the UK. Entrants onto the ONP must meet very strict criteria⁷ and pay substantial costs; many overseas nurses found it increasingly difficult to undertake the ONP following these changes (Solano and Rafferty, 2007; Adhikari, 2011).

Despite the decline in active international nurse recruitment, many non-EEA nurses continue to enter the UK 'through the backdoor' (Adhikari and Grigulis, 2013), with over 3,500 Indian nurses entering the UK between 2007 and 2016. Figure 1-1 illustrates the increase and sharp drop in the register between 1998 and 2016. The increase in the recruitment of Indian nurses since 2014 is clear in Figure 1-1 and anecdotal evidence from discussions with nurses over the course of this research suggests that many friends and family members were being recruited from India into some NHS trusts. Indeed, three quarters of NHS hospitals in England recruited almost 6,000 nurses in 2014, largely from European countries, but including the Philippines and India (Lintern, 2013). Such increments in the numbers of overseas nurses have prompted some to ask if this is the start of another 'upsurge in international nurses' (Buchan and Seccombe, 2012, p. 13). This upsurge is indicative of the cyclical nature of international nurse recruitment amidst changing economic, political and social contexts. Following the outcome of the British referendum on

⁷ Entry criteria for the ONP are: a) an overseas qualified nurse should have a valid NMC decision letter; b) IELTS score 7 in all categories (Adhikari, 2011, p. 158). Participants who arrived post-2006 have found it very hard to obtain the required IELTS score, and are thus unable to complete the ONP (see Chapters 5 and 7 for further discussion of the impacts of this on the nurses and their families).

European Union (EU) membership in 2016, the number of nurses from the EU registering to work in the UK has dropped by 96% from the previous year (The Health Foundation, 2017). Since the majority of international nurses registering in the UK since 2008 have come from within the EU, this suggests that the UK will return to non-EEA countries for nursing labour. Indeed, the RCN's most recent Labour Market Review (2016) points out that the UK is currently experiencing a major crisis in nursing, where demand for nursing staff has grown due to the ageing population, reforms to the delivery of health and social care, the push to increase nurse to patient ratios in the wake of the Francis Report⁸ and staffing guidelines, as well as the changing role of the profession, with nursing staff taking on more duties previously carried out by others. Responding to these shortages in the nursing sector, the Migration Advisory Committee (MAC) placed nurses on the Shortage Occupation List in 2016 (MAC, 2016), making it easier for UK employers to recruit candidates directly from overseas; specifically, from outside the EU. Both the RCN and the MAC have highlighted the current shortage of nurses is mostly down to factors that should have been anticipated by health, care and independent sectors, especially given the historic pattern of using migrant nurses to plug labour gaps and save costs. Thus whilst the recruitment of nurses from the global south slowed down in 2006, evidence suggests that significant recruitment from the global south to the UK will begin again in the near future.

The struggles of overseas nurses in the British workplace has been documented at length, with many studies identifying experiences of discrimination and exploitation (Allan and Larsen, 2003; Kyriakides and Virdee, 2003; Smith, Allan, *et al.*, 2006; Larsen, 2007; Batnitzky and McDowell, 2011) or underemployment and deskilling (Smith, Allan, *et al.*, 2006; O'Brien, 2007; Cuban, 2010). Cuban (2010, 2013) locates the mechanisms of this deskilling, at least initially, in the adaptation process,

⁸ The Francis Inquiry Report was published in February 2013 and examined the causes of the failings of care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The Francis Report outlined ways in which the NHS can improve care, raising the issue of staffing levels, with the report explicitly stating that inadequate staffing levels at Mid Staffordshire led to the poor quality of care. The reports identified improved staffing levels as central to the provision of good patient care.

which for many overseas qualified nurses funnels them into nursing homes to work as carers. Even when overseas nurses are able to register as nurses, this professional recognition does not automatically acknowledge their experience or clinical competence, with many overseas nurses allocated a pay grade for newly qualified registered nurses, irrespective of their qualifications or experience (Taylor, 2005). Some positive experiences are described in the literature, but significant numbers of migrant nurses describe not feeling personally or professionally valued by the British nursing profession. Many feel disappointed that their expectations have not been met. This has implications for job satisfaction, which in turn may lead to further migration to other nurse-recruiting countries, or else a return to their countries of origin (Kingma, 2006). However, whilst the NMC and the RCN routinely survey their members, there is very little known about how overseas nurses' work experiences intersect with both their local and transnational family lives, despite evidence suggesting that international migration is often triggered by the need to give or receive care (Ackers and Dwyer, 2002) and that opportunities to be close to family members are central factors in stimulating further nurse migration (Carlos, 2013).

Whilst there may be little knowledge of the connections between migrant nurses' family and working lives, the UK nevertheless remains a significant importer of nurses, turning to international recruitment to supplement the inadequate supply of 'home-grown' nurses. Such recruitment has been identified as exacerbating care crises in the countries of origin. As Yeates (2012, p. 245) points out:

Care migration entails the extraction of resources from poorer countries and their transfer to richer ones. Deprived of human care labour these extractive processes export to poorer countries social problems created by rich countries' under-investment in public care services.

Even with the decline in international nurses since 2006, the UK continues to have a diverse nurse population. Coupled with the likely recourse to international nurse recruitment in the present-day and the possibility of onwards migration from the UK, the need to understand overseas nurses' multiple experiences is paramount. Evidence

suggests migrant nurses experience everyday acts of discrimination and exclusion, which also reflect broader structural issues of institutional discrimination. At the same time, the impact of nurse migration on the central practices of family life are increasingly recognised in the literature, with family identified as both a central reason for migrating in the first place as well as shaping and being shaped by experiences of migration (Tyner, 2004; George, 2005; Adhikari, 2011). Despite this identification of family and the desire to care for family as integral in instigating nurse migration for Indian, Nepalese and Filipino nurses (Smith and Mackintosh, 2007; Adhikari, 2011; Ronquillo, Boschma, *et al.*, 2011), explicit links between these two different mobilities for care are not discussed in the literature on nurse migration. This thesis unpacks these links, focusing on nurses' accounts of their migration, work and family lives, and how they unfold over time.

1.2 Research Aims, Questions and Objectives

Through the lenses of the care chain and care circulation, but also extending the scope through a focus on constructions of the future, my thesis aims to add to our understanding of the intersections between migration and the provision of care in institutionalised (formal) and informal (familial) care settings and how these change over time. By placing Indian overseas nurses at the centre of my analysis, I foreground the connections between different mobilities of care (migration to provide care work in institutional settings, and care exchanges in the transnational family), and their connection to global processes. In particular, the thesis highlights the ways in which overseas nurses assert their agency through their migration, work and family relationships. Through an in-depth exploration of these care interrelations, it aims to identify the spectrum of overseas nurses' care relationships and the different facets of care practiced at individual, household, national and transnational levels embedded in these relationships.

Commensurate with this overall aim, the study's research questions relate to the unavoidable intersections between formal and informal care work. The main research question asks:

How does migration for care work shape multigenerational relationships of familial care over time?

Embedded in this overall question, are three other questions. Firstly, given the historical entanglement between nursing and migration in the Kerala context, how do these nurses account for their decision to become 'nurses on the move' (Kingma, 2006)? Secondly, given the historical importance of family and filial duties in Indian society, how do migrant nurses maintain and (re)negotiate caring roles in resident and transnational families? Lastly, given that much of the literature on overseas nurses' points to unsettling experiences in the workplace as well as pointing out that many migrant nurses desire for an eventual return to their homelands, often to care for family members, how are aspirations for the future shaped by both workplace experiences and multigenerational relationships?

To address these questions, I draw on a relational approach to nurse migration that sees the nurse as embedded within relationships that shift over time and space. The nurses' accounts of their own situations, as well as their orientations towards and interdependencies with family members, were thus central when developing the research design. This required 'a methodological stance that respects and uncovers the fluidity of changing practices of transnational caring and the interpretive nature of the migrant experience' (Evergeti and Ryan, 2011, p. 369). This thesis, in its commitment to using a methodology sensitive to the experiences of migrants, consolidates findings from other research that explores the everyday realities of being a migrant woman who is part of a transnational family (Huang and Yeoh, 2005; Burrell, 2008a; Wong, 2014). In order to surface these stories, I conducted in-depth interviews with nurses originally from Kerala who were trained in India and

who had come to the UK from 2000 onwards⁹. In-depth interviews, based on feminist principles of exchange and dialogue (Oakley, 1981), gave the nurses space to express their previous and immediate lived experiences of their work, their families, their hopes and aspirations, and the challenges they face (see Chapter 3 for more detail on the methodological principles guiding this research). The topics covered in these interviews were developed in dialogue with the literature discussed in this and the following chapter. However, before turning to Chapter 2, I briefly present a note on terminology and the structure of the thesis.

1.3 Structure of the Thesis

A variety of terms are used to refer to the international recruitment of nurses. Policy and scholarly literature on healthcare and the nursing workforce often uses the terms 'internationally recruited nurses' (IRN) or 'overseas nurse' (OSN) (Allan and Larsen, 2003; North, 2007). Whilst all of the nurses in this study were internationally recruited, O'Brien (2007) suggests that this 'rebranding' of OSN to IRN may be indicative of employers and policy-makers' desire to move away from the association of past generations of OSNs who have been traditionally used as cheap labour in the health service and often subjected to racial discrimination from patients and colleagues. In this thesis, the term 'migrant nurse' is used interchangeably with 'overseas nurses' to designate my research group. I use these terms because they are migrant labour from overseas, and because I do not want to recognise this group of workers as different from previous cohorts of migrant nurses, since their experiences of the British workplace are comparable to past generations. All of the people I interviewed had received their Registered Nurse (RN) qualification in India and had worked professionally as a nurse in India and, for many, the Middle East. Once in the UK, they worked in different capacities as carers whilst awaiting their Professional Identification Number (PIN) which would allow them to practice as RNs in the UK (see Chapter 5 for more discussion on the process of acquiring the PIN). I also use Kingma's (2006) notion of the 'nurse on the move' to draw attention to the ongoing

⁹ A full list of participants, their characteristics and their family care practices is given in Appendix A.

nature of these nurses' migration stories. I do not use the term 'foreign nurses' that is used in some literature on nurse migration, since many of the nurses are now British citizens and hence cannot be described as 'foreign'.

In terms of skills, I use the language of higher-skill to talk about registered nurses and lower-skill to talk about care workers as well as to delineate nurses from other migrant care workers. This skill division is important in two ways. It shapes the nurses' experience of work and career development in the UK context, with many nurses spending lengthy periods of time waiting for the PIN (see Chapter 5). As discussed in Chapter 2, the focus on nurses in this study is a deliberate attempt to further contextualise understandings of care worker migration, by broadening the focus on migrant care workers to include other types of labour, such as 'skilled' caring professionals. Although I use the terminology of high/low skills and un/skilled, I do so in order to reflect on the implications for the nurses when their qualifications are not recognised, as well as a means of broadening out the occupations that theorisations of feminised migration frequently rest upon. Positioning overseas nurses as care workers follows Kofman and Raghuram's (2006, 2015) argument that many migrant care workers are skilled workers, which broadens the focus of the debates beyond low-skilled work and work in the home (see also Yeates, 2009). Drawing upon this terminology does not indicate uncritical acceptance of this language however, and indeed, a revaluation of care would collapse such distinctions.

The thesis consists of eight chapters. In the next chapter, I provide an overview of the theoretical concepts that have informed this study. The chapter engages with one of the main approaches to understand the motivations, processes and impacts of care worker migration, namely the global (nursing) care chain approach. Illustrating some of the limitations of this approach, I discuss the transnational care literature, highlighting how useful this literature is for understanding the family dynamics for care worker migration. I also illustrate what a lens on imagined futures might bring

to the study of migrant care workers. In Chapter 3, I address the methodology adopted for this study, taking the reader through the design, data collection and data analysis stages of the research, and addressing the methodological challenges of the project.

Chapters 4, 5, 6 and 7 present the empirical data. These four chapters are structured chronologically according to three broadly overlapping migration *and* family life phases. In Chapter 4, their accounts of becoming 'nurses on the move' can be understood as a pre-migration phase that generally coincided with a time in their lives when they were single and childless. Chapters 5 and 6 describe the negotiations of resident and transnational familial care in the context of their migration to the UK, and so can be understood as reflecting a post-migration phase that typically coincided with getting married and having children. Finally, Chapter 7 addresses the nurses' dreams for the future, and hence reflects both a future migration/retirement phase as well as their imagining of themselves as older and as grandparents. In all four chapters the dynamic, mutual, multigenerational exchanges of care with family members in the context of their labour migration is the focus of the analysis.

In order to understand the experiences of a migrant nurse, it is important to understand the decisions underpinning their entry into nursing. Chapter 4 incorporates the three stages of the decision-making process (the decision to train as a nurse, its intertwining with the decision to go abroad and the choice of destination country) and uses a care circulation lens (Baldassar and Merla, 2014a) to understand these decisions as fundamentally rooted in a broad desire to care for self and family. Using this framework illustrates the temporal as well as the relational factors in the migrant nurses' decision-making process. This chapter not only challenges the idea of neoclassical migration policies that focus on the push-pulls of migration, but also serves as an indicator of complex family negotiations as adult children train as nurses to work abroad.

In Chapters 5 and 6, I focus on care in the migrants' lives post-international migration. How are these skilled migrants, after coming to the UK, sometimes from third countries, continuing to care in the context of their labour migration? In Chapter 5, I specifically focus on childcare in the context of skilled worker migration, tracing participants' navigation of their caregiving obligations and responsibilities, and illustrating the localised and transnational strategies that the nurses draw upon to meet these needs. The discussions offered in this chapter connects my study to international debates on care chains and transnational motherhood by illustrating how separation is a phase in the migrant nurses' migration and family biography, and is better understood as one of a multitude of transnational and localised strategies participants' draw upon to manage formal and informal care obligations.

In Chapter 6, I continue to focus on how participants engage in care relationships with family members in the context of their labour migration. The 'storyline' here focuses mainly on the multigenerational and dynamic caregiving relationships between the migrant nurses, and their families remaining in India, illustrating how caregiving obligations and capacities are multidirectional and change over time as their parents get older. The temporal focus enables a representation of how transnational nurses continue to give and receive multiple forms of care whilst working in the UK.

In Chapter 7, I explore how the migrant nurses talk about their aspirations and how they see their work and family lives unfolding in the future. Given the findings about the nurses' experiences in the previous two chapters, these reflective accounts are influenced and shaped both by the realities of their insertion into the hierarchal nursing labour market in the UK and their experiences of caring for family in the context of their migration. This chapter illustrates how the care activities and

practices in the present are not only embedded in the past, but also projected into the future. This reveals some of the initiatives and compromises made by the nurses faced with changing aspirations.

The theoretical and methodological implications of these aspirations are elaborated on in Chapter 8, which is the concluding chapter of the thesis. This chapter reflects on the conceptual and empirical contributions of the research and on the implications for international nurse recruitment in the UK. Finally, some questions and suggestions for further research on care and migration are raised from the nurses' experiences in transnational care labour migration flows, a process which necessitates longitudinal research methodologies in care worker migration. Widening the focus beyond the specific research agenda of the spectrum of care for and by overseas nurses, the thesis concludes by thinking about what the future may hold for the women and men who took part in this study and what their ageing as transnational migrants means for conceptualisations of transnational care. Through doing so, the thesis aims to contribute to broader debates about valuing care across borders and generations.

Chapter 2 Conceptualising Nurse Migration: Care Chains, Transnational Care and Imagined Futures

People do not spring up from the soil like mushrooms. People produce people. People need to be cared for and nurtured throughout their lives by other people, at some times more urgently and more completely than at other times. Who is available to do the labour of care and who gets the care they require is contingent on political and social organisation. Similarly, norms surrounding both the giving and receiving of care, while dictated in part by the nature of human need, are also conditioned by cultural and ethical understandings and by economic and political circumstances (Kittay, Jennings and Wasunna, 2005, p. 1).

As we saw in Chapter 1, there has been increasing interest in feminised migration over the past two decades, especially focusing on those migrating to perform care work in wealthier countries than their own. Indian nurses migrating to the Gulf, the UK, and other affluent countries form part of these feminised migration streams, working in hospitals, nursing homes and care institutions around the world, providing care to the old, sick and frail. They also often simultaneously (re)negotiate the care of their resident and transnational families. Migrant nurses are not only labour force or family members caring for others though; they are also people and as such also require care over their lifetime. The essential nature of the care that these nurses provide to patients in the UK and the reciprocal care relations within their families is clear in Kittay and her colleagues' eloquent articulation of care and caring, where they make strong claims for the connection between human interdependency and social, cultural and economic norms and organisation. In focusing on the relational contexts through which nurse migration unfolds, the thesis takes as its starting point a relational lens. Firstly, this means adopting an approach that broadly sees the world in terms of relations, which requires accepting that all that is social, and all that occurs in society, emerges in relation to other social factors in a variety of social contexts (Emirbayer, 1997). Secondly, to think relationally about nurse migration and the intertwining of family and work involves embedding the actor (nurse) within relationships that shift over time and space, rather than

prioritising separate entities as the fundamental unit of social analysis. A broad approach to care is thus necessary to fully incorporate the experiences of overseas nurses, one that can incorporate both their insertion into the global nursing labour market and one that can take account of the multigenerational and multidirectional aspects of transnational family care relations over time.

This chapter presents a conceptual framework that aims to capture the broad phenomenon of nurses migrating for care work, and their reciprocal care relations with family members in the context of that migration. It brings together feminist research on care labour markets and theorising of local and transnational care practices that migrants create and sustain. The main theoretical argument I advance in bringing these two bodies of literature together is that the family is deeply implicated in nurse migration, and that nurse migration cannot be understood solely through looking at the global processes underpinning the movement of nurses, nor by locating it within the networks of family duty and reciprocity. Rather, nurse migration is inextricably intertwined with how care labour migrants navigate a global political economy organised around neoliberal restructuring, as well as the social and cultural forces shaping their obligations and responsibilities towards resident and transnational families. In bringing these two approaches together, the utility of recognising a spectrum of care emerges, whereby work and family intertwine across space and time. However, whilst these two bodies of literature taken together provide a broad conceptual framework for understanding nurse migration and their transnational familial care negotiations, a more explicit temporal lens surfaces the role of the imagination in shaping migrant experiences and thus engages with their visions of care in the future. In taking 'imagined futures' seriously, I draw on a third body of literature that attends to the aspirations, dreams and hopes of migrants as a means of not only understanding patterns of migration and transnational caregiving, but the subjective experiences of the migrants themselves.

These three cross-cutting lenses provide a framework through which to read this thesis. Before I go on to look at these three lenses, I briefly turn to the concept of intersectionality since, for example, social class and gender, race and ethnicity have interacted and are reflected in the division of labour within nursing (Kyriakides and Virdee, 2003; Smith and Mackintosh, 2007; Batnitzky and McDowell, 2011) and migration often introduces new inequalities between family members, which are often interwoven along gender lines (Sinatti, 2014). Even within the closely defined focus on Malayali migrant nurses working in health and social care, the heterogeneity of migrant nurses, migrants, women and men, and their different subjectivities across time and space is important to acknowledge. Intersectionality is useful for interpreting some of these complex nuances—it allows us to think about the ways in which identities are multiple, and formed by the simultaneous and mutually constitutive workings of social categories, such as gender, social class, 'race', ethnicity, age, sexuality and so on (Choo and Ferree, 2010; Crenshaw, Yuval-davis and Fine, 2010; Crenshaw, 2011; Lutz, 2014). With a long history originating in the work of Black feminists and critical race scholars, intersectionality signifies:

The complex, irreducible, varied and variable effects which ensue when multiple axes of differentiation—economic, political, cultural, psychic, subjective and experiential—intersect in historically specific contexts. The concept emphasises that different dimensions of social life cannot be separated out into discrete and pure strands (Brah and Phoenix, 2004, p. 76).

Intersectionality rejects the idea that human lives can be reduced into separate categories because people are not singularly gendered nor classed for example. Rather than additive (race + gender + class) approaches or multiplicative analyses (race × gender × class) in an attempt to understand social location, intersectionality seeks to understand what is experienced at the *intersections* of power and inequality (Hankivsky, 2014, p. 255). In this way, classes are always gendered and racialised and gender is always classed and racialised and so on, thereby moving away from homogenous and essential social categories (Anthias, 2012).

Bringing together literature on transnationalism and intersectionality, Fresnoza-Flot and Shinozaki (2017, p. 875) argue that the axes of social divisions that acquire importance are *context-specific*. This calls for expanding an intersectional analysis beyond the nation state, instead paying attention to different experiences not only in different sociocultural contexts, but also, as Hulko (2009) argues, at different points in the life course. Indeed, Fresnoza-Flot and Shinozaki argue for the inclusion of 'generation' as an important intersecting social division in transnational relations. Their socially oriented definition of 'generation' is useful for this study, whereby it refers to:

Groups of individuals who are endowed [...] with a common location in the historical dimension of the social process. These people share with one another a 'particular type of social location' [...] determined by 'the way in which certain patterns of experience and thought tend to be brought into existence' (Fresnoza-Flot and Shinozaki, 2017, pp. 873–4 citing Mannheim in Kecskemeti, 1972, p.290).

Whilst, as returned to below, the idea of generation is used in transnational migration scholarship, it is not typically included in intersectionality debates, yet is often another dimension of social divisions. This is particularly important for this thesis since the central research question addresses how migration for care work shapes multigenerational relationships over time. In adopting an intersectional lens, that pays attention to transnational and temporal contexts, the thesis advances an analysis of gender, class, race, ethnicity, and age in terms of their intersections, not in isolation or as bounded variables, but instead viewing them as social relationships, entailing a power hierarchy within which gender, for example, intersects with other categories of difference (Fresnoza-Flot and Shinozaki, 2017, p. 875). Whilst intersectionality is not an explicit central analytical framework guiding the analysis of this thesis, I nonetheless draw upon it throughout. In the present chapter and chapters that follow, I discuss gendered migration, transnational family care and temporalities as they pertain to the migrant nurse experience, drawing attention to the implications they have for both the work and family experiences of nurse migrants, and highlighting, where appropriate, wider intersecting social relations within which these experiences are embedded. In doing so, I hope that the particular combination

of conceptual approaches used in this thesis will be a contribution to the field of migration and family research.

2.1 The Global Care Chain

The literature on gender and migration is replete with efforts to understand the globalisation of women's labour force participation. Care, and especially migrant care, is also often discussed in relation to *reproductive labour* (Yeates, 2009; Kofman, 2012), which attempts to make visible the fact that 'capitalist production is not self-sustaining but free rides on social reproduction' (Fraser, 2014, p. 70). Bakker (2007, p. 541) identifies three aspects in her definition of social reproduction: the biological reproduction of the species; the reproduction of the labour force; and the reproduction and provisioning of caring needs, all three of which are relevant to nursing. Scholarly interest in the *global* organisation of reproductive labour emerged from research on the global political economy that focused on the neoliberal drive from wealthier countries to outsource labour globally, to places where labour is cheaper i.e. 'the new international division of labour'. Feminists made the case that this 'globalisation of production' was accompanied by a 'new international division of reproductive labour' (Yeates, 2009). According to this concept, reproductive labour previously done by women in 'core' countries is increasingly provided by women from 'peripheral' countries who have migrated to 'core' countries to provide this labour. Whilst the migration of female labour to undertake paid reproductive labour is not historically new, what is new today is the increasing numbers of women who are migrating abroad (often alone) to do so, together with the long distances they travel (Ehrenreich and Hochschild, 2002; Yeates, 2009, pp. 20–21). This distinction between productive and reproductive labour helps focus a gender lens on international migration, as women are often recruited internationally to do reproductive work. Feminists have increasingly scrutinised what this means for care globally, with one theory gaining prominence amongst those working on gendered migration—the global care chain framework. The centrality of care in this framework focuses on its commodification in the context of labour market exchanges and the wider frame of political economy.

The theoretical framework of the 'global care chain' argues that reproductive labour has become a commodity that is bought and sold on the global labour market, and is particularly strong in theorising the presence of immigrant women in domestic and childcare work (Parreñas, 2001; Hochschild, 2002). This framework, and other related concepts such as 'the international transfer of reproductive labour' (Parreñas, 2001), identify systemic relationships of production and consumption that start in sending countries as producers of care labour and end in receiving nations as recipients of care. The 'global care chain' identified by Hochschild (2000) is described as a 'series of personal links between people across the globe based on the paid or unpaid work of caring' (p. 131). Hochschild argues that surplus value is siphoned from the home countries of migrant workers in the global south (usually called periphery countries in world systems theory) to the richer countries in the global north (usually called core countries). The concept argues that there has been a move towards outsourcing reproductive labour as a result of a 'care crisis' in richer countries (Williams and Gavanas, 2008; Orozco, 2010). This 'care crisis' is attributed to ageing populations, family structure changes, the feminisation of the labour force, and a shortage of public care services, all of which make it increasingly difficult for women in wealthy countries to perform reproductive labour (Anderson, 2000; Yeates, 2004; Williams, 2010).

The early literature on global care chains focused attention extensively on the transnational transfers of motherly love and care (e.g. Hochschild, 2000; Parreñas, 2001; Ehrenreich and Hochschild, 2002). According to this approach, many of the migrant women moving to wealthier countries than their own are married and have children whom they have to arrange substitute care for in order to work abroad. The next link in the chain is thus generated when women move from poorer parts of the source country to look after the families of these international care migrants, which in turn leads to a care crisis or an 'erosion of the care commons' in the global south (Isaksen, Devi and Hochschild, 2008). Hochschild (2000) argues that this type of

migration simply transfers the care deficit from households in richer countries to households in poorer countries, resulting in a 'care drain' (Hochschild, 2002, p. 17). As such, nations are linked through the extraction of human resources for care, specifically the 'emotional surplus value' of migrant women, which I discuss in further detail below. Hochschild's concept is useful in pointing out the interconnectedness of unpaid and paid forms of domestic and care work. It also draws attention to the importance of transnational networks in the globalisation of care and as such has become a favoured theoretical lens to capture the global transfer of physical and emotional labour from poorer to wealthier regions.

Five broad critiques of Hochschild's conceptualisation of the care chain have emerged through Nicola Yeates' (2004, 2009) development of the concept: firstly, the literature using this framework has tended to channel research into a narrow set of skills and occupations, namely nannies and maids. Yeates argues that broadening the focus to more skilled migrant care workers in different occupations reflects the increase in skilled labour migration that is a feature of contemporary migration. Focusing on skilled workers addresses the underplaying of the experiences of skilled women who navigate the care of their resident and transnational families simultaneously in the care chain and transnational motherhood literature (Wong, 2014). Secondly, a central focus of the care chain literature focuses on mothering and childcare and emphasises the emotional strains that mothers and children experience as a result of physical separation caused by the mother's migration. However, not all female migrant care workers are mothers 'sub-contracting' their childcare labour to other women whilst they work abroad. Many have care obligations towards their ageing parents or other family member(s), so focusing on care obligations towards other family members is important. Indeed, attention has more recently been paid to the caring relations that involve other family members such as elderly parents or the extended family. Men and fathers are also often excluded from the early accounts on care chains or are otherwise portrayed as absent fathers (although see Parreñas, 2008). This one-sided emphasis on 'global women' (and their suffering and exploitation) is criticised by a number of authors (Yeates, 2009; Williams, 2010;

Raghuram, 2012; Baldassar and Merla, 2014b) and contributes to a renewed research agenda where the care practices and experiences of men, sons, fathers and other members of transnational families are explored (Kilkey, 2010; Palenga-Möllnbeck, 2013; Fresnoza-Flot, 2014). This research field is discussed in further detail below. Thirdly, the range of sites of care could be expanded to move beyond a focus only on child-care, and include other forms of care such as health care, elder care, and social care. Fourth, Yeates suggests widening the focus to not only include *domestic* reproductive labour, but also the varying institutional settings in which globalised care work is provided, such as hospitals and care homes. Lastly, Yeates argues for the importance of paying attention to the historical contexts in which care chains are always constructed. These five elements steer attention towards other actors than the households directly involved in the practices of care.

The Global Nursing Care Chain

In critiquing Hochschild's original conception of the global care chain, Yeates (2004, 2009, 2010, 2012) argues that her expansion of the framework can be applied to other categories of care work, including, most pertinently for the purposes of this thesis, that of nursing, as migrant nurses are implicated not only as paid professionals but also, for example, as unpaid carers of ageing relatives 'back home'. She thus develops the concept of global nursing care chains as a framework for analysing the implications of the ongoing restructuring of the welfare state and healthcare systems in Western countries that has led to the production of the demand for a 'cheaper' and more 'flexible' healthcare labour. These demands are then partially supplied by migrant care workers in a broad range of occupational categories, employed under complex and shifting visa regimes. Yeates brings to the fore an intersectional lens to the study of care chains, by arguing that:

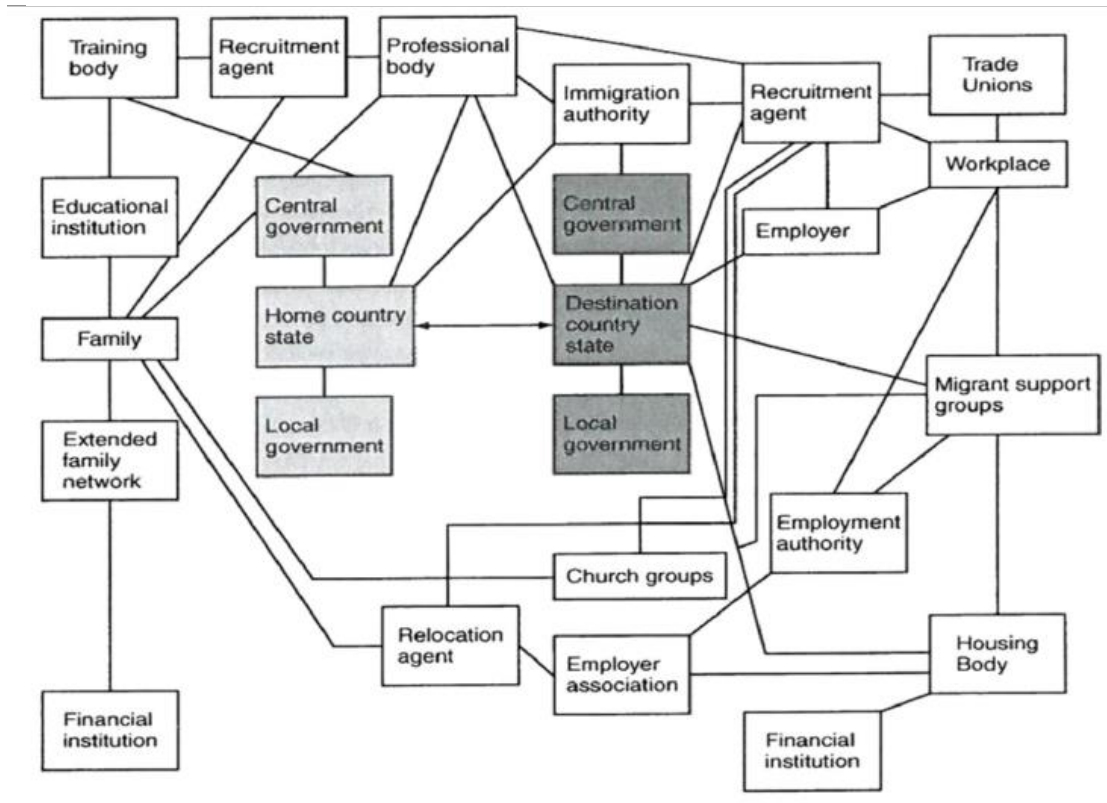
GCCs (global care chains) establish links between service-providers and service-recipients (and their families), links that are textured by wider socio-economic inequalities resulting from hierarchies of states, classes (and castes), genders and ethnic groups' (Yeates, 2009, p. 42).

This expanded concept retains the emphasis of the original on the feminised, devalued aspect of care labour, the public/private divide, the focus on various institutions and stakeholders who benefit from or facilitate the migratory process, as well as looking at the relationships between countries where feminised labour is consumed, and produced for export. In addressing the critiques outlined above, Yeates (2010, p. 426) broadens the original care chain concept to include a range of skills and occupations in the care sector and other actors within the family (see Figure 2-1), and applies it to the nursing sector, explaining that:

Countries at the top of the 'global nursing care chain'...are supplied by those lower down the chain. For example, the United States draws nurses from Canada; Canada draws nurses from the United Kingdom to make up for its losses to the United States; the United Kingdom draws nurses from South Africa to fill its own vacancies; and South Africa draws on Swaziland.

The concept of global nursing care chains would thus 'not only enhance the claims to reflect migration trends but also capture a wider range of institutional and regulatory environments' (Yeates, 2009, p. 50). This would involve looking at different care settings, such as hospitals and nursing homes, rather than strictly the domestic sphere, a broader range of agents and institutions, as well as acknowledging the varied types of care engaged in global migration. In broadening out the sites, sectors and skills involved in this form of gendered migration, the global nursing care chain more accurately reflects the diverse range of workers that comprise migratory networks, as well as challenging the idea of migrant care workers as 'immiserated women' and 'servants of globalisation' (Parreñas, 2001).

Figure 2-1 'Schematic presentation of the range of agents in global care chains'



Source: Yeates, (2009, p. 64 Fig. 3.4., reproduced with permission of Palgrave Macmillan).

Indian nurses have more recently begun to be included in the articulation of a global division of reproductive labour (Walton-Roberts, 2012; Walton-Roberts, Bhutani and Kaur, 2017). Employing Yeates' expanded framework, Walton-Roberts (2012) contextualises global nursing care chains originating in Kerala, India, pointing to the Indian and colonial state-market policies which underpin nurse migration from Kerala, and the problematic gendered and sexualised representations of nursing and its subsequent devaluing in the Indian labour market (also discussed in Chapter 1). Illustrating the importance of the local context, as well as these relational aspects involved in the structural and cultural production of the migrant nurse, several authors point to the role that status plays in stimulating migration aspirations (Nair and Healey, 2006; Nair, 2007; Walton-Roberts, 2010; Salami, Nelson, *et al.*, 2014). Prescott and Nichter (2014, p. 119) argue that nurses' experience of status is 'complex and in flux', incorporating both social and professional status, potentially

changing upon migration, and mediated by cultural and religious context. In India, for example, nursing has been associated with loose sexual morals and is seen to hold relatively low professional status (George, 2005; Percot, 2006; Nair, 2012; Walton-Roberts, 2012; Prescott and Nichter, 2014), yet their status in matrimonial markets have improved as a result of migration opportunities afforded by their profession (Percot, 2006; Percot and Irudaya Rajan, 2007; Walton-Roberts, 2012). However, despite such changes, George (2005) found that the stigma associated with nursing in India continues through generations, where some do not want to marry a nurse or a nurse's child. Walton-Roberts (2012) argues that these contextual details are important, and that global nursing care chain research must address more than just workplace contexts. This points to the importance of taking seriously the embeddedness of the family and local context in stimulating nurse migration, an argument further developed in Chapter 4.

The analytical framework Yeates developed to study these global nursing care chains mirrors the global commodity chain framework through its focus on 'inputs' and 'outputs' along the chain. In doing so, she identifies the role of the family in the production of the migrant care worker. The family, for example, is integral in the initial decisions to train as nurses and go abroad for certain national groups, such as Indian, Nepalese and Filipino nurses (Smith, Allan, *et al.*, 2006; Adhikari, 2011; Ronquillo, Boschma, *et al.*, 2011). Yeates (2009, p. 101) describes the decision to train as a nurse as an initial step in a household's internationalisation strategy, pointing to literature that posits that Indian and Filipino nurse migration is a decidedly family affair:

Family networks are most important in financing nursing education—often with the expectation that the family investment will be returned by the remittances sent by migrating nurses. So family expectations of migration are often built into the decision to send a daughter to nursing school (Redfoot and Houser 2005, 20 cited from Yeates, 2009, pp. 101–102).

However, sending remittances is not only an economic endeavour, but also implies 'caring for' family remaining in the home country, a point returned to later in the chapter. For now, the key point to note is that 'remittances not only serve the economic needs of transnational families, but also establish specific and emotional connections between family members and convey powerful shared meanings, such as what it means to be a 'good' mother' (Baldassar and Merla, 2014, p. 32).

Global Nursing Care Chains: Limitations

The expanded global care chain framework is an extremely useful way to conceptualise the linkages which exist at various levels transnationally, regionally and locally in social reproductive labour such as nursing. Yet there are some aspects that could be refined. Firstly, Raghuram (2012) has questioned whether global care chains are too unidirectional, portraying nurse production and migration as a simple tidy process. Indeed, the very image of a 'chain' evokes an image of identical links operating in a coherent, linear and causal manner, a point I return to in the following section in this chapter. Secondly, presenting migrant experiences in such a coherent manner does not capture the ambiguous emotional experiences that many migrant workers experience as they move through this imaginary 'chain', points I return to below and throughout the empirical chapters. Thirdly, scholars have also critiqued the framework for overlooking individual agency in its prioritisation of global inequalities (Briones, 2009). Fourth, global care chains remain heavily feminised in the literature, despite indications that there are a greater number of male nurses participating in labour migration (Connell, 2009; Healey, 2013) and the more recent inclusion of men in research on migration and reproductive labour (Kilkey, 2010; Näre, 2010; Gallo and Scrinzi, 2016). In my own sample, a fifth of the nurses interviewed were male. The archetypical nurse may remain female for now, but my interviews suggest that more men are entering the profession because of its opportunities for migration and hence confirms this call for the inclusion of men in research on feminised labour flows (see Chapter 4). Finally, although the family is integral to the feminist approaches that view nursing and other forms of care labour migration as indicative of an international division of reproductive labour, the care

flows between the nurses and their extended family members remain underconceptualised in two broad areas—emotions and the social relations and cultural values of the family.

Although the family is integral to the feminist approaches that view nursing and other forms of care labour migration as indicative of an international division of reproductive labour, it tends to focus on the *transfer* of care from one country to the next and the care deficits (in family and health systems in the case of nurses) engendered through this form of migration. The classic care chain approach, with its view of care and love flowing typically from migrant mother to child 'left behind', oversimplifies the emotional experiences of many migrants, by 'resting on the assumption that emotion is a stable commodity possessed by the subject' (Brown, 2015, p. 3). Applying a Marxian supply chain framework to the migration of care workers can certainly reveal the fissures of the global economy, highlighting how global structural inequality creates and is reinforced by an international division of labour that is gendered and racialised, and often leads to suffering (Anderson, 2000; Parreñas, 2001). Whilst this is certainly important, and indeed forms the structural background to the thesis, viewing emotions as stable and fixed commodities to be transferred from one spatial context to another leads to an oversimplification of the emotional lives of migrant care workers. This approach cannot capture the sort of emotional ambivalences often involved in labour migration and/or familial separation. Nonetheless, Hochschild (2000) sees the situation where migrant women leave their own children in the care of someone else in order to provide care for a privileged family's children as an 'extraction' of care resources and a 'global heart transplant', benefitting the rich child at the expense of the poor. She attributes the 'terrible sadness' resulting from such patterns as connected to the 'emotional surplus value' they produce when caring for 'first world' children rather than their own (2000, p. 134).

Mothers remain separated from their children, a choice freighted, for many, with a terrible sadness. Some migrant nannies, isolated in their employers' homes and faced with

what is often depressing work, find solace in lavishing their affluent charges with the love and care they wish they could provide their own children (Hochschild, 2002, pp. 21–22).

This suggests a view of care and emotion as objects, transferrable from the global south to the global north, as something held and possessed by the migrant mother and only transferable in situations involving co-presence, an argument developed in Chapter 6.

Even in Yeates' expanded and nuanced view of nursing care chains, her analysis of the 'transfer of motherly care' parallels Hochschild's in the sense that both posit emotion as a fixed, stable commodity that belongs to the biological mother and can be thus transferred from one object—the 'Third World' child—to another in the first world (Manalansan, 2006; Baldassar and Merla, 2014b; Brown, 2015). Although Yeates recognises that Hochschild's initial conceptualisation of transfers of motherly care from the global south to the global north was complicated by the transnational motherhood literature (Hondagneu-Sotelo and Avila, 1997; Parreñas, 2005a) and the fact that mothers continue to care following their migration, she nonetheless goes on to suggest that:

In GNCCs (global nursing care chains) what is being transferred is of course nursing care from patients in the source country to those in Ireland; but this migration also involves the transfer of motherly love...what is in fact involved is a double care chain—one in which the transfer of nursing care is entwined with the transfer of motherly care (2009, p. 171).

Brown (2015) argues that this approach to emotions implicitly conceptualises emotions as something possessed by the emoting subject, and emotions as something to be directed towards an object. There is no doubt that the care chain attempts to theorise a system of severe inequality and its implications for families. However, approaching these care workers and their families solely through a deficit lens does 'little justice to the complex system of social relations and cultural values in which

such care relations are embedded' (Fog Olwig, 2014, p. 133). Indeed, it fails to acknowledge the care work accomplished through extended kin.

The obligations between family members do not simply disappear or remain static when a nurse, or any migrant for that matter, migrates. Rather, from the perspective of the life course, we can see how the exchange of care fluctuates throughout the life cycle, both within and across generations (Ackers and Dwyer, 2002; Baldassar, Baldock and Wilding, 2007). For example, Isaksen, Devi and Hochschild (2008) write about the separation between Kerala female nurses working in the Gulf and their children remaining in India. The mothers continued to send gifts and talk regularly to their children, but both described intense suffering due to the lengthy periods of separation. Whilst the nurse mothers and their 'left-behind' children in the authors' study were never reunified, possibly due to the time-frame selected in the research design, other research on Kerala nurses illustrates that many families reunify after their initial separation (George, 2005; Percot, 2012). Whilst recognising the pain and suffering experienced in mother-child separation is undoubtedly important, several authors have shown that the period of mother-child separation often relates to a particular *phase* in the migration and family cycle (Hondagneu-Sotelo and Avila, 1997; Mazzucato and Schans, 2011; Andall, 2017). Migrating with children, leaving them behind and reunifying with them at a later date in the destination or home country suggests that in many cases, the period of being a 'transnational mother' (Hondagneu-Sotelo and Avila, 1997) is a strategy adopted by family units 'based on institutional and personal opportunities, resources and constraints in both the home and host societies' (Baldassar and Merla, 2014b, p. 27).

Cultural values of care also vary both within and between societies and this has a bearing on the practices and meanings of care within families. The notion of filial piety plays a significant role in Indian and Indian-British families whereby:

Parents and children construct their relationships via long-term bonds of intergenerational reciprocity and affection, in which juniors provide care for their senior parents in old age and after death, as ancestors in return for all of the effort, expense and love their parents expended to produce and raise them in infancy (Lamb, 2002, pp. 304–305).

Although practices of filial piety are being redefined in India in response to social and economic changes, children in India are still typically expected to care for parents in their old age (Lamb, 2002, 2009; Brijnath, 2012). Paying attention to the role of the family thus contextualises the processes involved in the production of the care worker, as well as illustrating the local factors involved in global processes. It not only implicates the desire and obligations to provide familial care in the initial motivation to become a nurse and migrate, points I return to in section three of this chapter, but also suggests that expectations of receiving support forms obligations between the migrant and their family members remaining in India that go beyond the duration of the initial migratory movement. This is an underconceptualised, yet important aspect of nurse migration and the global nursing care chain, and forms the basis of the arguments further developed in Chapters 4, 6 and 7. In this regard, my research makes an important intervention in the literature on global nursing care chains by paying attention to these understudied aspects. In order to capture ‘the growing awareness that members of families retain their sense of collectivity and kinship in spite of being spread across multiple nations’ (Baldassar *et al.*, 2007, p. 13) and to understand the reciprocal care flows between transnational family members and its fluctuation across the life course, I turn to conceptual developments in the literature on transnational care.

2.2 Care Circulation and Transnational Families

One of the interesting developments in the migration studies literature in the last two decades has been a growing awareness that migrants may not simply integrate into the country of destination, but rather, may engage in transnational practices that challenge the idea of migration as a complete project, ending in assimilation and integration (Basch, Glick Schiller and Szanton Blanc, 1994). The important point

here is that migrants may be incorporated into both their place of origin and the place of destination, and that the two are not necessarily incongruent. Whilst an acknowledgement of migrants' ongoing ties and connections to their places of origins are not new, especially when one looks to Thomas and Znaniecki's (1996) classic *Polish Peasant in Europe and America*, which highlighted how long-distance relationships between separated family members were sustained through letters, the number of families living lives over great distances has increased. In more recent years, migrants and their kin have been increasingly conceptualised as 'transnational families' (see, for example, Bryceson and Vuorela, 2002; Baldassar *et al.*, 2007), maintaining their sense of *familyhood*, even though they might not see each other or be physically co-present very often or for long periods of time. Transnational families are, by definition, spread across geographical and legal borders (Sørensen, 2005), are dispersed across international borders, and are comprised of family members who spend time in one country or another, depending on a variety of factors such as work, education, and care for other family members (Bryceson and Vuorela, 2002, pp. 3–7). Baldassar *et al.* (2007, p. 13) argue that the concept of the transnational family captures the growing awareness that members of families retain their sense of collectivity and belonging despite geographical distance, without underestimating the impact of distance and borders on these relationships and on the practices of transnational caregiving. Adding to this, Evergeti and Ryan (2011, p. 358) explain that the methodological turn towards 'transnationalism from below' sees 'family as a flexible social practice, providing an understanding of culturally produced notions of role and obligations towards caring responsibilities and how family relations develop over time'.

Drawing on Bryceson and Vuorela's notion of transnational families, the conceptual framework of transnational family caregiving was developed by Baldassar *et al.* (2007), and further elaborated upon by Merla and Baldassar (2011), Kilkey and Merla (2013), and Baldassar and Merla (2014b; 2016). According to this definition, family care is a constitutive feature of transnational families; in the absence of face-to-face interaction, the need to display care is greater (Yeates, 2009; Kilkey and

Merla, 2013). Drawing on comparative studies of care in transnational families, Baldassar et al. (2007, p. 204) argue that the 'practices of transnational caregiving also take place over time and are played out within individual, family and migration life cycles or life courses'. These care exchanges are mediated by a dialectic comprising the capacity (ability, opportunity), the culturally informed sense of obligation and the negotiated family commitments of individual members to provide care within specific family networks. These practices are largely 'organised by the structures of kinship and community, in particular the sense of obligation to engage in reciprocal care exchanges' (Baldassar, 2008a, p. 271). The focus here is on care that 'circulates' between transnational families.

Despite the increased phenomenon of the transnational family, these family forms tend to be stigmatised as 'deficient or at risk, fragmented, broken and under strain', a representation that the care chain literature tends to reproduce (Baldassar and Merla, 2014a, p. 12). Baldassar and Merla seek to interrogate this scepticism about transnational families more thoroughly, developing a conceptual framework that captures the 'practices and processes' of transnational care, thus positioning the transnational family as a common contemporary family form. Drawing on their previous work on transnational caregiving, the authors introduce the idea of 'care circulation', which they define as:

the reciprocal, multidirectional and asymmetrical exchange of care that fluctuates over the life course within transnational family networks subject to the political, economic, cultural and social contexts of both sending and receiving societies (2014b, p. 22).

Emphasising the reciprocal nature of care, Baldassar and Merla point out that care resources do not flow unidirectionally from migrants to their loved ones in the country of origin, but also the other way. They argue that the negative view of transnational families stems from a narrow conception of care as 'hands-on', therefore relying on families to be physically co-present in order to adequately provide care. Whilst not denying the challenges, conflicts and tensions these families

often experience, the care circulation concept and transnational care literature challenge the notion that geographical distance *negatively* affects familial relationships. This approach highlights that transnational families can, and do, exchange all the forms of care and support exchanged in families not separated by great distances, often circumventing the economic, personal, political and legal constraints of their situations (Baldock, 2000; Al-Ali, 2002; Baldassar, 2007a; Baldassar *et al.*, 2007; Zechner, 2008). Central to the concept of transnational caregiving is the understanding of care as a *multidimensional, multigenerational, and multidirectional* phenomenon (Horn, 2016a, p. 306, italics added), a conceptualisation that goes beyond the narrow commodification lens implicit in the care chains framework, and it is to this conceptualisation that the chapter now turns.

Transnational Families and the Circulation of Care: A Multidimensional Approach to Care

Because 'regular hands-on assistance [is] clearly not possible between family members who live far apart from each other' (Baldassar *et al.*, 2007, p. 4), understandings of transnational care go beyond the requirement of physical co-presence and hence draw on care as multidimensional. Drawing on Finch and Mason's (1993) five-dimensional definition of care, Baldassar *et al.* (2007) developed the notion of 'transnational care'. In transnational settings, personal (or 'hands-on') care can only be exchanged during visits when people are physically co-present. As such, visits, and having the resources (such as money, time, passports and visas) required to undertake such visits are an important aspect of caring across distance. Financial support as another dimension of transnational care can take the form of cash remittances or other goods or services, such as food and clothing, or paying for education and other household bills. Practical care in the transnational setting typically takes the form of exchanging advice or information, assisting with tasks or errands. This form of care can be provided during visits or across distance, and these can involve extensive, regular and frequent communication, as in the case of transnational mothering. Emotional and moral support, which can be expressed

across distance and in proximity as well as through all other forms of care, is 'arguably the bedrock of all relationships' (Baldassar and Merla, 2014b).

Scholars engaged with discourses on transnational care often deliberate on the differentiation between four elements of caring that emerged from the feminist ethics of care literature: 'caring about', 'taking care of', 'caregiving' and care-receiving' (Fisher and Tronto, 1990; Tronto, 1993). 'Caring about' is an orientation to observe what parts of the world require maintenance and repairs: this part of caring is often associated with affective dimensions such as attachment and love. 'Taking care of' or 'caring for' conveys the care given to a specific individual, which can occur in both distance and proximity. By 'caregiving,' Fisher and Tronto (1990, p. 42) refer to the 'more continuous and dense time commitments than "taking care of"', suggesting that it is largely a proximate form of care. The last element of caring is 'care-receiving': the response of the caree (caree is the person who is in need of care and receives care) to the three previous elements (Fisher and Tronto, 1990, pp. 40–44). However, these distinctions of care are not easily applicable in real life situations, where care relations are often a combination of different degrees of 'caring for' and 'caring about' (Milligan and Wiles, 2010). It is difficult to argue that emotional care ('caring about') is less necessary than personal caregiving ('caring for'); emotional support can also be understood as a form of 'caring for' (Baldassar and Merla, 2014b, p. 49). This is particularly the case in transnational contexts where there are limited opportunities for other forms of caregiving and moral and emotional support become important ways of expressing care and love.

Tronto's concept of care is nonetheless relevant to this study since it recognises care-receiving as an important part of a care relationship. In the study of migrant workers, care-receiving has had only a minor role, and the analytical emphasis has typically focused on the experiences of the carers, although there has been more recent calls for the blurring of the distinctions between care-giver and care-receiver (e.g. Huang, Thang and Toyota, 2012; Huang, Yeoh and Toyota, 2012; Baldassar and Merla,

2014b). For example, when included in the discussion, the literature on parents of migrants is often limited to the role of elderly kin as care-givers for the migrants' young children rather than as care-receivers (Parreñas, 2001), although more recent studies recognise that people occupy caregiving and care receiving roles along a spectrum of dependence and independence that changes over time (Zhou, 2013). This multidimensional approach to care is especially important for transnational families who act out and practice their love and attachment across distance; it also shifts the focus from a more dependency approach to care to a focus on reciprocity amongst multiple family members.

The Circulation of Care Over the Life Course: Reciprocities and Asymmetries

As well as viewing care as multidimensional, a multidirectional approach leads to the recognition that care is structured around notions of interdependency and reciprocity (Tronto, 1993; Fine, 2004). Whilst the differentiation between 'caring for' and 'caring about' often blurs in the transnational context, the feminist ethics of care is extremely helpful in moving understandings of care beyond the conventional view of a unidirectional flow of care from an active care-giver (the 'haves') to the passive care-receiver (the 'have-nots') (Sevenhuijsen, 2000). The conventional representation of care relations as dyads and unidirectional, which stems from historical constructs of disability, marginalises the care-receiver as being 'dependent' and lacking in autonomy (Fine, 2004), has been extended to other groups of people including the elderly and infirm. This discourse of dependency has been challenged by scholars asserting that 'independent' people also require care. Carol Thomas (2007, p. 88), for example, points out that while a frail older person might require a greater than average need for assistance with daily tasks, so too may the non-disabled businessman who may need the assistance of others to organise meetings, secure travel arrangements and take responsibility for the smooth running of their home and family life. Rejecting this dependency model of care, the notion of care circulation puts forward a view of care as 'representing an ongoing human activity that places individuals in relations of interdependence with each other throughout their life

course' (Merla and Baldassar, 2016, p. 282). The capacity and obligation to provide care and the need to be cared for are thus closely linked to the life course.

Bowlby, McKie, Gregory and MacPherson (2010, pp. 4–5) point out that the terms 'life cycle', 'life stages' and the 'life-course' are all concepts that attempt to encapsulate the largely predictable life phases that people encounter in the passage of time between birth and death. Over the course of the last century, these life events have become less predictable in terms of 'when, where and whether' they take place in the majority of people's lives, and the term life course has become the preferred term to sum up this process. Dewilde (2003) distinguishes between 'transitions' and 'events' of the life course. Transitions refer to the 'changes in the lives of individuals that are in accordance with the socially constructed life course' (p.118) and may be linked to age, such as leaving school or having children. Events, on the other hand, are not necessarily predictable and are not linked *a priori* to age (for example, war or redundancy). Dewilde sees the life course as a 'multidimensional concept, an amalgam...of the multiple, interdependent trajectories relating to the different institutional spheres in society' (p. 118). This approach is relevant to this study because it is a less chronologically driven definition that recognises that different life course transitions and events bring with them a greater need to give or receive care. Transitions between life phases relating to ageing, for example, involve care between adults and children and between younger and older adults (Bowlby, McKie, *et al.*, 2010). It is worth noting though that 'this imagining of life stages through the provision of care is a normative one that needs to be confirmed or questioned through caring activities by concrete individuals' (Alber and Drotbohm, 2015, p. 11). As indicated at the beginning of the chapter, a mushrooming of care homes in the Indian context suggests that not everybody provides care according to general expectations for a variety of reasons. Although, as illustrated in Chapter 3, I have not adopted an explicit life-course methodological approach in the study, a broad life-course perspective has helped me think about participants' accounts of their migration as nurses, their reciprocal care relations and how these change over space and time.

Understanding care as multidirectional and multigenerational can thus lead to recognition that care is structured around notions of interdependency and reciprocity across the life course, which are, as outlined above, integral to 'ideal' care in the Indian family (Lamb, 2002, 2009). The flow is reciprocal as family care is an exchange, circulating back and forth between those who migrate and family members back home. Although the return of care is not immediate and equivalent, there is an expectation and obligation of diffuse reciprocity (that at some point in the future, care will be returned). Moreover, the care circulation approach also sees the individuals involved in these transnational care exchanges as relational and interdependent. This brings into the fold multiple generations, as well as the able-bodied and those in need of care, family members who are often overshadowed by the spectre of the migrant mother separated from her children (e.g. Hondagneu-Sotelo and Avila, 1997; Parreñas, 2001a; Horton, 2009)¹⁰. Rather than viewing the ageing parents of migrants as burdens or as individuals in need of care, literature recognising the reciprocal nature of care across the life course recognises the significant contributions of ageing parents to the well-being of transnational families by providing emotional, financial and practical support (Horn, 2016b). This reciprocal approach to care across the life course is especially relevant to this study considering the fact that grandparents may receive care from their adult migrant children whilst looking after their grandchildren in the destination country, points further explored in Chapters 5 and 6.

However, moving beyond this dependency approach to care towards a view of care as multidirectional and reciprocal does not mean that care flows evenly between family members. Indeed, in Baldassar and Merla's (2014b) conceptualisation of circulation, they emphasise the *asymmetrical* nature of care flows between family members. The various forms of care described above can be exchanged in different

¹⁰ Although as noted above, there are an increasing number of studies extending the analysis beyond mothering to include fathers or migrant men doing care work (Kilkey, 2010; Näre, 2010; Palenga-Möllnbeck, 2013).

settings, but the experience of transnational caring is subject to a variety of factors such as gender, ethnic, class and power hierarchies and is further mediated by a host of other factors including resources, cultural norms, labour market integration, state policies and international regulations (Baldassar *et al.*, 2007; Zechner, 2008; Kilkey and Merla, 2013). These asymmetries can be gendered, as seen, for example, when transnational and local care burdens tend to fall most heavily on women, who generally receive less than they give (Ryan, 2007). Transnational families are also marked by power asymmetries between migrants and those remaining in the country of origin, most notably in terms of access, at least potentially, to material resources and life opportunities (Boccagni, 2015, p. 253). Different transnational families have different resources and capabilities to overcome distances, such as economic resources, social networks, access and familiarity with communication technologies (Kilkey and Merla, 2013; Reynolds and Zontini, 2014a). These factors account for and shape the asymmetries and inequalities, both within and between transnational families, in the capacity to circulate care. These asymmetries in the capacity to care is an important theme in my research and will be explored in Chapter 6.

Inequalities in the capacity to manage family obligations and provide care from afar often leads to feelings of sadness and guilt (Takeda, 2012; Baldassar, 2013). Some scholars have focused on the emotional consequences of migration, especially for migrant women (Parreñas, 2001; Schmalzbauer, 2004). As discussed in the first section of this chapter, the emotional suffering and pain caused by globalisation is often emphasised in the literature on care chains, exemplified in the following quote:

The pain of family separation creates various feelings including helplessness, regret, and guilt for the mothers and loneliness, vulnerability and insecurity for children (Parreñas, 2001, p. 361)

More nuanced research on transnational families suggests that emotional pain, such as that experienced by children with migrant parents, is contingent on factors beyond the migrant parents' physical absence (e.g. Coe, 2008; Fog Olwig, 2012; Poeze and Mazzucato, 2014). These authors take account of cultural and historical differences

in family practices that influence the experiences of emotion, recognising the multifaceted feelings that may be involved in transnational families. Indeed Boehm (2008, p. 788) makes the case that transnational family positions are often 'riddled' with 'ambivalent emotions', whilst Svašek (2008, p. 216) argues that the 'emotional life of migrants is often characterised by contradiction'. In her analysis of married Japanese women in Ireland, for example, Maehara (2010) illustrates how migrant daughters felt 'conflicting loyalties towards families' in Ireland and Japan. The migrant women in Maehara's study managed their often contradictory, inconsistent and ambiguous emotional experiences through intense emotion work, that required them to manage their feelings in a conscious effort to sustain relationships with significant others residing in multiple places. Similarly, in her research with Filipina domestic workers in Hong Kong, Constable (2004) points to the emotion work employed by her participants who framed their migration in terms of self-sacrifice and duty to support family remaining at home, whilst their lives in Hong Kong is not necessarily experienced as a totally selfless sacrifice, but also one of pleasure.

The concept of 'emotion work' has been used to understand some of these ambiguities and the difficulties that migrants and their families often experience when trying to care for each other across distances, as well as pointing to the time and energy involved in sustaining these care relations (Baldassar, 2007b, 2013; Ryan, 2008b). Hochschild (1983) distinguishes 'emotion work' from 'emotional labour'. The former is the kind of emotion work taking place in all areas of life in order to keep relations with others civil and regulated e.g. the parent suppressing anger at her child and mustering up kindness and a soft word. Through socialisation, people learn 'feeling rules', indicating the intensity and duration of emotions, as well as 'display rules' about appropriate emotional behaviour. Conforming to these rules involves the management of emotions and is thus understood as 'emotion work'. Emotional labour is the labour that workers do to maintain the 'right' emotions in the workplace and to suppress the wrong ones. She conceptualised this as labour because the emotional labour is being done for a wage, in return for exchange value (money) rather than use value. However, Hochschild's framing of emotion work and

emotional labour are contested and debated terms because, for example, they do not fully take into account how 'emotion is in the social relationship', rather than solely as an individual internal condition (Barbalet, 2002, p. 4; Burkitt, 2014). Taking on board such critiques, I nevertheless find these terms useful to draw on since it brings attention to the management of emotion not only in participants' transnational care relations, but also to understand participants' accounts of their everyday lives (see Chapters 6 and 7). Of course, such emotion work has temporal as well as spatial elements in that it becomes more intense during times of crisis and at different points in the life course. It is to the temporal aspects of transnational migration for care work and its shaping of familial care that the chapter now turns.

2.3 Temporalities in Transnational Care Worker Migration and Transnational Care: Imaginaries and Care Work

Implicit in many of the studies discussed above are ideas about time and the temporal experiences of migration. Migrant workers often speak about having no certainty over their future, or having to accept work with little structure or long working hours (Anderson, 2000; Datta, McIlwaine, *et al.*, 2010; Adhikari, 2011). Lengthy work days, precarity and insecurity are often the focus in care worker migration literature. In relation to care worker migration, Anderson (2007) has, for instance, considered the role of time in relation to the control of workers, including the impact of working time on retention, length of stay and changing immigration status. Similarly, temporality and time are implicated in the literature focusing on transnational care. The metaphor of care circulation (Baldassar and Merla, 2014b), for example, evokes an image of time as intricately intertwined with the idea of space and movement. Indeed, the notions of diffuse reciprocity, generation, interdependency and the life course, which as earlier discussed are central themes in the transnational care literature, point to the centrality of a temporal framework to this lens. However, despite the implication of time in these approaches, a theoretically oriented understanding of time, and especially the future, in care labour migration and

transnational familial care is underdeveloped and thus deserves further sociological attention.

There is much to be said about the relationship between time and transnationalism (see Griffiths, Rogers and Anderson (2013) for an overview of the treatment of time and temporalities in migration studies), but core to a sociological framing of temporalities in care labour migration and transnational care is an understanding of time as a social concept. Adam (2004) argues that people's lives need to be viewed through a 'timescape' perspective, which brings into view a temporal view of the world. Adam sees time as complex and multidimensional, involving an understanding of how people conceive of and experience time. In doing so, she brings into focus not only the past and the present, but also the future. Despite this intervention, some writers point out that many studies continue to reduce social worlds into linear temporal paths (Halberstam, 2005; Browne, 2014; Brown, 2015). Acknowledging the difficulties in seeing time only in a linear sense, scholars are increasingly seeing mobility and migration not as a series of forward-facing stages or events, but as a process of ambiguity and contradiction, involving, for example, seemingly inconsistent emotional responses to the processes of exile and return migration (Uehling, 2002). In the context of, for instance, fluctuating migration policies that encourage temporary guest-workers (Ruhs and Martin, 2008) and the flexible citizenship projects undertaken by global elites (Ong, 1999), it is thus important to consider mobility as non-linear—migration can and often does involve repetition, simultaneity, seasonality and cycles (Brown, 2015). Indeed, as highlighted in Chapter 1, nurse migration can be circuitous (Kingma, 2006), involving multiple 'stepwise' migrations (e.g. Carlos and Sato, 2011; Paul, 2011) and several returns and leavings of the country of origin during a life or the permanent return to one's country (Haour-Knipe and Davies, 2008), points I return to later in this section. Much of the literature on care labour migration also emphasises, explicitly or implicitly, the processes of social reproduction, which is also a temporal phenomenon. Some authors, for example, have explored how migrant adults reorganise the processes of social reproduction in the lives of children or elderly 'left

behind' (e.g. Colen, 1995; Parreñas, 2005a; b; Vullnetari and King, 2008), but a more theoretical understanding of time and temporalities is generally overlooked in these studies. Addressing this 'taken-for-grantedness', the rest of this section specifically examines a relevant theme that relates directly to two empirical chapters in this thesis—the emergence of migration aspirations that provides a window into migrants' constructions of their future (Chapters 4 and 7).

Embedded Imagined Futures

Despite Adam's call for a more temporally informed approach to the social sciences, one that takes account for the intertwining between the past, present and future, some scholars point out that the past has been prioritised in the social sciences, to the analytical exclusion of the future (Adam and Groves, 2007; Mische, 2009; Griffiths, Rogers, *et al.*, 2013). This is despite the notion that the global economy is underpinned by an 'abundance of futures' that lie in our big narratives and small acts: 'in every place where hopes and doubts are mobilised' (Rosenberg and Harding, 2005, p. 9). The lack of serious engagement with this may be due to some of the perceived challenges in empirically accessing what Adam and Groves (2007) call 'imagined futures', or the 'not yet', an issue addressed in Chapter 3. However, there are some innovative ways of overcoming these challenges. Crow and Lyon (2010), for instance, analysed the imagined futures of teenagers on the Isle of Sheppey by drawing on historical essays that invited them to imagine they were at the end of their lives and to reflect on their past. This provided interesting insights into the teenagers' understanding of their social world and their place in it. However, Mische (2009) argues that even when the category of the imaginary is taken seriously by sociologists, it is only to understand how people represent their present reality or how people imaginatively reconstruct the past.

To understand migrant nurses' future-orientations, we must think about life as something that neither exists in a past tense, nor in a future tense. This point is made by Mead (1959 [1932]), who developed a conception of human agents acting in time

that emphasised the importance of the present in human action. Central to this idea is that the present is the locus of reality, or that existence happens in the present. In a strict sense, he argues that only the present exists, always emerging from a previous present and becoming a new one. Mead acknowledges the existence of a past, but argues that this past is accessible only as far as it is present in the present. As the present changes, so does our knowledge and interpretation of the past, which is continuously constructed from the present and therefore revocable. The past is thus simultaneously revocable and irrevocable, but it is only its revocable form that we can deal with. Similarly, the future is based in the present, and is hypothetical and revocable. Thus, both past and future exist for human action only as dimensions of the present. Translated into a migration setting, Mead's thoughts on the past, present and future mean that migrants' decisions, trajectories and aspirations can only be studied in and known from a standpoint of the present.

Slightly shifting the emphasis but maintaining the view that we only live in the present because both past and future are imaginary realms, Adam and Groves (2007) point out that activities and practices in the present are not only embedded in the past, but also projected into the future. As 'we live in the ever-shifting present, we continually re-interpret the past, overwrite our biographies, and reframe our orientations to the future' (Neale, 2010, p. 4). Adam (2010) argues that conventional thinking understands the future as 'not yet' as not fact, but instead belonging to the realm of anticipation, to imagination, expectations, plans and desires. This ignores 'the fact that futures are made, shaped and created with every action, interaction and transaction' (Adam, 2010, p. 8). However, Mische (2009), in her unpacking of the relationship between aspirations and experience, cautions against researchers thinking that in the documentation of people's hopes, expectations or aspirations, we have somehow captured what they actually choose, achieve or experience. Indeed, people often make decisions based on analyses of the future that make it difficult to make accurate predictions, because of limited or incorrect information for example, which can lead to seemingly irrational behaviours (Johnson-Hanks, 2005). Regardless of whether these future projections 'actually' predict the future, scholars

engaging with the future argue that 'imagined futures' have an influence on action (Adam and Groves, 2007; Adam, 2008; Mische, 2009). They are real in their consequences, even if the consequences are different than the imagined futures that motivated the action. Actions and processes associated with futures are ongoing—there is a dynamic relation between these temporal modalities (Adam, 2008). In other words, what we do in the present and have done in the past is inherently linked to our futures. Similarly, our expectations or hopes for the future shape our present actions and redefine our past. These imagined futures and aspirations also 'do' something and play an important function in people's everyday lives. As Mische contends, they are mobilising forces, such that the 'forces of *pressure* pose and define a question. But it is the forces of *aspiration* which formulate and offer an answer' (2009, p. 694 citing Desroche 1979, p. 3, italics in original). As Neale (2010, p. 4) puts it, 'an analysis of future orientations and aspirations opens up new possibilities for understanding the seeds of change'. These insights are of critical relevance for Chapter 4, where the influence of family on career and migration decisions are discussed and in Chapter 7, where I empirically explore nurse migrants' accounts of their aspirations as emerging from a standpoint of a 'present' that is marked by emotional experiences such as pride, humiliation and discrimination (emerging out of interactions in, for example, everyday working life). However, Mische argues that sociologists should study these aspirations and imagined futures not only as projective dialogues with future selves, but also address the relational dimension of imagined futures.

Imagined Futures: Relational, Structural & Emotional Considerations

Drawing on Simmel's theory of relational intersections (which sees social networks as extending into the imagined future), Mische (2009) develops a relational approach to imagined futures. She uses the notion of *sociality* to refer to the way that:

Future projections are 'peopled' with others whose actions and reactions are seen as intertwined with our own. Not only do we engage in conversations with our imagined future selves, but we also imagine those future selves conversing and interacting with others (2009, p. 701).

She argues that some cultural groups may clearly imagine their futures as embedded with others, whilst others are more individualistic in their imaginaries. She also uses the notion of *connectivity* to describe the imagined logic of connection between temporal elements, arguing that sometimes the links between past, present, future are 'made explicit in future projections' (2009, p. 701). Imagined futures are thus relational and connected to others, reflecting a sense of reciprocal obligation into the future when care relationships change according to the development of the life course. Indeed, the relational dimensions of imagined futures are central to the formation of the transnational family, which 'derives its lived reality not only from material bonds of collective welfare among physically separated members but also a shared imaginary of 'belonging' which transcends particular periods and places to encompass past trajectories and future continuities' (Yeoh, Huang and Lam, 2005, p. 308). Although not employing Mische's terminology, Coe's (2016) recent study on the 'temporal orchestration of care' amongst Ghanaian female migrants puts forward the idea of care as temporally coordinated across the life course, and is thus similar to Mische's notion of imagined futures as 'peopled' with others. The women in her study orchestrated or 'entrained' their life courses to those of others in order to reciprocate care, often doing so by migrating internationally. Temporal coordination was tricky though and not always successful. Two of the challenges in orchestrating care that Coe identifies are particularly relevant for this study, particularly in Chapters 5 and 6 which focus on the negotiation of caregiving responsibilities in resident and transnational families. Firstly, the women in her study sometimes found it difficult to monitor temporal cues of others' life courses despite the ease and cheapness of long-distance communication and air travel. They were not able to assess the signs that would allow them to time their actions in relation to another's ill-health, for example. Secondly, immigration policy works against the flexibility of Ghanaian family life through its narrow definitions of family, and slow pace of the bureaucratic process, meaning the migrants in Coe's study could not reunify with family members at points of time when they were required to provide care. The concepts of orchestrating care across the life course, sociality and connectivity and their significance to the imagination of possible futures are thus relevant to the analysis of participants' accounts of their decision to migrate (Chapter 4), their desire

and anticipations to care for children and ageing parents (Chapters 5 and 6) and aspirations for settlement, stepwise migration and an eventual return to India (Chapter 7).

The relational aspects of imagined futures are clearly important, but in foregrounding the future, so, too, are structural considerations. As Ingold (2013, p. 735) suggests, 'cutting the imagination adrift from its earthly moorings' renders the imaginary as little more than a 'floating mirage above the road we tread in our material life'. Migration is shaped by and is simultaneously active in shaping the imagination, and Chambers (forthcoming) stresses the constraints and structural conditions that shape such imaginaries. In doing so, he argues that the imaginations of migrants can be influenced and structured to meet the demands of the labour market both domestically and internationally. Several studies on nurse migration, for example, highlight how future-orientations towards nursing and overseas options are influenced by the changing demands of the nurse-importing countries (Walton-Roberts, 2010; Adhikari, 2011; Ortiga, 2014). The selection of nursing as a career and the attendant migration decision can also be understood as triggered by a need to give or receive care, a point returned to in Chapter 4 where participants' accounts of their decision to migrate are discussed. Indeed, Ackers and Dwyer (2002, p. 152) illustrate that the desire to care can be a pivotal issue in affecting the decision to migrate, rather than any 'rational economic', profit maximisation motive commonly assumed in much migration literature. The desire to care for family not only contributes to initial career and migratory decisions, but the longing to be together as a family and the anticipation of future care needs also shape migrants' dreams for onwards or 'stepwise' migration. In making plans and dreaming about the future, overseas nurses often assess their structure of opportunities across multiple spaces (Amrith, 2010; Carlos and Sato, 2011; Carlos, 2013). In Carlos' (2013) study of onwards migration of Filipino overseas nurses, for example, the availability of social and economic integration policies, as well as reunification and citizenship opportunities for the *entire* family were significant factors in the nurses' plans for the future, specifically in dreaming of where and when to move next, and then finally

settle. This suggests that the desire to be reunified with extended family members, and the attendant physical co-presence that this facilitates, is a key factor in the future-orientations of overseas nurses, especially in their decisions as to where to go to next. However, these hopes for future reunification are also influenced by the institutional policies in nurse-importing countries. The countries promising citizenship, family reunification, and good working conditions become the countries that many overseas nurses strive towards. These are arguments that are developed in Chapter 7 through the exploration of participants' plans for stepwise migration and their dreams for an eventual return to India.

The significance of hope, desire and anticipation in migrants' future-orientations suggests that the future is marked by emotions, and that migration can be considered a means of imagining or creating futures (Griffiths, Rogers, *et al.*, 2013). In turn, these dreams, hopes and anticipations are what engender or renew global care chains and often produce and sustain transnational families. For many migrant care workers, emotions such as shame, guilt, anxiety and despair are often involved as they go about their daily lives (e.g. Anderson, 2000; Parreñas, 2001; McKay, 2005; Allan, Cowie and Smith, 2009; McDowell, Batnitzky and Dyer, 2009; Cuban, 2013). Migration can be a humiliating and exploitative experience, and difficulty in controlling their conditions of employment and relationships overseas can generate intense emotions for migrants (McKay, 2005). The shame associated with these structurally shaped experiences is not bounded to the confines of the labour market, but can spill out into other areas, such as family life, and have serious implications for some migrants (Adhikari, 2011). Emotions such as these can contribute to the shaping of imagined futures. Wettergren's (2015) work on shame and forced migration is a good example of this in the migration context, where she highlights the humiliating interactions her participants were subjected to, but also how they enacted emotion work in order to cope with and, in some cases, resist these emotional experiences. Her participants maintained a sense of hope, which hinged on an anticipation of increases in one's status and power in the future, and attempted to

preserve a sense of dignity and self-respect in relation to the external humiliations that shame the subject.

Whilst the contexts of reception differ for the majority of nurse migrants compared to those entering through the asylum system, Wettergren's analysis is potent as it brings to the fore the aspirations and hopes that migrants hold onto when experiencing difficulties. I find Boccagni's (2017, p. 2) definition of aspirations useful at this point; aspirations are 'emotionally thick representations of what one's future *might* and *should* look like, given the present circumstances and the experience of the past as re-codified from the 'here and now'". This understanding includes some of the points made already in this chapter about constructions of the future and their relation to the past and present, whilst also allowing for the inclusion of emotions such as fear, desire and hope. Hope, in this sense, can be viewed as an 'expectant emotion' (Ngai, 2005, p. 210) that rests on 'the capacity for imagination, on a sense of time and of temporal progress, on a desire to believe in a better future or in the possibility that something can change, and to some extent on uncertainty' (Pine, 2014, p. S96). However, Raffaetà (2015) argues that hope is not only a coping mechanism while waiting for a better future. In a similar line to Mische (2009) and Adam's (2008) contention that future-orientations 'do' something, Raffaetà argues that hope is a resource with which migrants' can realise their agency. It thus affects and effects people's lives in the present, and indeed emerges from reflections on the past and present. Hope and aspiration, as temporal and spatial fixes to such experiences that shame or humiliate the subject and as a means through which to practice agency, are empirically explored in Chapter 7.

Whilst future-orientations are clearly relational, influenced by structural contexts and laden with emotion, migrant imagined futures are also shaped by a variety of other factors (Halfacree, 2004; Chambers, forthcoming). Cultural and historical contexts can shape not only what is (or is not) imagined, but also how histories of migration and pre-existing connections contribute to contemporary movements (Chambers,

forthcoming). Kerala has a long history of out-migration, stemming from pre-colonial times when Kerala was a 'fulcrum' of world trade to the more recent trend of Gulf migration since the 1970s (Osella and Osella, 2003). Prior histories of colonialism and migration can shape the collective memory and in turn shape migrant imaginaries, although as Chambers (forthcoming) notes, imaginaries are also shaped, changed and transformed through the very act of migration itself. As was mentioned in the previous chapter, modern-day nursing in India has its roots in British colonialism (Solano and Rafferty, 2007; Walton-Roberts, 2012; Reddy, 2015). This historical and the existing post-colonial relationship between India and the UK, as well as the fact that the UK has been a key site of settlement for the Indian diaspora during the second half of the twentieth century (Ballard, 2002), can be understood as forming part of the imaginary of the UK as a specific destination in the global north for a 'nurse on the move' (Kingma, 2006).

2.4 Conclusion

This chapter has critically engaged with research that relates to the focus of this thesis, introducing the conceptual framework that is the point of departure for my study of Indian-trained nurse migration to the UK. Bringing together feminist research on care chains and transnational care, these different, albeit complementary, literatures bring to the fore how migrant nurses' relations of care must be understood within the context of their navigation of a political economy that contributes to the spatial extension of social reproduction. Their reciprocal, interdependent and asymmetrical caregiving practices and strategies must also be understood within the context of the social and cultural forces shaping their obligations and responsibilities. A broad approach to care is thus necessary to fully incorporate the experiences of overseas nurses — one that can incorporate both their insertion into the global nursing labour market and one that can take account of the multigenerational and multidimensional aspects of transnational family care exchange. Despite the criticism of the global care chains, it remains a valid tool for understanding the 'pump' that keeps the system flowing (Tronto, 2016). The processes underpinning the feminisation of labour, the global political economy, and the relationships between

states need to be considered in order to examine care labour migration. However, in its focus on the commodification of care and unidirectional care flows from the migrant to their stay-behind family, the care chain framework cannot capture the richness of the care relations between migrants and their families around the world. Addressing the overwhelming focus on migrant mothers and their 'left behind' children and extending the research to all migrants and their transnational families rather than just migrant care workers, the transnational care literature brings to the fore the reciprocal care flows between multiple family members, and addresses how these flows change over the life course. This research intends to challenge the prevailing assumption that geographical distance negatively affects family caregiving by emphasising the 'portability of care' (Huang, Thang, *et al.*, 2012; Baldassar and Merla, 2014b). In order to fully understand the spectrum of care relations that migrant nurses are embedded in, we need to draw on these two lenses as they each overcome the others shortcomings: the care chains need the improvement in thinking about familial care and life course that the care circulation lens provides, but we also need to hold onto the 'pump' to make the political economy underpinning the migration of care workers visible.

I have also argued that time is often implicit in studies on care labour migration and transnational care; addressing the future-orientations of migrants reveals the significance of the imagination and aspiration in driving decision-making processes and instigating further migration. These imagined futures are relational, and in the case of nurse migrants, the desire to care for family in the future can shape dreams and hopes towards future migration. Aspirations intersect with life course processes in that the social and cultural forces shaping obligations to care at particular points in time also shape migrants' plans for where they would like to be at specific points in their individual and families' life course. These imagined futures are influenced by structural forces, where the state imposes its own temporal order through narrow definitions of family and rigid bureaucracies. Attending to the temporal and to imagination also draws out some of the emotive aspects of migrant life and transnational care relations. Indeed, emotions are central to the fabric of (migrant)

life and can be understood as a background thread weaving not only through this chapter, but throughout the thesis as a whole. The complex, relational and temporal aspects that are at the core of this conceptual framework point to the need for a qualitative approach that can explore the ways that participants' experience and construct meaning in their lives. In the following chapter I outline and discuss the research methodology, setting out how research with migrant nurses originally from India generates empirical material in response to the questions set out in the previous chapter.

Chapter 3 Methodology

In the Introduction and Chapter 2, I discussed a range of literature and theoretical approaches which highlighted the relational and temporal aspects of the experience of transnational family care in the context of nurse migration. The empirical analyses in this study are based upon material emerging from qualitative in-depth interviews in Scotland and England that I conducted between November 2013 and August 2014. I firstly elaborate on the feminist methodologies guiding this research and the research design of the study before describing how I went about designing and doing the research. In the second section, I discuss how I conducted the analysis of this material generated through these interviews and issues of interpretation. In doing so, I reflect on my position in the research process as a whole, before turning to reflect on some of the challenges I encountered whilst conducting the research. Related to this, in the final section I outline some ethical issues related to the research. A point to reinforce here is that whilst reflexivity is discussed in a discrete section of the chapter, reflexivity has been an iterative process throughout the research and informs all of the above.

The methodology framing my research is founded on the assumption that both the commodification and moral aspects of care play a significant role in the reorganisation of care in the context of migration. When starting out, I did not have a clear sense of the ontological foundations of the thesis, but as the research developed, I was drawn to research that accorded value to care, connection and relationships. Underpinning such research is an 'ethics of care' approach that sees care as 'governed by and enacted through a relational ontology' (Doucet, 2017, p. 20). Such a relational ontology takes as its starting point that individuals exist because of, and through their relationships with others, and thus cannot be regarded as separate, individualised subjects (Tronto, 1993; Sevenhuijsen, 2003; Mahon and Robinson, 2011). According to this approach, relations of interdependence and dependence are a fundamental feature of our existence. The ethics of care is not without its critics though, with early critiques focusing on the dangers of essentialising women and

reinforcing the gender stereotypes constraining women to the private sphere (Ward, 2015). However, Tronto (1993) argues that rather than essentialising women as inherently more caring, a feminist ethics of care approach instead broadens our understanding of what it means to care, bringing it out of the private realm and placing it at the centre of people's lives. The framework thus has the potential to shed light on who gives care, where and why (i.e. the interpersonal and institutional experience of care-giving) as well as revealing the role of political structures in framing or (de)valuing care (Milligan and Wiles, 2010).

Approaching nurse migration from this standpoint underlines the relationality that underpins the various dimensions of the transnational mobility of care. For example, in Chapter 4 I illustrate how the decisions to both become a nurse and migrate are negotiated within a large relational network that includes families, friends and community, whilst in Chapter 7 I discuss how interviewees' experiences in their daily working lives often evolve out of relational moments with others (patients, colleagues, managers). Moreover, in Chapters 5 and 6 I demonstrate how, through the negotiation of care transnationally, participants are not alone in their daily practices—these practices of care are enacted through interactions with others. An ethics of care perspective recognises the importance of nurses caring transnationally, whilst recognising the limitations of purely focusing on caregiving—rather we are in relationships of interdependence throughout our lives. This is not to deny that caring relationships might also reflect dimensions of power and conflict of perceptions and interests (Chattoo and Ahmad, 2008). Rather, as Doucet (1998, p. 8) argues, viewing care within a relational framework that takes as its starting point the importance of close relationships and human interdependence for social and emotional well-being, has the potential to provide a fuller understanding of care responsibility and practices.

Such ontological foundations are complemented by my employment of a feminist epistemology which has informed every aspect of the research:

Feminists engage both the theory and practice of research—beginning with the formulation of the research question and ending with the reporting of research findings. Feminist research encompasses the full range of knowledge building that includes epistemology, methodology, and method (Hesse-Biber, 2012, p. 5).

This definition of feminist research acknowledges epistemology as a theory of knowledge concerned with what counts as legitimate knowledge and what can be known. This approach challenges the idea of objective knowledge by valuing alternate ways of knowing, such as subjective experience and by placing emphasis on the multiple power relationships involved in the research process (Haraway, 1988). What we know, and how we know it, depends on our position in social structures regarding different axes of power such as gender, 'race', ethnicity and class. Accepting the idea that our knowing depends on the politics of our multiple locations and the intersections of identities and social structures that construct these locations challenges the idea of the neutral 'objective' researcher. Epistemology is thus defined not only as 'theories of knowledge' but also as 'theories of knowledge production' (Letherby, 2003, p. 5). In this second meaning, reflexivity is itself an epistemological act. Through being reflexive and open about what feminist researchers do, and the relationship between this and what is known, we seek to make clear the background to the claims we are making. Reflection on knowledge production practices was thus of central concern from the outset of the research process. These were related to my concerns whether I as a white woman could (re)present the experiences of women and men from the global south. I return to considerations of power and the role of the researcher later in the chapter, but what suffices for now is that the research methodology I adopted draws on feminist epistemology that recognises the subjective experiences of participants and the context of knowledge production. In this sense, I do not make representative claims about the nurses' reasons for migration or the consequences of this but instead have designed the research so that the data emerging from my interviews with participants' are their *accounts* of migration, work and family life that are situated in the interview context.

3.1 Research Design

The previous review of theories and literature suggests a direction of travel epistemologically and methodologically. As a feminist research project interested in the relational and temporal experiences of overseas nurses, a research design that enabled participants' to discuss their experiences and relationships over time was crucial. In order to answer the research questions and stay true to the methodological foundations of the research, I therefore decided to speak to people who had experiences of being an overseas nurse in the UK. Yeo et al. (2014, p. 182) argue that the qualitative in-depth interview is an effective way of exploring the ways that participants experience and construct their lives whilst also paying attention to *how* they account for those lives. Interviewing provides insight into how people talk and think about their relationships and ties with others, the meanings they attach to them and how they interpret those relationships. I prepared for the fieldwork period by carrying out a pilot interview with a migrant nurse from Nepal who had experiences of many of the issues that I was interested in exploring in the interview context. The purpose of this interview was to see how the interview schedule flowed, how long it takes and whether some sections were more relevant than others. This resulted in minor changes being made to the interview questions and process, with adaptations being made about how I asked particular questions and prompts. Whilst I recognise that the interview is a representation of a single interaction that shapes the form and features of the data generated, my approach in this thesis views interview data as an important way to better understand other people's lives. The interview 'holds value beyond the context of the immediate research interaction' as it 'includes the participants' explicit interpretations and understanding of events' (Yeo, Legard, *et al.*, 2014, p. 180). The purpose of the in-depth interview is to describe and understand the meanings of central themes in the life world of the interviewees from their own points of view (Kvale, 1996). The qualitative research interview is thus a flexible research technique research in the sense that it allows the researcher and the research participants to adjust interview questions, ask follow-up queries, and omit or reformulate questions. The participant can, on the other hand, emphasise themes important to them, and thus make the researcher aware of other themes and questions relevant to follow up on. Employing the in-depth semi-structured qualitative

interview, I was hoping to gain knowledge about participants' lives, relationships and biographical experiences from their own perspective.

I entered the data collection/gathering phase with a set of assumptions and expectations, based on my immersion in the literature, as well as my personal and academic interest in nurse migration. Shortly after a lengthy trip to India, I was hospitalised for a food-borne illness (parasites, e-coli amongst other lovely infections); due to the initial unknown cause of my symptoms, I was put in isolation and had only the nurses and occasional visits from doctors for company. The regular nurses who cared for me, attending to my daily needs and holding my hand whilst I underwent more tests, were predominantly from India, the southern state of Kerala to be specific. I had just returned to Ireland from that region where I had visited some of the towns and districts the nurses were from, often picturesque rural areas. Despite my illness, my sociological imagination was piqued and I wondered why they had left their homes to come to Ireland as nurses. The women and men caring for me sometimes mentioned the difficulties in being separated from family members too. Although I was not a mother at that time, I had experiences of separation from family whilst working abroad in 2002, and I felt I could relate to some of their experiences of family separation. It was thus through this experience in an Irish hospital that I began to learn more about the phenomenon of nurse migration from India, and it was through this initial encounter that the idea of a research study was born. Moreover, I conducted research for my Masters dissertation on the phenomenon of Filipino migrant domestic work, drawing on a global care chains framework. Based on my reading and these personal and academic experiences, my entrance into the data collection phase was particularly 'sensitised' by the care chains framework and its focus on the reorganisation and redistribution of care in the context of migration. The framework of global care chains did initially guide my choices of who and what to look for and what questions to ask, but I still endeavoured to keep an open mind for unexpected turns and new experiences when I started the next stage of the research process.

3.2 The Research Process

Having introduced some of the methodological and epistemological underpinnings of the research, the following section outlines in more detail the research design choices concerning the 'who', 'where' and 'when' of the research.

Who, Where and When?

The primary source of data for this thesis are 25 in-depth (thematic) qualitative interviews with nurses originally from Kerala who were now working in the UK. Post-interview notes, written directly after each interview, are also relied on as data in their own right. In each of these notes, I recorded my experience of each interview encounter, reflecting on the emotional tenor of the interview, describing the interview setting and writing down what it felt like to be there, listening and talking about care in a research interview. I settled on a purposive snowball sampling approach when designing the research since this was the most suitable way of selecting the right participants for this particular research project. Purposive sampling involves choosing participants to participate in the study who are knowledgeable about the phenomenon being studied, whilst snowball sampling is based on the premise that people with similar characteristics know each other (Bryman, 2015). Participants were thus selected based on whether or not they met the following criteria, and were identified through snowballing;

- Born in India;
- Studied nursing in India, registered as a nurse and had work experience in India and;
- Migrated to the UK from 2000 onwards, with a minimum two years in the UK.

These criteria were analytically informed. For the purposes of this study, only nurses from Kerala were included in the sample, although I was open to including nurses from other regions. This reflects both the predominance of nurses from Kerala in the

Indian nursing profession and Kerala's position as a leading 'exporter' of nurses (see Chapter 1 for the historical foundations of nursing in India that led to the emergence of 'the' Keralan migrant nurse). Taking a group of nurses from a region that features prominently in the global nursing labour market allows for a deep analysis of the nurses' relational experiences and how these experiences intersect with the public, private and social spheres. The term 'migrant nurse' is used to include both those nurses recruited internationally having previously trained overseas and those nurses trained overseas who arranged their own employment in the UK. Both groups were included in the sample. The 2000 onwards time frame was chosen because, as discussed in Chapter 1, it represents the key period under which the UK significantly engaged in the recruitment of overseas nurses, but also includes the period when direct recruitment from non-EU countries stopped and it became more difficult to enter the UK as a non-EU overseas nurse. There was no age criteria in the sample, but the two-year residential requirement was to ensure that participants had some exposure to the themes relevant to the research.

Whilst I initially aimed to focus only on women, a number of men contacted me from the start of the project, and I revised my sampling criteria to include both women and men. Some scholars have pointed out that the focus on gender in migration literature has tended to focus solely on women (Pessar and Mahler, 2003; Donaldson, Hibbins, *et al.*, 2009). This is despite evidence suggesting that there has been an increase in men engaging in migration for care work¹¹ (Kilkey, 2010; Sarti and Scrinzi, 2010; Gallo and Scrinzi, 2016). As gendered migration was a key aspect of the research, and the men met the other criteria for inclusion in terms of education and year of arrival to the UK, it seemed important to include their experiences in the research. Out of the totally 25 interviews I carried out, five were conducted with men. Including men in the sample added to the diversity of the demographic

¹¹ In the nursing context, male doctors in the Philippines are retraining as nurses due to the migration opportunities involved (Brush and Sochalski, 2007). In their research on overseas care workers and nurses in the UK context, Cangiano *et al.* (2009, p. 67) found evidence to suggest an increase of men among recent migrant care workers —31 per cent compared to 13 per cent of UK born care workers were male.

backgrounds of participants as well to their biographical circumstances, situations and characteristics.

The UK was selected as a research site as it has historically been one of the most significant recruiters of international nurses (see Chapter 1). Whilst my initial research focus aimed to sample nurses from all over the UK, it became clear early on that I would face challenges in negotiating access.

Negotiating Access

As mentioned above, the thesis employed a snowball sampling technique to access participants, which is particularly useful when researching potentially hard to reach groups (Merrill and West, 2009). My first attempts to contact potential participants took place in the late summer of 2013. I knew that most of the nurses from Kerala were Christians and assumed they would attend mass and services at churches. However, I was reluctant to approach people at a place where people seek peace, asking if they knew any nurses who had been trained in India. After speaking to academic colleagues, friends and friends of friends to no avail, I got in touch with the pilot interviewee and asked her if she had any nurses in her workplace from India. She had a number of colleagues from Kerala and agreed to ask them on my behalf if they would be interested in participating in the project. She provided me with their telephone numbers, albeit with the proviso that these nurses were extremely busy with managing shift work and family life, so may not have the time for lengthy interviews. Nonetheless, I started to call them, introducing myself and the research, and scheduling visits with them. However, these interviews tended to snowball within the same Scottish city, and in order to avoid a response bias, I had to think of novel ways of contacting others. It is important to note here that geographical location was one factor in possible response bias but of course there are others, not least the characteristics of those who agreed to take part. However, it is impossible to know how these play out.

I began to contact Kerala and Malayalee Cultural Associations¹², which were located in cities and towns all over the UK. I was invited to attend cultural and family days organised by these associations, which took place on church premises. Following celebrations, I was introduced to groups of women, as well as individual women and men. I took the opportunity to introduce myself and my project briefly, asking them if they would be interested in talking to me about their work and family lives in the context of their migration to the UK. When asked why I was interested in nurses from Kerala, I shared my experience in an Irish hospital and my academic interest in the subject. The majority of the women and men I met shared their contact details with me, and said I could contact them for an interview. Their apparent enthusiasm did not necessarily translate into actual participation in interviews, however. Some of the nurses told me that they were simply too busy to spend time talking to me, others seemed a little unsure as to what I wanted from them and what I would do with their stories despite my assurances, and others simply did not answer my phone calls. This process of recruiting potential participants' seemed ethical at the time because I was invited to attend these events by organisers and introduced to many nurses. On reflection, however, there are some ethical issues in approaching people this way. The people running these associations acted as a form of gatekeeper—individuals who provide access to interviewees and reduce possible mistrust associated with the researcher (Creswell, 2007). However, gatekeepers are not neutral to the research. Using a gatekeeper indicates a social alliance and the status and role of the gatekeeper can influence how the researcher is perceived (Sharkey and Larsen, 2005). Although the organisers of events simply introduced me to nurses who were attending these events, some of the people I spoke to on the day may have felt under pressure to agree to an interview due to the social setting and implicit pressure from the gatekeepers. This raises issues about their right to refuse to participate in the study, as well as pointing to the potential difficulty of saying no in different settings.

¹² These Associations describe themselves as non-profit cultural organisations that promote social, cultural, charitable, educational and literary activities among people from Kerala located in cities and towns all over the UK.

Despite these issues, a small number of nurses I met through the Cultural Association events agreed to be interviewed.

In addition to meeting people through word-of-mouth and at community events, I also built up a rapport with the editors of the major online community newspaper, British Malayali, who agreed to do a profile on my research and publish it on their website. This was the catalyst for the majority of the interviewees getting in contact. Once the webpage for my research went live, I received dozens of text messages, emails and phone calls from people interested in the research. Some people did not meet my criteria because they were, for example, nurses' husbands or were currently training as nurses in the UK. Many others did, but from the outset said they did not have the time to do a full interview, but wanted to tell me about their experiences of living, working and caring for family whilst resident in the UK. I wrote up notes on all of these informal chats, and many also confirmed what others were telling me in their interviews, such as the difficulties they were experiencing in the British labour market, their desire to move to Australia because of such difficulties, and how they wanted to bring their ageing parents to the UK but could not due to immigration policy. These informal chats on the phone (as well as at other events) had the role of informing my thinking but, for ethical reasons, were not used as data in its own right since I did not have informed consent to use their stories as material for the thesis. Through the British Malayali advertisement, I also met the husband of a nurse from India who introduced me to friends, directly and indirectly. He subsequently wrote a follow-up of my visit to his home in the newspaper, which resulted in more people contacting me. Overall, this resulted in a wide sample of people with diverse biographies and experiences.

Location of Research

The research is based in England and Scotland - more specifically Northern England and Scotland. I made this choice for practical and analytical reasons. On the practical side, participants from these areas essentially chose me. Having sent out recruitment

letters to community groups all over the UK (Wales and Northern Ireland too), the vast majority of people who contacted me were based in these regions. After the initial burst of participants came forward, the ideological reasons for restricting my focus to Scotland and northern England became clearer. These areas lack the social and economic extremes of the global city of London, but many display the diversity, racial tensions, and class struggles that is characteristic of many British cities and towns. Furthermore, the nurses who arrived at the earlier stages of the recruitment period often said that they were the first members of the Malayali community in these cities and towns, and they worked hard to establish networks and community in these settings. The majority of interviewees were located in urban areas, apart from two nurses who were working in rural parts of Scotland. Lastly, since much of the research on nurse migration in the UK focuses on southern England and London, perhaps because there are many migrant nurses located in these regions, the focus on Scotland and northern England broadens the empirical basis for understanding the experiences of migrant nurses in the UK.

3.3 Conducting In-depth Interviews

The in-depth interviews with participants focused specifically on the key themes that had emerged from my reading and pilot interview—work, family and migration. More specifically, the themes were formed by my interest in how Indian women and men accounted for their decision to migrate, what it was like to work as a nurse in the UK, how they organised family life in the context of migration and what their future plans and aspirations were. To obtain knowledge about these themes, I asked about the participants' age, marital status, education and professional experience and invited them to tell me about their family, both in the UK and anywhere else in the world. This background information enabled me to get some idea about what kind of family the nurse came from and to better understand how they accounted for becoming 'nurses on the move' (Kingma, 2006).

The interviews were thematic and flexible; I had a number of topics that needed to be covered in the interviews but otherwise, I aimed for the interview to be as free-flowing and conversational as possible (see Burgess, 1984). I relied heavily on the interview guide during the first couple of interviews (Appendix B) but as I got more confident in interviewing, I noticed that I focused too much on the guide and felt like it impinged upon the conversational flow of the interview. To avoid this, I developed a list of keywords and some initial questions to remind myself of the themes that I wanted to discuss with research participants (Appendix C), and relied on the interview guide when I needed to prompt more or clarify a question. Shortly after the interview, I would make detailed notes of the interview. This was also where I recorded my reflexive notes on the interview encounter. Although interviews were recorded, I nevertheless tried to reconstruct in these notes some of the main themes that were discussed during the interview. Writing these notes contained some of the initial elements of my analysis, because the data never speaks for itself and descriptions are always 'theoretically impregnated' (Silverman, 2001, p. 69). Based on my rereading of these notes throughout the research process, I made some slight adjustments in the way, for example, I phrased questions or utilised research tools, but these post-interview notes were also analysed alongside the in-depth interviews.

As I was interested not only in interviewees' life histories, but in their accounts of why they migrated, their future aspirations and the changes in their multigenerational relationships over time, temporality was central to the research. Initially, I decided to try to capture some of these temporal aspects of participants' experiences by incorporating a timeline into interviews, a tool I thought would help participants to plot landmark events such as education, marriage, childbirth and migration and serve as an aide for discussing their experiences. However, the introduction of this timeline at the beginning of the interview felt awkward and cumbersome, and the two participants I attempted to use it with were uncomfortable trying to fill it out, which went against the idea of the interviews being as conversational as possible. I thus abandoned them and used the interview schedule and keywords as a basis for the interview: questions included themes regarding the background of the informant,

migration history, their biographical routes into nursing and migration, working conditions and relationships, family and transnational practices (Appendix B). In closing the interview, I always asked about their future plans and hopes. Introducing the critical dimension of time into the study of care migration allowed participants to discuss their 'imagined futures' and sociotemporal norms, as well as the temporalities of maintaining social relations in the context of distance. Whilst there are methodological challenges in 'accessing' the future, this thesis does not seek to get at objective 'truths' and the approach to the future is viewed in a similar way, in that these aspirations are subjective and situated. As Mische (2009, p. 702) argues, 'examining future projections is not to assume that they come true, but to explore the ways they deeply infuse social interaction, albeit in possibly contradictory and surprising ways'.

Each interview lasted between one to three hours, and occasionally I followed up by phone to clarify something that was not clear in the interview transcript. All interviews were conducted in English—the vast majority of participants had a high standard of English, having studied for their nursing qualification in English. I mostly interviewed people in their homes. The everyday intimacies connecting participants to other places and times were evident in this setting: the photographs of family on the walls, the computer with the webcam in the living room, the religious pictures sent from India on the shelving units and the regional food and drinks that participants often shared with me following an interview.

The interview guide I developed focused on themes that I knew might elicit some difficult discussion, such as separation from children or discrimination in the workplace. Based on my reading of, for example, transnational motherhood, and my experience of working with migrant domestic workers as part my Masters research, I was aware of the shame, guilt and loneliness that are common emotional experiences among mothers who are living apart from their children. Indeed, whilst narrating their experiences and discussing painful memories, some women cried and on a

couple of occasions, I too shed tears. When this happened, I offered to stop the interview and apologised for asking them to talk about memories which seemed painful for them, suggesting they have some water or tea. I asked if they would like to continue the interview or bring it to a close. However, everyone wanted to continue talking about it, as some of them claimed that it was the first time they were able to talk about issues such as separation from children, which, despite many of their friends going through similar experiences, was not discussed amongst them. Based on this, I initially thought that these interviews could be read as a reciprocal exchange, encouraging a more conversational rather than one-sided interview, whereby my empathic response would ensure that interviewees could make intimate disclosures. This style of interviewing adheres to what Rubin and Rubin (cited in Yeo, Legard, *et al.*, 2014, p. 181) call 'responsive interviewing' that 'emphasises the importance of building a relationship of trust between the interviewer and interviewee that leads to more give-and-take in the conversation'. At the time of interviews, I understood the intimate setting of the home, coupled with the chosen research method of in-depth interviews and a commitment to being a 'good listener', as providing a space for participants to navigate painful emotions in an ethical and sympathetic manner.

This process of qualitative interviewing is generally seen as benign, where the interviewee has valuable insights and the researcher contributes to a wider understanding of individual's lives and problems. However, as Duncombe and Jessop (2002) point out, close rapport can lead to the research interview moving into a quasi-therapeutic interview. With deeper rapport, interviewees become more likely to disclose more intimate experiences and emotions which, upon reflection, they would have preferred to have kept private from others (Oakley, 1981; Duncombe and Jessop, 2002). This has obvious implications for informed consent, whereby participants' may have regretted sharing aspects of their lives with me. Many of the interviews with participants, especially the women, can be understood as emotionally thick encounters and are illustrative of the necessity of employing research methods that can navigate difficult emotional terrain. However, such sharing of emotional

experiences also underscores the importance of remaining vigilant to the possible harm that can emerge from building strong rapport with research participants. This was difficult in practice. In asking participants about their relationships and attempting to listen to their responses in an empathic way, some reflected that the interview was almost therapeutic-like, but this raises ethical issues about how far I was able to 'manage the consent' of interviewees to participate in disclosing more or less private and intimate information (Duncombe and Jessop, 2002). However, it is also important to note that participants were not totally powerless and they could withhold their participation or full disclosure. Despite such concerns, the interviews yielded rich accounts of the migrant nurses' migration, work and family lives.

3.4 Transcription and Data Analysis

Whilst continuing to conduct interviews, I began to transcribe interviews. All of the interviews were transcribed in verbatim and fully, and my interview notes aided this process by helping me recall the interview setting as well as my own reflections on how the interview 'felt'. The original recordings were often referred to in order to check my impression on some passages when writing my analysis chapters. Since the 25 interviews were done over an eight-month period, each of which lasted between one to three hours, it made sense to start the early stages of analysis whilst continuing interviews. Although this thesis did not employ a grounded theory approach, I nevertheless drew on some of the data analysis methods recommended by Charmaz (2006). Rather than gathering all the data and leaving the analysis to the end, instead I analysed data as an ongoing process, writing analytical memos as I met and interviewed more overseas nurses, and allowing these memos to form the basis of some of the initial emerging themes. Charmaz (2006) recommends writing spontaneous and informal memos from the outset. By way of illustration, a short memo that I wrote following the transcription of the first five interviews is provided in Appendix D. In this memo, I discuss some initial ideas about the different ways that men and women account for their entry into nursing.

After the transcription of all of the data, I read through all the transcripts and post-interview notes twice, highlighting words or passages that I found to be interesting, 'pawing' the transcript (Ryan and Bernard, 2003) to get more acquainted with the data. I prepared a summary of each interview to summarise the main context for reference at a later stage, incorporating some of the post-interview notes that held more detail on the interview context. Following this, I entered the transcripts and post-interview notes into a computer-assisted data analysis software (QSR Nvivo version 10) and began coding. Coding is a process of defining what the raw data being analysed are all about, involving identifying the passages of text under some theoretical or descriptive labels (Gibbs, 2007). The method of coding chosen depends on the nature of the data available for analysis and the kind of research framework employed (Silver and Lewins, 2014). As described by Gibbs (2007, pp. 4–5), inductive coding works up from the data level, whilst deductive works down from the theoretical. Silver and Lewins (2014) conceptualise inductive and deductive approaches as existing on a continuum, with many researchers employing both approaches iteratively throughout the whole process of the research project.

This study used a thematic approach to data analysis and drew on both inductive and deductive approaches. In order to conduct a thematic analysis of the interviews, I began to code the text in NVivo based on the themes that had emerged through the analytical memos and rereading the transcripts. In doing so, I interrogated the transcripts for evidence which spoke to the literature reviewed in Chapter 2, as well as evidence that did not necessarily accord with these approaches. Some examples of the kinds of codes used were 'formal care work', 'familial care', and 'agency'. Each code included various other sub-codes such as 'decision to become a nurse', 'economic support' and 'financial autonomy'. Whilst NVivo encourages and facilitates such questioning and rigour, the codes, especially my *in vivo* codes, were developed from and remain grounded in my source material. NVivo allowed me to develop an evolving set of analytical categories, and break complex data and stories down into elements of meaning, before re-assembling these elements in a way which permitted some sort of discussion.

In the process of reading, listening and transcribing the interview data over several months, writing the analytical memos, and re-reading some key literature, it became apparent that certain central themes were emerging. These related to the multigenerational relationships underpinning both nurse migration and their transnational care practices, alongside the changes in this over time. These points went on to frame a subsequent re-coding of the transcripts. I organised the codes in chronological order following the various stages of nurses' migration processes and experiences, which was also guided by my research interview guidelines. In focusing on temporalities, however, the many roles overseas nurses play over the course of a lifetime emerged through codes such as 'nurses as children' and 'nurses in old age'. Focusing on the evolution of care needs over the life course, in turn, drew my attention to the significance of their re-migrations and internal migrations. Thus, although the thesis is organised chronologically, this linearity is probed throughout and the temporal aspects of caregiving and care-receiving roles, as well as caregiving arrangements, and their variations over the migration cycle as well as over the life course, are foregrounded.

Reflexivity, Ethics and Consent

At the beginning of the research process, I constantly reflected on my positionality and how this might impact on the research process and whether I could (re)present the nurses' stories in an ethical way. This was especially troubling given that Western feminist researchers have historically portrayed 'the third world woman' as oppressed and without agency and placed themselves in positions of superiority (Mohanty, 1988, 2003). Reflexivity is one strategy to guard against exploitative research. However even well-intentioned researchers can do harm if they are not willing to scrutinise their own role in the research process, as illustrated in the earlier discussion of the potential harm involved in doing 'rapport' too well (Duncombe and Jessop, 2002). Bearing in mind the historical power inequalities that are present between the global north and the global south, as well as the power differentials

between the researcher and participant, I attempted to navigate such disparities in a few ways. Initially, I reflected on some of the more visible attributes such as race, ethnicity and gender that marked the boundary of insider/outsider (Mullings, 1999; Liamputtong, 2008). I thought about how I as a white, unmarried, (then) childfree, woman from a Catholic-Irish working-class background conducting research in Scotland and Northern England, could go about studying women and men from similar racial, ethnic, religious (and varied class) backgrounds with diverse migration histories. How could these differences impact on the research process and how might I actually do reflexive research? There has been much published on the negative impact of some of these visible aspects of identity on a research project (Phoenix, 1994; Lundström, 2014). In an attempt to engage with some of these potential impacts, I thought how I might be able to seek shared spaces not wholly informed by identity-based differences (Mullings, 1999).

Presenting myself as someone who was knowledgeable about nurse migration from India, but wanting to know more, was one way. Viewing the interview as a reciprocal interaction where the interviewer shares personal details about themselves, is important in feminist research approaches (Oakley, 1981), although as outlined above, this approach carries with it some necessary cautions. Most of the interviewees asked me a lot of personal questions prior to beginning the interview, typically prior to the formal recording of the interview, but also during or at the close of the interview. Through the process of listening, empathising, and validating, shared experiences and connections are established between the researcher and the researched. During the pre-interview exchanges, I usually told participants that I had visited India multiple times, often knowing the region they were from. This led to numerous stops during the interview, where participants asked me if I knew what they were talking about, or had encountered a particular phenomenon in India. Most participants and their family members were interested in my marital status, my family living in Ireland and my religion. Unmarried and living with my partner at the time, many marvelled at the fact that I was not married and told me to put pressure on my partner to marry me. For some who missed the support of family and the

close-knit communities common in India, my own (admittedly privileged when compared to my interviewees) distance from my parents and siblings who were in Ireland and Australia was something I felt I understood as I too engaged in practices of care from a distance. This 'give-and-take' also moved beyond the boundaries of the interview context sometimes, for instance when I agreed to help a participant with their academic work for their nursing degree by proof-reading essays. Emotions were key here in helping me consider what was appropriate in different interview situations, and reflexively reflecting on how my own values and assumptions influenced these decisions and analysis. However, as I reflected more and more on the research process as a whole, from design to interviews to interpretation and writing up, I realised I could never be fully aware of my positionality, how they have manifested during the research project, how others interpret them, and how they might have influenced the research participants (Hopkins, 2009).

'Uncomfortable Reflexivities'

Feminist geographer Gillian Rose (1997, p. 309) argues that the subjective researcher-self that many feminists reflect upon 'seems at some level to be a transparently knowable agent whose motivations can be fully known'. She argues that this transparent known self then looks outward to the world, chronicling its position in the arenas of knowledge production, placing itself within the relations of power, where 'the circumstances surrounding data collection and analysis are made explicit' (Dyck 1993, 53-54 cited from Rose, 1997, p. 309). This is a double reflexive move, all resting on the notion of a complex but knowable space. Rather than engaging in this, Rose calls for engagement with other forms of reflexivity. Drawing on this in her reflections on insider/outsider research, Mullings (1999) suggests that an alternative way of practicing reflexivity is to 'recognise the extent to which the interview process is often one where both researcher and those who are the subjects of research create versions of themselves that are re-interpreted and re-presented in different ways. In such a situation researchers should be able to point out the uncertainties and gaps in interpretation that necessarily accompany the interview process' (1999, p. 348).

In the interviews, these uncertainties and gaps were often located in the gulf of silences, awkward encounters, embarrassing moments and other spaces that were saturated with emotion and feeling. Bondi (2005, p. 235) notes the mutability, fluidity and multiplicity of feelings in the research process and suggests that these changing emotional experiences only become apparent when researchers' ordinary 'flow' of feeling is interrupted by, for example, fear or persistent anxiety. Paying attention to emotions as relational (Burkitt, 2014) and the emotional tenor of the interview as constructed in the relational moment is one means of pointing to some of the gaps and uncertainties in interpretation identified by Mullings (1999). This helps develop a reflexive research practice that goes beyond both the transparent known self and the endless self-observation encapsulated by Stanley and Temple (2008, p. 278) in their critique of self-narrated description as the practice of reflexivity ('I went there, did this/that, they did/did not like me, it was hard'). Pillow's (2003) 'uncomfortable reflexivity' is one way where researchers can situate themselves and draw on the spaces 'between' the researcher, the researched and the social world. Uncomfortable reflexivities are 'messy' and present the 'uncomfortable realities of doing engaged qualitative research' (Pillow, 2003, p. 193). Such investigations create discomfort for the researcher, seek to know while at the same time situating knowing as tenuous and enable exploration of representations of ourselves as researchers. Reflecting on such moments of discomfort in the research encounter can also contribute to the substantive focus of research (Bondi, 2005).

One example of discomfort in my research that informs the substantive focus of the research can be found through my reflections on an encounter with one of the nurses and their account of their private childcare arrangements:

A woman of about fifty to sixty years stood by the stairs of the house wearing a traditional Indian nightdress as I walked into Denny's hallway. Denny, a 33-year-old male nurse from India who I was about to interview, walked straight into the sitting room and as I took my shoes off in the hallway, I said

hello to her, thinking her to be Denny's (older) wife. She smiled a shy smile at me and looked away, before running up the stairs at the sound of Denny's wife, Bintu, saying hello to me from the sitting room. Denny then came out into the hallway and locked the door, putting the key in his pocket, which I thought was a little strange at the time. I went into the next room and in the midst of the introductions, welcomes, tea and presumptions that the older woman was one of their mothers, I forgot about the woman standing by the stairs. (*post-interview note, 16th November 2013*)

Denny introduced me to his wife, who was also working in the UK as a nurse originally from Kerala, and their young son before we sat down to do the interview. After discussing his work and migration history, the interview moved on to asking him about how he organised childcare. Denny said that after a year of struggling with childcare and shift work, he and his wife decided to bring a domestic worker from India to live with them. This was the woman I had met at the entrance to the house. The context leading to their employment of this woman is discussed in more detail in Chapter 5, but for now it is worth considering that Denny's employment of the domestic worker was a household strategy that many in the global North use to achieve better work-life balances (Williams and Gavanas, 2008), as well as a household pattern that is quite common in India (Ray and Qayum, 2009). I was surprised by this, however, since the family lived on a working-class housing estate in a large Scottish city and Denny had mentioned the difficulty of paying for his mortgage and other expenditure, alongside his father's healthcare expenses, on his NHS Grade 5 wages. This raised questions for me such as to how could he afford the cost of a live-in domestic worker? Moreover, Denny's discussion of the woman on the stairs was strained and clearly uncomfortable for him, signalling to me that something was awry. At one point when I was asking him about his employment of the woman I had briefly met in the hallway, Denny physically moved his body to the other side of the couch and only returned closer to me when the interview moved on to a different subject. His visible discomfort was disconcerting for me and I felt awkward and embarrassed, not sure where to go next or how to salvage the rapport we had built up until this point, and guilty at causing him discomfort. I was also interested in what this might mean sociologically since his employment of a migrant domestic worker seemed an unusual practice. But I was simultaneously worried

about the possible precarious situation of the domestic worker, with the locked front door leaving me feeling very unsettled, whilst also feeling guilty about thinking badly of Denny and Bintu because they seemed like nice people and were so helpful to me.

This interaction clearly points to some of the challenges in doing research in people's homes, but what is its relevance to the research? When I turned to the interview transcript, there was in fact very little discussion on the subject of this domestic worker. The exchanges around Denny's employment of the domestic worker are instead to be found in the post-interview notes:

He literally just said nothing, stared at me with a blank expression on his face, it was really awkward. So different from what went before and after that part of the interview, where there was laughing and joking. It was actually quite strange, his face just went blank and his mouth shut tight—I feel awkward/embarrassed just thinking about it, like I've made a big faux pas. (*post-interview note, 16th November 2013*)

The emotion work of research is very clear here, clearly embodied in the sense that I could feel the tension, awkwardness and embarrassment running through my body, hot and cold, and it is also clearly relational—this was something happening *between* us. Laurier and Parr (2000, p. 99) argue 'acknowledging emotions and emotional exchanges orientates us *differently* within our research interviews'. Although there is little extrapolation in the transcript on the subject of the migrant domestic worker, the data is all in the relational encounter in the interview context. Reflecting on this and the emotional tenor of the interview encouraged me to think more deeply about the intersectional aspects of care migration and develop the argument that migrant women (and men) can be simultaneously providers of care work in public spheres and employers of care workers in private spheres. It also brought the perceived power of the state into the research encounter, whereby I implicitly raised questions about the legality of the employment of the migrant domestic worker in an interviewee's home. I had initially thought that the domestic worker was Denny's

wife so may have shown surprise when he told me who she was which may have made him uneasy, especially since I was a researcher in his home enquiring about a person who lived in his household under a fairly restrictive visa. Of course, Denny may simply not have wanted to talk about this at all. However, the 'actuality' of the researcher writing about what it felt like to be there in the interview context is less about claims to the truth, but more about 'presentness' and the sense of it happening now (Brownlie, 2011). Indeed, Pillow (2003, p. 193) says that qualitative research could benefit from leaving uncomfortable realities at the doorstep of the reader without trying to resolve them. Reflecting on these emotions and the messiness they present in terms of interpretation thus sheds light on some of the more substantive issues but they cannot be treated as the final say on the matter.

Although Denny's situation was unique in one sense, the embarrassment, shame and other emotions that often emerged out of relational encounters in other interview contexts also helped me in both reflecting on my own position in the research as well as aiding my analysis. It is useful therefore to think about 'reflexivities of discomfort' (Pillow, 2003: 181) here—'incorporating a reflexivity that accounts for multiplicity without making it singular and that acknowledges the unknowable without making it familiar'. This example is illustrative of how an exploration of emotional dynamics in interview relationships can be used as data to deepen understanding of both the interpretive process and the emotional content of nurse migration alongside caring for family in the context of migration, as well as the power relations of the research encounter.

3.5 Ethical Considerations

According to the ethical guidelines of University of Edinburgh's College of Humanities and Social Science, this research falls into level one. No vulnerable patients (or people) were involved and interviews and observations were carried out in the participants' social settings and not in their workplace settings. Moreover, the interviews were conducted when the nurses were off duty. However, this does not

mean that there were no ethical challenges. Whilst ethical considerations are implicitly discussed throughout this chapter, from my choice of research method to my reflections on my own role as a white woman conducting research on migrants from the global south, and my reflections on power in the research context, more needs to be said regarding the ethics of the research. In this final section, I specifically outline how informed consent, anonymity and confidentiality and transparency were addressed through the research process.

Informed Consent

Access to research participants and informed consent are two closely related issues (Smyth and Williamson, 2004). Throughout the research process, I reflected on whether potential participants felt they could refuse being interviewed (see earlier discussion on accessing participants through community events). Whether they understood fully what my research was about was also of concern. In order to explain the nature of my research briefly, I created a one-page information sheet (Appendix E) and gave this to people who seemed interested in the research. Once an individual agreed to participate in the study, I would re-send them the information sheet in case they wanted to ask any questions before our interview; participants received this information by email or I would hand it to them personally in cases when the interview was to take place soon. Before sitting down to interview, I went through this information sheet and offered several opportunities to ask questions about the research. At this point, participants were asked to sign an informed consent sheet (Appendix F) that explained the purposes and objectives of the study and outlined that participation is voluntary and anonymous so that the participant may withdraw at any time without having to give any explanation. Some participants read through the informed consent sheet very quickly and signed it, whilst others read through it very carefully and asked for clarity where something was unclear. No-one who agreed to participate in the research refused to sign it or withdrew from the study.

Whilst this seemed mostly successful, my attempts at being open and transparent about the nature of my research was unsuccessful on one occasion. When initially talking to Shobha on the phone, I gave her the background to the research and told her I would *not* be writing a report to the NMC based on my findings when she asked if this was one of my aims. Upon meeting and going through the information sheet and consent form, Shobha immediately talked about the unfairness of the introduction of new English language requirements for non-EU nurses (see Chapters 1 and 7). These new language requirements acted as a barrier to her entry into the nursing profession in the UK and she described feeling 'stuck' working as a carer in a nursing home. She followed this up with 'when you will put everything into the NMC, hopefully things will change' to which I replied 'Shoba, as I said, I don't think my thesis will really help change the rules. I'm sorry'. Similar sentiments that I would or could be an advocate for her and others like her were expressed at various points of the interview, illustrating the difficulties of maintaining transparency in research of this nature. Similar to Bondi's (2005) feelings about not being able to advocate for her doctoral research participants, I felt guilty that I could not offer her anything in return for her valuable time and her sharing of her story with me, and resolved to try to ensure that future participants knew fully that the research was highly unlikely to lead to any change in their immediate circumstances.

Confidentiality and Anonymity

Considerations regarding confidentiality and anonymity were critical to ensuring participation in the interview (Wiles, Crow, *et al.*, 2008). I decided to anonymise because of the sensitive material that was under discussion, in terms of work and family life, and indeed, many interviewees asked if they would be identified in the research prior to agreeing to participate. This was important because the nurse participants often disclosed events or incidences that are highly sensitive. In light of this, anonymity and confidentiality became two important ethical pillars in this research. To this end, to protect the anonymity of participants, I engaged with a process of anonymisation—changing all their names and the names of family members and other third parties mentioned in the interviews, as well as the names of

places of work and their exact location in the UK. Moreover, due to my snowball recruitment strategy, some of the participants in the study know each other. To avoid a situation where participants were able to identify each other, I entered the Malayali migrant nurse community several times, from different places and at different points in time. When detailing specific routes of migration and years, I took care that there was not too much information that could lead to identification e.g. detailing movement within India to the Gulf to the UK and movement within the UK. Furthermore, I deliberately omitted some identifiable characteristics such as their exact age, the precise length of time in different countries, or the number of children they have. To sustain confidentiality, all the raw data related to this study are saved in a password secured laptop computer and will remain there until 2018, after which it will be destroyed. All of this was communicated to the research participants in the Information Sheet and Consent Form, and hence from the beginning of the research.

One encounter during the research process made me seriously consider whether I should deliberately break confidentiality. One of the participants revealed during the interview that a regular gap in care meant that he and his wife would leave their infant child alone every morning for up to thirty minutes (see Chapter 5 for more discussion on this care gap). I was very concerned to learn that such a young child had been left on their own. After the interview, I had to seriously consider the ethical implications of knowing this and consider what I would do if I learned the child continued to be left alone. After re-reading literature on confidentiality in qualitative research (BSA, 2004; Wiles, Crow, *et al.*, 2008), and policies on leaving children on their own¹³, I had a discussion with my supervisors and a social worker colleague. This led to the conclusion that if I encountered anything similar in the course of the research, I would have to break my guarantees of confidentiality and anonymity, due to the potential harm that could come to such a young child being left unsupervised at home. I thankfully did not encounter anything remotely similar to this situation

¹³ The law does not state what age you can leave a child on their own, but it is an offence to leave a child alone if it places them at risk. The National Society for the Prevention of Cruelty to Children (2015) says that babies, toddlers and very young children should never be left alone.

during the remaining data collection period, so did not have to do this, but consider it important to include nonetheless.

This chapter presents the research design of the study and my choice of research methodology. This research question guiding this thesis calls for a methodological approach that can reveal the changing practices of transnational caring in the context of nurse migration whilst remaining sensitive to the experiences of migrants. The methods employed in this thesis were thus chosen to facilitate an in-depth consideration of the intersections between migration for care work and transnational familial care over time, through an empirical emphasis on Indian migrant nurses in the UK. The use of in-depth interviews allowed for participants' accounts of their migration, work and family lives to emerge, whilst the relational lens embedded these accounts within relationships that shift over time and space. The next four chapters offer empirically-based explorations of Indian nurse migration to the UK at different points in the overseas nurses' migration trajectory. This migration trajectory in turn loosely corresponds to particular stages of a participant's life course. Drawing on the interviews described in this chapter, Chapter 4 explores Indian women and men's accounts of becoming 'nurses on the move', while Chapters 5 and 6 provides a closer look at the practice of multigenerational transnational caregiving amongst a range of family members following international migration. Chapter 7 draws on participants' descriptions of their working lives and links these experiences to their plans and hopes for the future.

Chapter 4 Becoming a 'Nurse on the Move': Relational, gendered and life course migrations

In this first empirical chapter I examine how the Indian-trained nurses in my study account for their migration to the UK. I look at their multi-layered and relational accounts for their entry into nursing and their subsequent migration and how these different factors led to individual and family-based decisions. The analysis shows that whilst the potential for migration shapes the decision to enter nursing, and as such could be construed as a 'rational' strategy, these migrations are not the simple outcome of instrumental calculations. Rather, they are multi-layered, inflected with emotions and tensions, and are often ambiguous and ambivalent. Baldassar (2007a, p. 280) argues it can be difficult to unravel the political, socio-cultural and economic reasons for migration. Nevertheless, common factors emerged in participants' accounts of their journeys to the UK, with gender, life course and their relationships especially relevant in shaping migration decisions and patterns.

Patterns of migration and exchanges of care between migrant nurses and their 'kin back home' unfold in particular political, economic, cultural and social contexts that have to be considered in order to better understand the complexity of nurse migration and transnational care. As explained in Chapter 1, the British state's most recent recruitment of overseas nurses developed alongside a boom in nurses training for 'export' in India (Walton-Roberts, 2010). This leads to particular patterns of migration and shapes orientations towards potential destination countries. Addressing the research question 'how do Indian nurses account for their decision to migrate', I turn away from theories depicting migrants as instrumental actors, calculating the costs and benefits of migration, assumptions that continue to be employed in analyses of migration (Massey, Arango, *et al.*, 2005). Rather, accounts of migration decision-making are frequently, as Raghuram (2009) suggests, impulsive, complex, chaotic, contingent, conditional and coercive. By focusing on nurses' accounting of their decisions to become 'nurses on the move', I demonstrate in this chapter how

such decisions are embedded in relations of care and socioeconomic and cultural structures. Participants train as nurses and leave India to meet both family and personal expectations, and are influenced by friends, family and neighbours embedded in, as discussed in the first chapter, Kerala's historical culture of migration (Reddy, 2015). Furthermore, both training as a nurse and engaging in international migration requires family support and effort. Thus accounts of migration must also be discussed in the context of understanding nurses' family dynamics. This is particularly important in the South Asian cultural context (Thapan, 2005) where Nair (2012, p. 4) points out that 'family is in the minds of these nurses in the present and in their plans for the future'. Paying attention to the ways in which family and kin relations influence, enable and restrict participants in their nursing journey also foregrounds interdependencies across the life course, as well as gender, age and position within the family. A focus on transnational families and their caring practices thus has the potential to provide context for the decision to migrate and the role that families, communities and kin staying behind have played in such decisions (Ryan and Evergeti 2011). In this chapter, I discuss how the cultural norms and relational influences that formed the context for participants to enter the nursing profession are gendered; women and men account for this in different ways. Moreover, in considering nursing as a family 'investment', albeit an emotional as much as a financial one, it suggests the importance of considering the family history and background. This underlines the importance of viewing nurse migration within a timeframe that goes beyond a singular moment of decision-making, and the duration of their migration journeys.

In the second section of the chapter I discuss participants' choice of destination, since the nurses' described how they weighed up their individual and family's prospects in a number of potential destinations. Whilst an increase in all kinds of travel and mobility are key characteristics of the contemporary period of globalisation (Sheller and Urry, 2006), not everyone has the same freedom to move (Bauman, 1998, p. 2). As such, we need to understand the conditions under which such movements take place. As the nurses in this study are a group of people who

have several countries open to them as potential destinations, examining some of the circumstances that influence their choice of destination can reveal much about nursing in a globalised world. It also highlights some of the journeys 'in between' the UK ('here') and India ('there') (Burrell, 2008a). In doing so, it draws our attention to the national borders that migrant nurses encounter and how they negotiate these as they strive to meet their individual, professional and familial aspirations and hopes. Looking at these multiple borders also highlights their insertion into nursing labour markets in different contexts, and illustrates some of the privileges that this group of skilled care workers from the global south hold.

Although the commodification of care looms large in the background (because of how it is treated in the context of labour market exchange), I bring to the fore an understanding of care as 'generalised, asymmetrical reciprocal exchange governed by the moral codes of family and kinship ties, that is, the moral economy' (Baldassar and Merla, 2014b, p. 32). Whilst these are different definitions of care, they can and do coexist, especially when, for example, considering the interaction between economic activities and intimate transactions (Zelizer 2005). Moreover, it is precisely because nursing care is commodified globally that nurses engage in asymmetrical reciprocal care exchanges in this way. This chapter also shows, however, that obligations to care are simultaneously central to the nurses' accounts of why they became nurses in the first place, suggesting that migration for care work both shapes and is shaped by family care relations. Similarly, by viewing nurse migration as a family investment, we are directed back in time, and by seeing such migration as oriented towards participants' own futures, we are oriented towards the yet to come (Dalgas, 2016). This illustrates the importance of paying attention to life before migration, the subject of the current chapter, as well as their imagined futures and aspirations, the focus of Chapter 7.

4.1 Multi-layered Migrations from Kerala

The Entanglement of Nursing and Migration in Kerala

Despite the varying backgrounds of participants in this study, accounts of their entry into the nursing profession was closely bound up with the desire to migrate¹⁴, as suggested in the following extracts in response to my question 'why did you leave India?';

Everyone's ambition is to go abroad and make some money, isn't it? Each and every single nurses, the ambition is to go abroad, go to the Middle East, get some money. (Joji)

So I always wanted to go abroad. That was my [pause] that was the motive, why I went for nursing. Because I wanted to go abroad, that was always my intention. (Mary)

These extracts capture a sentiment repeated across the sample. Participants described having a strong desire to go abroad, or at least to engage in internal migration, and this was at the root of their entry into nursing. It is difficult, therefore, to determine which decision was made first, a point noted in research focusing specifically on Kerala nurse migration (e.g. George, 2005; Walton-Roberts, 2010, 2012; Nair, 2012; Johnson, Green, *et al.*, 2014) as well as nurse migration from, for example, Nigeria and the Philippines (e.g. Choy, 2003; Aboderin, 2007; Guevarra, 2010) and Irish nurses in Britain (Ryan, 2008a). Indeed, George (2005, p. 52) points out that after the Keralan nurses in her study had graduated, 'the question was not whether they were going to emigrate, but where'. The material gains to be had from going abroad are evident in Joji's quote, but there are several other underlying reasons in participants' accounts of why they became a 'nurse on the move', not least because nursing in India has been defined by low pay, low staff-to-patient ratio, as well as the threat of verbal and physical abuse (Nair, 2012). Gill (2011) argues that this underpins India's position as one of the primary recruitment grounds for overseas employers (particularly in the UK and US).

¹⁴ Of course, this is not reflected in all nurses from Kerala—this finding is particularly skewed since the sample are nurses that actually migrated; nonetheless, Walton-Roberts (2010) found that over two thirds of student nurses intended to go abroad after the completion of their nursing studies.

As explained in Chapter 1, the nursing profession in India has historically suffered from poor status. This negative status and the perception that nurses garnered greater respect overseas was also a central 'push' factor in the majority of participants' accounts of their migration. This finding supports previous research on Indian nurses and their migration aspirations (Percot, 2006; Thomas, 2006; Hawkes, Kolenko, *et al.*, 2009; Nair, 2012; Johnson, Green, *et al.*, 2014). Indeed, many participants described never intending to work in India when making the decision to become a nurse because of their awareness of the low status of nursing, and the accompanying low wages and bad working conditions. Participants also described a range of reasons for their decision to become 'nurses on the move' that extends beyond the workplace. Percot (2006) and Nair (2012), in their research on nurses from Kerala, argue that training as a nurse with the intention for migration has become a popular 'life strategy' amongst women from Kerala, where stages of their personal lives are built into the various stages of nursing. As Nair (2012, p. 123) puts it:

Nursing is a 'package' that contains a job, travel opportunities, some individual freedom, marriage and wedding plans including 'family planning'.

Whilst the notion of a 'nurse strategy' could be understood as a future-oriented guiding principle underpinning some participants' entry into nursing, this implies an instrumentality that obscures the multi-layered, temporal and relational aspects of nurse migration. Embedding participants' accounts in their biographies and family backgrounds makes visible the diversity and agency of nurses and their families, stretching not only into the past and present, but also into the future, suggesting that the reality is more messy, nuanced and diverse than Percot and Nair suggest.

Accounting for Migration: 'I Migrated to Support my Family'

A story of economic precariousness spurring labour migration resonated among most of my interviewees, both the women and men. The majority of these nurses responded to my questions about their migration with stories about the economic

insecurities they faced as members of lower- and middle-class families in India. This is not surprising given the economic context in Kerala, as mentioned in Chapter 1. Despite its reputation as being a 'paradise of social development/human development/social capital' (Devika, 2010, p. 752) and as a 'model' for development, the state of Kerala has one of the highest rates of unemployment in India and historically has suffered similar rates (Reddy, 2015). Many of the participants in my study responded to these conditions, as well as to multiple international recruitment drives, by training as nurses. However, even when describing their migration as economically motivated, it was not merely about making decisions based on calculations of the financial costs and benefits of migration. Family, both present and future, were central in participants' accounts of why and how they became a 'nurse on the move'.

Both training as a nurse and engaging in migration requires family support. Whilst nursing schools used to be government run, free and often offering stipends, most nurses must now register in private schools where fees may be quite high (Percot and Irudaya Rajan, 2007). All of the nurses in my study received financial and emotional support from family members and kin whilst they pursued their studies, and subsequently engaged in both internal and transnational migration. Jenny, for example, was supported by family members to become a nurse, as she missed out on a scholarship and had to pay fees, which her immediate family, namely her father, could not afford. The family networks she drew upon to financially support her pursuit of nursing are illustrated in this extract:

There were relatives, aunties, uncles who were very supportive of me, because I was the eldest grandchild of the family. So they were very supportive, they've always been very supportive of me, and my education. I'm in a family where if anyone has any problems, anyone will support. And this is kind of part of the Malayalee community, and it's there in Indian communities too. Everybody will come around. So my four years, a BSc degree nursing programme, was helped by so many of my family members, so my Dad put a lot of effort into it, sometimes my uncle helped, sometimes my auntie helped.

Jenny describes the 'Kerala' and 'Indian' norm of reciprocal support that facilitated her entry into nursing, suggesting that becoming a migrant nurse is not merely about family economies, but is also underpinned by a moral obligation to support family members. Support for their studies and migration(s) from extended family networks was common amongst most nurses in my study. Family members and extended kin were also described as providers of information about nursing as a profession, nurse training and the attendant migration opportunities accompanying nursing. As well as providing financial backing for their nursing education, these familial networks were thus highly influential in shaping participants' decision to enter nursing. This is not to suggest, however, that these relational influences were without tension and conflict.

The tensions involved in the intertwining of nursing and migration, and the family decision-making underpinning not only migration, but the initial step of nursing, are illustrated in the following extract. Leela is from a self-described 'low-income' background, and had an aunt who was already working abroad as a migrant nurse:

To be honest, I didn't want to become a nurse (laughs). My father has two sisters and one of them is a nurse and she was in Kuwait at the time when I was finishing my studies. So when it came time to decide what to go for, so it was the pressure from my auntie. You know, she was pressuring my father because she was saying if I wanted to get a job after my studies, then I should become a nurse. So I could help the family, see financially we were not so good. But I didn't want it, so the first year, you after six months we had a review asking if we were enjoying it or not. And I really wanted to leave. But I was asked to stay by the family. But now I really like it. So it wasn't a bad decision they made for me.

Leela's description of her entry into nursing suggests that her training was a 'family investment', ensuring the social protection, and hence, social reproduction of the family (Locke, Seeley and Rao, 2013). Migration was strongly encouraged by her family through their insistence that she train as a nurse, just like her Kuwait-based aunt. Although other interviewees were also from families of nurses (some of whom

had their education paid for by remittances) very few described the pressure that Leela felt from her family to become a nurse. Indeed, in Pothan's case, his mother who was a nurse was vehemently against it, but he went against her wishes and became a nurse because he dreamed of working abroad. Nonetheless, these networks were highly influential in family and individual decision-making across the sample as a whole.

The ability to materially support family, discussed in more detail in Chapters 5 and 6, can be understood as a form of 'care' because, as some scholars have argued, sending remittances shows care and commitment to the family left behind (see for example Zelizer, 2005; McKay, 2007; Cabraal and Singh, 2013; Singh and Cabraal, 2014). Indeed, remittances and economic investments can have multiple meanings:

In the Indian family, money is a medium of care and relationship. Money is ritually gifted at births, marriages and deaths to symbolise relationship. Money circulates between parents and adult children...Money is an important way for parents to express care for their children and for children to express their filial piety...Receiving money from children is testimony to being a good parent with filial children. Sending money home becomes one of the important ways of displaying family relationships (Singh and Cabraal, 2014, p. 223).

Thus the ability to earn, to send money to parents and to provide money to (potential) children is an important way of 'doing family' in the Indian context (Singh, 2006; Singh and Cabraal, 2014). The need for this display of family relationships is greater when the family is separated across borders (Cabraal and Singh, 2013), although, as discussed in Chapter 7, the pattern of remittances and direction of money are also open to change across the life course and generations.

Dalgas (2016, p. 202) argues in her study of Filipino au pairs in Denmark, that as well as being a medium of care, sending remittances also means participating in economic collectivities. Such collectivities act as a social security net, especially in

societies with weak or non-existing welfare regimes. Some participants, particularly those from poorer agricultural backgrounds, explicitly framed their migration as a nurse in terms of the lack of social services available in India. Gaya, for example, told me that she trained as a nurse with the intention to migrate, and that this was mainly due to her family's desire for financial stability and social mobility in the context of limited social protection from the Indian state:

At that stage, my family wanted to be more rich and things like that, we wanted to earn money, and at that time the younger ones started growing up and my father had so much responsibility with grandparents and things like that. It's not like here, NHS and free education. So money was really important in their life. And they were looking to me, so that's when my father said I should move from Mumbai to Saudi, so I got a job in Saudi Arabia.

Gaya's entry into nursing can thus be perceived as a form of transnational social protection for her family (Boccagni, 2011). Moreover, she explicitly referenced how her social position within the family, as the eldest daughter and grandchild of the family, alongside the sudden death of her elder brother, meant that it was she who carried the weight of the family's fortunes firmly on her shoulders. Similarly Beejuu told me:

Like at that time [before her nurse training], not now, in India and in Kerala, most of the men used to be farmers. At that time, maybe sometimes disasters come so you know sometimes the family will have very socioeconomic low background, so that makes you want to learn and want to earn more. That wish is there, that desire is there. So that made you want to get more. For the family.

Dalgas (2016) argues that when young migrants use au pairing as a means of contributing to their family economies, it is not just a sacrifice conducted for the sake of those at home, but also anticipates the au pairs own future situations. Whilst some participants in this study certainly described the importance of their ability to earn money and provide social protection for themselves and their families, now and in the future, they also framed their migration as a means to show they 'care about'

(Fisher and Tronto, 1990) family, as participants negotiated 'coherent connections between intimacy and economic activity' (Zelizer, 2005, p. 2).

Like Gaya, participants across the sample referred to their position within the family, as, for example, the eldest (grand)daughter or youngest son, as an important factor in their decision to become a migrant nurse. They described how this also influenced the level of responsibility they had towards their family. This indicates the 'particularistic kin relationships and negotiated family commitments that people with specific family networks share' (Baldassar *et al.*, 2007, p. 204). In this sense, becoming a migrant nurse can be read as connected to the asymmetrical and reciprocal care exchanges influenced by the ethics of care in the Indian family as well as their material realities. These multiple family members and kin thus constitute networks through which nurse migration is produced and reproduced. Moreover, whilst a variation on the theme of 'I migrated to support my family' was a frequently stated reason nurses provided for both their entry into nursing and their subsequent migration, the women and men in the study accounted for this in different ways. This underlines the importance of, as Parreñas (2015, pp. 31–37) notes, identifying the different meanings of 'economic' migration for women and men.

Accounting for Migration: The 'Burdensome' Daughter

An important underlying factor that influenced some of the women towards seeking employment abroad is that they are able to save significant amounts for a 'dowry' through a foreign salary. Marriage is expensive in India and families typically spend many times their annual income in paying for wedding celebrations and gifts for the groom and his household (S. Anderson, 2007). The pressure that their gender and position as 'daughters' requiring costly marriages put on their families came up frequently in many of the women's accounts:

My father used to say 'oh we've got four girls, and we will be having difficult times'. You know getting married, we have a

dowry system. So I used to think 'I wish I was a boy'. I even thought 'my god, why I became a girl?' (Pushpa)

In a society where families are obliged to pay dowries (*streedhanam*) for the marriage of a daughter and receive it for the marriage of a son, the female child has historically been designated a liability in Keralan families. Visvanathan (2012) argues that *streedhanam* has become a means of contracting marriages into desirable families, with different rates for each economic class. Saradmoni (1994) argues that the growing pressure for larger wedding dowries is increasingly evident across all religious and class groups in Kerala, and she links this to increased consumerism and individualism, which in turn influences (and is influenced by) transnational migration (see also Osella and Osella, 2000). In addition to the economic status of the families, the educational and employment qualifications of the bride and groom, as well as the woman's complexion, are all important factors in the negotiation (George, 2005, p. 42). George notes that the more daughters there were in the family, the more dowry the parents had to pay. The findings in this study are consistent with those of other studies, with some of the women describing themselves as 'burdens' to their family due to the pressures of dowry payment. This was especially true for those female nurses that were the eldest in their families, or where there were no sons in the family¹⁵.

Percot (2006, p. 50) memorably argues that 'the burden of having a daughter, as it is often said in India, turns out to be much lighter if she is able to get a nursing diploma'. Whilst some of the women recalled thinking about other professions, such as teaching, law and medicine, they said they entered nursing since: their family could afford it; because their secondary education grades met the entry requirements; because of the potentials for migration; and the 'guarantees' of a lifelong job in nursing compared to other professions. Economic constraints within households

¹⁵ Evidence from this thesis suggests that many of the female nurses paid for their own dowries as a result of working abroad. However, there was no need for a dowry at all for others because of the potential lucrative earnings that the migrant nurse brings to a marriage. This suggests that the dowry system is still in operation, but may be changing (see also Nair, 2012; Walton-Roberts, 2012).

emerged as particularly salient when discussing the feasibility of occupational choices—engineering was frequently mentioned as being too expensive, and medicine, whilst attractive to many participants, was too competitive as well as expensive. Alice, for example, said:

Nursing was probably the less expensive for you to go through. Whatever way you look at it, nursing is the less expensive route. So I went for it, by that time, I felt like I wanted to help out my family as much as I can, I don't want to be more burden on my family, so I probably would choose something which was less expensive than to put more burden on my Dad at that time. And doctor, there's too many people going for medicine, plus it's too expensive.

Indeed, many of the women in this study framed this guarantee of a nursing job as a global means of easing their burden on the family:

My Dad always had a, see there's a stigma back home with girls, you need a boy in the family to look after them. But as I said, it's all girls in the family, so lots of financial pressure. I have three sisters, but my Dad always sort of empowered us just to go and learn something and be able to stand on our feet. So that's probably why he wanted us to have some education which will always end up giving me a job at the end of it. So that was always in the back of my mind. I've got to do something that will give me a job at the end of it. So like, if I went and did a degree, I'm not guaranteed a job. So that kind of thing probably led me to going for nursing at the time. (Anisha)

The potential opportunities to migrate on the basis of a nursing qualification can be argued to be contributing to a change in status of nurses in India, and this is played out in the context of the matrimonial market in India (Gallo, 2005; Percot and Irudaya Rajan, 2007; Walton-Roberts, 2012). Nurse migration thus reproduces and challenges patriarchy simultaneously (Walton-Roberts, 2012).

A better marriage alliance means that the future husband will come from what is considered a 'good family' (Percot and Irudaya Rajan, 2007). The opportunity to get a 'good husband' meaning a husband chosen by the parents, coming from a reputable

family and with a good level of education, came up in many of the interviews with the female nurses (see also Percot, 2006). This was something that could be facilitated by nursing. In the following extracts for instance, Sindhu describes stalling her marriage so she could earn enough money to pay a hefty dowry and marry a man who she perceived to be from a 'better' family than hers:

My family knew that if you become a nurse, you have the potential to go abroad and to earn money. One of the things was money, and it was also about, we didn't have a good family; financially we weren't very financially sound at that time. You know, my father was doing agriculture so he had some money to live on, but it was just that he wanted the children to be settled. So once you are abroad and once you are in a good profession, you will get a good marriage.

So I need to make the money for my wedding, for dowry. The whole money I saved for the year here in UK, I didn't take a penny from my Dad, and it was like, a proper Indian wedding - I spent for all the wedding purposes and everything, so I had the money, I didn't have to ask my father or my brother to give me anything.

As daughters who would eventually marry, requiring dowries and traditionally not contributing to the family following marriage, Sindhu and other women in the study perceived themselves as strains on their family. This makes evident some of the links and intersections between kinship, gender inequalities and economic and political motivations in migratory moves. Moreover, the entanglement between entering nursing for material gains alongside feelings of being an encumbrance to the family unit and a desire to 'be a good daughter' and a 'good mother', as well as the more symbolic aspects of money in the Indian context, illustrates how nurse migration as an economic activity is:

Influenced and structured by moral dispositions and norms, and...in turn those norms may be compromised, overridden or reinforced by economic pressures (Sayer 2004, cited from Näre, 2011, p. 400).

In other words, participation in nurse migration can also be understood as a form of moral economy, which reveals the ways in which powerful non-economic factors

link with economic factors to influence decision making about transnational migration (Baldassar, 2007a; Näre, 2011). As this section has illustrated, these moral dispositions and norms are gendered. Although the male nurses appeared to be less constrained by the gender norms that influenced the women in this study, the male participants nonetheless also made decisions in consultation with their families, and with present and future family lives at the fore of their minds.

Accounting for Migration: Breadwinning for a 'Good' Family Life

The men's descriptions of their entry into nursing and their experiences working in India are comparable to the accounts given by female participants whereby the attraction of migration, the potential earnings and the 'guarantee' of a job were some of the main factors in choosing nursing. Their personal lives are built into the various stages of nursing, in the sense that they looked forward into the future, discussing future wives and children as guiding principles for their decision to enter nursing. All interviewees were acutely aware of the low status of nursing in India, and for the men, this was only compounded by their gender:

In my village, I am the first one going for male nursing and everyone was asking me, 'why you going for it, normally ladies going for nursing profession, why you go for it?' They laughed. But once I told why I'm going for it, they were ok. Because always there will be patients in hospitals all over the world, all the time. And if I go for nursing I will be in a job, anywhere in the world. Not like others, there was lots of graduated, very high degree people waiting at home without any job. They are looking for a job, but they don't get any job. But if I go for nursing training, I will get a job abroad. Sure, it's 100% sure. Ok, it's normally for ladies, but I will get a job abroad, no problem, it's a very good decision. (Joe)

People laughed at me when I told them I was going for male nursing, said 'oh, but it's for ladies', and they think men can't do this job because the work, it's seen to be woman's work, but I explained about the money and opportunities to go to Europe, the US. Because there is a stigma attached to male nurses, actually stigma to nursing for ladies too, but people need to realise that in this profession, the world is your oyster. (John)

All of the men described some variation of the above, sometimes laughing nervously when describing why they entered nursing, and hinting at the anxieties they had in relation to their status and the questions that their entry into nursing posed for their masculinity. Faced with the risk of unemployment, together with financial constraints and few alternative career options, as well as the possibility for transnational migration, nursing became an attractive option for the men in the sample. The men knew the job was perceived of as feminised, but when weighed up against the attractive aspects of the job, namely the international opportunities and the 'guarantee' of a job, they decided to pursue a career in nursing. However, this did not mean that they did not struggle. Indeed, as suggested by John and Joe, they had to justify their entry as men into nursing, and they did this typically by emphasising how it enabled them to materially support and care for their families.

Nursing is a strongly gendered profession, reproducing stereotypical perceptions of caring as associated with femininity (Smith, 1992; Choy, 2003; Kouta and Kaite, 2011). Thus when men enter this profession, it can challenge perceived ideas around masculinity. The men in this study used various techniques to (re)negotiate these challenges and their masculinity, including not answering many of my questions directly and stressing the more 'masculine' aspects of their work, and the good earning potentials associated with their decision to become a nurse (see also Näre, 2010):

If you go for a nursing job in UK, the average is maybe £1500, or something. But in India, Rs 1500 you are getting. That means not even £150 you are getting, like nothing. So that's not good for leading a good family life. In Jeddah, Malaysia, Singapore, all of these places, you are getting more than India. (George)

Whilst emphasising the economic aspects of nursing, the men in this study nonetheless framed their material desires within broader family objectives, emphasising particularly the connection between the potential opportunities entailed in a nursing qualification and their ability to secure a 'good' family life.

Throughout the interview transcripts the men referred to their desire for a 'good family life' and their striving to become 'financially sound' in order to achieve the role of the family breadwinner. Whilst the women nurses talked about being able to contribute to their families, wanting some financial autonomy within their marriages and their ability to secure 'good' marriages as the key reasons for entering nursing, the male participants' reasons were very much entangled with ideals about being the male breadwinner in the family and their ability to provide 'good' care to both their present and future families¹⁶. Denny, for example, turned to nursing after earning a degree in commerce and working in business for a number of years. Finding it difficult to earn a decent salary and secure steady employment in India, despite internally migrating from Kerala to Mumbai, Denny returned to university, retraining as a nurse when he was in his late 20s. He said that the salary that he was earning working in business in India was not enough to 'support a good family life' and hence he turned to nursing with its opportunity for migration.

When I asked him more about this 'good family life', he told me it was important for him to be able to earn money and support his wife and children, and his parents also, because he was the only son in his family. Ideally in Kerala, the youngest son and his wife would live with the parents and take care of them (Visvanathan, 1989). Entering the nursing profession and migrating was a means to achieve the financial stability needed to attain this vision of family life:

Nikki: What do you mean by a good family life?

Denny: Well, see in India it's different from here. Arranged marriage. And the family, the husband and wife's family, takes the family finances, reputation, jobs, if you're respectable, all these things. They look at all these background things. They want to see if you can look after

¹⁶ Although in practice none of the men interviewed were in fact the sole breadwinners in their immediate families, with all having wives who also work as nurses. This has implications for the division of labour in the domestic sphere, with the men taking on equal shares in childcare. This is discussed in more detail in Chapter 5.

their daughter and your children, give them good education, education is very important, make sure you have a secure life, support your own parents. Like this. For us, it's important to lead a good family life, it was important for my wife's family that I was a good husband, had money, had a future.

This idea of having a 'future' came up repeatedly in the interviews, with many participants linking particular life course transitions with the opportunities entailed in a nursing career. For the men, it was especially linked with the ability to secure a 'good' marriage. Indeed, after returning to college to train as a nurse and working for a year after graduation, Denny married a Malayali woman who was already working as a nurse in Scotland, and went through the adaptation process. Although he says it is difficult to save money in the UK and his wife still has to work, he said he would not be able to have the family life he can afford in the UK on a nurse's, or indeed a white collar worker's salary in India. A similar theme emerged amongst the other men in the study, where they felt the pressure to earn money, to have a guaranteed 'future' and to have enough resources to educate their potential children, a theme I return to in the following chapter. Thus we can see the orientation towards the future, and a weighing up of available opportunities in India, as central in influencing the men's accounts of their decision to enter nursing.

Although the ability to achieve a 'good' marriage was important for the women too, the gendered dimensions of this theme are clear. Many of the women became nurses at the behest of their family, or because they did not know what else to do, or because they saw female relatives living lives as nurses in far-flung places. The men in the study, in contrast, were much more decisive about their decision to become a nurse, partially because it involved justification to many people in their social networks for their entry into a feminised labour sector, but this was often entangled with a desire to become a breadwinner. To provide for family was a central theme in both men and women's migration though the men talked about this differently from the women. Indeed, Osella and Osella (2000, p. 118) argue that:

Migration may accelerate an individual's progress along a culturally idealised trajectory towards mature manhood: it may accentuate characteristics already locally associated with essentialised categories of masculinity.

The stereotypical Kerala male migrant is perceived as successful and wealthy, and many young Malayali men aspire towards this image. This links in with ideas about the male life cycle in Kerala. Migrating not only means escaping from unemployment but also facilitates a move away from young immature status towards full adult male status as a householder, which is defined by the combination of marriage, fatherhood and showing ability as a 'provider' (Osella and Osella, 2000, p. 120, 2002). Becoming a 'nurse on the move' can be read as one means of achieving this status, which the men in this study suggest would have been difficult to obtain if they had remained in India. In their work on domestic service in India, Ray and Quyam (2009, p. 120) point out that when male servants perform domestic (read feminine) or 'dirty' tasks, it leads to a questioning of their masculinity. They suggest that the men in their studies are 'failed patriarchs' on account of this. Whilst the performance of 'feminine' tasks led to a questioning of their gendered identity, the male participants' accounts in this research suggest that these men never considered themselves, or were considered by family members, as 'failed patriarchs'. However, as discussed in Chapter 1 and earlier in this chapter, nursing is still considered a low status feminised job in India. Rather than 'failing' to become a patriarch as in Ray and Quyam's research, the men in this study framed their entry into a feminised occupation as a means to become a 'successful' man within the patriarchal Indian context because it was a means for them to secure a 'good' marriage and become 'providers'. This was seen especially when men described their motivations for becoming a nurse. Nursing for Denny, for instance, was a means to move out of the liminal stage between graduation and marriage, allowing him take on the prescribed responsibilities to support and take care of his extended family, points I return to in Chapters 6 and 7.

This emphasis on breadwinning can also be interpreted as a way of addressing the marginalisation and subordination they experience as migrant men working in a feminised profession. It also moves the discussion of support from migrant men to their families beyond a unidimensional and instrumental analyses of breadwinning (see also Kilkey, 2014). This suggests that remittances and economic investments can have multiple meanings, especially in the Indian family where money is a 'medium of care and relationship' (Singh and Cabraal, 2014, p. 223). As Baldassar et al. (2007) note, what is considered to be 'good' care in a particular culture concerns *who* is expected to give and/or receive certain types/practices of care, and this is gendered in the sense that different expectations fall on women and men about what their appropriate caregiving roles should be. Both the men and women's accounts of becoming 'nurses on the move' can thus be understood as embedded in care relations governed by the moral codes of family and kinship ties. Migrating to support family was not the only reason participants gave in their accounts of migration, however. Many of the nurses in this study also framed their migration in terms of career progression and development, and personal opportunities, and these accounts were also gendered.

Accounting for Migration: Self-improvement and 'Freedom' from Family

Raghuram (2008, 2009) argues that when women's mobility is discussed, it is often represented as driven by economic imperatives rather than through the language of career or individual aspirations, or their aspirations appear to be embedded within familial objectives. Whilst the accounts discussed above are certainly embedded within the broader family context, some women and men simultaneously described their entry into nursing and subsequent migration in terms of a desire to lead another kind of life. Refrains such as 'I don't want to waste my life here working' (Preeti) and 'I wanted to see the world, to travel' (Poathan) were repeated by the majority of participants:

My motive was always the pursuit for, it was my intention actually. I mean western institutions, western hospitals had always fascinated me. It was always like a dream. All of us

have that dream, or imagination, or to some extent thinking that the western world the hospitals are modern hospitals, modern facilities, that it's very good to work in a modern hospital. (Roxy)

Roxy's dream of a better working life in the 'west' signal that some nurses migrated in an attempt to improve their nursing skills. The reality of working in British hospitals is discussed in Chapter 7, but for now it is worth reflecting on how the analysis shows that some nurses understood their migration to the global north as a way of engaging in self-improvement and fulfilling their dreams. These dreams were also influenced by family members and (religious) nursing networks, against the backdrop of a broader culture of nurse emigration. As Maryam told me about her entry into nursing:

My Dad's sister, my aunt - she's living in Germany just now, in Cologne. She comes home every year - she's a nurse there, she comes home every year with lots of her friends, German friends and all come to visit as well, they come to our home. And when she comes, I found it exciting, I always think when I was small 'oh, this is the bestest job in the world'. Maybe this aunt has influenced me. Maybe she came for another visit again, and I was influenced by her. The pictures of Germany and the hospitals in Germany, and seeing the pictures of her uniform, I can remember that. And then at that time, there's lots of people from my side, especially Catholics, all goes to nursing to get a job all over the world actually.

Maryam was impressed by the seemingly glamorous life of her aunt working abroad, and saw nurse migration as an opportunity for self-development. Others across the sample also described seeing family members and neighbours visiting India from the US, Europe and the Middle East, having not only accumulated wealth but also leading exciting lives. Like Maryam, these participants described these networks as having an influence for their entry into nursing. Nurse migration can thus involve a desire for a different kind of life. It can also be driven by personal ambitions, and a desire for job satisfaction, professional development and self-improvement.

Jenny, for example, came to the UK after three years working in Delhi. Unlike most of the other nurses in this study, Jenny did not train as a nurse with the intention of going abroad 'for the sake of family', or because of unemployment in Kerala. As she suggests in the extract below, her family were financially comfortable and her younger brothers and sisters were all studying:

Malayalees always think that you finished nursing and then you go abroad, and then you earn money, because that's the way it is. My family though, they were a middle-class family, they didn't have much financial burdens, but they always thought I should be independent and earn my money and live. My Dad was working, so there was no problem. So when I finished my nursing, I had always thought in my mind, 'I want to go to Delhi', because I was in the south of India and I wanted to go to Delhi.

In Jenny's case, there was a burning desire for adventure and a longing to experience life outside of the family home. The position of her family as self-ascribed 'middle-class' was important, and she accounts for this as influencing her aspiration for internal migration over international migration. Moving to Delhi allowed her to experience a different culture, new language, and meet new people without the pressure of circulating finances back to family remaining in Kerala.

However, participants' accounts of why they migrate are typically multi-layered and complex. When discussing her migration as a means for self-exploration and personal career development, Jenny also connected this with a desire to get away from the patriarchal structures of the Indian family and wider community, saying that nurses are 'always watched by everyone'. This ties in with Walton-Roberts' (2012) observation that the discourse of caste-based pollution surrounding nursing in India has been replaced by a discourse of sexual pollution. This discourse means that nurses are associated with loose sexual morals and are subject to increased surveillance within the family and community. All of the women pointed to this suspicion and surveillance. In this context, many of the nurses described migration as

enabling 'freedom' from the family and community, suggesting similarities with Parreñas' (2015, pp. 31–37) assessment of gender as a 'hidden cause of migration'.

Jenny's family supported her individual project of self-development and, after moving to Delhi, she initially managed her own income. This was quite an unusual practice in the context of Indian transnational migration, where family money is particularly important and adult working children, even when not living at home, contribute to household money (Singh, 2006). As described earlier in this chapter, remittances can be read as a 'currency of care' (Cabral and Singh, 2013, p. 56) in the Indian family and one way in which migrants maintain their sense of belonging in the family. However, whilst the self-improvement narrative was the initial motivating factor for Jenny, her nursing soon became a means for supporting her family when her father lost his job and the family started to build up debts in Kerala:

The family income is gone, so there was a bit of pressure on me. And everybody was looking on me [*long pause*] so I sent 80% of my salary back home, and every time I called them over the weekend, partly scared about what's coming next. My brother was studying and my sister was studying. My Mum and Dad were healthy, there was no health issues or concerns, but my Dad had his Mum and Dad to look after, and his sister was depending on Dad too. So there's a couple of people who were dependent on my pay.

As noted in Chapter 2, redundancy can be understood as a life course event (Dewilde, 2003). Events are usually less predictable than normative transitions; individuals can better plan for transitions than for events. The crisis in the family's finances triggered by her father's sudden unemployment was clearly a 'push' factor in Jenny's account of her migration and was described as a critical time for the whole family. However, she also held on to her project of self-development:

There was this thing about going to the Middle East, it was the most common thing. First thing, you find a job and then the next thing, you're looking for the Middle East, and this is something I very clearly told my family - I will never go to the Middle East. So my family didn't put any pressure on me, they asked me what I wanted. I was always very keen to read

magazines from abroad, like the Nursing Times, Nursing Standard, always had that fancy, how do you call it, fancy ideas about how nurses were abroad. Some kind of attraction towards that. And I always said to my aunt and mum, if I ever get the opportunity to go to Europe, I will definitely go, because I'll get some opportunity to professionally develop myself and that's what I wanted, not for the money, but I want that in my life.

Whilst the hierarchy of potential destinations that Jenny points to is discussed in more detail in the next section, the striving for self-development is clear in Jenny's account. Although Jenny was clearly ambitious in her nursing career, she did not create sharp distinctions between her own ambitions and the welfare of her family when the need arose. However, she did insist on having some control over where she migrated to, since she said she really disliked the Middle East, despite never being there. Later in her interview, she suggested that if the UK opportunity did not come along when it did, she may have been 'forced' to go to the Middle East, not by her family, but in order for her family to survive.

Even though Jenny did not send money to her family in the early stages of her internal migration as a nurse, the changing situation of her family over time—rooted in the context of unemployment and insecurity in Kerala—is illustrative of how the family investment in her education paid off. When her family was financially secure, Jenny was able to draw on family networks to support her nursing venture, and framed her nursing in terms of personal aspirations. The patriarchal norms in the family influenced her decision to go to Delhi but she emphasises that this was not, at least initially, an economic move; rather it was about freedom and self-development. However, when the family fortunes changed, her nursing qualification became a means to manage a risky economic period for the family. This had a powerful impact on her future migrations and Jenny started to circulate care back to her parents and a host of others from Delhi at first, and then the UK. Becoming a nurse is clearly a potential means of caring for the family collective, but this does not mean that these types of interactions are without tension. The long pause in Jenny's interview, when she was describing sending most of her wages from Delhi to her family, could be

read as pointing to some of the difficulties she experienced in remitting the majority of her earnings and the weight of expectation due to multiple family members reliance on her wage. This came into conflict with her personal career ambitions at points too, particularly when she thought she might have to go to the Middle East to work to support the family. Jenny frames this in terms of a generalised reciprocity but her account, and the extracts above, elucidates how a family crisis can surface some of the asymmetries and tensions involved in caring for family. Jenny's account of her entry into nursing and subsequent migration also illustrates the importance of taking changes over the life course into account as well as revealing the ways in which women's agency can change at different periods of their and their family's lives. The analysis also points to the ambiguities, choices and constraints that are also often involved in nurse migration.

Participants' accounts of becoming a 'nurse on the move' reveal some of the ways in which care is organised, how it flows in multiple directions between family members and across the life course, but also the asymmetry embedded in some of these exchanges. Whilst the moral obligation to provide for one's family clearly plays an important role in Indian nurse migration, households are not uniform, rational and unanimous units that calculate the costs and benefits for its members and 'send' family members abroad, as sometimes emphasised when families are considered in migration decisions (Raghuram, 2009). As discussed in this section, economic aspirations, a cultural and gendered sense of obligation towards the family, personal freedom and empowerment, as well as self-improvement and professional ambition all work together in the narratives of Indian migrants. It is also important Indian nurses are not a uniform homogenous group—gender differences play an important role, as does social class and position within the family.

This chapter has so far illustrated the importance of understanding accounts of nurse migration within a timeframe that goes beyond a singular moment of decision-making, and beyond the duration of their migration journeys. In order to look beyond

these bounded moments in time and narrow views of nurse migration as merely a response to labour market triggers, I have contextualised nurse migration within the relational milieus of participants, illustrating how family background, previous and future life transitions and events, and gender are central to their accounts of professional and migration decisions. This analysis has also highlighted the cultural, social, economic and political processes underpinning nurse migration. As the nurses in this study are a group of people who have several countries open to them as potential destinations, due to the global demand for international nurses, examining some of the circumstances that influence their choice of destination can reveal much about nurse migration in a globalised world. Again, a relational approach reveals much since participants also assessed their prospects in different places as interdependent with their families' objectives and aspirations.

4.2 Multi-sited forms of migration from Kerala to Britain

Stepwise Migration

When I asked the nurses in my study why they had chosen to migrate to the UK, it emerged that the UK was just one among many potential destinations, and that for a substantial number of participants, their journey to the UK involved multiple migrations. John, for example, did not see a 'future' in India as a nurse:

When I went for nursing in India, my aim was to go somewhere abroad, anywhere, because nursing in India, you don't get the respect. It's not counted as one of the high class jobs or anything like that. It's a low job, so there was no future for me in India.

John's cynicism about the lack of a future in India as a nurse indicates that whilst he did not necessarily expect to find success in any one particular country, nursing and its attendant opportunities for migration was a means to achieve this success. He describes his aspiration as to 'just go abroad', with 'abroad' being a destination in itself (Dalgas, 2016, p. 199). Transnational labour migration in this sense becomes a land of 'time travel', enabling 'another kind of future' (Coe, 2016). As outlined

earlier in this chapter, a nursing qualification is increasingly considered as a 'door to abroad', and, since the mid-1970s, Middle Eastern countries have been considered the most popular intermediate step to further migration to the global north for Malayali nurses (Percot, 2006; Nair and Percot, 2007). Paul (2011) has examined such migration patterns in her study of Filipina domestic workers in Hong Kong, identifying a hierarchy of destinations amongst her participants, with North America or Europe as the most preferable, due to their relatively high wages and better working conditions compared to other destinations. These 'top destinations' are more difficult to enter than, for example, some Middle Eastern and Southeast Asian countries. Paul (2011, p. 1831) explains that migrants thus often engage in a strategic and 'stepwise' movement towards their preferred destination. As such, the final destination can be planned in advance, whereas the first migration is more coincidental (Paul, 2011, p. 1864). This migration pattern has been identified amongst migrant nurses from many countries, who sequentially work in several countries (as transit points or stepping stones) until they reach the most preferred country (final destination¹⁷) (Buchan, 2003; Kingma, 2006; Carlos and Sato, 2011; Paul, 2011).

In accordance with these observations, many of the nurses in this study developed trajectories whereby they initiate their migration in a Middle Eastern country. George, for example, had his eyes firmly set on eventual migration to 'the West' when he migrated to Oman. He was particularly reticent to discuss his experiences there, instead emphasising that:

My intention was not to go to Muscat. Basically I went to Muscat for money. Purely the job in Muscat was purely based on money.

¹⁷ The preference for a 'final destination' is also open to change. The UK and Europe were seen as final destinations for some participants, but with significant international nurse recruitment currently taking place in Australia (Buchan, Naccarella and Brooks, 2011), and some participants experiencing hardships as migrants in the British context, many are now looking to move on from the UK, which was once considered a final destination. Chapter 7 discusses these issues in more detail.

Leela, who never worked in the Middle East, but had almost gone there when she came across an agency's advertisement for nurse recruitment in the local newspaper:

I did get a job in Oman, but it was taking another two or three months. And there was no definite date as to when I was able to go. But this thing [UK opportunity] came in the middle and it was quite fast processing, so I didn't want to spend time just doing nothing. And it's not just about the money. The living standards are definitely better here than the Arab countries. Even if I did go to Oman, my plan, eventually I wanted to come here or Australia or New Zealand so I just came here. It was always the plan, Middle East and then these other places. But I just quit that part and came straight here.

Leela and George and the other eight nurses who worked in other countries before entering the UK said that the salary and working conditions in places like Dubai and Oman were comparable in relative terms to the UK and other popular destinations. They nonetheless preferred to move from Middle Eastern countries due to strict employment and immigration policies, such as not granting citizenship to foreign nationals, as well as because their residency in the country was dependent on having an employment contract (see also Carlos and Sato, 2011; Carlos, 2013). Working in the Gulf gave George the time to accumulate the necessary resources (financial, social and political) that would enable further migration to his preferred countries—namely the USA, UK or New Zealand. During his time in Oman, he saved money for further migration, and took the International English Language Testing System (IELTS) exam so he could meet English language requirements for nurses in English-speaking countries. By working outside of India, he also developed his professional career through acquiring overseas work experience. These were transferable resources he built up during this time, all of which he hoped would allow him to access the labour market in his preferred destination(s).

George described his move to the UK as 'first-come, first-served', in the sense that he was ready to move to any of his preferred destinations and took the first available opportunity. He arrived in the UK in 2003 after three years in Oman. In her study of migrant Filipino nurses, Carlos (2013, pp. 46–48) argues that their stepwise

migration is 'a rational behaviour and strategy for the migrant and his family...a rational strategy in light of the variations in each destinations' nurse migration policies'. According to Carlos, migrant Filipino nurses go wherever there are opportunities for work, and as they move along their stepwise paths, accumulating various resources, the succeeding decision-making process determining whether and when to stay or move becomes more systematic. However, as discussed so far in this chapter, migration decisions are multi-layered and relational. As Carling (2001, p. 17) argues, migration is not simply a demographic event, a move from A to B, but a parcel of expected actions and consequences (although, as this thesis illustrates, a migrant's own particular experience is likely to diverge from this ideal-type version). When thinking about where they would ideally like to move, participants were often future-oriented, with family at the forefront of their minds. They described keeping these considerations in mind as they compared the migratory and social reproduction regimes in the potential countries that had available to them (Yeates, 2014, p. 185).

Family in the Choice of Destinations

When nurses described making their decisions about destination countries, they preferred places that would allow them to settle, buy a house, raise a family and obtain citizenship. These possibilities do not exist in Middle Eastern states where migrants are typically confined to narrow economic roles with limited social and political rights (Yeates, 2014; Khadria, 2015). A small number of participants were already living separately from their husbands and/or children whilst living in India, highlighting that separation and absence in families is not something that occurs solely because of international migration, but is also an aspect of family life within countries¹⁸. For these participants, a desire and will to be together in proximity as a family unit was an important factor when deciding where to go, since they could not live together in India:

¹⁸ This is illustrative of some of the links between internal and international migration, whereby internal migration to large Indian cities for work is the first step towards international migration. Participants' recognised that the experiences gained from internal relocations had prepared them for international migration, especially since they needed work experience in the Indian context in order to work abroad.

I was actually in Saudi Arabia, and meanwhile I had my son. So I ended up leaving him with my mum. I couldn't bring him to Saudi because I couldn't bring my family there. My husband worked in Dubai. He couldn't take me there because he was in oil rig fields, where women are not allowed, family are not allowed. So it was like, you couldn't meet up anywhere at all. So we used to go home and see my son. So it was really getting, you know, three people in three different places. So it was really hard. It was the same in India. When I was in Mumbai, I used to go and live with him in Kerala for six months and then I will come back and work again and then go back for six months. I could visit on the weekend too. So I could go and visit him very often there. (Asha)

The overwhelming focus on international migration and global costs obscures the fact that the same patterns are often taking place internally. Such internal separation or the difficulty in living together as a family in the one place might spur people to leave their country of origin and reproduce periods of separation under different conditions. This desire for proximity and co-presence was thus central to these nurses' orientations towards particular countries that recognised them not only as a labour force, but as people with relational ties.

The Middle East represented a group of countries that allowed easy entry because many of these countries had a well-established foreign worker employment policy and a developed recruitment system (Carlos, 2013). Many Indian, and Keralan, nurses take up jobs in the region, albeit, as discussed above, with the intention of moving to a more preferable destination. In the 1970s, Indian nurses started to be hired by the newly built hospitals in various Gulf countries (Percot, 2006), when these countries began to employ a large expatriate labour force after discovering oil. Research on Indian migrants in the Gulf estimate that around four million migrants reside in the Gulf, with over half of these hailing from Kerala (Percot and Irudaya Rajan, 2007). These scholars estimate that approximately ten per cent of these migrants from Kerala are female i.e. 150,000, and a significant number of these female migrants, estimated between 40,000 and 60,000, are working in the Gulf as

nurses¹⁹. It is evident from my interviews that finding work in the Middle East is relatively easier, faster and cheaper than other potential destinations. Because of nursing shortages, due to a range of sociocultural reasons, there is an urgent need to fill vacancies (see, for example, Adib *et al.*, 2002, for a discussion of the low status of nursing in Kuwait). The recruitment process from India to the Middle East typically takes between two-three months for participants, compared to two years in the United States (Matsuno, 2009). Participants had networks of friends, family and nursing colleagues already present in these countries who helped with the paperwork and recruitment.

However, despite some Middle Eastern countries openly and actively recruiting international nurses, the working conditions after arrival can be difficult (Percot, 2006; Kodoth and Jacob, 2013). Participants in this study described experiences of oppressive working and social conditions, especially for women. They were unable to practice their Christian religion openly, and for those who had children, they had little rights for reunification. Alongside such experiences, some of the nurses suggested that they simultaneously felt 'free' there. Gaya, for example, spoke of her time in Saudi Arabia quite ambivalently. She said she simultaneously enjoyed and disliked her time there, missing her children, feeling the constraints of the Saudi Arabian state and the pressure to remit. Yet she also enjoyed the freedom afforded to her in a country away from the surveillance and obligations of the family and the respect given to her in the workplace. Being a migrant, a woman and a Christian, she felt affected by Saudi Arabian laws that did not afford her full rights as a worker, that restricted her mobility and forbade her to practice her Christian religion openly. This intersection of gender, race, nationality, class and religion brought with it a unique set of challenges and opportunities. It also led to a sense of ambivalence, as she was aware of how nursing was stigmatised on the basis of gender and class divisions in India.

¹⁹ Although there are no official statistics, the authors created these estimates based on statistics of Indian nurses in Gulf hospitals and by visiting the United Arab Emirates (UAE).

The life in Saudi, we don't have much freedom, especially for the female. And we were not allowed to take off our family. I got married when I was working in Saudi, but I couldn't take my husband with me. My job was ok, because I was working in the government hospital, ministry hospital, savings was ok, work was actually really satisfactory. But you know at that time I was really at the top of my skills, I should say, because I was trained in a mission hospital with Irish nuns. My English was good. Now it's not. At that time, when I would speak to the people they used to think I was a doctor, like you know the way I was speaking. My training, like three years, I was in Bombay in also a nun's sisters hospital, so I had good English. Local people in Saudi are really, they were just coming to nursing, like there was not many of the nurses from their community. So we had very good chance to develop our career. I mean [Saudi] was the most satisfactory time in my life. Because I had money, I had freedom in work. There was not much interference from family and I could save money. But family, that was the problem. Both my children were born in Saudi.

It is worthwhile considering this tension between Gaya's differing accounts of 'freedom'—she simultaneously felt free yet also completely constrained whilst in Saudi Arabia. Immigration policy on family reunification²⁰ in Saudi Arabia meant she suffered a painful separation from her family, yet this separation also afforded her an increased sense of autonomy. Gaya stayed in Saudi Arabia for twelve years because her family were reliant on her remittances, and eventually reunified with her husband and children in the UK. Indeed, her desire to reunite with her family in one place was one of her primary motivations for moving to the UK. I return to the issues of mother-child separation in the next chapter, but for now the institutional contexts shaping preferences towards particular countries is important.

Research has shown that the institutional contexts of both the home and destinations societies play a central role in shaping the resources and constraints of transnational

²⁰ Family reunion is possible in Saudi Arabia but is quite restricted. Since migrants are primarily considered as temporary workers, integration policies and projects are largely absent, and workers hired under the kafala (sponsorship) system generally are not permitted family reunion (Rahman, 2011)

family caregiving (Al-Ali, 2002; Baldassar, 2008a; Zechner, 2008). This was an important factor when participants were weighing up their prospects in different countries, as illustrated by Rosy, who had a young child at the time of her initial migration to the UK:

Nikki: And just going back to before you left India, had you considered anywhere else before you went to the UK?

Rosy: I wanted to go somewhere, like, you know, out of the country and work and that time, it was like, the UK recruitment started at that time, it was 2001, 2000, that was when people started coming here. So then, I thought it was the best option. I hadn't really considered UK before this. I heard about people going to Dubai, Saudi, the Middle East, but I didn't hear much about England. Then about 2000, in 2000 it started recruiting people as the nurses.

Nikki: And had you considered the Middle East before this?

Rosy: No, no, because it's family. It's very difficult to take the family in the Middle East place, so I was a bit concerned about that so. I wanted to take my family, wanted to be able to stay there and buy a house if I wanted to, take citizenship if we wanted. Not possible there. I wasn't married then, but was saving for marriage, so family was on my mind. Middle East is not good place for family.

Similarly, Maryam made the decision based on where she was able to get a visa that would allow her and her husband to live together:

Then I got the visa and then me and my husband got married, and I went to Singapore and he went to Dubai, because he felt so bored in India alone. So he went to Dubai and I went to Singapore. But in both places we couldn't stay together you know, because of the visas. So I got a visa for here so we could be together.

The difficulties in obtaining citizenship and family reunification in Middle Eastern countries was thus a key concern for participants who went to the Middle East, as well as for those who went straight to the UK, illustrating the importance of family considerations in nurses' accounts of their migration as nurses.

Permanent residency (PR) is allowed in some Middle Eastern countries, such as Kuwait, which allows migrants to bring in their immediate family members. However, Kuwait restricts the number of dependents of migrant workers by putting a salary ceiling on those workers who are allowed bring family with them (Shah, 2006, p. 2). Obtaining PR does not assure them and their family the right to permanently stay in the country, however, since this status is tied to employer sponsorship. PR and re-entry permits are issued with specific validity dates, and only renewed by showing proof of employment. For the Indian nurse migrants in this study, the difficulty in maintaining PR and, more so, obtaining citizenship in Middle Eastern countries had important implications for family settlement. Susanna, for example, spent over ten years working in Kuwait and gave birth to two children whilst there. She described her time in Kuwait as largely enjoyable:

I was very happy in Kuwait, nice job, good money. But not so good for settling. First of all, children's education. They are not having an education after 10th standard or Plus 2²¹. And we have to send children to India for higher studies. Here in the UK, there's good education here, so we can keep our children with us, we don't have to send back to India or send them to their grandparents. They are British citizens, so no problem for them here, they can do their highers, go to university. But we can't become citizens in Kuwait, so it's not so easy. Means it's better for children to go to India for education, go to grandparents or our siblings. So we came here, keeping our children with ourselves is good, very important.

The ability to settle long-term with family, educate their children, buy a house, and obtain citizenship thus becomes a central factor in their preferences for particular countries. None of these possibilities exist in the Middle Eastern states, where migrants are excluded from social and political involvement (Yeates, 2014). Furthermore, Susanna's emphasis on her children's education is connected to the culturally informed sense of what is considered 'good' parental care—something repeated across the sample—which highlights another intersection between different

²¹ These secondary school grades in India are equivalent to the UK's GCSE level.

forms of social reproduction (e.g. paid nursing care work and the social reproduction of the family through education).

For the Indian-trained nurses in this study, policies regarding family reunification and integration were important factors when considering where they would like to work. The United States, with its perceived supportive policies and practices related to migrant families, high wages and good working conditions, was the most preferred destination for many of the women and men in this study. The U.S. Commission on Graduates of Foreign Nursing Schools (CGFNS) offers an exam in many countries that is an excellent predictor of passing the National Council Licensure Examination (NCLEX-RN), which is required to practice as a registered nurse in the US (Aiken, Buchan, *et al.*, 2004). Some participants had sat these exams in India multiple times but had never managed to pass. Following these failed attempts, they shelved their aspirations for working in the United States (at least temporarily), instead setting their sights on countries that were going through significant recruitment drives, as well as offering good salaries and working conditions compared to the initial transit destinations. The UK and Ireland, who were recruiting nurses from India directly in the early 2000s, hence became central destination countries for the nurses in this study.

In the UK, a migrant typically acquires 'indefinite leave to remain' (ILR) after living in the country for five years, and is allowed to apply for British citizenship, alongside family members also resident for five years or more. This means the whole (nuclear) family can enjoy the rights and privileges accorded to UK-born citizens, such as free education and social services, rights typically not extended to migrant workers in Middle Eastern countries (Shah, 2006; Khadria, 2015). The nurses in this study thus constructed their preference for certain destinations based on the ease of getting a visa, the ability to acquire citizenship, and the degree to which the countries'

immigration policies were 'family-friendly'²². Although multiple factors influenced participants' preference for certain destinations, a relational lens brings to the fore some of the nuances of stepwise nurse migration. Carlos (2013) similarly found that family was an important consideration in the stepwise migration patterns of Filipino nurses in Dubai. However, despite Carlos emphasising the importance of reunification and citizenship opportunities in migrant decision-making and hinting at the future orientations of nurse migrants, she does not connect these findings with the transnational family nor transnational care literature. This leaves us with a rather narrow view of nurse migration, with nurses rationally weighing up the pros and cons of certain countries. Whilst the findings in this chapter certainly show that participants evaluate the institutional contexts of nurse recruiting countries, the analysis also reveals how participants evaluate these in the context of their capacity to engage in proximate and transnational care relationships. They evaluate the care resources available at home and abroad, and frame their decisions as influenced by a culturally informed sense of obligation to provide care. These are not simply instrumental decisions, but rather involve hope, uncertainty and a desire to care for family members.

4.3 Conclusion

The story of nurse migration from Kerala can be told from several perspectives (Walton-Roberts and Rajan, 2013). It is clearly connected to the international demand for nurses, which helped nurses map their migration opportunities, building phases of their personal lives into its various stages; it is also possible to view nurse migration from the perspective of networks and the reproduction of the nursing workforce; nurse migration from Kerala is also an exemplar of the brain drain or circulation debate. Yeates' (2009, 2012) work on the global nursing care chain can include all of these approaches. However, as outlined in Chapter 2, a major element of global care chain perspective has been the idea of unidirectional transfers of care

²² Countries with existing support networks were also an influential factor for some participants. These networks were typically made up of other nurses from Kerala whom participants had met during nurse training or through working together in India or the Middle East.

through the nodes of a care chain—from women in the south who sell their caregiving labour to families in the north in exchange for money. In the context of nurses, Yeates expands the concept to include a range of other sites (e.g. hospitals) and skills, thus conceptualising nurses migrating from the global south as selling their reproductive labour to institutions in the global north. In conceptualising these care flows as unidirectional however, the care chain literature suggests that nurse migration jeopardises family solidarity.

In this chapter I have presented a different, yet complementary, story that is embedded in the accounts that nurse migrants themselves give. The focus here is on how *they* made sense of their migration. In doing this, I have argued that the transnational migration for nursing is embedded in the mutual exchange of personal, practical and emotional support to present and future family. By drawing on a care circulation lens, I have brought to the fore the multi-layered and multi-sited, as well as the ambiguous and ambivalent, ways in which migrant nursing is embedded in family, past, present and future. I have argued that, rather than unidirectional and dyadic, the potential for present and future care exchanges are embedded in nurses' accounts of their migration. These care exchanges are multidirectional, asymmetric and complex, involving conflict, tension and expectation. By discussing how migration decisions are not just individual nurses' decisions, but also family based, I demonstrate how migration is embedded in relational contexts and socioeconomic and cultural structures. This allows us to view nursing as a family investment, rooted in nurses' culturally informed sense of obligation to provide care, both in the present and in the nurses' own future situations. Hence I have argued for the importance of gendered, relational and life course analyses of nurse migration.

In this chapter, I have also argued that, although economic security was a predominant incentive for participants' entry into nursing and their subsequent migration, the women and men in this study also portray their career choice in terms of self-development and ambition, with nursing used as means to engage in a

different way of living. This challenges representations of migrant care workers as 'immiserated' and migrating simply for family survival. I have also argued that, although salary and working conditions are important factors influencing participants' choice of destinations, institutional contexts governing possibilities for family reunification mobilised participants towards more favourable environments, thus highlighting how they navigate migration regulations in a variety of potential countries, and the central role that family plays in these decisions.

Whilst the nurses in this study did not know exactly where specific destinations might lead them, many of them have explicit socioeconomic goals they want to reach as a result of their migration, and they often viewed these goals through the lens of a cultural sense of obligation to care for family. Their contributions to the families left behind—such as paying for the dowry or educational expenses of a younger sibling or paying for improvements for houses or building their own house—are tangible examples of the economic achievements that gives the nurse a position as a daughter, son, husband or wife contributing to the welfare of the family as a whole. However, when changes in the lives and needs of those in the destination country occur, it influences their transnational care practices. This chapter has also pointed to the issue of mother-child separation in the context of the nurses' migration. It is to such experiences and a focus on childcare post-arrival to the UK more generally that the thesis now turns.

Chapter 5 Negotiating Work and Childcare in the Context of Migration

Responding to new migration opportunities, shaped by structural and gendered inequalities, and moral and cultural obligations to care, the previous chapter illustrated the nurses' accounts of how and why they became 'nurses on the move'. Economic, family, and life course issues were central factors for understanding participants' accounts of their entry into nursing and decision to migrate. Such considerations did not disappear following their departure for the UK. However, approximately ten to fifteen years after leaving India for the UK, sometimes via a third country, the family relationships that nurses in this study are embedded in do not remain frozen in time. They alter as needs and responsibilities change over the life course (Ryan, 2015). Indeed, the nurses in this study have experienced marriages, births, miscarriages, promotions/demotions, further migration, children growing, the loss of parents, or witnessing (from afar) them becoming older and frailer. Such changes shape and drive a diversity of family obligations, support needs and exchanges of care (Wall and Bolzman, 2014).

The aim in this chapter is to discuss specifically how the Indian-trained nurses in this study negotiate their childcare responsibilities post-international migration. As discussed in Chapter 2, the care migration literature pays a great deal of attention to the processes underpinning transfers of physical and emotional reproductive labour and their impacts on households and families (Hochschild, 2000; Parreñas, 2001; Yeates, 2009). Sensitised by the global care chains perspective and its focus on the redistribution and reorganisation of care in the context of migration when collecting the data constituting this chapter, I initially envisioned writing a chapter on childcare in the context of nurse migration using terms such as 'care deficits' and understanding separation as 'endangering familial intimacy' (Hochschild, 2000; Ehrenreich and Hochschild, 2002). I was thus somewhat surprised to learn that the women who migrated as mothers had all been reunified with their children. In addition, the women and men who had children following their migration to the UK

were also living in propinquity to their children. This suggested to me that the period of transnational motherhood and its attendant caring practices can be better understood through a diachronic lens rather than presenting a 'snapshot' view (Baldassar and Merla, 2014b; Bonizzoni and Boccagni, 2014).

The first section of this chapter thus reflects on transnational motherhood as a phase in the migration and family life course, and as a childcare strategy. Since the majority of the nurses' spouses and children co-reside with them, the key focus in the rest of the chapter is the nurses' negotiation of their caregiving strategies in response to their work and migrant status, as well as changes that happen over personal and family life courses. Indeed, the arrangements migrants are able to make if children move with them or if they give birth to children after they have migrated is under-researched (Datta, McIlwaine, *et al.*, 2010). These strategies take on local and transnational forms. By viewing the period of transnational mothering as a phase in the migration and family cycle and focusing on the broad range of strategies participants deploy, the chapter illustrates how nurses' strategies of caregiving take place within and across borders, as well as connecting the public sphere of paid care work with the private sphere of unpaid and paid care work (Wong, 2014). This reveals complex family and social dynamics that change over time, as well as pointing to some of the intersections between migration for nursing care and transnational family care. Although this chapter is organised loosely around phases of migration and thus could be read chronologically, it is worth noting that participants continue to draw upon a range of these strategies over time, and these are not mutually exclusive nor linear strategies.

Before analysing participants' strategies, it is worth quickly reviewing their family biographies that brought them to the point where they had childcare responsibilities in the UK (see Appendix A for a description of participants' demographic, migration and family characteristics). Eleven interviewees, all women, had been involved in transnational care for their children in the past, and one participant, Beejuu, was still

separated from her children at the time of interview²³. None of the men in the study had experience of being transnational parents, because all only married and had children after they had arrived in the UK, with some suggesting that they had not been in a financial position to marry before engaging in international migration (see Chapter 4). Twelve participants had their children after their arrival to the UK, and two participants had no children²⁴. This meant that twenty-two participants had child/ren present with them in the UK, and amongst this group, twenty had at least one young child (aged ten or less), and three participants had children who were all older (aged ten or more).

5.1 The Phase of Transnational Motherhood

The biographical experiences of the ten²⁵ nurses in this study who migrated as mothers, illustrate that childcare could take place in multiple locations—India, the Middle East and the UK—and that childcare arrangements and care practices changed over time. The initial stages of their migration period was generally characterised by transnational mothering, and some reflected on this time sadly. As Preeti explains:

In 1994 I was pregnant with my first one. I had to come back for delivery from Saudi. I left her, then after the delivery, I stayed forty days with her and then joined back to work. Then my in-laws looked after my wee one, my husband was in Dubai on oil rig. It was really hard, hard times.

The anguish and guilt that Preeti and others said they experience to this day points to the persistence and intensity of the emotions associated with separation from children, points made in the literature (Hondagneu-Sotelo and Avila, 1997; Parreñas,

²³ Since our interview in 2014, Beejuu has returned to Kerala to be with her husband, children and parents, reflecting her long-term strategy of earning enough money in the UK to allow her to become a full-time homemaker and leave the workforce.

²⁴ The voices of these participants, John and Roxy, are not included in this chapter, which focuses on participants with children. However, their experiences are included in the analysis of transnational care exchanges with family in India in Chapter 6.

²⁵ Eleven women had experience of transnational mothering. Eleven of these migrated to the UK as mothers. The other participant had children following her arrival to the UK, but as discussed later in the section, sent her child back to India to be looked after by her mother.

2001; Pratt, 2012). For those participants who were mothers whilst working in the Middle East before their arrival to the UK, the lack of family reunification policies in some of these countries meant they were separated from children for lengthy periods. Gaya, for example, spent over seven years separated from her children. This had implications for her capacity to provide proximate care for her family remaining in India. Her children were very young at the time and technological advancements in communications were not yet available to her, so although she tried to phone regularly, she felt deeply disconnected from her family. Giving up nursing, Gaya eventually returned to India to be with her children. However, the constraints of the joint family contributed to her decision to try to come to the UK, so once again, she became a 'nurse on the move' and a transnational mother.

As discussed in Chapter 4, some interviewees experienced separation from their children due to their internal migration as nurses within India. They wanted to live together as a family, but found this extremely difficult in the Indian context. Asha, for example, could not find a job nearby her mother who could look after her child whilst she worked. Her husband worked in a different state, so rather than putting her child in paid childcare for long periods, she left her son with her mother and visited every second weekend. Her desire to live together as a family was a contributing factor in her decision to go to the UK (see also Chapter 4). However, in order to 'be together', these women had to undergo a(nother) period of separation due to the British labour and migration context shaping non-EU nurses' insertion into the labour market.

The challenges and uncertainties associated with their work and immigration status at the early stages of their migration to the UK resulted in an initial period of *planned* separation, for a variety of reasons, such as visa and work status, and inadequate living conditions (in terms of housing and income):

I came as a Senior Carer so I was not having the proper money or visa to have the family or keep the family here. So what we did, we sent both the kids to India from Kuwait where we lived then, they were looked after by my parents. The younger one was only two and the elder one was six years. So we sent them there and my husband was working in the Middle East. After I came here, six months, we needed all the paperwork, salary slips and all that to bring the husband here. So I worked here for six months in the residential home and then the employer let me bring the husband here. So then I brought him here after the six months. We didn't have enough money to keep the children here, so it was nearly two years before they came. (Susanna)

As Susanna suggests, she was aware that she would be separated from her children for a period of time due to the constraints of her migrant status. She thought her children would be able to come to the UK quite quickly, but it took her over two years to save enough money for their dependency visas. Participants' needed to show 'adequate'²⁶ income and housing in order to qualify for family reunification. For some participants who became registered nurses relatively easily, this was not a problem. However, those nurses who were 'stuck' as care workers in nursing homes rather than working as registered nurses in hospitals found it difficult to meet these requirements.

For those participants who were recruited directly into the NHS, as well as some who were recruited into nursing homes, the institutional context was set up so as to allow them to reunify with their husbands and children relatively quickly. These nurses were automatically enrolled into overseas nurses' adaptation programmes, which meant that it was relatively straightforward to acquire the Nursing and Midwifery's (NMC) Personal Identification Number (PIN) within three to six months. This PIN

²⁶ At the time the nurses came to the UK, they had to satisfy a UK Home Office official that they could financially support their dependent family members. This was very difficult to do when they were on the low wages of a carer. Until they were working as nurses or had saved enough money, they were unable to invite their spouse and children to the UK. A minimum income of £18,600 was introduced in 2012 for citizens or residents to bring a spouse into the UK. For those who are also bringing dependent children the post-2012 threshold rises by £3,800 for one child and £2,400 for each additional child (Sumption and Vargas-Silva, 2016).

allowed them to work as registered nurses, and thus gave them the adequate salary, status and living conditions to reunify with their husbands and children fairly quickly. However, some participants felt that there had not been sufficient monitoring by the NMC of adaptation placements nor of mentoring systems. This situation was exacerbated by the lack of adaptation places for overseas nurses because no trained mentors were available (Smith, Allan, *et al.*, 2006). Parish and Pickersgill (2005) noted that in 2005, 39,000 overseas-trained nurses were waiting for adaptation courses whilst working in the British care sector. These problems influenced the introduction of the Overseas Nurses Programme (ONP), as was discussed in Chapter 1. However, Smith *et al.* (2006) argue that this still left a significant backlog of nurses awaiting ONP places.

Lengthy waiting times for adaptation and the ONP were evident in many participants' stories of their working lives in the UK, with some working as carers on minimum wages for up to two or three years whilst waiting on their adaptation:

My husband came after around six months [pause] Because I was a carer, it was only like £4.05 per hour, so minimum wages, so we needed to pay the house rent and all the other bills, it wasn't enough to get the family, my son, over. It was difficult as well, like I had to wait about two years. It was a tough time. (Rosy)

In 2001, September I came to Liverpool through one of the agency, you know, then I did two years working, waiting for adaptation to get that PIN number, we had to do the adaptation to work as a nurse. So we have to work as a carer, you know like, supervised carer. So was only minimum wages, so like £4.05 or something, for like over two years. (Joji)

Rosy and Joji's protracted period of time working as carers can be viewed as contributing to their deskilling, whereby they do not get to practice their nursing skills, but also constituted a source of cheap labour for the private nursing homes where they worked (see also Cuban, 2013). Their location at the lower end of the care labour market clearly had wider implications for the social organisation of

family life. The group of women in the sample who were unable to rapidly access these adaptation programmes were separated for longer periods from their spouses and children than they had initially anticipated when they planned on leaving India. Not having the appropriate work permit nor sufficient finances meant that these participants were unable to provide proximate care for their children. Instead, as mentioned earlier in this chapter, they attempted to care transnationally for their children and were supported in doing so by a range of other actors, grandmothers in particular and fathers if they were resident in Kerala (although many of the nurses' spouses also lived abroad, working in the Middle East whilst waiting for their dependency visas to come to the UK).

The period of being separated from their children undoubtedly caused some of the mothers in this study pain and suffering, with some crying whilst recalling this time in their lives. However, it was nonetheless perceived as a *transitional* condition, a necessary step to be taken before returning to the 'ordinary' relationship of co-presence with children (Boccagni, 2012, p. 264). Transnational mothering, in other words, was a *phase* which one had to go through, despite the sufferings involved—not a desirable condition, nor a goal in itself (Boccagni, 2012). This indicates the dynamic aspects of mobility for family structure, but also the institutional resources and constraints in both home and host societies. Reunification was delayed for this group of women, not because of their migrant status (i.e. they followed official and legal paths in their entry to the UK) but because of their relatively unprivileged positions as low-paid carers in the British stratified nursing system, which made it difficult for them to establish themselves in the UK and hence acquire the capacity to immediately invite their spouse and child(ren) to the UK. Once they obtained the NMC PIN however, they were able to secure sufficient economic resources to improve their living conditions, pay for flights and visas, and realise their dream of reuniting with their family in the UK.

This is where the experiences of the women in this study depart from women in some other studies of migrant care workers, where family reunion was a continually postponed dream (Pratt, 2012). The women in this study, with their education and nursing qualifications, were able to (eventually) acquire the necessary resources to reunify, illustrating the importance of an intersectional analysis in studies of feminised labour migration (Fresnoza-Flot and Shinozaki, 2017). They were able to tap into their status as 'skilled' migrants, despite their experiences of discrimination and downward deskilling in the UK (See Chapter 7 for further discussion of participants' experiences of labour in the British context), and eventually reunify with families. The study of overseas nurses as skilled migrant care workers who have regular migration status, coupled with an attention to the passage of time, thus illustrates the transitory and varied nature of transnational motherhood.

While transnational family life eventually led to reunification with their children, the linearity implied by this is misleading, as the period of separation may be reproduced at different times under changed circumstances. As illustrated in Gaya's story, she engaged in transnational mothering whilst in the Middle East, reunifying with her children in India, before engaging in transnational mothering again. This reflects the stepwise migration pattern that many migrant nurses follow (Amrith, 2010; Carlos and Sato, 2010; Paul, 2011), discussed already in the Introduction and Chapter 4. However, transnational mothering is not experienced just by women with children born abroad, but also by women who face difficulties in taking care of children born in the UK. This pattern of transnational mothering is rarely discussed in the literature (although see Bonizzoni, 2014). In my study, it was the difficulties of adequately caring for children in the context of long working hours and a lack of informal support that prompted these care crises in the two mothers who sent their children back to India to be cared for by family members.

Jenny, for example, described the difficulties in looking after her first child after he was born. Based on this experience, she decided that she did not want to go through

this again, and negotiated care of her child with her mother who would remain in India:

She could come frequently to support me with the childcare, so it was a great help. When she wasn't there, we struggled. Because I finish work and my husband would start work. And if I was getting a late shift, we had to depend on someone, which we didn't want to. Troubling someone is not good. Don't want to go for childcare and things, because I was very sceptical about that, leaving my child with someone else, would they look after him, I don't know much about that. And it's very expensive - £400-£600 for childcare. And I thought 'what's the point?', you're earning all this money and then just handing it over for childcare, it's too much. So we wanted to manage it by ourselves, which was very stressful. So Mum kept coming and supporting. It worked. And then when I had my second one, which was some years later. Em, Mum came over again for this delivery and then she went back. At that point, I decided I will not have the same situation what I had with my elder one. He was too small, we've got the elder one already with us, and having another baby at home would be a bit more stressful. And so I left him back home for one year. I left him when I went for my maternity leave and I left him for one year.

Jenny very clearly weighed up the care resources available to her in both the UK and India, pointing to the expense of childcare, as well as a wariness of the market's involvement in her intimate family relations, and the constraints of working long hours. Based on this and her previous experience, she made the decision to employ the unpaid care of her mother in India in order to balance her work/care obligations in the UK. Reiterating 'it was only for one year, that's all', Jenny made clear that this period of separation was an intentional, although difficult, phase for her and she was reunited with her son just over a year later. Of course, this arrangement 'worked' and made sense for Jenny because, as Boccagni (2012, p. 269) argues, the period of separation was expected to be a transient condition, foreshadowing a return to 'natural' co-residential family arrangements.

Jenny's experience of separation, as well as the other accounts discussed above, reveal how family members' experience of separation is often connected to changing circumstances. This group of mothers reconfigured their caregiving strategies in response to changing demands of their multiply-situated workplaces, drawing on both local and transnational strategies that shifted over time. A temporal lens also reveals that parenting and childcare not only take place transnationally, but also in local contexts following reunification, something we know very little about (although see Krogër, 2003; Wall and José, 2004; Doyle and Timonen, 2010). It is to nurses' accounts of their negotiation of childcare in the UK that the chapter now turns, which brings into view other actors, and illustrates some of the difficulties the nurses experience in balancing work and family life as well as their navigation of such challenges.

5.2 Negotiating Childcare Between Parents

Dislocated from their familial support and wider kin networks, participants employed a number of strategies based on a combination of both formal and informal care in order to manage work and childcare. Sharing personal care and domestic work more equally between both parents was a common strategy for almost half the participants. They often worked in opposite patterns to their spouses; one parent worked the night-shift whilst the other worked the day-shift. This was made possible due to nursing being a shift-oriented occupation. Indeed, the six participants who were married to another nurse or a carer tended to rely on this to meet their childcare responsibilities, although this was reliant on a workplace that allowed flexibility and encouraged a child-friendly working environment. Some participants had managers who were very supportive and sympathetic to their attempts to reconcile their childcare and working lives:

Like we can always adjust shifts. If we, if both of us are working, we can adjust the shifts and my manager is pretty flexible, really really nice and helpful. (Rosy)

Whilst some participants described managers and workplaces that were 'family-friendly', allowing them to signal their preferred shifts and swap with their colleagues, not everyone had such sympathetic managers, as Pothan describes:

In my hospital, there's an e-rostering system which is not child-friendly at all. So both myself and my wife work in the hospital, but they're not very flexible to give us. Sometimes we will be on the same shifts. And our son is only one years old, so I think he's too young to go to nursery, maybe another year or so. So it's getting very difficult. So my wife has reduced her hours and has gone to part-time to accommodate childcare, and I have to take annual leave in between.

The contrast between Rosy and Pothan's experience of negotiating their shifts around their childcare indicates that the efficacy of this strategy is predicated on supportive work environments and child-friendly work practices.

Whilst rotation of shifts between the parents was a common strategy, the difficulties involved in this type of arrangement were apparent. George, who was married to Anitha, another nurse from Kerala, responded to my question about managing work and childcare, illustrating the struggles involved in trying to 'balance' these worlds:

Nikki: And just in relation to childcare. How do you organise that?

George: That's the hardest part. You have to work opposite and you know, I work full-time and so does my wife work full-time. And so we do normally get one day off together a week. If you're on the night shift, and the next day she's on the day shift, obviously you can't sleep. You've got the school-run and everything. It's really hard.

The stress of working opposite shifts came through in many participants' accounts, with particular emphasis on the difficulty in managing during times of crisis, such as when a child was sick or following the birth of a child with disabilities. This was often when participants called on family members from India to come and help them (see Chapter 6 for more discussion on the support that participants received from

their parents when they came to visit them in the UK). In several cases, parents described only seeing each other for one day per week, having only fleeting interactions on the other days, when they met during the handover of children. Of course the balancing acts that Rosy, Pothan and George attempt in their daily lives are not exclusive to migrant families, but also reflects neoliberal reforms of the welfare state in the UK, where childcare (and care more generally) is increasingly privatised (Pollock, 2004; Grimshaw and Rubery, 2012). The majority of nurses in this study have acquired either PR²⁷ or British citizenship and are therefore eligible for state benefits, such as childcare subsidies, but they cannot easily afford the high costs of formal childcare²⁸, nor access childcare that would adequately cover their shift work patterns. Whilst the rotation of shifts as a strategy to manage employment and childcare is based on the 'dual-earner model', other families negotiated one parent becoming the primary carer of children. Since the women earned more as nurses than their spouses who were not nurses, this meant in many cases, it was the fathers who took on more childcare responsibilities as the nurses continued to work full-time, becoming the main earner in the family.

5.3 Turning to 'Father-centred Care'²⁹

Whilst transnational caregiving is qualitatively different from 'local' caregiving by the very fact that the capacity to exchange care takes place over national borders (Baldassar *et al.*, 2007, p. 15), caring amongst resident families in the UK often involves a range of actors, and is shaped by transnational arrangements. The majority of the nurses who were mothers at the time of migration to the UK had children who

²⁷ At the time of my interviews with participants, the UK Home Office Border Control Agency's regulation for foreign nationals was that, in order to become a permanent resident (PR) in the UK, a person had to live and work in the UK for five years as a work permit holder. After five years, s/he becomes eligible to apply for permanent residency or a settlement visa. After acquiring this visa, a non-EU nurse no longer needs to obtain a work permit when applying for a new job—she has freedom to work wherever she likes. Individuals with PR can travel in and out of the UK as they like, once they retain some social links to the UK.

²⁸ In Britain, the average cost of sending a child under two to nursery is £222.35 per week for full-time hours (The Money Advice Service, 2017)

²⁹ 'Father-centred' care draws on Wall and José's (2004) conceptualisation of 'mother-centred' care in their analysis of migrant childcare strategies. Their typology of strategies does not include a father-centred approach to childcare.

were quite young, often babies or toddlers. Upon reunification, the nurse and her husband had to manage by themselves, according to the work schedules of both parents. Evidence from interviews and informal discussions with nurses and their spouses suggests that childcare was often 'father-centred', where the fathers in the family cut back on employment or left the labour market in order to undertake caring duties whilst their wives went to work:

Sometimes I work days as well as nights. So he works 9-3, he drops the kids to school and then he picks them up after work. So that's what he does. So he's gone part time now in order to go, to fit the childcare actually. To fit in with the childcare. (Mary)

This turn to father-centred care was a renegotiation that was significantly influenced by the nurses' husbands' migration category as 'dependent' and their insertion into the UK labour market, as illustrated in the following extract:

Nikki: Can I ask you how you made the decision for you to work full-time and your husband to work part-time?

Cecelia: Because they came as dependents, I came for adaptation and I got a job. And of course, as nurses, we are the ones earning more than, so that's why I'm doing the full-time job, because if he works full-time also, he won't get that much. So we can't balance it, the finance. And the children too. We needed to mind the children, collect from school. So I decided to work the full-time and him the part-time [laughs]. So it's very different from back home, he would be looking after us [laughs]. Big difference.

The policies governing the nurses and their family members' insertion into the labour market, emerging from their categorisation in the UK's migration regime, meant that participants were required to work a number of hours (37.5 hours) in order to meet the requirements of their work permits. As mentioned earlier in the chapter, most participants and their family members have since acquired PR or British Citizenship, meaning that they are no longer required to work a minimum amount to fulfil visa

obligations. Since the nurses are the ones with the relatively good salaries³⁰ and secure contracts, father-centred care appears to remain a common means to meet childcare responsibilities within the Indian nurses' family, even whilst participants stressed that this was not the preferred division of labour in the household.

Moreover, some of the nurses' husbands had difficulty entering the British labour market, as often their 'foreign' qualifications were not recognised (see also George, 2005; Percot, 2012 for similar accounts of nurses husbands' circumstances following migration). After arriving in the UK, often on spousal visas, the husbands of the female nurses in this study were often unable to secure work in the areas where they had worked in India or the Middle East:

He was working in the supermarket in Tescos as a baker [laughs]. His profession has changed from hotel management in Kuwait, he came over here then he was in bakery work because children, when the children were here, we cannot go for work like night-time. Because I am on day-time work, he cannot go in the day time so he stopped that hotel management here. And after coming to the UK, he worked in Tesco, in the bakery as a baker [laughter]. (Susanna)

Many of the female nurses across the sample described their husbands as being trapped in low-paid, low-skilled jobs. In Gallo's (2006) ethnography of migrants from Kerala in Italy, many of the men evaluated Italy as 'not a good country for men'. The same could be said for some of the husbands of the nurses I met. Beejuu, for example, managed to secure visas for her family to join her after eighteen months of separation. Her husband got a job as an assistant cook in a hotel, unable to get a job commensurate to his experience as a teacher. They managed childcare by him taking part-time hours and working in shift rotation, whereby Beejuu worked the night shift whilst her husband worked a day shift and vice versa. Beejuu said her husband got 'fed up with this, no life, just at home all the time' and when his mother

³⁰ Most of the nurses in this study were on Band 5 of the NHS pay scale. The scale in 2013/14 (time of interviews) ranged from £21,388 to £27,901. The 2017/18 Band 5 pay scale is £22,128-£28,746.

suffered a minor illness, he returned to India with the two children, whilst Beejuu remained in the UK:

He is the youngest one. So he's gone to look after them. He is responsible for them as he's the youngest. He's there nearly three years now so I, you see, we need financial support now. Like when you go there [to India], we have some expenses, we need money. He's not now working, he's just trying to get a business now, like so I had to stay back for some financial support. That's why I stayed back here.

The pressure of deskilling coupled with the obligations Beejuu's husband had in India to his parents thus contributed to Beejuu's return to transnational care for her children. She talked about sending regular presents to her children, regular visits to sort out uniforms and school books, daily communication as well as financial support, but predicted a much-hoped for return to India in the near-future—I subsequently heard that she did indeed return to Kerala.

Such arrangements (men as primary carer and woman as main breadwinner) is a marked difference from the idealised patriarchal organisation of care and work in the Malayali family, where fathers are typically the breadwinners and mothers are associated with the home (Osella and Osella, 2000; Isaksen, Devi, *et al.*, 2008). Globalisation, as Kimmel writes, 'disrupts and reconfigures traditional, neo-colonial, or other national, regional or local economic, political and cultural arrangements. In doing so, globalisation transforms local articulations of both domestic and public patriarchy' (2001, p. 24). In transnational nurse migration, the migration of men as 'dependents' creates new domestic power relationships, undermining the husband's ability to act in accordance with Indian ideals of masculinity (see Chapter 4). In Kerala, the image of these men as 'following their wives' is a negative one. They are commonly mocked in novels, films or newspapers as emasculated, with their wives seen as exerting control over them, reversing the 'normal' role (Percot, 2012). In discussing their husbands' role in childcare and their lack of careers, the women in this study who relied on father-centred care often drew on tropes of sacrifice, describing men who had hurt their careers for the good of the family upon migration

to the UK. The sacrifices that their husbands had made by giving up, or reducing, their commitment to paid work and taking on the role of a stay-at-home parents were not, however, portrayed as sacrifices performed to support their wives' careers. Rather, participants stressed that these sacrifices were made for the benefit of the children:

He is actually a very dedicated Dad, like not going back to his career or anything. That's for the boys, not for me to concentrate on my career, but for the boys. He's working with Tesco, because he had trouble to get a good job when he came over to UK, and because we had problems with childcare. Because our families are not here, and I was working full time. 37.5 hours per week. So he's only working part-time. So it's a sacrifice. He's working with Tesco, so he works at night-shifts there. He's stuck there. [laughter] So I totally regret that, I kind of spoiled his career, because I brought him over here, where he couldn't find a good job. So that's why he just started with Tesco at that time. Then our children were born. He couldn't find another job and we just thought, let the boys get a bit bigger and then he can find or do another course or something to get back to his work. So it takes ages, ages then. Even though now he's thinking about going backwards in his career. So that's why he's doing this course now, so hopefully he will get a good job after this.
(Maryam)

As Maryam suggests, this renegotiation of men's role in formal and informal care exchanges were not without its costs. In describing their husbands' deskilling, underemployment and their role as the primary caregiver as sacrifice, participants' accounts were notably marked by expressions of guilt and regret. This may have been one way to reconcile the reversal in gender roles and the men's economic dependence on their nurse wives.

Quite often the women laughed nervously when discussing the differences in the gendered division of labour since coming to the UK, comparing it to the way life would be if they lived in India:

I would be a full-time Mum in Kerala, not working unless I really had to. Maybe stay at home looking after the kids. And

he going to go to work and he's going to feed us [laughs].
That's what would happen if we were in Kerala, it's different.
I think the pay for nurses are better than the pay he gets, so
that's why we couldn't afford I can go to part-time until he
gets a good job. So once he gets a good job, then I can move
to part-time. Then he can be the main earner [laughs].
(Cecilia)

Cecilia and the other women's laughter points to the difficulty of reading emotion in the interview context, suggesting they were uncomfortable in discussing their husband's stalled careers and the altered division of labour regarding childcare and earning. This is illustrative of how a focus on emotions can surface different aspects of nurses' accounting. In interviews and informal chats with female nurses, they frequently indicated they felt guilty and full of regret because of their husband's deskilling that had occurred alongside their own often (limited) career progression in the UK (see Chapter 7 for more detail on the nurses' accounts of their working lives). These feelings of regret and guilt must be analysed in the context of the altered division of labour and the stereotypes of nurses' husbands as emasculated. Guilt, regret and uncomfortable laughter was one way that the female nurses in this study resolved tensions between the idealised patriarchal organisation of care and their everyday realities. Indeed, some of the nurses also suggested that although they were the higher earner in the family, their husbands retained control over the family finances, suggesting that despite many husbands taking on the role of primary caregiver, other dimensions of the traditional division of labour in the home remain intact. However, others in the sample described sharing tasks in the household such as cooking and cleaning more or less equally between the couple. This suggests that whilst some husbands may have done most of the childcare, the traditional division of labour in the home is not fully transformed.

Constraint rather than choice was often emphasised in participants' accounts of their turn to father-centred care as a strategy to meet their work and care obligations. As McKie et al. (2002, pp. 898–899) note, it is not simply personal choice that leads to women rather than men giving up their jobs to look after children, or indeed, decide

to work part-time. Instead this reflects the strong adherence to traditional domestic and family roles, as well as government policy regarding caring and work. However, in the context of the nurses in this study, it is the husbands who are encouraged by the policy structures to give up their jobs or take up part-time work, at least whilst the children are young. The addition of the migration regime, determining migrant category and entitlements and influencing earning potential, establishes a particular context by which the father emerges as the most likely candidate to become the primary carer for children. Class is also relevant here, as the nurses, whilst skilled professionals, are not elites, so the costs of childcare also delimit options for childcare, as Jenny points out in the earlier extract when discussing her decision to send her younger child back to India. Participants' guilt over their husbands' lack of career in the UK and the sacrifices they have made in order to care for young children also points to the intersection of different temporalities in negotiations of work and care—the temporality of the life course, with its different and differing dependencies, as well as the temporality of career paths, within national and global economies (McKie, Gregory, *et al.*, 2002, p. 905).

Locke, Seeley and Rao (2013, p. 1882) argue that migration often involves (re)negotiations of social reproduction by migrants and their families, negotiations that are heavily inflected with gendered power relations in ways that are specific to individual and family life course. This points to the temporality of these arrangements, as well as illustrating how adjusting to labour market constraints and opportunities can lead to changes in the gendered division of labour. Of course, this is not something particular to migrant nurses, or migrants *per se*. However, the childcare negotiations within the families in this study were specifically related to the women's migration as nurses, and their husbands position as 'dependents' who had 'followed their wives'. The discussion of father-centred care highlights some of the more invisible actors involved in discussions of transnational families, although more recent literature on care migration has started to pay attention to men in care work (Näre, 2010; Sarti and Scrinzi, 2010) as well as the gendered dynamics of transnational families and the processes of their social reproduction (Fresnoza-Flot,

2014; Kilkey, 2014; Gallo and Scrinzi, 2016) and the variability and dynamism of these arrangements. Of course, this study also included men in the sample. However, these men did not have experiences of being a transnational parent, in the sense that they only had children after their arrival to the UK and continued to co-reside with their nurse wives and children. This illustrates one of the ways in which 'transnational migration affects women and men in gender specific ways' (Salaff and Greve, 2004, p. 160). However, rather than focusing only on how migration places a heavier burden of responsibility on women, the analysis in this section reveals some of the costs for fathers and the emotion work that women do to navigate such costs. Whilst many participants routinely arranged their childcare through the rotation of shifts, or through father-centred care, and on rare occasions, left their children in the care of others in India, gaps in care for their children often emerged. The next section reflects on how participants looked beyond the nuclear family to extended and fictive kin, drawing on both local and transnational solutions, within the public and private spheres, in their quest to meet their care obligations and commitments.

5.4 Localised Negotiation of Formal and Informal Childcare Resources

Transnational families engage in care that is both proximate *and* transnational (Wall and José, 2004; Kröger and Zechner, 2009; Kilkey and Merla, 2013; Wong, 2014). Following reunification and in the absence of affordable state-run childcare, the nurses in this study described drawing upon shifting combinations of local and transnational networks in their attempts to provide proximate childcare (Ryan, 2007). Many participants described how, despite rotating shifts, they still encounter times when they were not able to cover childcare between the two parents:

My wife works opposite to me. And there are some clashes between us, because of duties, so we will swap with other staff. Sometimes we have to send the kids to the child-minders. Usually, according to the culture, we never send the child to the child-minder when they are three years old, because we are a bit concerned about it. We don't want to send them, we want to keep them with us. But when we, you know, different country, different things, so we have to adapt

to that as well. So we had to send our kids to the child-minder sometimes. (Thomas)

Whilst Thomas used a childminder occasionally, it is interesting that the overwhelming majority of the families in my sample did not make use of nannies, childminders or nurseries. From the little they said about this, financial considerations and an uneasiness at allowing strangers to care for young children especially, were reasons for not relying on such help. Furthermore, Shah (1998, cited by George, 2005, p. 94) contends 'religious, cultural and linguistic traditions thus prevent such South Asian families in the United States from using McDonald's, European nannies, or microwave ovens as comfortably as a white family, even if they can afford it'. Whilst this point is debatable, many participants in this study suggested that they do not feel comfortable leaving their children with paid childcare providers. Anisha was the only person in the sample who used a nursery for her children, although she said that this was quite an unusual practice amongst the Indian families she knew. As one of the few nurses in the sample who was working at a high grade in the NHS, and with a husband who had a good job, she could afford to spend money on childcare. However, this was not the case for the majority of participants, who were at the lower end of the NHS pay scale for nurses and who often had spouses working in low-paid jobs. As described in this chapter so far, participants instead tended to adjust shift work, or leave children with family members either resident in or visiting the UK (discussed in more detail in the following chapter), or with friends and neighbours in the UK.

In her work on Irish nurses in Britain, Ryan (2007) illustrates that women relied on different sets of networks, both in Ireland and the UK, over the life course. One set of networks that participants in this study drew upon when experiencing a gap in care were other Malayali nurses and their families. Some of these friends were women and men that they had trained as nurses with. Susanna, for example, talks about her surprise at meeting friends from her nursing school days:

Same flat, same school, can you believe it! But they moved after marriage, no before marriage, to Muscat, you know Gulf countries, Oman. But after that, we didn't have any touch. Then when we came here, we found out that they are here, in the same place. After a while, we came to know that they are here. It was so nice to know this. So you know, when the community comes, you know each other, people, so we met each other.

This friend, and other nurses she had met in the Middle East continue to live and work alongside Susanna in the UK, forming a supportive community that sometimes look after each other's children, particularly during times of crisis. When Pothan, for example, had to return to India last minute due to his grandfather's imminent death, the community helped his wife with childcare:

There are a few families here, so we help each other a lot. If there's an emergency, kids and stuff. My wife had to go to work, so the kids can go to someone else's house to be looked after. So in an emergency, there are, you know, we got nearly 15 families from India, from Kerala. We all help each other. That is how we work in India even, we help each other you know. The community is the same here, we help each other, like family. Even money-wise, we will help each other. So I went home for the week no problem.

Relying on the Malayali community during his time of crisis, Pothan referred to the reciprocal and kin-like nature of these community relations. Other participants also described how they drew on fictive kin when they experienced gaps in their childcare cover, sometimes referring to these friends as 'like family' or 'sisters'. These were often close friendships that had been formed in nursing schools back in India, illustrating the significance of networks operating informally between migrant nurses in influencing their strategies for combining paid work and childcare (Ryan, 2007, p. 299).

Although supportive, most participants also noted their Malayali friends were also under pressure from combining long hours with childcare arrangements and hence could not be relied on as a regular form of childcare:

Here you don't get any support from anybody. Because even my friends who are staying next door, I can't go and help them because I am working. And they are also working. You can't take care of their children and your own. You cannot do. But back home, it's not like that. You can even give to your cousins and go - just give the children to the cousins and go. That is what is missing here, I'm missing that a lot here. (Beejuu)

You don't have anybody, if the kids are poorly, or even if you are poorly, you don't have anybody to cook for you and pick up the kids. You have good friends, but again, it's not like family, you can't always mind them like that, maybe one times or two times or in an emergency, but not every time, you can't do that. (Anisha)

Support from friends was thus not like support from family—it was not a form of unconditional support that they were able to rely upon regularly, but rather a stop-gap to meet occasional care shortages. The support that these professional nursing networks provide in localised settings nonetheless, however, is another way that participants meet their caregiving responsibilities in the absence of the expected proximal family support they would receive in India. A small number of participants also described non-migrant support for childcare, namely neighbours who were of similar religious backgrounds. Preeti, for example, had an elderly Irish neighbour who used to mind her children occasionally after school if she or her husband could not make the pickup time. In turn, she would bring this woman to the local church on Sundays. Others mentioned Filipino neighbours that were also nurses and Catholics that they would sometimes exchange childcare with. These were not regular arrangements though. It thus appears that whilst the Malayali community, neighbours and friends could be relied upon during times of crises, regular and more everyday care gaps tended to be managed within the family. As a result, many struggled in the absence of extended familial support. This was most stark in Denny's case in particular, where he turned to private care for support (see Chapter 3 for a methodological discussion about the 'uncomfortable reflexivities' involved when Denny revealed his use of this form of care in the domestic sphere).

Denny and his wife, Bintu, are both full-time nurses, caring for their young son by working opposite night and day shifts. The couple initially relied on their parents for childcare and other household responsibilities, such as cleaning and cooking, when each came for six months to help out with the first year of their son's life. The couple then struggled for a year on their own, trying to balance their working lives with having a young child, and not using commercial care or getting support from the Malayali community because 'everyone is too busy too'. Denny recalls this period:

We did one year like that. We had to do rotation night and day, it was so difficult. So difficult to adjust to life like that. Totally different. And that's difficult, so difficult. Even sometimes, couple of hours may be difficult, because maybe there's a crossover.

The couple rotated shifts, with Bintu working nights and leaving work at 7am to catch the bus, which got her in the door at around 7.30am. Denny left home for the morning shift at around 7am, leaving their one-year-old child alone in the house for approximately thirty minutes most weekday mornings (see Chapter 3 for a discussion of the ethical considerations I had to make following this interview). The difficulty in negotiating work with childcare within the nuclear family is most apparent here, resulting in a thirty-minute window every morning where it was difficult for the couple to meet their caring obligations. After a year of this, they decided to bring a domestic worker back with them from India. Bridging the public sphere of paid care work and the private space of unpaid and paid care work by employing a live-in domestic worker from India, Denny and Bintu represent a dual-income couple who shifted the burden of care to another woman in a live-in-care arrangement³¹. The care work literature has not attended to how flows of skilled and unskilled labour intersect in the spaces of the home or how migrant care workers might be implicated in the reproduction of inequalities (Wong, 2014). This may be due to the relative lack of

³¹ As discussed in Chapter 3, the encounter surrounding the employment of this woman was stilted and uncomfortable. One possible reading of both my and Denny's discomfort in the interview is that this woman was undocumented, especially considering that live-in domestic workers, particularly those without legal status, are often vulnerable to exploitation (B. Anderson, 2007).

research on skilled worker migration, as well as treating the public and private aspects of such workers' lives as separate.

Denny was alone in the sample in his employment of a live-in migrant domestic-worker in the UK. However, other participants often brought up their past use of domestic workers in India and/or the Middle East when discussing their current care arrangements in the UK. This illustrates the range of informal and formal strategies that the nurses draw upon in different contexts and at different times of their lives. Pushpa, for example, had live-in help when she worked in Delhi, a luxury she said she was able to afford because her husband had a good job at that time (although, as per the earlier discussion in this chapter, since his move to the UK, he has worked in a number of relatively low skilled jobs). Asha spoke about her sister-in-law's employment of a servant to help her with childcare and household responsibilities and told me she had enquired into bringing a domestic worker over to the UK, but could not because of visa restrictions. Reflecting on her disappointment, she stated:

Comparison is a normal thing, it was like this here and it was like that there. My sisters got maids coming to do her work, my in-laws and my family have got maids. Here you are the maid, you are the driver, you are the cook, you are the everything here. But that's the way it is. I'm not the only one. There are hundreds of them like that, there are thousands like that. That's the way the system is.

Other participants who spent time in the Middle East used domestic labour to help them navigate work and childcare. Susanna, for example, employed domestic workers from India and Sri Lanka to help with her childcare and domestic duties, and Gaya paid Filipino nurses to mind her infant son whilst she worked in Saudi Arabia. Although the use of domestic workers was a thing of the past for the majority of participants, they continued to compare lives past and present when thinking about their childcare arrangements.

The turn to migrant domestic labour as a solution to participants' own care crises is very interesting in the context of feminised migration and globalising care, because it suggests an interconnection between these two forms of globalised care labour and the hierarchies involved in terms of the migration of care workers. These hierarchies emerge out of the intersection of class, gender and immigrant status, and point to the reproduction of social class in care chains. Wong (2014, p. 33) argues that the literature on care worker migration neglects to attend to 'how women can be simultaneously providers of care work in public spheres and sites and employers of care workers in private spheres across multiple spaces and scales'. Whilst migrant care workers are typically seen as subject to the forces of globalisation, the analysis above illustrates that they can also participate in the employment of other migrant women in their quest to manage their work and care responsibilities. The involvement of participants in what is generally portrayed as 'exploitative' relations in the global care chain literature further extrapolates on global care relations that are structured along various axes of inequality.

The global nursing care chain literature argues that the recruitment of nurses from the poorer countries to richer countries is structured by gender, class, race and geopolitical inequalities (Yeates, 2009). Yet participants' ability to be working parents is sometimes predicated on the back of a further set of gender and class inequalities, highlighting the importance of paying attention to the diversity of women from the global south (Raghuram, 2004; Baldassar and Merla, 2014b) as well as the necessity of employing a transnational intersectional lens in the analysis of migrant care workers (Fresnoza-Flot and Shinozaki, 2017). Overseas nurses' use of migrant domestic labour demonstrates the value in bringing together a care chain and care circulation lens. The care chain lens facilitates the mapping out of the exploitative global relations that underpin the migration of both nurses and domestic workers whilst the care circulation lens broadens the focus to include multiple actors and takes into account the ever-changing interdependencies and contexts in which the nurses in this study live. Employing a domestic worker, though fraught with complexity, allows families like Denny to cope with high childcare costs whilst also

fulfilling their familial obligations to send money back to India. If Denny and Bintu could bring their parents to the UK on a longer term basis, the couple's childcare and eldercare obligations might be met, and they may not have any need to employ a domestic worker. The institutional contexts that makes this impossible are discussed in the following chapter, when the key focus turns from childcare in the context of nurse migration to reciprocal care relations between the nurses' and their ageing parents remaining in India. Before doing so, I will reflect on some of the findings of this chapter.

5.5 Conclusion

The objective of this chapter was to discuss how the Indian nurses in this study negotiate their childcare responsibilities post-international migration. As suggested in the introduction to this chapter, I initially conceived of childcare in the context of migration predominantly in terms of separation and rupture. Instead, what the analysis in this chapter reveals is that a focus on the dynamic nature of transnational family life makes visible some of the constraints and motivations underpinning family separation across borders, as well as the ways in which the nurses in this study navigate and attempt to overcome this arrangement. What emerges in this chapter as a central dimension of skilled migrants' caregiving are the changing circumstances of work and family life in shaping childcare arrangements.

The analysis extends the literature by illustrating how the migrant nurses in this study continually reconfigure their caregiving strategies in response to changing demands of their multiply-situated workplace(s), and their (and their spouses') shifting migration status, as well as the changes that happen over personal and family life courses. The period of transnational motherhood was a phase in participants' lives, perhaps to be reproduced in the future as they encounter new care challenges, but finished for the present as the majority of participants lived in proximity to their spouse and child/ren. Their mobilisation of support from local and transnational family relations and local social networks to meet their care needs illustrate the

creativity and agency in alleviating some of the care challenges that migration engendered. In turn this challenges the tendency of those employing a care chains lens to portray migrant women from the global south as helpless victims of the global economy (Evergeti and Ryan, 2011).

The chapter also illustrates how the caregiving strategies of skilled migrant women and men are embedded in political economic systems—in particular, the analysis highlights how social policy regarding childcare and employment shape the patterns of their labour market and caregiving experiences. Immigration policies specifying who can enter and under what conditions, visa restrictions, as well as the (non-)recognition of qualifications and deskilling that often accompanies this shape the duration of family dispersal across borders as well as gendered division of care labour within the family. This shift to father-centred care marks a potential shift in the division of labour in the private sphere, and is largely invisible in accounts of care worker migration which tends to emphasise how women bear the burden of care work more heavily than men. This is not to say men's participation in childcare somehow rubs out gendered asymmetries in caregiving; rather, the analysis points to the different ways in which migration for nursing intersects with familial care, and there appears to be costs for men as well as women. Finally, and related to this point, this chapter also makes the empirical case for the importance of an intersectional lens for understanding how power operates between differently positioned women (and men) in the global economy. The nursing care chain framework facilitates thinking about the global processes underpinning international nurse migration; Yeates' (2009) framework argues for the inclusion of nurses due to their different care skills as well as their (relative) positions of privilege compared to domestic workers and nannies. This allows for an understanding of nurses as occupying positions of privilege sometimes. Whilst they are considered skilled professionals, this and the previous chapter illustrates that they do not come from elite backgrounds. Their caregiving options and choices are thus often constrained by their (and their family members) changing migration status, as well as their position in the lower end of the nursing hierarchy (Smith and Mackintosh, 2007). An intersectional lens, recognising

the interplay between gender, class, race, migration, and citizenship for example, is important for understanding the processes underpinning the stratification of care labour globally (Colen, 1995). It also illustrates how participants come to or want to employ paid domestic caregivers in their homes, to mediate the tensions associated with balancing work and family, an exploitative practice that reinforces their class privilege (Wong, 2014).

The relatively undiscussed issue of migrant nurses as simultaneously providers of care work in public spheres and sites and employers of care workers in private spheres suggests a care chain analyses might be the most appropriate approach when thinking about how participants organise their children's care in the UK. However, the use of multiple formal and informal, proximate and transnational care networks that participants in this study have drawn upon at different points in their lives suggests that imagining care as *circulating* can add something to the analysis; it captures the multiple actors involved in reciprocal, multidirectional and asymmetrical flows of care, and how these might change over time, illustrating the synergies between these two different, yet complementary approaches. Regardless of the lens, the chapter advances research on care chains and care circulation by presenting the various intersectional tensions that the combination of professional work and caregiving pose for skilled and mobile Indian women and men. Whilst this chapter has focused on various dimensions of transnational parenting over time in the context of nurse migration, the next chapter emphasises the reciprocal and multigenerational aspects of caregiving in the Indian nurses' transnational family, illustrating how people occupy caregiving and care receiving roles along a spectrum of dependence and independence that changes over time (Zhou, 2013)

Chapter 6 'Everybody is there for me...and I'm always there for them': Reciprocal Care across Transnational Space

Still my mum is there for me, my uncle and aunties, everybody is there for me. for any advice I want, anything I do, and they will always ask me too. And I'm always there for them as well if anybody needs. So it's not that I'm here, earning all this money. If somebody needs that, I'm always there to give that to them...I feel like it's my turn now to do this now. I'm very happy to do this. But it's more than money, we do what we can, they do for me and I do for them, they had my son for over a year. So I don't take it as 'oh, it's a burden, I have to do this' or anything like that. Because I was supported when I needed it, so I'm supporting when someone needs. And the cycle goes on. (Asha)

The previous chapter, which illustrated that the period of transnational motherhood was typically a phase at the earlier stages of migration to the UK, challenges the idea that the children of migrant nurses were 'deprived of the joys of physical contact, the emotional security of physical presence and the familiarity allowed by physical proximity' (Parreñas, 2005a, p. 335). Similar arguments have also been made about the fate of the elderly. Media reports and public discourses favour an 'alarmist' view of the desertion of aging parents in transnational families, where they are portrayed as being left behind and uncared for by their migrant children (see Knodel, Kespichayawattana, J., Saengtienchai and Wiwatwanich, 2010). As discussed in Chapter 4, a prevalent cultural norm in the Indian context is that parents and children will provide reciprocal care for each other; in Kerala, the youngest male son and his wife are expected to care for aging parents (Visvanathan, 1989). Visions of a 'crisis' in the contemporary Indian family is thus centred on ageing and elder care, spurred by daughters-in-law working outside the home, as well as the transnational migration of male and female adult children (Lamb, 2009). In this context, nurse migration could be understood as a process that deprives the nurses' families and elderly parents of the care they need and expect, or in other words a 'care drain' (Hochschild, 2000, p. 17).

However, in the opening extract of this chapter, Asha describes her transnational family as 'being there' for one another, despite the geographical distances separating them. This suggests that these families may continue to care for each other in diverse ways³². As discussed in Chapter 2, a growing body of literature has illustrated that migration does not necessarily disrupt familial bonds and that transnational families employ different strategies to overcome physical absence and distance, sustain bonds and exchange care (Bryceson and Vuorela, 2002; Kilkey and Merla, 2013; Baldassar and Merla, 2014b). Following this literature, this chapter discusses participants' accounts of reciprocal and asymmetrical care exchanges with their (ageing) parents remaining in India, examining their transnational care strategies and the provisioning of care within transnational families, and its changes over the life course. The nurses in this study ranged in age from early-thirties to mid-fifties so it is not surprising that the ages of their parents vary. Some participants had what can be described as 'young-old' parents, who were in reasonably good health and able to travel. Others, what Baldassar et al. (2007) call 'old-old', are not in good health or have difficulty being mobile. As parents age and experience acute and chronic health issues, transnational family care practices and the provision of care have also changed since the nurses left India ten to fifteen years ago. The opening extract to this chapter, where Asha describes the care relations with her family remaining in India as a 'cycle', intimates some of the issues that will be explored throughout the chapter. Themes such as familial obligation and duty, intergenerational reciprocity, and the changes in these as family members shift between independence and dependence over time are all discussed as central aspects to the migrant nurses' experience of transnational care.

In this chapter, I take the connections that some participants' made between their care for elderly patients in Britain and the care for ageing parents remaining in India as a starting point. In doing so, I am not equating the nurses formal care work with

³² This chapter is based on participants' accounts of their care exchanges with family members in India and thus cannot verify, for example, whether participants' parents feel that this care is satisfactory and/or meeting their expectations (see Chapter 8 for further discussion on the limitations of the data).

their informal familial caring nor do I suggest that this constitutes a 'transfer' of care from family in India to patients in the UK, as per Hochschild's (2000) argument on 'care drain' (see Chapter 2). Instead, I suggest in this chapter that culturally informed ideas about 'appropriate' intergenerational familial care seem to influence how participants talk about caring for ageing patients. This leads some to reflect on their own obligations towards their parents remaining in India. The rest of the chapter then turns to participants' accounts of everyday care relations within the transnational family. Whilst the financial aspects of transnational care were touched upon in Chapter 4 and are returned to in Chapter 7, the focus in these latter sections remains on virtual caring practices and 'the visit' because these were the main ways that participants said they exchanged various forms of care with their transnational families. Regular communication and reciprocal visits were important ways to 'stay in touch' and 'be there' for each other. However, many participants also referred to times when their parents experienced health issues and problems. The final section of the chapter reflects on the emotion work and intense effort that is often required to 'be there' when parents encounter the challenges of ageing, returning to the use of information and communication technologies (ICTs) and visits during these times of crisis. In reflecting on both 'routine' and 'crisis' care (Baldassar *et al.*, 2007), the aim of the chapter is to highlight some of the ongoing and everyday attempts to maintain presence in the context of physical absence. This illustrates that the different types of caregiving arrangements participants and their families rely upon are dynamic and vary over individual, family and migration life cycles. Indeed, the focus in this chapter is the everyday nature of these long distance relationships and how the nurses continue to engage in meaningful care relations with their families in India. Through doing so, the chapter brings to the fore the (asymmetrical) reciprocal and multigenerational care exchanges between the nurses and their families in India (Baldassar and Merla, 2014b).

6.1 Making Connections Between 'Here' and 'There': Caring for elderly patients

Since their arrival in the UK, the majority of the nurses have had direct experience of working with elderly people, either through care homes or through their work in NHS hospitals. Several participants made connections between their physical absence from their family members in India and the care they provided to their sick and ageing patients:

I'm not there with them [parents], but I'm here looking after patients. So I think, this is how I would like to look after my Dad, my sister. (Sindhu)

Wherever you go in the world, you have to look after your patients like your own Dad, your own Mum. Because you're not looking after your own Dad, your parents, you are looking after somebody else. So you have to consider that 'this is my Dad, this is my sister, this is my Mum, this is my grandmother'. So I got that, you know, that touch, so wherever I work, I think 'this is my patient, this is my Mum, this is my Dad, brother, sister'. So that's my approach. (Joji)

In the care home it was good, because in one way, I got a chance to care for the elderly. Because, that is how we come up in India, it is the culture. In India, we care for our own grandfather, grandmother, so much. So in life you get some opportunities to do something, sometimes we have to enjoy that. So I had to look at it in this way, that I'm getting some opportunities to care for some elderly, while my parents are home, my grandparents are far away. (Thomas)

The connections that Sindhu, Joji and Thomas draw upon between 'here' with patients in the British hospital and 'there' with family in India might be interpreted as illustrative of some of the links that Hochschild (2000) and other care chain scholars suggest—that 'care' is displaced from parents and other family members (as well as health systems) in the global south to the global north (Isaksen, Devi, *et al.*, 2008; Isaksen, 2012). At first glance, this could certainly be read in this light, where the gains and losses of nurse migration are unevenly spread between the UK and India. India has lost skilled qualified nurses (Gill, 2016), whilst simultaneously gaining from remittances (Khadria, 2006). Participants' described the multiple ways

in which they missed being physically present with their parents. For example, Anisha missed the warmth of a hug from her mother during a difficult time in her life, Joe talked about how his parents wanted to see and hold their grandchildren on a daily basis, and Cecilia wants to 'simply sit' with her elderly mother and keep her company. In turn, as discussed in Chapter 1, the UK reduced its spending for nurse education, training, and staffing as well as increasing tax revenue from nurses, their partners, and the working families that got nursing home beds for their frail, elderly parents (Isaksen, 2012). The nurses' role as daughters, sons and grandchildren in turn influences the relationships they establish with the person they care for. But can this be understood as a loss of care and love from families in India to the UK? Rather than a 'transfer', participants' perception of patients is terms of family relations can be read as an articulation of their distinct values, systems, and ethics of care.

The relational dynamic of nursing clearly involved the nurses' own sense of what was appropriate care. This can be understood as a 'migrant ethic of care', where migrants' life experiences and cultural values shape their experiences of what constitutes 'good care', and thus influences the way they work (Datta *et al.*, 2010). In the following extract, for instance, Beejuu compares the treatment of patients in British care homes and hospitals with the norms of intergenerational reciprocal support for the elderly in India:

My mother wants me home. All of them want us home. I want to be there to look after them. When they are old, like you know, like the same feelings here, when you see them in the nursing home and you see people with dementia, you just feel that they have to be looked after. It's the same way, you think about your parents the same way. They should be looked after. They're old now. They should not be neglected; we should not be neglecting them. I'm really feeling this now actually. You see a patient who is really old, you feel sometimes, 'is he a Dad or is she a Mom or a brother', you know I do really feel that. I feel like that. I wonder where their families are. It's hard.

Beejuu is clearly drawing on an ideology and norms about appropriate care for parents. When confronted with what she perceived as the neglected bodies of elderly patients, she was also confronted with her own obligations towards her family, which in turn surfaced feelings of guilt at her inability to 'be there' with them to provide 'hands-on' care. This perception of elderly patients as abandoned appeared to create unease for Beejuu, which she attempted to redress by drawing on family-based relations with her patients. Both Beejuu, and Thomas in the above extract, drew on a moral framework that is deeply informed by Indian national culture and values, and closely linked with their views on who ideally should be responsible for the provision of elderly care i.e. their adult children (Visvanathan, 1989; Lamb, 2009).

In almost all talk about elderly patients in the UK and family life more generally, participants invoked images of the Indian multi-generational family, frequently constructing India as being 'more caring' and superior to British care values. Nursing homes were likened to prisons, and participants emphasised that this was not how elderly people were treated in India. Maryam, for example, when discussing her experiences of working in care homes said:

I was always feeling sad seeing the grandparents and seniors in the home. Like in our atmosphere in India, it was totally different. We don't send out parents to a nursing home, we just keep them with us until they die. So I just felt so heartbroken sometimes, when people leave their fathers and their grandparents there. But that's the system of how it goes in this country, it's not good for seniors.

Like Maryam, most participants said that care homes were not the norm in India and in the cases where they did exist³³, it was due to an inadequate family support system and was thus 'shameful' for the family. This supports research that shows the strong preference in Indian families for elder care to occur within the home (Brijnath, 2012). Care homes are, in this sense, spaces that symbolise an abdication of familial

³³ The provision of care for older people in India is increasingly provided in care homes and the industry has mushroomed in India since the 1990s (see Lamb, 2009; Menezes, 2014 for more details on the increasing use of institutional homes for elderly care provision in India).

responsibility, and studies in this area point out that the stigma against care homes results from their associations with the abandonment of relatives, family conflict and psychological distress (Lamb, 2009; Brijnath, 2012). Working in nursing homes in the UK seemed to remind some participants of their parents' and grandparents' own care needs and their obligations to them, and prompted unease about the fate of their ageing parents.

In a very broad sense, the care and love that patients receive from migrant nurses could be read as 'displaced' from the global south to the global north. However, this would not accurately represent participants' accounts of their relationships and exchanges of care with parents and family members remaining in India. Although some participants drew connections between their nursing of patients 'here' to their absence from family members 'there', they did so by drawing on a 'migrant ethic of care' that was influenced by the norm of intergenerational reciprocity within Indian families (Datta, McIlwaine, *et al.*, 2010). This suggests that emotional responses to patients are occurring within a relational and biographical context, and they are of course also connected to the professional values of nursing (Burkitt, 2014). This is illustrative of the argument made in Chapter 2 that emotions are not a fixed and stable commodity possessed by the subject, nor an object transferable from the global south to the global north. The remaining sections in this chapter further illustrate that argument, demonstrating that it *is* possible to care in the context of physical absence. As Yeates (2009, pp. 49–50) suggests, rather than a displacement of care from family members in the global south to children or the elderly in the global north, feminised care labour migration may be more about a transformation of care than a straightforward 'transfer'. Indeed, as Asha suggests in the opening extract to this chapter, care often 'circulates' between family members residing in home and destination societies (Baldassar and Merla, 2014b). Nevertheless, it is clear that when women and men move for work and leave family members behind, the care relations that the nurse migrants were part of prior to their migration to the UK are reorganised. These points are explored empirically in the rest of this chapter, where I

focus on participants' accounts of their everyday care relations with family members 'left behind', and how these care practices have changed as their parents age.

6.2 Maintaining Emotional Bonds Across Distance through ICTs: Reciprocities and Asymmetries

As illustrated in the above discussion, the tension between what some participants feel they *should* be doing compared to what they *are* doing often leads to feelings of guilt and unease. Lamb (2002, 2009) argues that material support, the services of caring (such as cooking, cleaning, providing companionship and so on) and intimacy within the family are central dimensions to reciprocal exchange within the Indian family. Participants in this study intimated similar understandings in their accounts of what constitutes 'good' care. Lamb (2002, p. 308) suggests that *physical* proximity is key to the creation and maintenance of emotional and physical intimacy. She found that older people joined their emigrant adult children in the United States as a means to practice intergenerational reciprocity. However, the British setting provides a different structural context where it is extremely difficult to sponsor non-immediate family members beyond a six-month visitor visa, a point returned to later in the chapter. Participants in this study thus turn to innovative ways of 'caring for' and 'caring about' their ageing parents in the context of their migration to the UK. In these sections, I draw on the temporal distinction between 'routine' and 'crisis' distant care to capture the varying forms of care across the life-course (Baldassar *et al.*, 2007). Routine care follows a regular pattern of communication and regular visits to 'stay in touch'. Crisis care is typically required during crisis events in the transnational family life cycle, such as the period immediately following migration, in the lead up and period after the birth of a child, following miscarriage or a period of illness when a particular need arose, or when parents lose their independence and become frail or ill. Baldassar (2007b, p. 394) notes that these patterns of routine and crisis caregiving change over time due to developments in communication and travel technologies. In reflecting on participants' accounts of caring from a distance during these different periods, the analysis reveals the time, effort, and resources involved as participants figure out new ways to care and create emotional closeness. The

predominant way that care was practiced was through regular visits (to both the UK and India) and through regular communication facilitated through ICTs. The rest of this section reflects on the use of ICTs to provide 'routine' care in the everyday.

The exchange of emotional care is at the core of transnational family relations, and transnational communication is vital for migrants to convey that they 'care about' their ageing parents (Baldassar *et al.*, 2007; Zechner, 2008). ICTs are not only a means for unidirectional care though, as participants' described their parents as supporting them through these technologies. Communication practices, such as making a call or instant messaging on social media sites, become key practices through which all types of family comes into being, although accentuated in transnational ones (Madianou, 2016, p. 185). An extract from a post-interview note following my meeting with Alice is illustrative of some of these issues:

Not long home from a night shift in the care home where she has worked for the past four years, Alice stared at the laptop screen in front of her as we wrapped up her interview. From her flat in a northern English town, she concluded that the lights were out in her village in Kerala, a prediction she made due to the lack of a green dot beside her brother's Facebook profile and the unanswered Skype call just before my arrival. She had been looking forward to talking to her mother, telling her about her children, what she was going to eat that day, enquiring about the family and neighbours in India. During these calls, Alice tended to be vague about her work in the nursing care home, because her family thought she worked for the NHS as a registered nurse, a job she imagined within her reach upon leaving India in 2008. Alice communicates with her family every day, through Skype, Viber, SMS messages, email and Facebook, although her brother, who lives nearby, has to set up the calls for her mother as she finds technology difficult to operate. Whilst she visits India once every year or two, the everyday contact with her family in India allow her to feel close to her parents, particularly her mother, who is a diabetic. Alice regularly gives advice to her mother regarding diet and exercise, and gets multiple texts throughout the day detailing her mother's blood sugar levels. Alice said this makes her 'feel useful and close' to her mother, and she likes to think that the advice she provides to her mother with her health is akin to the care she gives the

elderly people she looks after on a daily basis. (*post-interview note from interview with Alice, 8th March 2014*)

In briefly describing Alice's routine contact with some members of her family in India, the centrality of communication technologies in emotionally bridging geographical distance between family members is clear (Wilding, 2006; Madianou, 2012; Madianou and Miller, 2012; Baldassar, 2016). Alice uses a combination of 'polymedia', or a 'plethora of internet- and mobile-phone based platforms such as email, instant messaging (IM), social networking sites (SNS) and webcam via voice over internet protocol (VOIP)' to manage her relationships and exchange care with family members back home (Madianou and Miller, 2012, p. 1). Through regular communication, Alice shares details from her everyday life, she checks in on family members and they check in on her, she monitors and advises on health issues, and tries to protect family members from details of her life that might cause them distress. She said sometimes the content of her calls 'do not matter, we talk about everything and nothing', but it is the act of being in touch that matters to the family. This suggests that:

Communication technologies, instead of being used (however unsuccessfully) to compensate for the absence of our close ones, are exploited to provide a continuous pattern of mediated interactions that combine into 'connected relationships', in which the boundaries between absence and presence eventually get blurred (Licoppe, 2004, pp. 135–136).

Indeed, participants frequently talked about knowing everything that was going on back in India through constantly being 'in touch' through such polymedia environments.

Wilding (2006) argues that transnational families can share an experience of co-presence through these virtual ways of being together. The practical and mundane aspects of the nurses' regular communication with their parents and extended family back in India were frequently used as a means to maintain and (re)produce emotional closeness:

I miss my parents and my family, but it's still, I can talk to them at least every day. Compared to when I first moved and was studying, and was writing letters. It would arrive weeks later. But now we don't hardly write anything anymore [laughs]. People won't communicate with letters now, isn't it? It's all phone, texts. We are so close now. (Joji)

The speed at which communication was now able to take place compared to the earlier stages of her migration clearly allows Joji to 'feel close' to her family members not only in India, but around the world. Regular communication was also a means to give and receive emotional support for some participants in the study:

Before I was married, I used to ring them at least three times a day if I was feeling on my own, I was quite homesick. Every day without fail I ring them. And you know because there is Skype and things, Whatsapp. I stay in contact with my sisters everyday also. I don't use Skype every day, once in a week or so. But I ring them definitely. The one who I don't ring because it's too expensive is the sister in Kuwait, because it's too expensive, but I send voice messages to her, texts, Facebook. Everything. Every day with parents though. Especially now that I have a daughter, she's their first grandchild. So I send pictures every day. (Leela)

Leela's account of her changing ICT use is linked to changing care needs connected to her migration and individual life course. At the earlier stages of migration, when she was a homesick young nurse working in a care home in a rural area, she called home regularly and received emotional support from her parents in India. As she said 'I cried and they would listen'. She is now more settled in the UK and has a young child, sending pictures of her daughter to family members around the world. Since her parents had not yet met their first granddaughter at the time of interview, the ability to have regular video-calls and send photos regularly and cheaply was very important. She said that it allowed her family to 'know' their daughter and her daughter to get familiar with her parents and Malayali language. Similar sentiments were repeated across the sample, whereby ICTs facilitated the maintenance and development of relationships between grandparents in India and grandchildren in the UK. Leela's description of her combined use of multiple ICTs to communicate with multiple family members in different locations is also illustrative of how all

participants weigh up the best mode of communication depending on the costs and needs of multiple family members.

However, as discussed in Chapter 2, the reciprocal exchanges of care between family members is often asymmetrical, with women tending to shoulder the responsibility of transnational and local care (Ryan, 2007; Baldassar and Merla, 2014b). Studies on South Asian families point out that kin work is highly gendered, and deeply embedded in the formation of women's 'ethical and moral selves' with a strong sense of duty and obligation to the family (George, 1998). This is also connected to the ideal South Asian woman as the dutiful wife, the obedient daughter-in-law, and the self-sacrificing caregiver. Although both the women and men in the study described regular and frequent contact with their parents, the work of regular and daily communication fell more readily to the women in the sample, with some of the men describing their wives as being the main initiators of contact. George, for example, said 'I do try to speak to families at least once every two weeks, but she [his wife] phones at least twice weekly [laughs] and the kids are in regular contact with parents for once or twice a week as well when my wife is talking to them'. The other men in the sample described using Facebook to share pictures and Whatsapp to chat, but it was invariably their wives who had synchronous communication with family remaining in India, more regularly and for longer durations.

The women in the sample described their regular communication with parents in India as typically consisting of gossip and mundane details of everyday life, and about 'staying in touch', suggesting that this constant flow of messages (texts, emails, phone calls and so on) comes to 'represent the closeness of the relationship with faraway kin, regardless of the actual content of each message', allowing people separated by vast distances to 'be there' for one another (Baldassar, 2014, p. 394). Several of the women described calling their mothers when they felt homesick, and how the mundane details of village life make them feel somewhat better. They laughed telling me about their parents' shock when they called to inform them about

events taking place in their village or town, which they had found out about through social media before their parents knew about them. Of course, exchanging such mundanities involved being able to contact parents at the push of a button, which also enabled an 'ambient' and omnipresent sense of their presence in their daily lives (Madianou, 2016). Laughing and sharing such mundane details constituted emotional support circulating to and from geographically dispersed family members; the content of these conversations can be understood as aimed at 'being present' with the other person. The intense effort and emotion work involved in this was evident however. Mary, for example, described regularly falling asleep whilst Skyping with her mother after a night shift. Roxy phoned her sister and parents every day before and after her shift in a busy and understaffed hospital to 'just talk about nothing', and spent most of her days off talking to them. Joji said she stayed on the phone literally all day on her days off. However, the women who engaged in this pattern of communication often emphatically stated that they did *not* consider this as a burden. It can be considered work nonetheless, because it involved a lot of energy, time and commitment. One reading of their reluctance to call this constant communication a 'burden' could be that it is a way of assuaging the guilt that some feel, especially as their parents age and were sometimes more vocal in their desires to have all their children back in India. It also points to the strength of the cultural gendered norm of caring as something that women do. This form of 'being together', besides regular but infrequent visits, was thus the only way to be together on an everyday basis, so the women in the study had to work extra hard at making it work.

Whilst many participants described talking about 'everything' with their mothers in their attempts to maintain emotional closeness, some admitted that they withheld details about their lives from their parents. 'Protecting' family members remaining in India from news that could upset them came up in several interviews with women, requiring emotion management. Alice, for example, who was working as a Senior Carer in a nursing home, unable to achieve the language requirements set by the NMC, was very careful with what she shared with her parents about her daily working life:

I'm just waiting until I can become a nurse, and then I'll tell her. I don't want to worry them. She [mother] would just get so upset, she just wants me to be happy. I will tell her, but only when it's over.

As discussed in Chapters 1 and 4, nursing has traditionally been seen as a low-status job in India associated with stigma (George, 2005; Nair and Healey, 2006). To tell her parents that she engaged in the body-work typical to a nursing home—such as changing bedpans and washing bodies—felt shameful and ‘embarrassing’ to Alice. She made the decision to withhold this information and these emotions from her parents until she found what she understood to be more dignified work, thus reinforcing the image of the ‘good daughter’ at the same time as the ‘ideal immigrant’ (Cuban, 2017, p. 186).

Although only Alice and one other trained-nurse continue to work as carers, other participants described keeping aspects of their working lives from their parents (see Chapter 7 for a discussion of participants’ working lives). Some participants described keeping personal information from their families in India. Rosy, for example, recalled a time when she was seriously ill, yet did not tell her mother because she did not want to worry her. The disruption to their daily communications, as well as the sound of Rosy’s weak voice, signalled to her mother that something was wrong. Eventually Rosy’s husband told her mother that Rosy was in hospital, but the couple decided not to tell the family in India about the serious nature of her illness. Equally, some participants had experiences of their families in India not disclosing information they thought might upset them:

Sometimes they don't want to give me trouble or tension. They don't want to say they're unwell. But I know by their voice and can see by looking at them, that something is wrong. My mother normally says everything to me but my father hides some things. (Preeti)

Although ICTs can be a medium for generating and maintaining closeness, and as Preeti suggests, the visual aspect allows one to see the other person and monitor their physical health through visual cues, they also allow for the withholding of

information. However, the lack of disclosure discussed here, whilst mediated through technology, is not that different to offline relationships where complete openness is rare (Brownlie, 2014). As Brownlie (2014, p. 182) goes on to note, beliefs about what should be kept private interact with other feeling rules, such as not wanting to worry or burden family members. Whilst care and emotional support certainly circulate between the nurses in this study and their family members around the world, the withholding of information and desire to protect family points to the emotion work and management that goes into sustaining bonds across vast distances. However, it is also important to note that not everyone involved in these transnational family networks have the same access to, nor the capability to use, such an array of communication technologies.

Whilst the chapter thus far illustrates some of the ways that participants and their parents exchange care through ICTs, the disparities in access and use of these technologies illustrate that the 'digital divide' is not a thing of the past (Wilding, 2006; Madianou, 2016). The global 'digital divide' can be described as an 'inequality in the power to communicate and to process information digitally' (Hilbert, 2011, p. 480). Such inequalities can be seen both within and across transnational families. Transnational family communication is contingent on the communication equipment and practices that the family can access, afford and that they are familiar with using. For example, participants' frequently made comparisons between the quality, availability and price of internet broadband in the UK and India. Showing me the communication hub he had set up in his sitting room, consisting of a desktop computer, webcam and speakers and referring to the cost of the set-up, George, for example, said:

We do have the webcam, but that is not going to work [laughs]. You know because the internet speed is not as good as here, you know. It's quite bad. It's quite slow in India, so that's a kind of rubbish. Sometimes it doesn't work. So, mainly over the phone. The phone. And obviously they see the photos over Facebook.

George's problems with using these new media are related to slow and unreliable internet networks in rural India where his family are based. As discussed earlier in the chapter, Alice also experienced difficulty in getting in touch with her family due to frequent power shortages and a lack of reliable networks in her village, suggesting that economic conditions and infrastructure also delimit the dynamics of transnational communication (Parreñas, 2005b). The global disparities in access to these technologies suggest that the internet remains unavailable, inaccessible and unaffordable to a majority of the world's population, with over one billion people offline in India, despite experiencing a huge rise in the use of ICTs in recent years (The World Bank, 2016, p. 7). George and Alice's problems illustrate that infrastructural inequalities can render the technology meaningless, or symbolic of the structural obstacles in communicating over vast distances.

It is not only inequalities based on access to technology and infrastructure however that obstruct the flow of care through a plethora of technologies; inequalities within and between transnational families regarding familiarity with ICTs can act as barriers to staying connected with geographically dispersed family members (Madianou, 2015). Some participants described how their parents did not know how to use computers due to their educational levels. Cecilia's mother, for example, was illiterate which not only meant that she had difficulties in accessing ICTs, but it also meant that she could not travel alone to the UK, due to the difficulty in navigating air travel (which also speaks to inequalities in accessing developments in travel technologies). In these cases, the telephone and international calling cards were the most prevalent form of transnational communication. As well as inequalities based on the political economy of India and parents' educational levels, many participants identify age and physical health as other factors influencing their parents' ability to access such technologies, a point also made in other studies of transnational care (Merla and Baldassar, 2011, p. 154). Age was implicated in asymmetries not only pertaining to knowledge of how to use such technology, but also the physical health to use it. Preeti's description of her efforts to communicate over distance with her mother is illustrative of these issues:

She can't hear as well, so I fixed a hearing aid for her last time, and it was very expensive, but she's not happy to use that. She said she can't hear anything, so when I phone, she can't talk as well. You know, she asks somebody else to tell her what I'm saying. It's quite sad.

These inequalities based on infrastructure, generation, health and class emerged as important dimensions of the digital divide in the sample, necessitating further emotion work during communications. Not being able to communicate easily with parents in India clearly made Cecilia and Preeti sad, especially since this was central to their expression of their care and love for their parents. However, such disparities in people's access and use of technologies did not impede participants' engaging in reciprocal care exchanges with family remaining in India. Preeti and Cecilia and those who also had 'old-old' parents stressed the importance of visits to India. As Preeti said 'thank God she's still there you know. When we go there, she's still there. Our parents are there at home, so we're very eager to go home. So hopefully we will go, we will see. We still need to find money'. I will return to ICTs as a mediation of care later in the chapter when I focus specifically on practices of care in the context of parents' healthcare issues. However, it is to 'the visit' and some of the issues that Preeti intimates that the chapter now turns.

6.3 Transnational Care and the Changing Geographies of The Visit

In the time since they left India for the UK, participants' physical absence has led to the reorganisation of everyday family care relationships. Preeti's parents, for example, have become quite elderly and her father is in need of 'hands-on' care. Since most of the family are nurses or married to nurses abroad, her brother and his wife returned home to take responsibility for the daily care of her parents. Asha relies on extended family and neighbours to look after her ageing parents since both she and her sister do not live near them. Pushpa sends regular money to her sister to support her looking after her mother on a daily basis. However, even when care is reorganised and ageing parents are 'cared for' by someone else in the family,

participants described being deeply involved and knowledgeable about the caring arrangements for their parents, through regular communication and frequent visits.

Participants talked about their relationships with their parents and other family members remaining in India by drawing on the norm of intergenerational reciprocity. As touched upon earlier in this chapter, many participants emphasised that adult children should provide care for their ageing parents, in return for all the energy, expense and love their parents drew upon to raise them in infancy and childhood, and for supporting them until they were 'settled'. Variations on the themes 'elderly parents should live with their family' and 'children should look after parents' were repeated across the sample. Of course, as Lamb (2002, p. 325) points out, the 'actual practices and experiences surrounding ageing in India (as elsewhere) are, of course, highly complex, varied and fraught with ambiguity', and this is certainly the case in this study. As discussed in the previous chapter, participants frequently arranged for relatives, particularly their mothers, to join them in the UK at various points. Visiting, in both directions (by adult children to parents in India, and by parents to adult children in the UK) as well as visits by other kin, were important aspects of maintaining relations for the participants in this study. Regardless of the direction or reason for the visit, most participants tended to emphasise reciprocal obligations and a cultural sense of duty underpinning this mutual support within the family:

My Mum came over and she was there during my delivery time and the baby was born and she looked after him and she looked after me. It goes around, because now I try to look after her. This is the system in India. (Jenny)

As discussed in the first section of the chapter, participants frequently drew on an ethic of care that emphasised intergenerational reciprocity when talking about both patient care and care within their own families. Jenny also points to this norm. Although her mother no longer visits the UK for a variety of reasons which I return to later in the chapter, inviting her mother to the UK was a means for Jenny to also look after her mother. Her mother would help out with the children, but in turn, Jenny would try to show her mother she cared during these visits by taking her on

days out, cooking for her on days off, spending time together, and buying her gifts. Inviting parents to the UK was thus one way of 'being together' and enabled participants to express their love to their parents. This was not always straightforward, however.

Although all participants' parents in this study continue to live in India full-time (for reasons elaborated on below), many take regular and routine trips to the UK. During these visits, participants described the support that their ageing parents provided in the form of childcare, cooking and cleaning (see also Chapter 5). This support was seen as especially helpful during the period when children are young and amongst those participants who negotiated their childcare through working opposite shifts.

They would like to look after us and our kids, that's the main thing. Rather than us looking after them, they would like to look after our kids. So they are missing that kind of, they feel like they are missing out. They have been here once, for six months and then gone back. After my son was born. And they helped us with childcare. (Sheela)

This marks a reversal of the expected direction of care exchanges. The envisioned 'Indian' system of intergenerational support, as mentioned earlier in the chapter, expects that adult children not only supply material support, but also provide key services, such as cooking, cleaning, and domestic chores (Lamb, 2002). Most participants would like to have their parents come to the UK to live with them full-time so they could look after their parents in proximity, allowing them to sustain the bonds of intergenerational reciprocity that many viewed as central to an 'Indian' and 'good' family.

However, life in the UK as experienced during these short six month visits did not seem wholly satisfactory for their parents, despite participants describing their parents' 'happiness' at spending time with their grandchildren and their willingness to do household chores and support their adult children. Studies on the experiences

of migrants' older parents in the destination country draw attention to their feelings of loneliness and social isolation, which suggest that proximity to the migrant does not automatically resolve eldercare issues or offer emotional satisfaction (Baldock, 2000; Neysmith and Zhou, 2013; King, Cela, *et al.*, 2014). These issues are evident in Rosy's description of her parents visits to the UK:

You can imagine them coming from the hottest country and coming here, they suffer. So they don't like it, but they, my Mum always says, 'if you want me to come I will come and help you', but they don't like the cold [laughs]. Like sitting in the house, like in our country, they will go their relatives and they will go to the neighbours and they will talk to people. But when they come here, they can't do anything, they're just sitting in the house, childcare or child minding, they can't do much by themselves. They like to spend time with children. But nothing else. So they don't really like to come here, but they always say if I need help, they will always come. Life is very different in Kerala, and my Dad came once and he said 'I'm not coming anymore' [laughs]. Because they have their own lifestyle, for years and years they've been used to it, but when they come here, they can't do anything. Also, they are getting older now.

Although Rosy's parents' views on their visits to the UK are not included here, their reluctance to visit the UK can also be read as linked to transformations in generational relationships. The adult children are busy working and do not have much time to spend with their visiting parents, whilst they in turn take on the domestic responsibilities of the household (see also Lamb, 2002, 2009). Rosy said her parents 'were there' for her, but she knew that asking them to come to the UK was not in their interest, especially as they were getting older. The cool climate in the UK was also mentioned by most participants as a reason why parents' were increasingly reluctant to travel to the UK for lengthy periods of time. Shobha similarly described her mother's only visit to the UK by saying 'she was supposed to come for six months, but she stayed only three months. She didn't like it here. It's cold and boring, she wanted to go back. So she went back'. The cold British weather was described as particularly hard for their parents to manage as they aged. Ageing and healthcare issues presented obstacles for parental visits to the UK more generally, and alongside institutional obstacles, shape the direction of the visits

between participants and their family members in India. Before turning to the participants' accounts of how they manage their parents' healthcare issues in the context of physical separation, I briefly reflect on some of the institutional contexts shaping the direction of visits between family members 'here' and 'there'.

A key structural process influencing parental visits to the UK, and therefore transnational family practices, especially when they involve non-EU family members coming to the UK, are the immigration regimes of destination societies (Bernhard, Landolt and Goldring, 2009; Kilkey and Merla, 2013; Merla, 2014). Drawing on Kofman's (2004) work on family-related migration in their discussion of the centrality of the transnational family to British family studies, Reynolds and Zontini (2014b, p. 262) suggest that:

A long-term objective of policies setting out to increase the immigration control of non-European Union (EU) (and Global South) migrants could ultimately be to disrupt and curtail their transnational family relationships and practices.

The majority of participants in this study now hold either PR or have obtained British citizenship so can move freely between the UK and India. However, as non-EU citizens, their family members face increasingly stringent migration regulations in their border crossings. These tightening immigration laws—immigration restrictions on pre-entry tests, visa restrictions on non-EU citizens and proposed increases to the sponsorship and income requirement thresholds—directly inform whether participants' family members can live with or visit them (Reynolds and Zontini, 2014b, p. 262).

In her research on Mexican families navigating the US border, Boehm (2008, p. 793) argues that 'the state penetrates and disrupts family unification, in part because of the state's presence in family life'. Boehm identifies the state's definition of the 'family' itself as a central way that the state disrupts families. European Union migration laws regard the family as nuclear and Britain introduced Immigration Rules in 2012 that

introduced a near-impossible threshold to sponsor an adult dependent relative to live in the UK³⁴. The result of this narrow approach to the family overlooks 'problems generated by caring at a distance...cultural differences in familial relationships, and the role of grandparents or other collateral relations in providing nurturing and support for different members of the family' (Kofman, 2004, p. 246). Although many participants, particularly those with 'young-old' parents, still invite their parents to visit and assist with childcare, for many, it has become much more difficult to do so, involving a lot of paperwork, effort and money. Maryam, for example, described gathering over twenty documents to support her parents' application to visit her to help her with childcare whilst she was doing nursing exams. It was successful on that occasion, but she referred to the parents of multiple friends who had their visa applications rejected, despite handing in similar documents and having comparable family circumstances. Other participants said they were increasingly reluctant to go through the whole process on a regular basis. They were aware that sponsoring family members to visit the UK is increasingly difficult, requiring a lot of effort for a visa that only lasted six months. Others said they were not able to show significant savings in their bank accounts, so did not bother going to the effort of applying for a visitor visa since they knew it would be automatically rejected. The ability to invite parents is thus dependent on the institutional context of the UK and the capacity of migrants to meet these (changing) institutional requirements and associated expenses (Kilkey and Merla, 2013; Merla, 2014).

Migration policies were not the only institutional obstacle facing the nurses in their desire to reciprocate care to their parents. The age and physical health of their parents as well as the British welfare system also influenced the direction of these visits. For example, the 'young-old' parents were in reasonably good health and able to travel to the UK frequently, to help nurses meet their work/care obligations by looking after

³⁴ Under the rules introduced in 2012, relatives must demonstrate that they, as a result of, 'age, illness or disability, require long-term personal care to perform everyday tasks e.g. washing, dressing and cooking... [and are] ... unable even with the practical and financial help of a sponsor to obtain a required level of care in the country where they are living' (JCWI, 2014). It is almost impossible to succeed in this visa category, with the All-Party Parliamentary Group on Migration (APPG) stating that this visa category has 'in effect been closed' (JCWI, 2014).

their children and domestic duties (see Chapter 5). Whilst 'young-old' parents came to the UK to help their adult children with childcare and domestic responsibilities and to 'be with them', this became much more difficult as participants' parents became older, ill or frail. Because non-EU visitors have no recourse to public funds, they must pay for any healthcare treatments that they need during their visit³⁵:

My mum came over after they were born. I asked her to come over to help, so she came over at that time for six months. She stayed for five months I think. The visa only gets for six months initially, but she stayed five months, because she was not that great. Because she has health problems and stuff like that, so she was not keeping that good, so the healthcare system in here, she won't get any free treatments because we have to pay for everything if she goes to a GP or doctor. So that's why, and it wasn't affordable at that time to take her and treat her here. So she went back. (Maryam)

So it's risky for her to be brought here in case anything happens to her, I need to pay for the whole health services, which I won't be able to afford. Just to be on the safe side, we didn't bring her back. Even though we had a visa, we didn't bring her back, because if anything happens, I'm not happy to spend, because I haven't got anything to spend. (Sindhu)

The multiple risks involved in bringing parents to the UK was repeated by many participants. Whilst Maryam and Sindhu are both British citizens, the macro-processes of state regulations complicate their family life, pointing to how participants' weigh up the risks and costs in sponsoring ageing parents to visit them in the UK. Instead of family reunification or visits to the UK, many Indian nurse migrant families opted for (or were forced to rely upon) visits to India in order to share periods of physical co-presence or to provide 'hands-on' care to their ageing parents. In the process of this, they lost access to a valuable source of support as they navigated childcare and household responsibilities whilst working full-time (see

³⁵ Under new rules introduced in 2015, people who live outside the EEA, including former UK residents, now have to make sure they are covered by personal health insurance when visiting the UK. Anyone who does not have insurance will be charged at 150% of the NHS national tariff for any care they receive (UK Department of Health, 2015). At the time of interviews in 2013, the NHS did not cover non-EEA citizens for health expenses and participants spoke about the difficulty in getting adequate health insurance for their parents for their visits to the UK that would cover these possible costs.

Chapter 5). These quotes also clearly point to the health problems that the nurses' parents were increasingly experiencing. Indeed, after discussions of 'staying in touch' through ICTs and visits, much of the discussions about care relations with parents residing in India focused on healthcare matters. As such, the analysis now turns to how participants' navigate caregiving in the specific context of parents' declining health, returning to how both visits and ICTs mediate 'crisis' care relations.

6.4 Managing Healthcare Issues Across Distance and Separation

Some of the care arrangements discussed up until this point have been based on scenarios where the ageing parents are healthy and independent. However, relationships are not frozen in time, but rather alter through the life course as needs and responsibilities change (Ryan, 2015). This can shape the spatialities of care that occur when the parents' dependency is increased, mobility is restricted and more proximate forms of care are required. At the earlier stage of the family and migration cycle, the nurses' parents supported their migrant adult children, for example by helping them financially with their nursing education and initial migration costs (see Chapter 4), looking after their children either in India, the Middle East or the UK at different points in time (Chapter 5) or as detailed earlier in this chapter, providing emotional support through phone calls and letters in the early stages of migration. The reciprocal nature of these care exchanges are clear, whereby the nurses' sent remittances back to India (Chapter 4) and as discussed in this chapter, also provided emotional support to their parents through the polymedia environment. As their parents have aged, the direction of caregiving has changed and participants began to (re)negotiate caregiving arrangements for their parents and kin remaining in India. This suggests that reciprocal visits, and the support that parents typically provided to their adult children and grandchildren during these visits, would become a thing of the past for most participants as long as they remained in the UK.

Achieving co-presence through regular visits to India was thus very important to the nurses in this study, with some returning once every year or two to spend more time with their parents. The scholarship on transnational elder care notes that parents' increasing age leads to an intensification of caring through a greater frequency of communication and more 'routine' visits home (Baldock, 2000; Baldassar *et al.*, 2007; Zechner, 2008). Pushpa's husband, for example, had recently started returning to India multiple times per year to look after his ailing mother, with Pushpa showing him how to cook porridge for his mother (Pushpa said her husband could not cook and she took on all the cooking responsibilities in the UK). Susanna changed the frequency of her visits after her mother had an accident:

We used to go every two years. Actually I went every year, because she fell down and broke her hip so I went there, I went once to see her. Like every year we were going, but not all family are going every year. All family are going every two years. But in case anyone is sick or ill, or not feeling very well, like your parents, then we go. Last year, my husband went by himself. Because his Mum was not feeling well, so he went himself.

Susanna describes the regular 'routine' visit to India that involved the whole family and how, during times of emergency when a 'crisis' visit was necessary, only one member of the family travelled, due to financial restrictions, to provide more 'hands-on' care for their parents. Following her mother's surgery, Susanna spent two weeks tending to her in the hospital, washing her body, preparing her meals and liaising with her mother's medical team. Whilst Susanna was able to provide practical care to her mother on this occasion, the distance between India and the UK was not always easily surmountable. Susanna's mother never fully recovered from her broken hip and the following year her brother called her to tell her that their mother was gravely ill. Susanna booked a flight to India for the next morning, securing compassionate leave from her NHS job. However, whilst she was waiting on a connecting flight, she was informed that her mother had died. Susanna's capacity to navigate distance both spatially and temporally was thus central in shaping her ability to care for her mother during these times of crisis, and many participants described similar difficulties in getting to India during times of crisis. Since her mother's death, Susanna has made a

vow to visit India more regularly, saying 'when they are alive, we have to go and visit them. That's all we can give them, isn't it', suggesting that the experience of her mother's death from afar has resulted in more regular 'routine' visits. However, difficulties in managing multiple care roles also posed problems for participants when their parents experienced health care crises in India.

In the UK policy context, little attention is paid to care-giving and -receiving that stretches beyond the nation state. This has implications for those who work in the UK but continue to exchange care with family members outside of the UK. The 'working time regime' in the NHS is constituted by policies that regulate working hours and holiday entitlement. The 'gendered care regime' is related to policies on the right to time to care, and the rules on the location of dependents recognised in the right to time to care (Kilkey and Merla, 2013). Participants' position in the labour market as NHS or private nursing home workers means that they are entitled to time-to-care provisions. This means they have the right to request 'reasonable time off work' for 'emergencies involving the person that you care for where they live in the same household as you and/or the cared for person reasonably relies on you to make arrangements to care for them' (NHS Choices, 2015). Requesting time off to care for family members was difficult in practice however. Participants' described the difficulties of negotiating sufficient time off that would warrant the expense of a family trip to India to care for and sustain bonds with family members remaining there. Negotiating time off work was especially difficult during busy times for annual leave, such as Christmas and school holidays.

The continuing dilemma of managing dual care roles transnationally whilst working as a nurse were detailed by Rosy and Mary:

We can't go during the school days because they're missing the school days as well, so we have to wait for the school holidays. And then it's very difficult during the summer holidays for the annual leave from work, to get for us as well.

So I can't drop everything and go to India and look after them [her two parents, critically ill on two separate occasions]. Because then my husband and children need me too, it's too difficult for them without me. But then I'm worrying about my parents. It's so difficult. (Rosy)

I have my father who had a stroke in 2010, and we go, we try and go often, every year. But because of school holidays, we can't take them off school. and school holidays is the only time when we can go. They have given us a warning letter from the council, saying that if we take them off school time, we will get fined. And we got fined once. (Mary)

This pull between obligations towards family members is not unique to transnational family members. However, the vast distances involved and the cultural norm of looking after parents in old age placed considerable stress on Rosy and Mary. The gendered aspects of this come through particularly in Rosy's extract, where she feels the need to fulfil expectations of reciprocity towards her parents in India, whilst her husband and children 'need' her too. The difficulty she felt in deciding whether to remain with family in the UK or go to her parents in India was palpable in the interview, especially because her brother also lived abroad. She fidgeted and was tearful but she also was insistent that her parents were cared for by extended family and neighbours in India and by the siblings when they returned to India. Whilst it would be unwise to argue that Rosy and Mary's problems in returning to India to care for their parents amounts to a 'care drain' since they still managed to care for their parents, it is nevertheless clearly difficult for them when they felt like they were not fulfilling their obligations towards their parents.

Family circumstances, gender and expected social roles within the family are also important when considering the 'crisis' visit:

If my husband's Mum or Dad had a massive fall or something, then he has to go and see them. We are five children in my family house, so they [parents] have others. But in [husband's] house, they are only two and his sister is also here. So if something happens, then he has to go. They have help and all, lots of family and neighbours, but if

something massive or something, like if someone had a heart attack. Then he has to go. Even I have to go if something happened. But no, a simple fall or a trip or something, no, no need. They get help, and we stay here unless something serious. (Joji)

I wish I had another brother or sister who just, you know, that's one of the insecurities in their mind, that they don't have anyone to look after them when they get older. Because I'm the only son, it's my responsibility. They're in their 60s, they're ok, they have only small little health problems, but they're fine. But it's the future, that's the one difficult situation I have to face in life. I might have to go back to India for a few years to take a break and stuff. We just have to see what happens, some things you can't predict in your life. (Pothan)

Joji suggests at the end of the extract that she hesitated to make the journey back to India if something not too serious has happened, something others across the sample repeated. However, this was only feasible because these nurses had multiple family members remaining in India who were on hand to look after their ageing parents on a regular basis. This is contrasted by Joji's husband and Pothan, who were part of families where all the adult children were migrant nurses, meaning that their parents were both living alone in India. Pothan's other siblings were all abroad and although Pothan said it was not something they were actively worried about at the time of interview, he was acutely aware of his responsibility as the only son, and how this may thwart his intention to move to Australia, a point returned to in the following chapter. This points to some of the 'negotiated commitments' taking place in the transnational family, whereby the cultural shared expectation of 'who provides care for whom, how much, when and why' (Baldassar, 2007b, p. 393) as well as the family's history of migration means that Pothan is highly likely to return to India to care for his parents. This worry about care gaps for ageing parents is not only related to participants' physical absence, but is also connected to the changes brought about through the use of remittances. As mentioned in Chapter 4, remittances were frequently used to pay for nursing training for a number of family members, thus contributing to the employment of family members, and stimulating their migration, which in turn necessitates the further reorganisation of familial care.

The high costs of travel, difficulty in obtaining leave from work and other care responsibilities in the UK all figured in considerations prior to returning to India for 'crisis' visits. During these times of tension, the nurses said their family members in India mostly valued proximate care and virtual communication was 'not the same', although they also said that these technologies were crucial in allowing them to keep abreast of their parents' health and to frequently communicate with their siblings (see also Baldassar, 2016). The need to 'be there' physically with parents, especially as parents age and at these points of crisis, collapses any distinctions between 'caring for' and 'caring about', since 'being there' was understood as a significant expression of care and love (Baldassar *et al.*, 2007). This suggests that emotional and moral support becomes particularly special when it can occur face-to-face (Baldassar *et al.*, 2007). The importance of co-present support was especially so for the women in the sample who were the only daughters in the family, such as Preeti:

My Mum used to tell me 'it's ok if you go, but I need you here, you need to look after me when I am in pain, when I am in need'. Because I'm the only one girl, she loves me so much. It's different looking after you know, son and in-laws. It's very different. I don't know, I was telling my husband, I'm really now, I really want to look after them because they are in that age.

Preeti's brother, who used to work in the Middle East, 'had to leave his job' to return to India look after his parents, living in a traditional joint family with his wife and children. However, Preeti and others said how being cared for by their sons and daughters-in-law was not enough for some parents and they wanted their daughters close-by to care for them during their times of need. Gender and sibling order were clearly important in the intergenerational care arrangements for ageing parents. This led to intense feelings of guilt navigating the pull between parents in India and children in the UK, as suggested earlier in this chapter and returned to in Chapter 7. Preeti felt very guilty at not being able to fulfil her mother's wish of returning to her to support her in her old age. She was not able to 'be there' in the ways that her mother wanted her to be, although, importantly, Preeti's remittances paid for her

parents' healthcare expenses, so she felt like she was supporting them in some way. However, medical or health problems were not always acute. Most of the participants' described their parents' healthcare issues as more chronic in nature, and as associated with diabetes, dementia, and mobility problems, for example. The chronic nature of these healthcare problems typically meant that participants integrated these issues into more daily care practices for their parents and family members, typically through managing, monitoring and advising on their issues.

In addition to experiences of co-presence engendered through the 'polymedia environment' discussed earlier in the chapter, some participants also talked about giving their parents and loved ones' medical advice and practical care through these mediums. When their parents experienced lapses in health, there was typically a burst of activity between the nurses in the UK, their siblings in India and family members elsewhere in the world (see also Baldassar *et al.*, 2007). When Sheela's mother experienced some complications related to her diabetes, Sheela's brother read her mother's blood sugar readings out over the phone or Skype or sent this information through text messages. Sheela called her brother and mother multiple times per day, giving dietary advice over the phone and talking to the family doctor regularly. Joji described her daily contact with her parents as centring on their healthcare issues and her monitoring of her father's condition:

I just ring, and ask 'how are you, how is everything'. They are ill now, like heart, my Dad is a heart patient, so I ring, 'how is your health, have you been to the hospital and got the check-ups. Have you eaten? Don't eat like this, don't eat potassium'. Because he had bananas on his farm, so his potassium went up and he had a massive heart attack. It's his sodium and potassium that went up. So he has to eat all these things, I give him advice on the phone.

The visual and embodied aspects of video chat systems like Skype, Google Chat or Facetime particularly facilitated the provision of a practical form of care, as Joji illustrates in her description of recent Skype calls with her parents:

She had a fall. Then she grabbed my Dad, so both of them fall. So I find out about their legs, see how it is healing, have you been to doctor, have you had x-rays, stuff like that yeah. I get them to show their legs.

Joji described calling her parents and siblings more frequently as a result of their fall. Her monitoring of her parents' broken bones can be seen as a form of practical and emotional care provided by the migrant in the UK to their parent based in India. The practical aspects are focused on 'caring for' and problem-solving, whilst the emotional aspects are more focused on 'caring about', assuring them that they will be alright and assessing their emotional states. Whilst the phenomenon of 'double-duty caregiving', where a practicing health care professional provides care to an older relative, has been discussed in several studies (St-Amant, Ward-Griffin, *et al.*, 2014; Ward-Griffin, Brown, *et al.*, 2015), the migrant nurse who provides care to relatives normally resident abroad is not generally discussed. This is unsurprising, since the type of 'hands-on' practical care required in looking after elderly or infirm relatives is typically understood as requiring co-presence. Participants in no way conveyed that their monitoring of the parents' health through ICTs was the same as 'being there' to take their temperature, administer medication or change their bedpans, or just to sit with them. However, participants' use of 'polymedia' to give medical and medication advice and to monitor their parents' health clearly allows them to 'cross borders in new ways' (Reynolds and Zontini, 2014a; 2014b). This involves intensive emotion work and management. For example, some of the women described feeling 'sad' when they saw their ill and ailing parents, but tried to 'make them happy' by telling them stories about their grandchildren or talking about their next visit to India and all the things they would do. In the context of their limited visits to India, diminishing visits from parents to the UK, and their parents' declining health, these communication technologies are important to participants because it is one of the central ways they are able to express their care for their parents. This 'care-by-proxy' (Baldassar, 2008b) is not perfect, but it is better than not having any way to communicate at all. As Baldassar (2014, p. 394) points out, the 'virtual communication and co-presence does not mean 'less than real', as people experience each other in full and meaningful ways, despite the distance separating them'.

6.5 Conclusion

In this chapter, I showed the strategies that participants employed to maintain and sustain reciprocal care exchanges with family members in India, and how these changed over time. These issues apply to many migrants around the world. However, the specificities of these strategies for migrant nurses from India emerge from their status as migrant nurses and carers in the UK, and their specific national and family values regarding intergenerational reciprocity.

The analysis in this chapter illustrates that the connections that participants made between being 'here' in Britain looking after elderly patients, and not being 'there' in India with their ageing parents suggests a particular ethic of care and points to norms and values regarding looking after ageing family members. Participants talked quite openly about the differences in care values between the UK and India, constructing India as a 'more caring' country than the UK, especially when it came to the value and care of elderly people in society. Participants' accounts suggest that their caregiving in the workplace is influenced by Indian and familial ideologies based on intergenerational reciprocity and ideas of what is considered 'good care'. This echoes the idea of a 'migrant ethic of care', which emphasises the distinct values that migrant women and men articulate, that are fundamentally shaped by transnational migration, nationality, and gender (Datta, McIlwaine, *et al.*, 2010). However, this expectation of adult children as the providers of care for their ageing parents threw up some uncomfortable questions for some nurses, namely whether they were able to fulfil their own care responsibilities when so far away from their own parents. This is not to say, however, that nurse migration leads to care gaps for the elderly family members, but it does point to some of the anxieties that caring for the elderly in the UK can bring up for migrants who also have ageing parents in their home countries.

The analysis also illustrates that whilst distance certainly was an obstacle to being physically co-present with parents and providing hands-on care, it does not mean that participants were unable to engage in reciprocal care exchanges. Whilst physical proximity and 'being' there in person were considered ideal for the nurses and their family members to care for each other, it was not always possible and the nurses turned to innovative ways to care for and care about their parents remaining in India. In these sections, I illustrated how participants reorganise care for parents between siblings and family members remaining in India, engaging in emotional, practical and financial forms of care by participating in frequent and sometimes constant communication with them, organising multidirectional visits and sending remittances (Baldassar *et al.*, 2007; Zechner, 2008). Care was not uni-directional however; participants' parents, through regular communication, were frequently emotional pillars for their migrant adult children, especially at the earlier stages of migration, or when participants were experiencing hardships or going through major life events such as pregnancies. Their parents, when healthy, regularly visited the UK and helped participants with childcare and domestic duties, marking a shift in generational relationships. In the context of increasingly stringent immigration regulations to the UK, participants' found it more and more difficult to bring their parents to the UK, which had implications for how they met their childcare needs (see Chapter 5). However, as parents aged, their care needs also changed and this brought about changes in both the frequency and direction of visits and the mediums for communication.

In this chapter, I have also illustrated how women nurses shouldered more of the responsibility for caring across distances, and emotion work emerged as central to their experiences. They were often caught between children and spouses in the UK and ageing parents in their natal countries, and this often led to feelings of guilt that they might not be able to give as much as they could or should, especially for health and medical problems. This became particularly acute when participants reflected on the care that they were providing elderly patients in their daily working lives, where they felt that they were supposed to be 'there'. The difficulties in communicating

with parents because of inequalities in infrastructure, access and familiarity also suggest some of the asymmetries in multidirectional care flows. The findings suggest that although communication technology is central to the ways that the nurses in the study exchanged care with their families remaining in India and sustained relational bonds, the intimacy of physical proximity, especially as parents age, cannot be easily replaced by technology.

By highlighting both the ease and difficulty of maintaining family ties, this chapter has shown that rather than being fragmented, broken or at risk, transnational family relationships are transformed and reconstituted in new forms. Suggesting that distance and absence do not automatically prohibit the exchange of caregiving, this chapter has illustrated how transnational care activities ebb and flow at different stages of the individual, migration and family life cycle. The lines between caregiver and care-receiver become blurred, with participants simultaneously and diachronically giving and receiving care. As with the care arrangements explored in Chapter 5, these reciprocal and multidirectional flows of care are framed in the context of institutional policies in the destination and origin societies. At a macro level, factors such as immigration policies, visa restrictions, working time regimes, gendered care regimes, and travel and telecommunication infrastructures are crucial to mutual care arrangements between the nurses and their parents since it sets the boundaries of care exchanges (Kilkey and Merla, 2013). The changing direction of the visit is illustrative of how the spatial and temporal configuration of transnational families' life are influenced by changing economic and political environments (Kilkey and Merla, 2013). However, families are creative in how they create intimacy over distance, pointing to the interplay of structure and agency. Imagining future possibilities and familial care is another expression of agency and a chance to improve opportunities to exchange care amongst family members. It is to such future orientations that the next chapter turns.

Chapter 7 Imagining Futures while Caring in the Present

The previous chapter illustrated that transnational families are reconstituted in new ways, and distance and physical absence does not automatically prohibit the exchange of caregiving. Rather, care circulates between different family members to different degrees over the life course. In this context, participants' localised and transnational care exchanges with family members were embedded in political economic systems, particularly the British immigration regime, as well as their insertion into the labour market. This chapter now turns to reflect in more detail on participants' experience of the workplace and how this shapes their families' lives in Britain more generally. In line with the overall aims of the thesis in viewing nurse migration and transnational family caregiving as a dynamic and temporal phenomenon, I connect these experiences of the 'here-and-now' to their imagined futures. Indeed, as Coe (2016) suggests, migrant imaginaries are also temporal imaginaries. The first empirical chapter, Chapter 4, pointed to some of the hopes and aspirations that participants' described as contributing to their decision to leave India—these dreams of a better life and for a better future highlighted the entanglement and intersection of both work and family aspirations. Yet research conducted on migrant nurses in the UK, and in other popular destination countries suggests that their experiences in the workplace are not necessarily congruent with their idea of what life in these countries would be like (Smith, Allan, *et al.*, 2006; Alonso-Garbayo, 2007; Adhikari, 2011). Despite this tension between aspirations and expectations on the one hand and the reality of being a 'nurse on the move' on the other, very little research focuses on these incongruences, including how they are managed, and how aspirations might evolve and change in the context of such biographical experiences.

The women and men in this study described their motivations and aspirations for migration at the intersection between different mobilities for care—specifically nursing care and family care. Participants spoke about their various work experiences

upon arrival to the UK, and it is easy to think about their aspirations as *occupationally* focused (Portes, McLeod and Parker, 1978) —securing a job that would allow them to access higher wages through international migration were central to the nurses' accounts of migration. However, as illustrated in Chapter 4, becoming a nurse with an intention to work in a wealthy country was less a goal in and of itself, but more of a means of achieving individual and family well-being and ensuring the social reproduction of the family, and hence is a multi-layered and relational decision. Social and economic integration policies, as well as reunification and citizenship opportunities for nurses' families were also important considerations in where to migrate to initially. As discussed in Chapters 1 and 4, stepwise migration is common amongst nurses and the limited available data suggests that many nurse migrants move on from the UK or return home (Buchan, 2003)³⁶. Indeed, as pointed out in Chapter 1, many migrant nurses would prefer 'circular' or return migration rather than permanent settlement (Kingma, 2006), especially if family members remain in the country of origin (Haour-Knipe and Davies, 2008). Migrant nurses are also likely to move again, to return home or settle in yet another country if they have been treated badly (Kingma, 2006). The majority of the nurses in this study intimated that they hoped for an eventual return to India, sometimes via another country. In the light of this assessment of migration as an ongoing project amongst migrant nurses, the aim of this chapter is to consider some of the factors contributing to participants' imagined futures. Their desire for an eventual return to India, their plans to remain in the UK or their harbouring of dreams to work elsewhere in the near future all feature in these accounts of imagined futures. Participants also reflect on some of the obstacles they see as preventing these hopes from materialising.

³⁶ Nurses in the UK are required to renew their registration every three years. Based on the limited data available, Kingma (2006, p. 18) calculated that less than half of the non-EU foreign registrants in 1995 reregistered in 1998, suggesting that over three-quarters of overseas nurses who migrated to the UK in 1995 were no longer active in nursing practice four years later. Buchan (2004) and Yeates (2009) also note that the UK is simultaneously a destination country for internationally mobile nurses as well as a potential source country for other countries such as Canada and Australia. Once nurses obtain British passports, it makes it a lot easier for them to move to these countries to work as nurses (Carlos and Sato, 2010).

The reality of life as a migrant nurse in the UK is well discussed in terms of the deskilling, discrimination and marginalisation that migrant care workers often experience in their working lives post-international migration (e.g. Allan and Larsen, 2003; Smith, Allan, *et al.*, 2006; Smith and Mackintosh, 2007; Allan, Cowie, *et al.*, 2009; Adhikari, 2011). The transnational relational aspects of their lives have also been discussed, albeit to a lesser degree (George, 2005; Yeates, 2009; Grigulis, 2010; Adhikari, 2011). However, these studies have tended to limit their temporal scope either to the past or present, or else reduce time into linear temporal paths, seeing migration as a series of forward-facing stages or events. As discussed in Chapter 2, Adam (2004) stresses the need for taking time seriously, not only by focusing on temporal constructions of the past and present, but also by considering the future. She points out that activities and practices in the present are not only embedded in the past, but also projected into the future, suggesting that our lives are both embedded and extended in time. Indeed, the participants in my study continued to look ahead into the future whilst experiencing deskilling and discrimination, often embedding these desires in multigenerational considerations. As such, this chapter asks 'how are aspirations for the future shaped by both workplace experiences and multigenerational relationships?' These are not just empirical questions as to whether aspirations have 'objectively' been met, but rather a means of exploring current aspirations and views of the future. In addition, Boccagni (2017) argues that reflecting on migrants' current aspirations sheds light on their emergence from a standing point of the 'present'; for the nurses in this study, their 'present' is generally marked by their differing experiences of inclusion in the UK.

Since a search for professional respect was one of the 'push' factors for leaving India (Nair, 2012; Walton-Roberts, 2012; see also Chapter 4 in this thesis), I turn in this chapter firstly to participants' accounts of their experiences in the workplace following their migration to the UK. By looking at the institutional context and the daily social practices between participants and their patients, colleagues, and managers, accounts of exclusion, humiliation, pride and ambivalence emerge and this reveals tensions between some participants hopes for their working lives in the UK

and their actual experiences. I then turn to how their hopes and aspirations for their family have been (un)met as a result of their living and working abroad. Participants pointed to both their personal and their family's experiences outside of the workplace as also influencing their overall migration experience, which, in some cases, spurs them on to imagining new geographical horizons for a better future. Finally, inspired by Boccagni's (2017) work on the biographical basis of aspirations, I highlight how their current aspirations emerge from a biographical standing point of a 'present', which for some is generally marked by disappointment and their limited and subordinate inclusion in the UK, whilst others describe feelings of pride in thinking about their achievements since coming to the UK. This, as well as participants' personal and family life stage and their assessment of the opportunities available to them leads to the emergence of different aspirations for the future.

7.1 'The way they are treating us was not like the way I expected...I hoped for better': Working in the UK

As discussed in Chapter 1, nursing has until very recently remained an undesirable profession in the Indian context, and the low status of nursing has been one of the major push factors in nurse migration from the Indian subcontinent (Walton-Roberts, 2012). In addition, Nair (2012) has illustrated how nursing in India has been defined by low pay, low staff to patient ratios, as well as the threat of abuse. As identified in Chapter 4, some participants perceived a 'lack of future' available to them as nurses in India. Other participants spoke of anxieties in relation to their status, typically discussing their profession in terms of (dis)respect, and often framing their decision to migrate within a global search for professional respect. This aspiration thus invokes both a temporal and a geographical space. Since all of the participants left India with the intention of garnering more respect professionally, it is thus worth reflecting on their workplace accounts, where the predominant tone suggests that this global search for respect continues. As will be discussed later in the chapter, this disappointment with working conditions has implications for participants' imagined futures.

In terms of workplace experiences, the findings in this study mirror previous studies that have examined the situated experience of working as a migrant carer in the UK context. Such research found evidence of a labour force marked by persistent stratification based on race and ethnicity (Kyriakides and Virdee, 2003; Smith, Allan, *et al.*, 2006; Henry, 2007; Mistry and Latoo, 2009), detailing processes of deskilling and its connection to restrictive immigration legislations (O'Brien, 2007; Cuban, 2013), as well as sexism, racism and classism within the nursing profession (Smith and Mackintosh, 2007). Based on her study of the trajectories of migrant nurses to the UK, Sandra Cuban (2010, p. 186) argues that migrant nurses too often become 'nurses on the ropes' in their search for a better life, eventually becoming deskilled in a political economy of care. Cuban (2010, 2013) also notes the capacity for advancing in spite of oppressive conditions, but overwhelmingly identifies the institutional barriers that migrant nurses often face in having their qualifications recognised, barriers that eventually lead to deskilling.

Two nurses in this study, Shobha and Alice, were still working as care assistants at the point of interview. Both detailed instances of bullying from their colleagues, as well as describing feelings of isolation and a sense of despair at not being able to practice their nursing skills or have their nursing qualification recognised. They both felt 'stuck' and trapped. Many of those who had since left the private independent sector or had been recruited directly into the NHS also described similar experiences from colleagues and managers in both sectors, experiencing exploitation, marginalisation and discrimination in various ways. Some told me about racist comments from patients, such as being told to 'go back to your country', or experienced patients who refused to accept their care, as seen in Beejuu's description of an encounter with an NHS patient that took place a week before we spoke:

When I went to him, he didn't allow me to take his shots. He said 'go away', he was like in his 70s, but he didn't have any dementia at all. So I went into him and he said 'go away, I don't want you'. And I felt like something and said it to my

colleagues, 'I think he doesn't like me so can you go and take care'. And when she went to him, he said to her that he doesn't want me because of the country difference, the different nationality. So that night, I didn't do anything to him. So whenever he buzzed, I went to him but he said to me that 'I don't want you, I want that other girl'.

Other participants noted similar experiences with patients. Beejuu and these participants seemed to accept that racism and discrimination were inevitable parts of the job for nurses from minority groups, although most said the majority of their interactions with patients were pleasant, and left them feeling like they were respected and valued by their patients. This respect from patients and their families was something that they had not experienced in the Indian or Gulf context, where they acutely felt the status issues in nursing. This suggests the importance of situating nurses' experiences within the context of their wider migration and work biographies, and can thus be interpreted as a partial (but unsatisfactory) fulfilment of their desire for professional respect. However, relationships with patients only formed one aspect of the everyday interactions that nurses experience in their working lives—relationships with managers and colleagues were even more salient in participants' descriptions of their workplace experiences.

The majority of the participants described instances in their daily interactions with colleagues and managers that can be understood through the conceptualisation of discrimination and/or stigmatisation developed by Michèle Lamont and her colleagues (2016). The authors distinguish between discrimination and stigmatisation: discrimination in their work refers to incidents where their participants believed they were deprived or prevented from accessing an opportunity and resources due to their race, ethnicity or nationality; incidents of stigmatisation refer to a wide range of experiences, including where interviewees experienced disrespect and being stereotyped, through being ignored or overlooked, underestimated, over scrutinised, misunderstood, shunned, discriminated against, or when their dignity, honour, relative status or sense of self was challenged. This range of experiences corresponds to many of the encounters in daily life that participants in

this study described. Gaya, for example, described the difficulty in moving beyond the bottom of the nursing hierarchy and securing professional development and promotional opportunities, and she put this down to discrimination based on her nationality. She said this was not the only experience of discrimination in work though. When asked for specific examples, she found it difficult to pinpoint an exact incident, saying 'I just cannot say, I can't remember now, but it's there always. It's subtle'. Similarly, a small minority of participants identified experiences of blatant racism, but the majority of nurses in this study described their experiences in much more ambiguous terms, illustrated through, for example, the division of labour on the ward. Three interviewees perceived that foreign and ethnic minority nurses had to do more of the 'dirty work' of nursing, or as Mary put it 'it's the little, little things, they don't give us patients who are very, very critically ill, or they give us patients who have loose stools every time in the cubical'. This division of labour as expressed through both overt forms of discrimination and subtle 'little things' is consistent with other research on the racial and ethnic division of labour in nursing hierarchies (Smith, Allan, *et al.*, 2006; Henry, 2007; Yeates, 2009; Batnitzky and McDowell, 2011), though this work understands these experiences broadly in terms of racism and discrimination. However, many of the nurses stated that their experiences in the workplace could not be described in this way. Understanding such experiences thus requires an alternative frame of analysis, one that can include feelings of being excluded or overlooked.

Lamont et al. (2016) found that stigmatisation is frequently experienced without discrimination, but can contribute to the sense of being disqualified. In their attempts to describe some of the problems they experienced in the workplace, participants often stated that it was *not* racism. Rather, they identified their problems in the workplace as exclusion and marginalisation, which they thought was based on perceived cultural differences and around different ways of socialising:

I feel quite isolated here, and excluded. It's not a good feeling. At the back of my mind is 'are they talking about me, or did I interrupt badly in that', and things like that. You don't

want to be creating an atmosphere there, so sometimes you just have to just say 'ignore it, ignore it, ignore it'. But how many times do you say 'ignore it'? You feel, why are you being ignored anyway? (Sindhu)

Sindhu's anguish at this exclusion within her unit is evident from this account, but she insisted:

I never felt racism here, or things like that, but we, lots of my colleagues, we felt that we've been left alone and ignored. And that makes a big difference. You think you're an alien, which you shouldn't.

The sense of being overlooked that Sindhu describes are harder to identify as incidents and are difficult to measure because their manifestation is typically internal, and the result of neglect rather than overt aggression or blatant racism (Lamont, Silva, *et al.*, 2016). As Sindhu suggests, these experiences do not typically result in participants' making complaints, since feeling ignored is not something one can easily make a complaint about. Instead, Sindhu ignores this although it affects her well-being, adding to the 'wear and tear' that accompanies perceived racism.

Although Sindhu managed her experiences of being overlooked internally, others tried to participate in informal social activities in an attempt to form relationships with colleagues. Anisha, for example, emphasised the importance of socialising for feelings of inclusion and to overcome being seen as 'other'. Yet despite trying to be 'more integrated', Anisha still described feeling removed from her local colleagues, especially in their understanding of her motivations for coming to the UK:

They wouldn't treat you so bad that you'd leave and walk away from the job, but you can see it just in comments that people say, make in passing. Then they'll ask you things like 'when will you go back to India? How good is your life there?' Patronising sort of. 'How much money is it converted into your money? How can you get things like that? Would it be, oh you will be a millionaire back home with this kind of money!'

Of course, the local nurses could be simply dreaming about what Anisha could do in India with a British salary, but Anisha perceived this as a means to assert their superiority over her. Other participants identified similar questions about their motivations for moving to the UK, appearing uncomfortable at the underpinning logic of this type of question—that they were purely economic migrants and coming from a background of relative deprivation. Anisha and Sindhu's descriptions of being stereotyped as poor and being left out can be read as dimensions of stigmatisation.

These various forms of discrimination and stigmatisation were not what participants were expecting from working in the UK. Although some participants did not describe having any explicit expectations prior to their migration to the UK, others had very clear ideas and hopes about their lives in the UK. Roxy, for example, was bitterly disappointed at her treatment by her colleagues in the care home she worked in during her adaptation period:

I definitely felt that the way they are treating us was not like the way I expected to be treated in a western country. I hoped for better. So I thought the UK was a very educated, I mean educationally very high profile people, meaning that they were very much educated. And educated wise we always had a very high expectation of English people. I mean they're at the top of the world in all aspects, not just in learning. So I had an expectation of each and every person in this country. And so many were not like this, they just didn't like us being here.

Roxy's pre-migration impression of the UK as a 'civilised' place suggests some pre-existing ideas about and meanings attached to the UK, which speak to Indian and British colonial history. As outlined in Chapter 4, participants hoped to engage in professional development upon their arrival to the UK. However, as discussed in Chapter 5, many nurses went through lengthy waiting times for the adaptation programme to allow them to practice as registered nurses in the UK. This left some feeling upset at their inability to practice their nursing skills whilst they were 'stuck' as carers, leading to a sense of being undervalued. However, all but two of the nurse

participants had managed to meet the changing institutional requirements and have their qualifications recognised and were thus making use of their skills.

Despite the above experiences, participants also discussed their professional achievements, and described simultaneously feeling 'more respected' as a nurse in the UK, which did meet one of their goals for leaving India—to acquire more respect for their profession. This issue of respect in the UK came up repeatedly though in ambiguous ways. Some of those participants who were vocal about the negative aspects of working in the British health and social care sector simultaneously described getting more respect here in the UK than in other countries they had worked. Cecilia, for example, told me about multiple run-ins with her colleagues and managers which she attributed to both racism and cultural differences, and she described coping with this by just keeping her head down and getting on with her work. She also said:

Here, actually we get more respect than the other countries I believe, for the nurses. They are treating girls there [India], the doctors are the big bosses, like that. But here we get the respect more than the other countries. Nurses here, we get respect. And even valued is the word I can say.

Whilst being careful not to justify any of the above accounts of indignities in the workplace, Cecilia and some other participants continued to frame such experiences in the context of their previous work biographies, saying that the UK was a better place to work than other places. Of course, this could be read as a strategy akin to Hochschild's (2003) participants' ways of managing their expectation gap, with Cecilia developing a 'myth' to reduce tension in the workplace and create harmony with her colleagues, in the process neutralising the desire to complain or move on to other countries. Cecilia also described an encounter where a colleague told her that she would take her nursing license from her. Given that Cecilia had earlier described in the interview the difficulties she went through to acquire her professional nursing license in order to work the UK, and as discussed in Chapter 5, the NMC PIN was essential documentation to practice as a nurse in the UK, this was a very serious

threat. Cecilia's response to this was to just keep her 'head down' in work and keep her distance from her colleagues. She thus stopped responding to these slights in order to avoid the costs, emotional in Cecilia's case, of a more vocal response (Lamont, Silva, *et al.*, 2016).

Moreover, because Cecilia was one of the few nurses who was ambiguous about a return to India, Cecilia's strategy to manage this expectation gap could also be understood as a means of managing the tensions between her desire to return to India and the obligations, responsibilities and other considerations keeping her in the UK. Cecilia's response is not necessarily conscious but should be read within the broader context in which she finds herself (Lamont, Silva, *et al.*, 2016, p. 4). Confrontation and complaining to management are possible responses, but Cecilia described an occasion where she brought a similar incident to her supervisor's attention; the response from her manager was to bring Cecilia and the other woman into her office and asked them to resolve their issues, resulting in Cecilia being asked to embrace the other woman and forget about it. Based on Cecilia's previous experiences and the difficulties in speaking out about what she perceived to be disrespect based on her nationality, her reframing of the British context as a place where she felt valued and respected was shaped by her biographical experiences as a migrant nurse. Other participants responded to similar interactions by demonstrating a strong professional work ethic ('I show them how good a nurse I am'), or through emotion management (I just try to ignore it, tell myself it's ok') (Hochschild, 1983).

Some nurses in the study drew upon this idea of professional respect and the comparatively good wages as providing a continued motivation to remain working in the UK, at least until retirement anyway. For others, these negative experiences have made the UK seem like an unwelcome place and they dream of leaving the UK as soon as possible. Such biographical and relational experiences lead to both the emergence and shaping of aspirations beyond the UK. Whilst their treatment in the British workplace provides some clues as to the reasons why some participants

dream of further migration and an eventual return to India, turning to participants' accounts of their individual and family members' experiences of life in the UK and where they are currently at in their family life cycle presents another dimension to this complex story.

7.2 Hopes and Aspirations for Family

Whilst interviewees discussed all the life course transitions and events they had undergone since migrating as a nurse, it is difficult to identify which aspects of their previous aspirations had been realised (and indeed, this is not the intention of the chapter). More clear is the emphasis on relational changes, with participants comparing their family attachments over time. As discussed in Chapter 4, everyday and intergenerational social reproduction were complexly intertwined. Participants often moved in a quest to achieve a 'good' family life. This typically involved the pursuit of financial security, and a heterosexual marriage with a partner from a 'respectable' family, as well as the ability to provide culturally appropriate care for family and extended kin, present and future, dependent on one's responsibilities and commitments. Building houses and acquiring property in India was important, as were attempts to help their family in terms of social mobility. The desire to have a future together as a family in one geographical place was emphasised in many interviews, as touched upon in Chapters 4, 5 and 6. This desire to reside in one place influenced participants to look beyond the Middle East and towards countries with more favourable family reunification policies, the UK being one of them at the time of their migration over a decade ago. In the context of such accounts of migration, it would be oversimplistic to only pay attention to their working lives. The following section therefore explores how participants' aspirations for a 'good' family has played out and evolved over time.

Shifting Patterns of Remittance Sending

As discussed in Chapters 4 and 6, participants often migrated to provide material support to family and to obtain better incomes and living conditions. Participants

who migrated in order to help family remaining in India typically met their immediate socioeconomic aspirations fairly quickly, especially for those nurses who were able to move into the NHS soon after arrival and who did not spend lengthy periods working as carers whilst waiting for registration or trying to find a job. In the initial stages of their migration, almost all participants described sending money to their parents and family to support them financially, providing them with economic resources so as to improve their material circumstances:

We didn't even have electricity in my house when I studied. And when I went to Saudi, that is the time we took electricity. Home...I know my mother and father, they worked hard. But they can't afford pipes in the rooms, and all those things. They need to carry the water. So I did all those refurbishments in the house, and all those they needed.
(Pushpa)

The construction or improvement of the family home was one opportunity for visibly improving their own and their family status, as highlighted in other studies of migration (e.g. Parreñas, 2005b; Vullnetari and King, 2008). In addition to making these home improvements, Pushpa assessed that her decision to become a nurse and migrate had allowed the family to meet their aspirations for social mobility. Gaya similarly said:

My mother used to tell me, only because I went out of my house, otherwise my family would have been down. They're grateful, my parents are extremely grateful to me. Because always my mum says 'if Gaya was not there, I don't know what we would have been'.

Remittances in these cases were considerable sources of income that contributed to the overall social mobility of the family. Remittances have also been central to sustaining Kerala's economy since the 1970s, although the social effects of these cash flows are ambiguous, with some commentators suggesting that they have led to the erosion of reciprocal obligations that bind the community (Osella and Osella, 2000; Devika, 2012). These flows of money can also place a tremendous burden on those who send them (Levitt and Nyberg-Sørensen, 2004). Pushpa, Gaya and others in the sample who came from poor families, describe experiencing some of these

hardships at the earlier stages of their migration, where they were unable to accumulate capital for their own needs or investing back home. However, as this thesis has shown so far, transnational care practices and relationships change over time, and remittance flows are no different.

The majority of participants said that whilst remittance sending was prominent in the early stages of their migration, the frequency of sending money has since reduced. Whilst a small number of participants reported regularly sending economic support to their parents and siblings remaining in India, sending money on a monthly basis, others talked about changes in the frequency of their remittance sending since arriving in the UK over a decade ago. Thomas, for example, explains:

I used to send, as soon as I started here. But nowadays, with the kids here, there are too many expenses. And I can't send the money like that. Sometimes I will send something like pocket money to my father. But I can't send bulk money from here these days, because it's not practical. Because we need to use the money for the mortgage and everything [laughs], childcare, mortgages, the kids' tuition fee, all these things. Too much is coming out. But when I was single, I used to send money.

The direction of money shifted from Thomas' parents to his children, from supporting extended family in India, to supporting his children in the UK. This suggests the evolution of aspirations accompanying the biographical transition from single man to husband and father. Thomas' original aspirations to build a dream house in India and support his family, had shifted somewhat and he was now focused on his children's future through investment in their education:

We are saving. But em, we are not planning to save for that bit [remittances]. We are planning on saving for the kids' education. Because if you are here, if we are staying here, we need to have a lot of money for the university.

Thomas' biographical transition highlights the shifting nature of aspirations in terms of what participants hope to do with their finances. But, as demonstrated in Chapter

6, participants continue to engage in other forms of transnational care practices beyond financial support. A smaller number in the study still have responsibilities and commitments to remit, although this is dependent on the family's socioeconomic circumstances. For example, whilst Thomas sent pocket-money, others sent money more regularly. As described in Chapter 4, Jenny did not have to send money until her family was hit by crisis and she became the main earner in the family. Joe described his parents as poor farmers, who needed regular support, illustrating the class element to remittance sending amongst the sample. Economic support to parents in India was also gendered. Joe, as the eldest of three brothers, described being financially responsible for his parents. In contrast, Shobha stated there was 'no need to send now because I'm married, that's the custom', the custom being that wives became attached to their husbands' family following marriage, ceasing obligations to her natal family (George, 2005). However, these customs were open to negotiation, with Beejuu and Joji describing making an agreement with their husbands when they married that they would be able to continue supporting her parents after marriage. Joji does not send much now, but her husband sends over £250 per month to his mother in India. Pushpa also told me that her financial support for her parents and family had stalled because she set them up financially at the start of her working life, before she was married.

Whilst economic support to parents is undoubtedly important as a gendered care practice within transnational families, and as suggested in Chapter 4, part of the initial logic of migration, examining how the frequency, meaning and flow of remittances might change over time suggests that, like other forms of care exchange, economic support evolves over personal, migration and family life cycles, and according to the care needs of specific members of the transnational family networks. Projects of building or improving family houses, and buying land were important at the early stages of the migration cycle, and these were often connected into participants' desire for an eventual return to Kerala, discussed in more detail below. Other participants described family in India looking after their empty properties, which was also interpreted as a form of practical care and support. Most participants

in the sample now send money back to India to pay for the healthcare expenses of their parents, especially for those with 'old-old' parents (see Chapter 6). Overall, participants seemed satisfied with their ability to support their parents and families in terms of economic and material support and, as discussed in the previous chapter, participants also helped family members become nurses. This all went some way to improving the family's social status although, as George (2005) notes, a tension between the material improvements in status and the stigma continues to cling to nurses and their families when they return to India, so social mobility is not automatically conferred across borders. However, in the context of meeting their short-term socioeconomic goals and their changing biographies, how have their other aspirations regarding family played out?

The 'Good' Family as Seen from the 'Here-and-now'

At the beginning of interviews, I asked participants to tell me about their entry into nursing and, as discussed in Chapter 4, the desire to have a 'good' family was at the core of many interviewees' motivations for becoming both nurses and migrants, with some participants described wanting a 'good' marriage, facilitated through social mobility that the promise of nurse migration brought (Walton-Roberts, 2012).

Whilst, as mentioned earlier in the chapter, it is difficult to know which aspects of their previous aspirations have materialised, participants often discussed changes in their relationships and care practices. For example, whereas parents and siblings were at the fore of most participants' minds when leaving India, children were now central to their lives. The centrality of their children's career and education to their idea of what constitutes a 'good' family, and good parenting came through strongly in most participants' accounts of their family life and their reasons for remaining in the UK. Explaining the cultural importance of appropriate care (Baldassar *et al.*, 2007), Sheela, for example, told me:

The parents need to keep the children well looked after and to keep them in a good position to get a good job and a good family, to live a good family. Like that. But here [UK], I feel like that, you know, once they are 15 or 16, they are independent and they can look after themselves. And the

parents are not bothered by what job the children is doing here. They don't care about if your education completed, whom you are marrying. But in our culture, they are more bothered about, the parents have more involvement in children's career, so education is important. Even they think after educating, getting a good job, if you are not going to be married to a good family, they are thinking that's not secure. Because they are thinking about that part of life, to guide and even after marriage, they are caring more, so like that they are guiding and giving guidance throughout their life, so later life, we do the same thing back to them. That's what, life is like. Education is important.

Sheela is clearly drawing on ideology and cultural norms about what constitutes appropriate care for children. Similar to the earlier discussion in Chapter 6 where participants constructed India as a superior culture for elderly care compared to the UK, Sheela also compares the care for children in Indian families as superior to British families where 'they don't care if you are educated'. She draws on a moral framework whereby not caring about children's education is understood as an abdication of responsibility. A key role in not only mothering, but parenting more generally, was thus ensuring not only access to money and material resources through which to meet the physical needs of children, but also to provide for the child's future through education.

The need to earn enough to guarantee that children had the financial resources required to study and thus improve their lives was central to the majority of participants' accounts. Kofman and Raghuram (2015, p. 120) argue that, women who bring their children with them to the destination societies also emphasise education as a way of ensuring that the next generation achieves a status that they themselves have struggled to achieve. Similarly, in this study, education was given as an important reason for remaining in the UK. Joji and Preeti, for example, when reflecting on all that they missed about India, both spontaneously explained:

At least our kids are getting a good education and all. They get a good education, I'm not saying they're not getting education in India, they get education there, but there's a

limitation. But here, if they are brilliant, they can go anywhere to the uni, there's no restriction for the payment, isn't it? So I'm very glad. But in India, you have to pay for everything. (Joji)

So for us, our priority is family, the kids are important. I can struggle, my husband can cope. We want our children to have the best. In here, it's ok, you get everything free, at least university is free. You don't have to pay that much, like £2-3000. But back home, even from nursery school, we never got any money from the government. Only if you have money, you can study, you know what I mean? Not even a single penny we got from the government. The private schools are so much money, the same like the private schools like here. It's a lot of money. So that's the main reason that I stay here. To give the kids more opportunities, to study here. (Preeti)

Joji and Preeti's reflection on the costs of a good education in India, and the barriers that such costs pose to middle-income families such as theirs illustrates that the policy context and the proliferation of private education in India is also a factor in shaping future aspirations for their children. Both emphasised that they can cope with life in the UK because 'at least' the education system in the UK is excellent. This idealising of education could also be read as a means of coping with or minimising workplace experiences described above. Indeed, the notion of being a parent willing to sacrifice all 'for the sake of the children' (a constant sentiment I heard) was central to participants' accounts of why they remain in the UK (see also Huang and Yeoh, 2005). This came across very strongly particularly in the women's accounts, connecting to the idea of the South Asian woman as the self-sacrificing caregiver with a strong sense of duty and obligation to the family (George, 1998). The education of children in the UK can thus be understood as a key factor in both participants' accounts of why they remain in the UK and as a means of coping with some of the indignities they experience in the workplace. Indeed, children's education and their aspirations for their future featured prominently in participants' hopes and dreams for the coming years.

Aspirations for children's education and securing a good future for them is important for participants' view of their own futures. However, in addition to some of the negative workplace experiences outlined earlier in the chapter, some of the nurses in this study described how they and their families' had experiences of racism outside of the workplace:

I didn't have any real problems in work, it was more just here in the area and in school. And some people saying 'what are you doing here?' When we came we had so many problems as well, the kids had so many problems in school, racial problems. Here also we had problems. Being attacked several times. Broken windows and throwing stones. It's been a very stressful time. (Preeti)

Although the vast majority of participants had not experienced as violent an experience as Preeti and her family had, Asha described her and her family's decision to leave Northern Ireland as rooted in a series of racially motivated assaults in her area. When her and another Keralan nurses' cars were burnt out during the night, she said this was the last straw and made plans to move to what she perceived to be a more racially tolerant city in northern England. Others pointed to some of the problems that their children experienced in school:

And even the kids had a problem like, 'why are you here in this country? you are black'. They came home crying, they were crying like three or four times. So much difficult times, so with everything, you know sometimes we think it's not a place to, you know [pause] but we came anyway, we had to, because we couldn't be together otherwise [long pause]. (Preeti)

My son was scratched on the face, hit on the arm, punched. Everything. Racial bullying. They call him chocolate, brownie, coloured, chocolate. (Mary)

My son came home one day and said 'you know what Paul said, I can't go in the sandpit because I'm not white'. He's a four-year-old child and he said 'because I'm brown, he didn't let me play in the sandpit'. Me and my husband was heartbroken, completely heartbroken. (Anisha)

Although it was a small minority in the sample who described their children as experiencing interactions such as this, these accounts of working and bringing up children in the UK provide a snapshot of the nurses' lives in the present and embedded in the past. However, as discussed in Chapter 2, experiences in the present are not only embedded in the past but are also projected into the future (Adam, 2010). This constructed future also has a relational aspect, whereby multiple generations influence and inhabit these temporal locations (Mische, 2009). It is to participants' hopes and plans for the future that the chapter now turns.

7.3 Imagined Mobilities for Care

Drawing on participants' depictions of their insertion into the British labour market and its attendant hierarchies, as well as their experiences of raising and educating children in the UK, is a good starting point for understanding how their future aspirations might be shaped. As Chapter 2 illustrated, these imagined futures matter, in the sense of having significance in people's lives, and more literally in the sense of having an impact on the material world. The above sections illustrate aspects of participants' everyday work and family lives, which are also embedded in the past. In this section, I reflect on how participants' descriptions and responses to the 'here-and-now' shape and are shaped by their imaginings of the future.

'Our families are there, kids are here': Desires and Obstacles in Aspirations for a Return to India

The majority of the participants in this study dream about an eventual return to Kerala, suggesting that becoming a 'nurse on the move' was initially conceived as a temporary phenomenon (Kingma, 2006). None of the nurses in this study envisioned working as nurses if they managed to return to India whilst still at working age (see also Percot, 2006). Chapters 1 and 4 illustrate the working conditions and status issues for nurses in India, so participants only ever aspired to return to India upon retirement or else if they somehow managed to accumulate enough resources to return and open up a business (Denny for example said he would run a private

nursing home in India if he returned to India in his 50s with money, whereas Alice said she had a dream of opening a burger restaurant in Kerala). Hopes for a return to India therefore have to be understood as part of a strategy that established they would be in a particular place (India), at a particular time in their life (post-retirement). As mentioned earlier in the chapter, building or improving family houses were important at the earlier stages of migration and these projects were often connected to participants' desire to return to Kerala:

I'd like to go back. Once the kids are settled, I would like to go back. I miss my country. Family and my house, like that was my dream, I wanted to get a house but you know, then nobody's living there...if I was working in India now, I can't ever dream of my house, you know, that much of a house.
(Rosy)

Rosy's dream of building a big house was fulfilled through her labour abroad, and she now dreams that she will be able to live in this house in the future. India, and houses built in Kerala, are imagined as the site of a future return for Rosy and others in the sample, 'the place where the fruits of working abroad can be properly realised, either in eventual retirement or in the more immediate future' (Burrell, 2008b, p. 16). The dilemma that she faces now though is that although she now owns this house, the fact that she moved abroad and had children poses a significant obstacle to her desire to live there. This is summed up through the 'myth of return' concept which explains how migrants dream of returning to their countries of birth but in reality often end up staying in the destination country (Anwar, 1979).

Many nurses also described wanting to return to India as they longed to be geographically close to and to look after parents and family members:

So my ambition is, as I told you - one - I don't want to work up to sixty years. So that's, it will all come together. I can earn some money and go back, and settle back and look after the parents. That's my ambition, my hopes. (Beejuu)

As this thesis has illustrated throughout however, care exchanges are reciprocal, and participants also envisioned returning to India as part of their own care plans for the future. Sindhu and Cecilia, for example, said they did not want to grow old in the UK, and would never go to a nursing home. Instead, their dreams lay in a return to India:

When somebody gets ill here, you put them in a nursing home. I don't want that. Like I'm sure every family thinks like that, but if I'm fit enough to look after him [husband], or he's fit enough to look after me, he says we go home, we go back there [India]. If we pay somebody, get a private nurse to come in day and night, that's why we've got the house there. And we have relatives too. (Sindhu)

Sometimes they come in black and blue. Coming in after two days on the floor. And nobody knew they were on the floor. It's shocking. [long pause]. Seeing this is very sad. It's sad. So we don't want this for our future, it's a shame for the family. So we will return to India when we are old, hopefully. (Cecilia)

In imagining their own care in the future, Cecilia and Sindhu both draw on an idealised image of care in the Indian context, where elderly people remain in their homes and with family members (see also Chapter 6). They envision that their children will stay in the UK if they returned to India, a point I return to below, meaning that their children would not be there to reciprocate care as per cultural norms. When I asked Cecilia who would look after her should she return to India in old age whilst her children remained in the UK, she said 'I have got people, neighbours, far off family relatives who can come and help'. Similar sentiments were shared amongst the nurse participants, who, having seen first-hand what growing old in a nursing home in the UK looks like, were adamant that this would not happen to them. Hence, a return to India as ageing retirees was central to the majority of the participants' life plans. Some participants recognised that their hopes to return to India may never materialise because of, for example, the tensions between their own desires and the preferences of their UK-resident children, an issue returned to below. Even in this hypothetical situation, they nevertheless imagined a return to Kerala. As

George said 'even at the end, we have to be back home. Even if I died or anything, we going to be resting in peace at home'.

As participants have laid down roots in the UK, acquiring mortgages, loans and credit cards, they have found it difficult to save enough to return. Some said that whilst they dreamed of returning, there were too many challenges involved in settling back in India. The biggest challenge usurping the desire to return were participants' children, who were either born or had spent significant periods of their childhood in the UK, and were firmly embedded in the British education system:

We were planning on going to Australia or somewhere a bit more warmer climate, and I got even the PIN number for there, the registration. I had the registration to go, but the children, they are not willing to go. They don't want to go from here [laughs]. They don't want to lose the community and friends here. And they are getting educated here. So we thought, if they want to go, when they go, we'll go with them to Australia or wherever. But the children are happy here.
(Susanna)

Similarly, Maryam eventually hoped to return to India, but found the timing tricky, as they did not have enough money to return or go anywhere else just yet, but she felt if she left it too long, it would be hard for her children to settle there, a point also made by Sindhu:

It's very difficult when a child is brought up here, take them away from here, it's totally different. Like I came here for work, it is totally different there. The standard of living is totally different. To come down to the level that I have been brought up in, it's not easy.

These 'reality checks' led to systematic postponement of their return to India or movement elsewhere. As Sindhu points out, whilst India is a desirable option for her in the future, it is not one that is suitable for her British-born children. Indeed, some participants mentioned that there was an age which with thereafter, they could no longer expect their children to settle in India, due to their lack of familiarity with the culture and language of India. The influence of the younger generation on imagined

futures was repeated amongst participants with children. As Boccagni points out, the 'expected emplacement of the future does not depend only on the relative success of their immigrant trajectories, or on their living standards here and now. As, or possibly more significant is the reach and strength of intergenerational ties and obligations' (2017, p. 11). This is illustrative of the point made in Chapter 2, that aspirations are 'peopled' with others (Mische, 2009) and are thus relational, and often reflecting a sense of reciprocal obligations into the future.

This pull between what their children want and what the nurses want for themselves or their parents can result in a tension between meeting their future care obligations in India *or* the UK, as encapsulated in Thomas' struggle in thinking about his future plans:

At the minute, my plan is going back to India, because I want to settle in India. Purely because my family is there. But at the same time, there's a pull-back. We don't know. The kids have to decide it. Because if suddenly in two or three years time, the kids say they don't want to go, then we are stuck. And if the kids are saying that way, we don't know what to do. Because our families are there, kids are here. One has to be there. This question is answerless for the time being, but the plan is I want to go. My wife wants to go...we will see.

In answering my question about their future plans, participants often spoke about this tension between intergenerational responsibilities and the uncertainty this tension threw up for them. It appeared for the most part that they put their children's needs and wants before themselves or their parents, not that uncommon a pattern in families in general (McCarthy, Edwards and Gillies, 2003). These relational tensions and uncertainties tended to roll forward the present so that participants like Thomas and Susanna, whose children's needs tended to trump their own, were unable to see their future beyond their current lives in the UK. When it is unlikely that children will return 'home', participants' aspirations about their own future 'become irremediably more indeterminate, or at least multi-sited' (Boccagni, 2017, p. 11). The following section reflects on these multi-sited aspirations.

Stepwise Migration: Aspirations to Move to Other Nurse Recruiting Countries

Bauman (1998, p. 2) argues that the freedom to move 'is the main stratifying factor' of today's global society. As discussed in Chapter 4, international mobility was explicitly acknowledged by participants as a way of accessing certain types of resources, such as material and social status, and was intertwined with participants' decisions to enter the nursing profession. Being mobile and acquiring the potential to be mobile was relevant to all participants, and this value on mobility did not disappear once participants had reached UK shores. The resources (financial, social, political and cultural) accumulated throughout their work, family and migration biographies allow participants to imagine what their lives could look like. Aside from aspirations for an eventual return to India, something common amongst migrants in general, some of the nurses in this study also dream of leaving the UK for new geographical horizons, whilst others plan on remaining in the UK. This section reflects on these accounts. Aspirations to stay or move for work need to be articulated in the context of 1) their working contexts, which as described earlier in the chapter is characterised by a general sense of disrespect, deskilling and exclusion, as well 2) an awareness of potential opportunities available elsewhere, and 3) their personal biographies (Boccagni, 2017).

Many of the participants who described incidents of discrimination and stigmatisation in their daily working lives were often the most certain of their plans to leave the UK. These nurses were not yet in a position to retire (age-wise and financially), so instead had their sights set on new countries in which to go and work. A common topic of discussion brought up in formal interviews and during conversations at Malayali Cultural Association events was the number of Malayali nurses who had recently moved to Australia from the UK. Participants had numerous friends who were now working as nurses in Australia and were in touch regularly with their compatriots in the UK. They described these Australia-based nurses' lives as consisting of good wages, better working conditions than the UK, lots of sunshine

and a more family friendly lifestyle than their own in Britain. Dissatisfaction with their working and family lives in the UK coupled with hearing about the 'Australian dream' led to a number of participants talking about Australia as a potential future option. The nurses in this study described the Australian nursing sector as one that would recognise their skills and experience, and a country that has more family-friendly work and immigration policies. As Sindhu said, 'in other places maybe we would be more valued'. However, given that research suggests similar experiences of discrimination and exclusion in the Australian labour market for African nurses (Mapedzahama, Rudge, *et al.*, 2012) as well as restrictions placed on the migration of parents (Baldassar *et al.*, 2007), one has to query this portrayal of Australia as the 'land of opportunity'.

Regardless of the potential gap between portrayal and reality of life as a migrant in Australia, Pothan was taking stock of his occupational opportunities, at the time of interview. Having deduced that his promotion prospects are limited in the UK mainly because of his marginalisation from the 'cliques' on the wards and the cuts to the NHS, his preference for working and raising his family was shifting further and further towards Australia:

We went to Australia to complete our registration a couple of years ago, it's one of the processes you have to do. So I went around hospitals for informal chats, like informal visits and I found that they're very child friendly, they're more family orientated and they can accommodate you. And obviously the weather is a big factor for us [laughs]. Yeah, they're very family orientated in the work-place, so I mean, when we said to our employers, they said 'we're not family friendly, hospitals in the UK'. So this has made our minds up, we hope to go. I don't think I'll ever get promoted if I stay here. You know, that's another thing about moving to Australia. There are more opportunities there, there are private hospitals as well as public hospitals. I don't think I will ever get promoted if I am here in this hospital.

Sheela's reasons for looking to Australia as a potential future destination lay in her experience of deskilling in the British context, where her previous experience

working as a highly skilled nurse on a cardiac unit had not been recognised and she was currently working as a nurse in a private nursing home:

We hear all about them nurses in Australia. They are very well off and they say it's better than here, children enjoy more, because there's more sun and they can play, there's more freedom and everything is good there. That's what they are all saying. They are all praise about it, about Australia. Work is also very good, you're recognised for your experience that you do. Your experience from your home country as well counts, but here it doesn't count. I mean, I had about five years, no I had about four years of experience before I came here. But that wasn't counted. When I came here, and when I got my PIN, from that only was it counted.

Both Pothan and Sheela refer to the multiple indignities that are shaping their desire to leave the UK, as well as their awareness of other potential employment destinations available to them. Both have British citizenship, UK experience, and a UK nursing license; it was much easier (and cheaper) for them to get to Australia than if they had Indian passports and work experience (Carlos, 2013). Their view of the future is of an open and accessible place (Adam and Groves, 2007), one that is potentially full of positive developments associated with the opportunities entailed in nurse migration. In their case, making practical steps to move countries was a way of managing the corrosive effects of stigmatisation and discrimination. Moving to Australia in this sense is symbolic of their aspirations for self-achievement as well as an agentic act that challenges their position as racialized others in the labour market. However, as mentioned above, their dreams of a move to Australia may not necessarily lead to the fulfilment of their dreams, but may actually mirror some aspects of their lives in the UK. Australia was not the only destination that participants were considering in their desire to 'move on' from the UK; other nurse recruitment countries were also considered as some participants' weighed up the 'external structure of opportunities' (Boccagni, 2017).

As outlined in Chapter 4, the Gulf was a popular potential destination for those who had previously worked there, even when they described their time there as difficult

and full of challenges. Mary, for example, who earlier described her and her children's experiences of discrimination in the workplace and playground, dreams about a return to Dubai where she worked as a nurse prior to coming to the UK. In her contract with a private hospital, there was an explicit clause that forbade her from getting pregnant during the first two years of working. After the hospital found out she was pregnant, her contract was immediately terminated and her visa was revoked, prompting her return to India. Yet Mary would prefer to return to Dubai where she claimed that she would be treated more fairly than she had been in the UK. Mary was quite explicit in her reasons for looking outside the UK for work when she told me:

I don't think that this is an attractive place for bringing up a child, especially a non-white child. You know what I mean? I've never felt it a safe place for my son or my daughter. We are just fed up of this place actually. You get to the point actually where you just want to leave this place, there's no point in living here just to be classed as nobody. You don't have a sense of...who are you here? Nobody. You know like that. Even though we work hard, we have never lived on benefits. We don't have any kind of any benefits or income support, or anything like that. We pay our tax, we pay our tax, we pay insurance. We contribute to everything in the country. And we look after the sick and elders. And this is what we get.

The accumulative disrespect that Mary and her family have experienced since their arrival to the UK over a decade ago can be understood to shape her desires to leave the UK. Mary and others like her described themselves as migrants who contributed to society, which they thought should guarantee them some respect in the British context. Mary's aspirations to leave in the future thus emerge from a standing point of her 'present', which has been generally marked by a racially subordinate position in the UK.

Mary, Pothan and Sheela's hopes to leave the UK can also be interpreted through the lens of vulnerability, which has received a lot of attention in, for example,

sociological theories of risk and uncertainty in late modernity (Beck, 1999).

Exploring the subject of vulnerability, Brownlie (2014, p. 193) asks:

Whether being vulnerable is the framing through which we choose to interpret our way of being in the world. Not perceiving ourselves as vulnerable might be one reason for not talking about vulnerability, but there could be others. We might, for instance, see ourselves as vulnerable yet still choose not to talk about it, either because it makes us feel uneasy to do so or because we believe we will not be heard or, indeed, may be actively silenced.

Misztal (2011, p. 128) recognises the importance of the subjective accounts of vulnerability but simultaneously locates the core of all experiences of injustice in 'objective conditions'. Drawing on this multidimensional understanding of vulnerability, Brownlie (2014, p. 198, italics in original) suggests that 'even if we do not *perceive* ourselves to be vulnerable, *objectively* we might well be so since our understanding of vulnerability, like wellbeing, are fallible'. Mary, Pothan and Sheela all point to objective conditions that may render them vulnerable, such as their treatment in and outside of the workplace. However, it would be prudent to not simply view their utopic framings of life in Australia or the Gulf as irrational or ill-informed dreams. Rather, given their current positions in the UK, these hopes for the future could also be read as a reflexive way of navigating such vulnerability, seeing life in the UK as representing a vulnerable *time* in their lives rather than necessarily viewing themselves as vulnerable *beings* (Brownlie, 2014). This points to some of the ways that people creatively manage their lives as they navigate constraints in an effort to flourish (Cieslik, 2015).

Maryam's dream of an eventual move to the US was not prompted by unpleasant experiences in the workplace or aspirations for career progression, but instead emerged from her husband's lack of a career in the UK, which, as discussed in Chapter 5, was connected to immigration policy in the UK. Her husband dreamed of becoming a computer engineer in the US and was taking online courses at the time of interview in a bid to 'upskill'. Maryam seemed resigned to follow her husbands'

plans, despite the unlikelihood of his dreams coming to fruition, saying 'I don't think we'll make it to US...but we will go wherever he decides. You know, if he wants to do that, we will do that. I try not to say no'. This could also be read as a response to the reversal of status in the division of labour in the household, whereby Maryam's husband retains control over deciding the family's future (see also Chapter 5). All of these experiences point to both the multi-sited relational settings that nurses are embedded in, as well as their awareness of the potential opportunities they have available to themselves as nurses.

However, the majority of participants, whilst talking about a much-longed for eventual return to India, did not envision going to another country to work as a nurse. When asked where they saw themselves in the future, they talked about staying in the UK with their children. Although many of these participants had talked about their multiple sufferings in the workplace, in contrast to the group who planned on leaving the UK to work in another country, this group were more self-reflexive about their plans to remain in the UK. Prompted by talking about her life over the course of the interview, Preeti, for example asked herself whether it has all been worth it:

Well, sometimes I ask myself if it has been worth it, and sometimes we think that it's not, I don't know. It was not a wise decision. And then sometimes we think, I don't know, it's difficult to know...my husband had a nice job and I took the decision to come over here, you know.... And if we were there, things might be different. But you never know. But you get a chance, when you're young you can travel and you can work. But em, we didn't have any problems. Like we were ok, we had some problems here, but you get problems anywhere. I mean we have friends in India, and they have so many financial problems, or mother working in Saudi, father in Kuwait and children in India. So we are ok.

It is interesting that Preeti, after describing the multiple indignities that both she and her family had suffered since their arrival to the UK, struggled to interpret or articulate her emotions. Brushing off these experiences as problems that could happen anywhere in the world, she points to the vulnerability 'built into' an

unpredictable world (Misztal, 2011). However, in evaluating her life as inevitably involving both good and bad experiences, Preeti does not frame her story in terms of vulnerability, but rather contends that life is characterised by both sadness and happiness. In doing so, she suggests that whilst life can be challenging sometimes, she also just 'gets on' with things (Brownlie, 2014).

This shared sense of 'getting on' in an unpredictable world was a sentiment repeated by others in the study, who engaged in techniques of the self similar to those promoted by the happiness experts (Brownlie, 2014, p. 206). For this group of participants, they often interpreted the hardships they had experienced in relative terms, seeking perspective through comparison with the challenges that others experience. Rosy, for example, said towards the end of her interview:

It's like everybody, in everybody's life, some sad things happen and some good things happen, so we need to omit some stuff which is like, we missing our family, missing our place, some problems at work, but we are, we got family here, but some people, some Indian nurses, like my sister-in-law, my husband's brother's wife - she's got two kids and she works in Saudi, so every year she got 50 days holidays, so she's coming every year to see the kids. So that's hard. So compared to her, compared to that type of working lifestyle, we are happy, because at least we've got our family here.

It's like a big achievement I think. It is, it's a big achievement, to come from my country, you know like, to work here and to get through so many things. And to have my family together here. So, we achieved like almost everything, most of the time we are here, so it's a good part, a big part in here [in the UK]. If I was in India, I'll be honest with you, I wouldn't be able to afford anything like this, like this lifestyle, but now, it's like, I'm happy anyway.

Through relativizing her problems, Rosy makes her vulnerability both ordinary and universal, as something that everyone experiences. Moreover, in reflecting on both good and bad experiences, she suggests that the good in her life takes its meaning from the challenges and suffering she and her family have endured (Cieslik, 2015, pp. 426–427). One way of reading this is that by self-reflexively neutralising

problems such as these by taking a bigger picture, Preeti and Rosy are more likely to see a future that rolls forward the present rather than aspiring for further migration.

Of course, potential migrants do not only need to have the 'capacity to aspire' (cf Appadurai, 2004) but also the 'capacity to realise' (Carling, 2001) their migration project. For the nurses considering further migration, this is influenced by their perception of the external structures of opportunities and their access to resources, given their present circumstances. Moving to Australia or the Gulf with a family costs a lot of money, and thus requires access to economic capital and resources. Similarly, the self-reflexive neutralising that makes the decision to remain in the UK more palatable also requires being able to reflect on some of the joys of life since their migration to Britain and feeling like the decision to remain is a choice. As mentioned earlier in this chapter, two of the trained nurses, Shobha and Alice, struggled to get their education and qualifications recognised in the UK context (see Chapters 1 and 5 for more discussion of this process). Both described being unable to engage in stepwise migration because they did not have the financial resources nor the option of leaving. Still working as carers, they have not been able to use their time in the UK to accumulate the necessary resources that would facilitate a move to Australia, namely finances and British nursing experience. Deskilling is bound to entrench them further in the lower echelons of the nursing hierarchy, even though they have both acquired a British passport and hence have the potential to be more mobile than they were upon entering the UK:

I've come here all the way from India, just because I want to progress in my career and I want to do good for this country and my family as well, I am upset but have no option, so just working in care homes. I can't do anything, I can't go anywhere. Need some money to go to India, need some money for Australia. So I'm stuck here. All I can tell you is that nobody likes to work here as a carer, but there is no other option so they are working here. (Alice)

Unable to have her professional qualifications recognised, the impacts of entering the British social labour market as a carer and undergoing a process of deskilling extends

beyond the workplace for Alice. Her construction of the future was not viewed as open, but was rather limited in the sense that she felt 'stuck' both professionally and geographically, and was unable to see her future beyond this. Stepwise migration was thus not open to all participants, and indeed both carers described their inability to hope for further migration, at least in the short-term. The institutional context surrounding their arrival to the UK has led to limited employment opportunities, both in the UK and global nursing market. However, like most other participants, both still hope for an eventual move to India following retirement. Although a return to India in the future may suggest the end of transnational family care practices, most participants said that they would most likely continue to lead transnational family lives following this return.

On the Move Again: The Reproduction of Transnational Circulation on an Intergenerational Scale

One of the older nurses in the sample, Pushpa was in her mid-50s at the time of interview, arriving to the UK during the early stages of the state's active recruitment period. Pushpa, who was actively planning her retirement, talked about her nursing career and life in the UK facilitated multiple opportunities for both her and her university-going children. She hoped her future would involve a split in her time between India and wherever her children ended up, which she suggested would probably be the UK, or Dubai, depending where their careers and/or marriages took them. However, she was looking beyond her children and imagining her role as a grandmother living transnationally, thus adding a further generational layer to these imagined futures:

If they have children, maybe I have to stay with them. But I don't like to separate, I don't want him [husband] to go there alone. We want to be together. I'll be getting older. So better to go to India, come back here for six months and see children, how they are getting on. Stay with them for few months. Mind their children, maybe bring them back to Kerala.

Owning multiple properties in Kerala and planning for her children's marriages, Pushpa's post-retirement plans are close to being realised. Other parents in the sample also envisioned a future where their children would live in the UK whilst they remained in India, shuttling back and forth to provide care for their adult children and grandchildren. In imagining that they would split their time between India, the UK, or wherever their children end up living, Pushpa and other participants' aspirations for the future illustrate the importance of examining migrant nurses' imaginings, and highlights how the 'flying granny' (Plaza, 2000) phenomenon can be reproduced across generations. It also points to the reproduction of transnational care circulation on an intergenerational scale, whereby further mobility is triggered by the need to provide personal, 'hands-on' care and support for the next generation. This resonates with Ackers and Dwyer's (2002, p. 151) work on intra-European migration for care, suggesting that mutual care between multiple generations needs to be seen from the life course as a whole.

7.4 Conclusion

Broadly speaking, I have explored in this chapter how the nurses in this study talk about their aspirations and how they see their work and family lives unfolding in the future. These highly reflective accounts are influenced and shaped both by the realities of their insertion into the hierarchal nursing labour market in the UK and their experiences of caring for family in the context of their migration. This chapter illustrates how the nurses' care activities and practices in the present are not only embedded in the past, but also projected into the future. This reveals some of the initiatives and compromises made by the nurses faced with changing obligations and hopes for the future. Whilst the accounts presented in Chapter 4 suggest that aspirations to leave India initially were quite straightforward, participants' hopes for the future at the time of interview were not so clear-cut, since life in Britain was much harsher than they were expecting and due to the fact that the majority had children living in the UK. Participants' accounts of their encounters in the workplace reveal experiences of stigmatisation and discrimination and the ways in which some people have tried to counter such experiences.

However, this is not the main purpose of my argument in this chapter. What emerged as pertinent is the different ways that participants talked about these experiences and how these accounts contribute to their constructions of the future. Their experiences in the labour market suggest that some of their expectations have not been met. This is unsurprising given the historical experiences of migrants in the NHS. Some of the nurses explicitly talked about their experiences of overt racism, whilst others performed emotion work and reflexivity in the interview context in order to talk about and explain their experiences. Of course, part of the reason why some are unable to articulate their experiences is because what they are experiencing is somewhat different from the more overt forms of racism of the past, which have been made illegal in Britain. The nurses' experiences instead mainly lie in subtle interactions, leaving them sometimes unsure as to what exactly happened, but with a lingering sense of being on the margins. In response to this some, but not all, participants 'put their head down' and 'get on with things' in an attempt to downplay tensions.

Yet the analysis also reveals that the way participants describe these troubling interactions is not only connected to the subtle nature of many of these encounters. As discussed in Chapter 2, activities and practices in the present are not only embedded in the past, but also projected into the future. Based on their insertion into the global labour market as nurses, some participants weighed up their opportunities on a global scale and constructed the idea of a better 'future' based in Australia or the Middle East, where they could leave their negative experiences behind in the UK. These participants do not see themselves as vulnerable, but rather see their time in Britain as vulnerable; they constructed their futures in Australia and the Middle East as open, with the potential to bring new and better things for them and their families. The analysis also revealed how other participants were highly reflexive in their accounts of work and family life in the UK, weighing up the good and the bad, and managing and neutralising negative experiences. They reminded themselves (and me) that they were in a good place, somewhere that allows them to dream of many things that would not have been possible had they remained in India. This is not only

in relation to money, but to the quality of their children's education, as well as the respect garnered in the workplace, even whilst they simultaneously describe instances of discrimination and marginalisation. In comparison to both their past and their knowledge of other peoples' situations, they do not perceive the challenges they face only in terms of misery, but rather as a universal part of life in an unpredictable world, involving both good and bad things. These nurses' constructions of the future were much more indeterminate, with participants describing life, at least in the short-term, as much the same as now.

The analysis also revealed that all of the nurses longed for an eventual return to India. Many pointed to the chief obstacle they would encounter in attempting to return to India, mainly the fact that their children have been brought up in Britain and are able to get a high-quality education there. Their experiences speak to the 'myth of return' concept (Anwar, 1979), whereby they maintain transnational ties such as obligations to relatives in India and economic and social ties, preventing them from becoming too disconnected from their ideal future homes. However, participants nonetheless imagined their return to India, with many navigating the potential separation between them and their children by envisioning the reproduction of transnational lives and caring practices.

If anything, this chapter highlights the ambiguous nature of migration. It shows how participants' constructions of the future are shaped by their biographical experiences, relational pressures as well as the changing structural landscape of nurse recruitment. Moreover, their hopes for the future need to be understood within the overall context of the life course, whereby intergenerational ties and obligations ebb and flow according to changing care needs. The literature on nurse migration often focuses on their negative experiences in the workplace, and this chapter certainly supports such findings. However, by extending these experiences into the future and paying attention to migrants' aspirations, a further set of family and work nuances and relational complexities are surfaced, as well the interplay between individual agency

and structural factors. This points out that nurse migration is not simply a form of labour exploitation or care extraction, but is also about reciprocal care relationships that make transnational family life possible now and into the future.

Chapter 8 Conclusion

Throughout this thesis, I have foregrounded on the one hand the structural and gendered inequalities that underpin accounts of migration and caregiving, and on the other hand the relational interdependencies and moral and cultural values that sustain multigenerational care between family members. In doing so, my primary purpose has been to expand knowledge of the intersections of feminised labour migration and transnational family caregiving. While these intersections have attracted significant attention from feminists writing about gender and migration over the last twenty years, this research has been largely limited to the experiences of women working in domestic work and to aspects of their motherhood and has tended to reproduce representations of women from the global south as immiserated and lacking agency. This creates a gap in understanding the experiences of the rising numbers of women (and increasingly men) migrating as nurses from the global south to the global north, and the (partial) privileges afforded to these women and men as a result of their insertion into the labour market as skilled migrants. This study, therefore, has aimed to contribute to not only broadening the skills base of the migration-care intersection scholarship, but also extending the theoretical application to new dimensions of migration—men migrating as nurses and transnational family care beyond ‘motherly’ care—and to move beyond seeing the families of migrants as broken or ruptured due to geographical distance.

In this concluding chapter, I first review the research questions I raised in the Introduction chapter and illustrate how they have been addressed by the empirical chapters. In doing so, I draw out and restate a number of the core findings of this thesis and the key contributions of the study. On the basis of an assessment of the claims made in the thesis and of the remaining knowledge-gaps, I also reflect on the methodological limitations of the study, and what this suggests for future research. Finally, I discuss some of the practical and conceptual implications of the study.

8.1 Findings and Contributions

The theoretical contributions of this thesis turn on the bringing together of the global nursing care chain and care circulation frameworks and extending their scope by embedding the migrant in her relational context, which stretches across generations and into the future. The specific case of nurse migration was chosen because it a particularly strong instance of the entanglement I seek to demonstrate. Nursing is a profession that is inextricably tied up with both family and migration in the Indian context (Nair and Percot, 2007) and the phenomenon cannot be understood solely as either economically driven or care driven, instead being contextualised by both spheres. In order to incorporate both spheres, this thesis amalgamates Yeates' theoretical framework of the 'global nursing care chain', which is a useful framework for understanding the position of overseas nurses within a feminised global care economy, with Baldassar and Merla's (2014b) framework of 'care circulation' to examine the moral dimensions guiding transnational care in the Indian nurse family. This is an analytical attempt to complement the political economy perspective of the movement of commodified care with an analysis of the mobilities of care from the perspective of family duties and reciprocity. In doing so, I depart from Yeates (2009) by paying more attention to the nuances and dynamic aspects of care in the nurse migrants' family. Indeed, as far as I am aware, this thesis is the first to draw on the 'care circulation' framework to examine the processes of reciprocal and asymmetrical care flows between migrant nurses and their family members both resident in the UK and remaining in India, an area which has hitherto been predominantly understood within a narrower care chain approach that sees care between family members as unidirectional. Tronto (2016, p. 268) argues that in most circulating systems, there is a pump or force to 'keep the system flowing'. In the case of nurse migration, this 'pump' can be understood by framing nurse migration between India and the UK as reflective of the international division of reproductive labour (Yeates, 2009). However, by grounding the analysis in a very specific context, the thesis also reveals how the Indian cultural ethics of care and economic realities which bind family members together in multigenerational networks of family obligation and reciprocity similarly act as a 'pump' underpinning nurse migration.

The care chain and care circulation frameworks are complemented through the adaptation of an explicit temporal lens into the conceptual framing of the thesis. The concept of care circulation has a temporal element built into it already, with its focus on mutual care between multiple generations in the family over the life course. However, I also address the importance of taking seriously the future-orientations of migrants, not only seeing these orientations as connected to the past and present, but also as generative and productive in their own right. Attending to the role of aspiration sheds light on how both nursing chains and care circulations are reproduced. Taken together, these three conceptual framings cover both the spatial and temporal aspects of the intersections between the transnational movements associated with nursing care and transnational family care.

Throughout this thesis, an intersectional lens has illuminated aspects of these migrant care workers' lives that challenge the popular representation of the migrant care worker as a poor, uneducated, subordinate and unskilled woman (Hondagneu-Sotelo and Avila, 1997; Parreñas, 2001; Ehrenreich and Hochschild, 2002). The four empirical chapters complicate simplified classifications of discrimination and privilege amongst this group of migrant workers (Nash, 2008). For example, the female nurses in this study can be understood as (partially) privileged, in terms of their education and profession, which has facilitated their movement as documented migrant workers from India to the UK. However, they are simultaneously disadvantaged on the basis of them being migrant women from the developing world in the UK, whilst also belonging to a profession that has historically been viewed as 'dirty' in the Indian context. By including in the study men who do what has largely been understood as feminised work, the thesis also draws attention to male and female migrant workers' experiences at the intersection of class, race and immigration status. Since the empirical chapters are loosely organised according to different stages of migration and life course, the chapters implicitly illustrate how the intersecting, mutually co-constituting factors that constitute a person's situation can both hamper and enhance possibilities within different contexts of emigration and immigration at different points in time. The thesis is thus illustrative of an

intersectionality that pays attention to changing transnational and temporal contexts. The first empirical chapter focused specifically on the Indian context, where the participants accounted for their decisions to migrate. It is to this context and to the first research question that the chapter now turns.

How do Indian nurses account for their decision to become 'nurses on the move'?

India is in the process of transforming itself into a nurse 'production' country, in the style of the Philippines, with the government publicising 'the view that India has large-scale nursing unemployment and therefore can afford to lose thousands of nurses' (Healey, 2006, p. 229). India is simultaneously experiencing a scarcity of nurses, with many nurses migrating to countries in the global north to overcome dismal working and social conditions (Gill, 2016). In the first empirical chapter (Chapter 4), I explored the way Indian nurses accounted for their decisions to become 'nurses on the move'. These accounts are clearly connected to the global demand for nurses, to the status of nursing in India and to nursing networks stretched across India and the globe, and hence the global nursing care chain thesis as developed by Yeates is very relevant here. However, in this chapter I presented an alternative story, one that emphasises how transnational migration for nursing is embedded in family obligations, reciprocity and material realities, as well as structural and gendered inequalities.

Interviewees described joining the nursing profession with the explicit intention to engage in international migration, but it is the migration opportunities engendered by nursing that makes it an attractive professional choice in the first place, especially since nursing in India has historically been a low status and low-paid profession (Gill, 2011). This has been noted by others studying nurse migration from India (Nair and Healey, 2006; Percot, 2006; Nair, 2007, 2012). In this chapter however, I create a new conversation between this argument and the literature on transnational family caregiving, and as a result familial care and caregiving are foregrounded as central to

driving nurse migration. Doing so illustrates the difficulties of separating out migrating to provide nursing care and migrating to provide familial care, since nurse migration simultaneously involves both. Accounts of entering nursing and the subsequent choice of destination countries were deeply embedded in the nurses' relational contexts and ideas of family obligations and duty, and were often triggered by the need or desire to provide care for family members present and future. Focusing on the links between the nurses' labour migration and the care between nurses and their family members brings to the fore two important points. Firstly, the timeframe of the migration decision stretches out from the singular moment—into the past, where nurse education is seen as a family investment that can secure wages and ease the 'burden' of being a daughter, and into the future, where nurses imagine stages of their personal lives and their associated care responsibilities as mapping onto migration opportunities. Secondly, it suggests the centrality of family considerations and the ability to provide care when nurses are considering what countries might serve as suitable destination countries. As discussed in Chapter 7, the UK, with its restrictive family reunification policies, is not an ideal place for reunifying with family members beyond the nuclear family, and such restrictions contribute to hopes for onwards or return migration that allow physical co-presence between the nurses and their ageing parents. Accounts of becoming a 'nurse on the move' then is rooted in the idea of migration as an ongoing process and one that is deeply embedded in both hopes for the future as well as obligations and duty to care for family members.

Analysis of the nurses' accounts of their entry into this international labour market also surfaced some interesting gender differences. For the women in this study, especially the older ones, there were not many other career choices available to them, other than gendered professions such as teaching, with cost of further education and the weight of being a 'burden' on the family significant in their accounts of why they chose to become nurses. Bearing in mind their socioeconomic backgrounds and their families' needs as well as the possibilities for social reproduction, the women, in discussion with their families, entered nursing typically with high hopes for

international migration and the social reproduction of their families. In turn, the migration opportunities entailed in nursing are changing the status of the profession in India, with increasing numbers of women and men from other regional, religious and class backgrounds joining the ranks of nursing recruits in India (Walton-Roberts, Bhutani, *et al.*, 2017). This changing status is also reflected in the increasing number of men joining the profession.

Serious attempts to rectify the lack of a gendered analysis in the migration process have emerged over the past twenty years, resulting in a voluminous amount of work relating to women and migration. Despite evidence suggesting that men, and indeed migrant men, are indeed entering nursing in larger numbers than before (Cangiano, Shutes, *et al.*, 2009), there is no research to my knowledge that pays attention to the different ways that women and men account for their migration as nurses. Walton-Roberts (2010), for example, includes male nurses in her study of student nurses post-graduation plans in Kerala, but she does not attempt to draw out any gender differences from her participants. This is surprising, since the decision to enter a feminised profession with inherent migration opportunities adds another dimension to understandings of the connections between gender and migration. Moreover, whilst recent studies are increasingly paying attention to men in gendered migration, this research tends to reproduce the focus on domestic work and what can be understood as low-skilled care work. This thesis, with its inclusion of a group of men engaging in skilled gendered labour migration, thus addresses an empirical gap in this research field.

The perception of nursing in the Indian context as a 'door to abroad' and its attendant opportunities was a means for the men in this study to obtain the type of income required to have a 'good' family life. All of the men talked about their decision to enter nursing as one that challenged their masculinity, albeit one that allowed them to perform it at the same time through engaging in waged work and having the means to marry and start a family. Here, the connections between labour migration, familial

care and future-orientations are made visible, whereby engaging in nurse migration facilitated the men to pursue their aspirations for family life. Adopting a gender lens, that is inclusive of both men and women, thus surfaces the gendered ways that women and men talk about their decisions to become migrant nurses. The family is deeply implicated for both women and men, albeit both genders talk about their obligations and the ability to achieve a 'good' family life differently, which is reflective of the broader sociocultural and political context in India. They want to care for their extended family members through remittances, as well as establishing the resources to engage in 'good' marriages and establish their own families. However, such care is also shaped by Kerala and India's position within the international division of reproductive labour and its historical context of colonialism. The value of employing both the care circulation and global nursing care chain frameworks and grounding analysis in the particular cultural context is thus evident here. Once participants left nursing school, most of them quickly put themselves in positions where they would be eligible for international migration, which, as discussed in the rest of the thesis, has implications for the way they and their families live their lives.

How do Indian migrant nurses maintain and (re)negotiate caring roles in resident and transnational families?

This question has been investigated in two separate chapters, Chapters 5 and 6. As discussed in Chapter 2, the care chain literature remains overwhelmingly focused on female care workers, 'motherly' care and the ways in which this form of migration negatively affects the quality of migrants' care-giving practices. Such negative effects, according to Hochschild (2000), are brought about through the loss of physical co-presence and the transfer of love from the global south to the global north. In contrast to this approach, Chapters 5 and 6 puts distant and proximate forms of care configurations and (re)negotiations at the centre of the analysis. In doing so, these chapters illustrate that love and care are not finite commodities, and that migration does not end caring relations between migrants and their kin 'left behind'. Rather it transforms these practices, which ebb and flow at different points in time.

Chapter 5 takes as its starting point a focus on childcare in the context of migration. Whilst this focus on women with dependent children might seem to reproduce the focus on 'motherly' care, the chapter illustrated that this was a phase in the migration and family life course. Some of the women had been separated from their children for years when they worked in the Gulf countries, and this was repeated for some after their arrival to the UK. For those who were married prior to their migration, their husbands joined them—many of whom also work as nurses—with children typically joining the family between three months to two years on a permanent or temporary basis. I argued that this demonstrated that transnational motherhood, for the women in this study, was a phase coinciding with stages of their migration journey. As the nurses acquired their licence to practice as a registered nurse, with great difficulty for some, they were joined by their families or began to have families in the UK. A new set of care challenges emerged following reunification or the birth of children. Participants, like many families in the UK, were faced with the difficulties of negotiating childcare in the context of their daily working lives. The key finding from this chapter was that the nurses continually reconfigured their caregiving strategies in response to the changing needs of their children and the demands of their workplace, relying on geographically diverse but coordinated family and non-familial networks to assist them with their childcare responsibilities. The chapter also illustrated the structural conditions framing the nurses' negotiation of childcare. Immigration policies and the NMC's changing requirements for registration presented obstacles particularly for those who arrived at the end of the UK's recruitment drive, which had the effect of channelling some participants into low paid care work that did not recognise their nursing qualifications or experience. This has direct consequences for the nurses in terms of the length of their separation from spouse and children. Nonetheless, those who experienced separation from their spouse and children were eventually reunified. These accounts of the renegotiating of caring roles is illustrative of how migrant nurses can occupy positions of privilege whilst simultaneously being marginalised on account of their position as Indian

women and men in a nursing profession that is organised along gender, class and racial divisions of labour (Smith and Mackintosh, 2007).

Chapter 6 took as its focus a different set of care relations that the nurses in this study were embedded—their parent and sibling relationships. Rather than only seeing the nurses as providers of financial care towards their parents remaining in India, I articulated in this chapter (and throughout the thesis more generally) their roles as transnational caregivers *and* receivers in the everyday context. In focusing on *how* people talk about their lives through these accounts, the connections that some nurses made between ‘here’ (caring for elderly patients in the UK) and ‘there’ (caring for ageing parents in India) were surfaced. This demonstrated the importance of paying attention to reflexivity not only on behalf of the researcher, but also on how participants are reflexive about their informal and formal care roles. By making these connections, participants pointed to both the moral frameworks that influenced their views on who should be responsible for the provision of elderly care, as well as surfacing feelings of guilt that they were not ‘there’ to provide hands-on care to their ageing parents. However, although they were not physically ‘there’ with their parents, other forms of care (emotional, practical, personal, financial) flowed between nurses and their family members in quite meaningful ways. These care flows were not necessarily symmetrical though, with both the men and women’s accounts suggesting that the women did most of the emotion work when attempting to maintain and sustain relationships with family in India. Moreover, as their parents age and their support to their adult children decreased, some participants envisioned a return to India at some point in time, especially if they are one of a number of siblings all based abroad or the only son. These exchanges of care are thus dependent on the capacity, obligation, and negotiated commitments which change over time (Baldassar *et al.*, 2007). Inviting parents to the UK to assist with childcare and domestic responsibilities marked a change in intergenerational relations at a sociocultural level. The envisioned ‘Indian’ system of intergenerational support was not fully forthcoming. Their parents were unable to access any social rights in the UK, despite providing unpaid care to children resident in the UK at frequent and

lengthy durations. As their health declines, the nurses in this study described increased reluctance to invite their parents to the UK. However, the accounts presented throughout this chapter illustrate the innovative ways that the nurses and their family members cared for one another, and the ways in which they overcame challenges through visits and communication technologies.

The temporal nature of transnational family care is evidenced in such changing dynamics, where personal 'hands-on' care is provided on a temporary basis through visits. Besides such routine visits, crisis care is also enacted through visits, and is embedded in the broader routine work of caring for and about, and transnational emotional care that is mediated through technologies, resources, visits, and the capacity and resources to travel. Framing all of these reciprocities are a set of cultural obligations and expectations of what it means to be a 'good' Indian family. Whilst some participants framed the care as 'good enough', the guilt at being unable to perform hands-on care at regular and frequent intervals suggest that these obligations and expectations are never completely fulfilled because of distance. This was further complicated by the dilemma of multiple responsibilities between children 'here' in the UK and parents 'there' in India. This was especially the case for the women in the study, who shouldered the burden of care more than the men described in their accounts of caring relations with their parents, although some of the men's position as the eldest in the family made them aware of their duty to provide hands-on care in a joint household and hence put a different form of pressure on them. All of these reflections on the care of parents and children in the context of their migration brought participants to a point where they considered and reflected on what their futures held in terms of work and family life.

These two chapters taken together resonate with a feminist ethic of care, embedded in interconnection and relationality (Sevenhuijsen, 2003). The relationships discussed highlight issues of interdependency between individuals and family members, which demands that we pay critical attention to making visible hidden

connections between care and power (Bondi, 2008). The constant employment of a range of transnational and local strategies to meet their and their families' care needs reflects the implications of working in market economies that do not recognise caring responsibilities. The two chapters, and indeed the thesis as a whole, contributes to migration scholarship by broadening our analysis in and beyond the mother-child relationship, instead situating care across borders and generations, and in the mutual exchanges between a broad range of family members. This analysis of overseas nurses' caregiving also contributes to contemporary sociological theorising about care, by asserting that care is best understood as *both* reproductive labour, and as an exchange governed by the moral codes of family and kinship ties. Instead of focusing on the negative consequences of women's migration in migrant-sending countries and framing this in terms of a 'care deficit' (Hochschild 2000: 136), this analysis of multigenerational reconfigurations and renegotiations of care shows that care serves as an important resource for the nurses themselves as well as their resident and transnational family members. By shifting the research focus away from domestic workers to overseas nurses, and from mother-child focused, unidirectional relationships into extended family networks, these chapters' present empirical evidence that demonstrates the value of multigenerational care for both transnational families and the nursing labour market itself.

How are aspirations and imaginations for the future shaped by workplace experiences and multigenerational relationships?

In Chapter 1 I illustrated how the development of the contemporary global nursing labour market has its roots in the colonial past. This period laid the foundations for a division of labour in the British nursing hierarchy based on gender, race and class, whereby migrants continue to be located at the bottom of the ladder. Similarly, the control and regulation of nurse migration can be traced to this historical context, whereby the British state has repeatedly relied on migrant labour to fill labour shortages (Solano and Rafferty, 2007). Experiences of discrimination and stigmatisation were common amongst participants, whereby they described feeling deskilled and devalued, struggling for recognition and inclusion, as well as the

relentless feeling of being treated unfairly. These findings corroborate a body of work already documenting racism and deskilling in the nursing workplace (see, for example, Allan and Larsen, 2003; Kyriakides and Virdee, 2003; Smith, Allan, *et al.*, 2006; Batnitzky and McDowell, 2011 for the British context, and; Walani, 2015 for a literature review of the global context). Participants also reflected on their and their families lives outside of the workplace, with more overt instances of racism experienced; some described experiencing racial violence, with their children being at the receiving end of hurtful comments about their skin colour. This also contributes to literature that connects race and racism to migration (see Erel, Murji and Nahaboo, 2016 for an overview of literature in the British context).

What is new and significant in this chapter however is the connections drawn between the ways in which these experiences were presented in the nurses' accounts and how participants imagine and talk about their future. Some participants saw their time in the UK as representing a vulnerable time in their life, but did not necessarily see themselves as vulnerable. They imagined a better 'future' for themselves and their families in Australia or other nurse recruiting countries. Others perceived their experiences in the UK as simply part of life in an uncertain world, full of positive and negatives, and their future was more indeterminate. Whilst embedded in accounts of other experiences, the stories of the nurse migrants reveal the significance of considering constructions of the future for driving onwards and return migration as well as more permanent settlement. This moves the analysis beyond the much critiqued 'push and pull' economic models of migration, and instead illustrates how considerations for the future generation and for the future care of their parents and themselves are central to migrant imaginaries.

This chapter also resonates with a feminist ethics of care, illustrating that future aspirations are 'peopled' with others and are thus relational, often reflecting a sense of reciprocal obligation into the future (see Chapter 2). The persistent consideration of their loved ones when constructing their futures in particular places points to how

migrants try to 'orchestrate' their life courses to those of others in order to reciprocate care, which often involves both the reproduction of transnational families. As Coe (2016) notes of her Ghanaian female migrants, temporal coordination is not easy and the same can be said for the women and men in this study. Some participants, for example, maintain a hope to return to India to provide 'hands-on' care to their elderly parents, whilst at the same time they want to remain close to their own children who have been brought up in Britain, and who, they imagine, will need their support as they enter university, marry and have children. They imagine India as the best place for their own care in the future. Imagined futures are thus intertwined with life course processes, whereby some participants imagined themselves as grandparents shuttling back and forth between India, the UK and unknown destinations to provide a culturally informed form of care to their transnational families. Whilst this return to India may remain a 'myth' and never materialise, it is nonetheless an important finding, especially in the context of the UK's current nurse shortage. Firstly, because it suggests that the retention of Indian nurses in the British healthcare labour force is not simply about workplace experiences, but is also about how such experiences shape imagined futures. The evidence in this chapter suggests that nurses who describe overly negative experiences will leave the UK if they have the resources available to them and if their children are agreeable. Secondly, it reveals that such relationship-oriented hopes are also caught up in structural contexts. The conditions of work in the UK as well as the potential opportunities in other nurse 'importing' countries allow nurses to imagine themselves remaining in the UK or leaving for other places. Immigration policies regulating the nurses and their family members' movement in those imagined destinations contribute to shaping preferences for particular countries. By highlighting the future-orientations formed around further migration and transnational care, I have identified future possible patterns of global nurse migration that are tied to particular labour and migration policies in multiple countries, as well as influenced by family considerations extending beyond the nuclear family and across generations. These imagined futures in turn contribute to the 'pump' that 'keep[s] the system flowing' (Tronto, 2016, p. 268; see also Chapter 2), and are thus

central to the reproduction of both global nursing care chains and transnational families.

These three questions elucidate some of the broader issues around the interconnections between migration for care work and transnational care in families. By addressing these questions, I have answered the main research question, illustrating *how* migration for care work both shapes and is shaped by multigenerational relationships of familial care over time. In sum, I have argued throughout the thesis that family is deeply implicated in nurse migration in the Indian context, illustrating that becoming a 'nurse on the move' in the first place is a means of meeting family obligations and duties. Migration for care work in this context is thus shaped by multigenerational family relations and the asymmetrical and reciprocal care exchanges influenced by the moral codes of family and kinship ties. However, such migration for care work in turn shapes multigenerational relations of care over time, since the care exchanged between family members becomes stretched across distance and time. Whilst continuity is stressed in the thesis, by showing how families continue to 'be there' for each other, the normative expectations of care in the Indian family are not always fully met in the context of migration. Since nurses are not physically present with their family members in India whilst working in the UK, practices of care transform and migrants rely on visits and communication technologies to engage in reciprocal, asymmetrical care exchanges. Imagined futures suggest that the intersections between migration for care work and transnational familial care stretch into the future, and may contribute to the reproduction of transnational families and shape future transnational care practices.

By placing nurses' accounts at its heart, the thesis has illustrated the complex and often ambiguous feelings they experience as they take part in feminised migration flows and care for resident and transnational families. Through this close empirical engagement and rigorous engagement with the broader literature on gender, care, migration and transnational families, the stories told to me over the course of this

research contribute to our knowledge of transnational care in the context of labour migration and helps refine our theoretical frameworks of care chains and care circulations. Before reflecting on the implications of this research, I first consider some of the methodological limitations of the project.

8.2 Methodological Limitations and Future Research Directions

I am confident that the research design and in-depth interview method employed in this research provides a rich set of data to explore the intersections between mobilities of care and their connection to global processes but like all research projects there are limitations to these data. Before examining some of these, it is worthwhile reflecting on the argument developed in Chapter 3 about the importance of maintaining a reflexive awareness of the dynamic relationships between researcher, participant and the research process. Gadd (2004, p. 398) argues that reflexivity is enhanced considerably when researchers have a period of time away from their data and once their investments in their original research questions have diminished. Indeed, after a period of maternity leave before writing up the thesis, I found some of my coding redundant and viewed temporalities and time as more relevant than I had previously considered. The time away from the project, as well as experiencing bereavements and birth during the research period, made me much more sensitive to the dynamics of transnational family life and the changing care needs of both myself and differently located family members. In time I may develop a different perspective on some of the arguments developed in the thesis. Nonetheless, as illustrated in Chapter 3, all decisions made throughout the research process have been made in line with methodological rigour, with an explicit methodological base to inform its design and execution.

Biases in the Sample

Research participants were selected because they met analytically informed criteria that would enable an investigation of the connections between nurse migration and

familial caregiving. Specifically, participants were chosen based on their training as nurses and their migration to the UK as nurses from Kerala, India. Even though they met the criteria for inclusion in the research, the participants are nonetheless a self-selected group of volunteers. Whilst one participant described conflict with her brother who was jealous of her earnings abroad, the majority of the sample framed their transnational familial relations as overwhelmingly harmonious and did not talk of conflict. However, some participants told me about friends who had declined to take part in the research because they had a difficult relationship with family members remaining in India. This suggests the sample could be biased towards those who were either part of families who successfully engaged in transnational care, or who did not disclose less positive family relationships in the interview context. Similarly, I heard about an Indian nurse who was currently going through a disciplinary procedure in her hospital workplace that she believed was down to discrimination. I was told that this nurse found it too upsetting to talk about her work and thus declined to participate in an interview when her friend asked her. On the other hand, I also had participants who had clearly agreed to be interviewed because they wanted to discuss their grievances with me. As I outlined in Chapter 3, one participant thought I was in a position to do something about such grievances. The sample includes those who were concerned about their treatment in the British workplace, but also a number of people who decisively said they were not discriminated against and those who described positive experiences in the workplace (see Chapter 7 for more discussion about participants' framing of unsettling experiences). It is thus difficult to know if the sample is biased towards those who have had more negative experiences since arriving in the UK. Nonetheless, it is possible that my methodology limited the inclusion of participants who were both experiencing difficulties in their families and/or who were experiencing current significant difficulties in the workplace.

One-sided Accounts

The data generated comes entirely from nurses' retrospective accounts of their decision-making, experiences and future-orientations. I was not concerned with

accessing an 'accurate' account of 'what they were really thinking', but rather how nurses account for their lives, that is, how they understand and talk about their lives. However, by focusing only on the nurses' accounts of transnational family life, only one side of the equation is represented and we do not know how, for example, ageing parents feel about their diminishing visits to the UK or if they feel the care they are receiving is 'good enough'. One way to address this would be through a transnational methodological framework that was attuned to the 'intersection between the networks of those who have migrated and those who have stayed in place' (Levitt and Glick Schiller, 2004, p. 1012). A multi-sited ethnography would have facilitated moving away from a 'single site design' in order to 'examine the circulation of cultural meanings, objects and identities in diffuse time-space' (Marcus, 1995, p. 96). This might have contributed to a more nuanced understanding of transnational care, especially from the perspective of the kin 'left behind'. To fully incorporate the relational perspective foregrounded in this research, the research design could have taken into consideration the perspectives and experiences of all the family members (mothers, fathers, children, grandparents, other significant kin). Yet as Carling, Menjívar, and Schmalzbauer (2012, p. 208) point out, transnational families and care networks are not clearly delimited by geographical location, and thus can be 'elusive objects of study'. In their reflection on the methodological challenges often encountered through studying transnational parenting and children left behind, the authors argue that while 'one-sided accounts will provide limited understandings of interpersonal *processes*', they nevertheless 'yield valuable information about *experiences* at particular locations in transnational family networks' (2012, p. 208, italics in original). The aim of this study was to offer just such an in-depth understanding of experiences of transnational caregiving relations in the context of labour migration to the UK.

'Snap-shots' of Migration, Work and Transnational Familial Caregiving

Whilst the methodology focused on participants' accounts of migration, work and familial care and their changes over the life course, they nonetheless resulted in 'snap-shots' of transnational family caregiving at the time of the interview. A one-

time snapshot misses the many ways that migrants engage periodically with family members during ritual events for example (Levitt and Glick Schiller, 2004). The centrality of time to the decision to become a 'nurse on the move' and to caregiving practices, that ebb and wane across the family, work and migration life cycles are key findings emerging from this research. These findings might have been elucidated more clearly through a methodology that incorporated a more explicit longitudinal aspect that was sensitive to mobilities. As Kofman (2012, p. 153) argues:

To investigate the different forms, orientations, and directions of care, one would need as a first step to adopt an approach that follows longitudinally and spatially the migrant so as to capture care giving and receiving.

The care circulation framework suggests that we should 'follow the thing'—care—in all its permutations over distance and time (Baldassar and Merla, 2014b). One way of doing this would have been to accompany the collection of migration, family and work biographies with a longitudinal research strategy that enabled me to follow the migrant nurses in real time and space. Observing nurses who were in the process of leaving India for the UK and following the evolution of their transnational family caregiving practices and experiences in the workplace may have provided some insight into their actual practices contemporaneous with events and an interesting point of comparison. However, the participants in this study describe a process unfolding over years so such a focus would have required a much longer time frame for data collection than that available. Moreover, direct nurse recruitment was not occurring in significant numbers at the time of data collection, so it may have proven very difficult to meet nurses who were preparing for entering the UK at this time. Pragmatics aside, central to this thesis is a research question that focuses on how nurses' account for such transitions rather than a mapping of their real time transitions. Such an approach would have thus led to a different research question.

Notwithstanding such practical difficulties, the central significance of the temporal and relational aspects to nurse migration and transnational family caregiving suggest that future projects could do well to incorporate a longitudinal and multi-sited

approach. Since a number of the nurses in this study indicated that Australia may be on their future horizons, one way of incorporating this methodology would be to follow nurses from the UK to Australia and explore the changes and continuities in caregiving practices in the context of incorporation into new labour markets. In view of the likelihood that the UK will attempt to recruit nurses from India and other regions in the global south in the near future, another future area for research would be to employ a multi-sited ethnography and 'follow' the care between family members in India and the changes that take place following arrival to the UK. Despite such limitations and possibilities for future research, the research design for the current project was in concert with my aim to better understand the intersection between Indian nurses' labour migration and their experiences of transnational family caregiving engendered by such movement. Gathering the experiences and perceptions of overseas nurses through in-depth interviews met this objective. I now turn to the implications arising from this work.

8.3 Practical and Conceptual Implications

This thesis has implications for a range of stakeholders. It has implications for policy-makers interested in nurse recruitment and retention, as well as those interested in experiences of racism and discrimination in the workplace. The fact that migrant workers continue to have transnational care responsibilities following their arrival to the UK would also be of interest to labour, migration and social policy-makers. Inequalities in access to communication technologies suggests that initiatives to improve access and capacities to use such technologies would benefit transnational families. Theoretically, the thesis offers interventions into the 'global care chains' framework that explicates the migration of women from the global south to provide care in the global north (Hochschild, 2000) as well as elucidating Indian nurses' care circulations. Whilst all of these could engender rich discussion, in this section I focus specifically on the implications of my findings for care in migration policy as well as reflecting on the implications of the findings for a feminist ethics of care. I focus on these two implications particularly since they emerge as central

concerns once we adopt a view of care that goes beyond its treatment in the labour market and view it as a reciprocal and relational process.

Care in Migration Policy

A range of moral, social and political implications emerge from the focus on nurse migration and multigenerational care in transnational families. Some feminists envision a state that takes on a feminist ethics of care as a public ethic, whereby social policies recognise interdependence and are organised in ways that value and support caregivers (Tronto, 1993; Kittay, 2008). Restrictive migration policies do not value nor support caregiving that takes place across borders, and if anything such policies 'create barriers for migrants to easily move back and forth and neither facilitate nor encourage the move of entire families' (Kittay, 2008, p. 150). Given the increasing feminisation of international migration, the phenomenon of families separated across borders will become an increasingly common family form. As such, this research points to the need for social policies in both destination and origin countries to recognise the commonality of such family forms and value the care taking place between migrants and their family across borders and generations.

What are the implications of a multigenerational and temporal approach to care for our thinking about migration policies in particular? Firstly, the stories presented in this thesis suggest restrictive immigration policies make it difficult for migrants to meet their reciprocal care obligations to multiple family members at different points in time. Migrant nurses, with their eligibility for worker and (increasingly problematic) citizenship rights, can be understood as a (partially) privileged group of care workers when compared to, for example, domestic workers who are often undocumented and have minimal rights. However, they are still at the mercy of immigration policies that intersect with their family care practices at different points in time. As illustrated in Chapter 6, for example, many of the nurses have stopped inviting their parents to the UK because they fear the financial repercussions of their parents falling ill whilst visiting. Despite being a source of childcare and hence

supporting the nurses to tend to the nation's sick and elderly, their parents do not have any social rights in the UK. As Chapter 5 illustrates, this has impacts on the nurses' situation in the UK. Those couples who rotate shifts between them to cover childcare have little time together as a family and describe themselves as exhausted. Others rely on father-centred care, which has implications for their husbands' careers, an aspect of deskilling that tends to remain invisible in sociological literature on care and migration. Secondly, and connected to this first point, restrictive migration policies such as these make other countries with less restrictive family migration/reunification policies more attractive, and heighten uncertainty about how nurses will secure care for themselves, their parents and their children in the future. Restrictive family immigration policies are thus a factor in stimulating 'stepwise migration' (Paul, 2011), and hence impact on the retention of nurses in the British healthcare sector. When nurses leave the British healthcare system for other countries, their departure exacerbates labour shortages and hence can be interpreted as contributing to future recruitment drives for international nurses. Moreover, such state regulations are shaping patterns of caregiving and receiving that are integral to reciprocal intergenerational family obligations. Through alerting us to the potential future prospects for transnational families and care worker migration, and the issues likely to be raised by such migration, this thesis suggests that policy makers need to look at labour, migration and childcare policies holistically if the UK is serious about holding onto its current nursing labour force.

Feminist Ethics of Care & Transnational Care Migration

Central to the global care chains literature is the notion that women's migration for care work entails a transfer of social, economic, and in the case of nurses, health resources from origin to destination country. As Isaksen (2012, p. 74) argues, 'international nurse recruitment is not a win-win situation'. India loses skilled and qualified nurses, human capital, and the investment to the economy that would otherwise have been made. In the case of nurses, the scarcity of health workers also negatively affects the quality and efficiency of a country's healthcare service (Gill, 2016). At the same time, when migrants work abroad, the destination country gets

increased tax revenues that go towards paying for social service and benefit systems. In the case of migrant nurses, the destination country also gets reduced costs for education, training and staffing (Isaksen, 2012). Similarly, the childcare nurses' parents provide during visits to the UK is unpaid, yet it enables the nurses to manage their work and childcare responsibilities in a more balanced way. Drawing on Folbre's (2001, p. 230 cited from Yarris, 2017, p. 144) proposal that 'the costs of providing care need to be explicitly confronted and fairly distributed', Yarris (2017, p. 144) argues that the costs of social reproduction should be shared across national borders:

Imagine a world where caregiving for children or elderly parents in home counties was compensated in part through payments made to migrant women workers by employers in destination countries?

Whilst Yarris focuses specifically on compensation for caregiving in transnational familial care work, her argument regarding payments for the costs of social reproduction can also be extended to compensate for the loss of nurse labour force to source countries. Calls for financial compensation in the form of tax, tariff or direct transaction from destination to source country have been discussed since the 1970s, although no evidence exists on its practical implementation since that time (Plotnikova, 2011).

Although compensation may be a means of practically addressing inequalities arising from care shared across borders, the notion of justice implied in such calls for compensation surfaces other conceptual implications. Neysmith and Zhou (2013), in their study of Chinese grandparents' transnational caregiving experiences in Canada, recently argued that the distribution of care responsibilities needs to be one of the pillars in the pursuit of transnational social justice. They argue that neoliberal policies in countries like Canada and the UK are partly responsible for injustices occurring within transnational families, whereby their labour policies are based on an adult worker model that does not recognise that the adult worker may have reciprocal care duties that stretch across borders. These intersections between work, the

childcare and eldercare needs of migrant families and the cultural ethics of care, as illustrated throughout this thesis, have implications for how we might conceptually rethink a feminist ethics of care in the broader context of international migration and transnational care.

Neysmith and Zhou (2013) emphasise the more difficult aspects of transnational familial caregiving. Whilst I have gone to great lengths in this thesis to argue that transnational care does not simply involve suffering, their argument is nonetheless interesting for thinking about the conceptual implications of transnational multigenerational care in the context of nurse migration. It brings to the fore the point that unjust economic, social and cultural structures, at individual, household, national and international levels, condition and enable the actions of women migrants to both engage in care worker movements and to engage in reciprocal familial care across borders. Neysmith and Zhou (2013, p. 154) suggest that mapping the 'dense relations of interdependence that connect people cross-generationally and transnationally and show[ing] how these relationship-based responsibilities are caught in the immigration policies that are concerned with the quality and quantity of the labour force' can provide an empirical basis for developing social justice arguments that have caring relationships as a key dimension. This thesis, with its focus on the connections between migration for nursing care and familial care, adds to such an empirical basis, and encourages an approach that conceptualises activities and practices in relational ways. By mapping out such relations of interdependency and reciprocity between a group of migrant care workers and their families, this thesis presents evidence that contributes towards an agenda that calls for the revaluation of care and a recognition of interdependency as fundamental to human life.

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Appendix A: List of nurse participants, their migration biographies and their transnational family care dynamics

Pseudonym	Age	Year of arrival to UK	Worked in third country prior to UK?	Current occupation/grade	How long waiting on NMC pin?	Separated from children? What country & how long?	Care dynamics within the Transnational families ³⁷
George	30s	2003	Oman	NHS Registered Nurse, Grade 5	Six months	No	George lives with his nurse wife, Anitha, and their children. Both his parents and his in-laws remain in India. Both sets of parents live in joint family households with George and his wife's siblings, and they send money for healthcare expenses or celebrations. They return to Kerala regularly and invite their parents to visit the UK so they can spend time together as a family. George talks to his parents on the phone every one to two weeks, but it is Anitha who regularly calls the family, multiple times per week.
Preeti	40s	2003	Saudi Arabia	NHS Registered Nurse, Grade 5	18 months	Saudi Arabia (three years); UK (three years)	Preeti lives with her husband and four children. She is the youngest of nine children. She sends money regularly to her siblings for their children's education, marriages and to her parents for healthcare. They also send money to her husband's siblings and parents. Her parents are elderly and experience a lot of health problems, and used to visit the UK a lot, but not anymore. Her youngest

³⁷ The transnational family dynamics are recorded as they were at the time of interview (2013/14).

brother returned from the Middle East to take care of them. She talks to them every day but says her parents want her to return to India soon, although her husband has plans to return to the Gulf.

Gaya	50s	2005	Saudi Arabia	NHS Theatre Nurse, Grade 5	One year	Saudi Arabia (six years); UK (14 months)	Gaya lives with her husband and three children. She is the eldest daughter and grandchild in her family. She used to send money back regularly to family members, and paid for sister to become a nurse. She only sends money for her elderly mother's healthcare expenses now and her mother does not travel to the UK anymore. Her father died some years ago and her mother lives with her sister and her family. She has another sister who works as a nurse in the Middle East and also sends money. They try to meet as a family at least once per year in Kerala.
Denny	30s	2008	No	NHS Theatre Nurse, Grade 5	Six months	No	Denny lives with his wife and child. He has a brother living in Kerala and his other siblings are either migrant nurses or married to migrant nurses from Kerala, all living in Europe. His parents live with his brother in a joint family. His parents are increasingly experiencing health problems. The resident brother and his wife do most of the physical care, but Denny returns regularly to assist with healthcare issues. He only uses the telephone with his parents, but increasingly Skypes his brother.

Sheela	30s	2008	No	Carer, private nursing home	Two years	No	Sheela lives with her husband in the UK and has one child. Her mother and mother-in-law came to the UK to help her when her child was born. Her mother-in-law is now helping her own daughter with her children, and her own mother has become sick so they do not visit the UK anymore. Her parents live with her eldest brother and his wife. Her parents are more conservative than her husband's, so they will not accept money from her. But she visits every one to two years and calls on a daily basis to check in with them, especially since her mother has been diagnosed with a chronic illness.
Beejuu	40s	2005	No	NHS Registered Nurse, Grade 5	18 months	UK (eight months following initial arrival); UK (sent children back to India two years prior to interview)	At the time of interview, Beejuu was living alone. Her husband and children had returned to India, so her husband could care for his ageing parents. As the only son, he is responsible for them, especially since the rest of the family all work abroad too. At the time of interview, she was saving intensely and was waiting on her Overseas Citizenship of India status so she could return to India as a British citizen. This meant that she had not returned for over nine months. However, she calls multiple times per day. Since the interview, she has returned to Kerala.
Susanna	40s	2005	Kuwait	NHS Registered Nurse, Grade 5	18 months	UK (almost three years)	Susanna lives with her husband and children. She returns to India every two years and tries to go for special occasions. Her parents used to live with her sibling, but have passed away. Before they died, she did not send money to them as her brother took

responsibility, but she sends money for big purchases, education and healthcare. She paid for nieces to become nurses and helped them migrate to the Middle East. These nieces now support Susanna's brothers and their families. She talks on the Skype and through Facebook everyday with her siblings outside of India, but only phones those who live in Kerala.

Anisha	40s	2000	No	NHS Registered Nurse, Grade 7	Six months	No	Anisha is one of a large family, and her parents are still quite young. Two of her sisters also live abroad and another lives in a different state. She might have to return to India to care for her parents if they get unwell but for now they continue to visit the UK regularly, along with her in-laws. She and her siblings alternate visits to India to visit her parents. The family also visit Anisha's in-laws all of their children living abroad. They talk as a family once per week when her husband participates in the call, but in between makes daily calls to her parents, more if there is an event of interest going on.
Jenny	40s	2000	No	NHS Registered Nurse, Grade 5	Six months	UK (one year)	Jenny lives with her husband and three children. She is the eldest sibling in her family. In the past, she used to financially support a number of members of her family, but only supports for healthcare expenses now since her brother has now taken on responsibility for the family. She still helps out quite a lot, and says she monitors how things are going for the family. She returns to India with her children every year. Her mother has come to the UK on numerous occasions to help out with

childcare. Her father is increasingly suffering from health problems. Her mother does not like to leave Jenny's father alone, so does not come to the UK now.

Maryam 30s 2005 Singapore NHS Registered Nurse, Grade 6 18 months No

Maryam lives with her husband and two children. She has three siblings, one who works in the Middle East as a nurse. Her parents live with her brother, although they are not old or in need of support. Her in-laws are also young. Both her parents and in-laws visit regularly and help with childcare, and she does not worry about their health whilst they are in the UK. She phones them every day, but does not send money as they are financially stable. She also Skypes regularly and keeps up to date with everyone through Facebook. She tries to visit India at least once per year, for special occasions or during the school holidays.

Alice 30s 2008 No Carer, Nursing Home Cannot pass IELTS so has not received PIN yet No

Alice lives with her husband and child. Her parents live in India and live with her brother. Alice visits every year or two, but finds it difficult to save for trips to India since having a child. She calls her family every day through a plethora of communication technologies Her mother has a chronic health problem and does not visit the UK. Alice monitors her health through her daily calls and visits. Alice hides from her family that she is working as a carer.

Joji	40s	2001	No	NHS Registered Nurse, Grade 5	18 months	No	Joji lives with her husband and children. She has two sisters who are also migrant nurses. Her parents and in-laws used to visit the UK regularly, especially to help with children, but they are not very well now so have stopped coming. The family return to India every two years. She sends money regularly to them and they live with her brother. Joji calls her parents on the phone for hours on her day off, and calls her siblings every week. Her in-laws live alone as both her husband and siblings live abroad.
Rosy	30s	2001	No	NHS Registered Nurse, Grade 5	18 months	UK (two years)	Rosy lives with her husband and two young children. She depended on her parents and in-laws for childcare in the past, but her mother is currently experiencing healthcare problems and her in-laws are getting older so they do not visit the UK anymore. Her parents live alone as her siblings are all either working as nurses abroad or are married to nurses and living abroad. Brother. Her parents are 'young-old', although her mother was quite ill at the time of interview, and both parents have been seriously ill in the past. Rosy pays for their medical bills, talks on the phone twice per day and visits every two to three years.
Thomas	30s	2002	No	NHS Registered Nurse, Grade 5	Six months	No	Thomas lives with his wife and children. He is the eldest son. He feels responsible for his parents, but has siblings living in Kerala. His parents are financially stable, so he just sends money occasionally. They are young and not experiencing health problems. He calls them every week by

phone, but his wife calls more regularly. His parents do not want to visit the UK anymore as they find the weather difficult.

Sindhu	40s	2003	No	NHS Registered Nurse, Grade 5	Six months	No	Sindhu live with her husband and two children. Both of her parents have passed away, but her siblings remain in India. Before her father passed away, she paid for all of his healthcare and returned to India regularly to do health checks on him. She continues to return to India regularly to see her siblings and in-laws.
Mary	40s	2004	United Arab Emirates (one year)	NHS Registered Nurse, Grade 5	Three months	UK (two years)	Mary lives in the UK with her husband and two children. She has one sister who lives in the north of India with her family. Her sister visits her parents regularly. She does not send them money as they are financially stable, and they send money to Mary occasionally. Her father had major surgery since she left India and requires assistance, so the family pay for a nurse to come to him every day. She calls on Skype every day after her shift in the hospital, and has a family Skype every Sunday.
Joe	30s	2002	No	NHS Registered Nurse, Grade 5	12 months	No	Joe lives in the UK with his wife and children. He is one of three siblings and all live in Europe. Joe continues to send money to his parents for support and to relatives also. He alternates visits to his parents with his brothers and tries to go once per year. He talks on the phone to his parents most days. They both have chronic health issues. Joe and his siblings have yet to decide who will return to care for his parents. Two of the siblings will remain

in Europe whilst the other returns. The two in Europe will then financially support the whole family. Joe is not sure what way it will work out in the future.

Pothan	30s	2003	No	NHS Registered Nurse, Grade 5	12 months	No	Pothan lives with his wife and two children. He has siblings who are all living and working abroad. As the eldest son, he is responsible for his parents when they get older. They are not elderly and do not have serious health problems, but are lonely and worry about their future as both children are abroad. His parents and in-laws used to come to the UK to help with childcare, but do not come so regularly now as Pothan is trying to save money to move to Australia. His wife calls more regularly, but they Skype as a family once or twice per week.
Cecilia	50s	2004	Oman (6 years); Saudi Arabia (4 years)	NHS Registered Nurse, Grade 5	6 months	Saudi Arabia (four years); UK (one year)	Cecilia lives with her husband and two children. Her elderly mother lives in India with Cecilia's brother. Other siblings live nearby so she is not worried about her mother's caregiving arrangements. Nonetheless, she wants to be there with her and won't invite her to the UK because of her age. Her in-laws are dead so she mostly calls her mother and siblings regularly.

Shobha	40s	2006	Oman (one year); Saudi Arabia (six years)	Carer, Nursing Home	Cannot pass IELTS so has not received PIN yet	UK (four years)	Shobha lives with her husband and two children. Her parents live with her brother and sister-in-law. She calls them on the phone, and visits every two to three years, although would like to visit more. Her mother came once to the UK but did not like it. Even if her parents were willing to visit however, the family cannot afford the associated expenses. She sends money to her family and in-laws for special occasions or when someone is in need.
Pushpa	50s	2001	Saudi Arabia (five years)	NHS Registered Nurse, Grade 7	3 months	UK (six months)	Pushpa lives with her husband and three adult children. She is the eldest of a large family. One of her siblings is a nurse and another is married to a nurse; they all live in Europe. Her parents live alone, and are ageing. She sends money to her siblings remaining in India to look after them, although they live in different states, and calls regularly to check up on how they are doing. Her mother-in-law is not well and her husband returns regularly to provide hands-on care to her. Pushpa is planning her retirement and hoping to move back to India.
Leela	30s	2008	No	Staff Nurse, Private Nursing Home	Six months	No	Leela lives with her husband and young child. All of her siblings are nurses and live abroad. She used to support the whole family, but now her siblings are nurses too, the family is more secure. She only sends money for healthcare expenses or special occasions. Her parents are 'young-old' and live in India. She calls every day through phone, Skype and sends pictures through WhatsApp. Her parents have not visited the UK yet as she does not have

the savings to invite them. Leela is aware her parents are getting old and worries about what the family will do in the future, especially since her mother-in-law is also becoming very frail.

Asha	50s	2001	Saudi Arabia (three years)	NHS Registered Nurse, Grade 5	Three months	Saudi Arabia (three years); UK (two years)	Asha lives with her husband and children. She is the eldest in her family. When she had her children, her mother came regularly to help out. Her parents are ageing so she does not invite them to the UK anymore. She has a sibling living abroad. One sibling lives in India but does not live in Kerala, so her parents live on their own for the moment. She phones her parents every day, talks to her sisters on Skype every week, and tries to visit once every year or two.
Roxy	30s	2007	No	NHS Registered Nurse, Grade 5	One year	No	Roxy has three siblings, two in India and one the Middle East. Her father has recently been diagnosed with a serious illness. They live with Roxy's sister and she looks after their everyday care needs. Roxy talks to them on the phone every day, monitoring their health, and she visits twice per year. Her family do not visit the UK. She used to send remittances every month, which was used to pay for her siblings' education and marriages. She sends money occasionally for healthcare expenses.
John	30s	2002	No	NHS Registered Nurse, Grade 5	Six months	No	John lives with his wife. All of his siblings are either working as nurses or married to nurses from Kerala. His parents are living in India and come to the UK every year for six months, and then return

to India, before leaving to visit another sibling. John used to send money, but not much anymore. Between the siblings, they pay for their parents' visas and flights and occasional healthcare expenses. He visits India once every year. The siblings do not know who of them will return to India to care for their parents as they age, but John says one of them will. The other siblings will then financially support the sibling who has returned and their parents.

Appendix B: Semi-structured Interview Guide

PART 1: BIOGRAPHICAL OVERVIEW

So, we'll start the interview now. First can you tell me a little bit about yourself? Use the timeline if it would help you remember when important things happened in your life.

Prompts: Like where and when you were born and some key events that have happened in your life, like a marriage, birth or death, job changes, or when you first left your home, or India?

➤ **Your family life in India before you left**

Where did you live in India? (region, city or village)

What was your work/professional life (profession, salary, work timetable)

➤ **Can you tell me a little bit about your family life back in India before you left?**

- what type of household did you live in (extended, nuclear)?
- Can you tell me a bit about any household tasks between members of your family, like who did the cleaning and cooking? Who looked after the children?
- Did anyone ever need to be looked after or supported, like an elderly or sick relative or someone who had a disability or young children? Who tended to do that?
- Can you tell me a bit about the care arrangements for young children and/or elderly people at that time?
- [if elderly person in household] What would happen if your grandparent became sick or needed constant looking after? Whose responsibility would this be? Did your family ever get outside help? Why/why not?
- What kind of outside help was available to your family in India at that time? Did you ever use these?

- what about emotions in the family? How open was love expressed?

PART 2: MIGRATION HISTORY

I'm going to move onto the next section of the interview, which focuses on how you came to leave India and live in the UK and what your family life was like before you left.

- I'd like you to tell me a little bit about why and how you left India and how you came to live in the UK if that's ok? We can use the timeline here if that would help.

Probes:

- What were your reasons for leaving India?
- What countries did you consider?
- Remind me when you left? Did you come straight here?
- How did the actual moving from India take place, how was it organised? Recruitment agency? With the help of family/friend networks?
- Did it cost you any money?
- Did you leave India alone?
- Do you have a work permit? Was it difficult to get one?

PART 3: WORK HISTORY

I'd like to ask some questions now about your nursing career.

- Can you tell me about why you wanted to become a nurse? How did you go about doing that? How did you come to be where you currently are working now? We can use the timeline here if that would help.

Some of this might have been addressed in the migration section, as nursing and migration are closely connected in the literature. If respondent has not mentioned any of the following, once s/he is finished I will ask her the below.

Prompts

a) decision to become a nurse

- Why did you want to become a nurse?
- (Was the opportunity to migrate a factor in your decision?)
- What about your gender or sex? Was being a woman/man important?)
- Deciding to become a nurse - was it a sole or family-based decision?
- (How did your family feel about you becoming a nurse?)

b) training as a nurse

- did you pay for your training? How?
- Did you work for a hospital after the training?

c) employment in India

- after you trained as a nurse, what was your first job? And what were your jobs after this?
- How was working in India? How was caring for patients? Relationships w/other staff?

c) (if not addressed in the migration section) what was your first job in the UK?

- Under what terms and conditions were you employed i.e. set hours, visa tied to the employer?

- What other jobs have you had since then?
- I'd like to ask you some questions about what it was like working in India compared to working here in the UK, and about any differences or similarities that you notice about the two workplaces.

Prompts:

a) culture in workplace

- What can you remember when you first started working in the UK? What were your first impressions? How did you feel in the first days and weeks? How do you feel about it now?
- Different tasks compared to India?
- Looking back, how prepared did you feel for work in the UK?
- What helped you settle into the workplace?

b) identity in the workplace

- Are there any differences in how you are treated by patients here? Or by staff/doctors/management?
- Re India – how did this make you feel at the time? How do you feel about this now?

Prompt:

c) emotions at work

- what about your emotions in work? Do you feel you use your emotions in your everyday work? How do you show people you care for them?
- Is this different from the way you would have felt in India?

d) practicalities of work

- What kind of work contract do you have and what type of working timetable (part-time, full-time, shifts, typical schedule)? How does the workload in the UK compare to that back in India?
- What is the leave policy of where you work?

What do you think being a nurse means in India? Is this different from the UK?

PART 4: FAMILY

I'm going to move on to the next section of the interview if that's ok. In this section, I'll ask you a set of questions about your family and caring arrangements now, asking about family members who are in the UK, India or different places, about the

different ways that you might help or look after your family as well as who looks after you.

- So firstly, can you tell me who is in your family and where they live?

Would you mind if I quickly sketched out on the other side of the timeline so I can remember who is where?

- I'd like to know a little more about the people who live with you;
any children – relation to respondent, age, sex, birth place, nationality, number of years in UK
any adults – relation to respondent, age, sex, birth place, nationality, number of years in UK, profession

Additional Questions for partner (if applicable)

- job
- when did he/she start working?
- How long has he/she been in this job?
- Type of work contract?
- Type of working timetable (part-time, full-time, by shifts, typical schedule)
- Does he/she have another professional occupation?
- Just in relation to your marriage, was it arranged (married before or after moving?). Was your profession ever brought up when you were arranging your marriage, like because you had migration opportunity or anything to do with how status of nurses is in India?
-

Marriage – arranged

- Are there any people needing assistance or support living with you (apart from children)?
- **Can you describe a typical day for you when you are working? And not working**

Prompts:

- How many hours do you usually work per day? Shift work?
- (if respondent single, no children) Do you look after anyone or help someone out regularly here in the UK that is not in your family? Who are they? What do you do?
- Who does the cooking, cleaning and other chores in your household? Do you share this?
- What about childcare?
- Any contact with family in India?
- Emotionally look after anyone?

- Personal time?

PART 4A: CHILDCARE (TRANSNATIONAL AND IN UK)

NOTE: APPLY ONLY IF THE RESPONDENT HAS A CHILD/CHILDREN. IF NOT, GO TO NEXT SECTION

➤ If respondent has children living in the household in the UK

I'd just like to follow up with you about childcare if that's ok. You've mentioned that you work xx hours a day/do shift-work usually. How do you manage to combine this with looking after children? How do you feel this works? What doesn't work so well?

Probes:

a) times when child needs care

- Caring for child during the night (if applicable), the weekend, holidays, when he/she is ill
- Gaps – are there some days/some hours when you don't have anyone to look after your child?

b) help with looking after children

- do you have any help with childcare?

(partner/grandparents/friends/community/formal support)?

- What are your reasons for choosing this person/provider?
- Are you satisfied with the childcare?

c) Time of crisis

- Do you remember a time of crisis when you needed help in looking after your family here in the UK, like during a pregnancy or when a child was born, or during exams? Tell me a bit about what this was like. Who helped with childcare? Did you have any difficulties? How did you cope?
- How do you think your current childcare arrangements compare to what would be the norm in India? How do you feel about this?

➤ If the respondent has children in India

I'd like to ask you about your children in India if that is ok. You've mentioned that they live in India and you obviously live here. I've spoken to a lot of nurses with similar arrangement and they have different kind of arrangements with family members or they pay people to look after their children. Can you tell me a little bit about what kind of caregiving arrangements you have in place for your children?

- Who looks after them on a daily basis? What does this person do?
- Do you pay the person minding your children for this?
- [if father in India] What about their father? Does he look after the children too?

- Can you tell me a bit about the kind of support you give to your children?
How do you do this? (probe – do you send them money, gifts, emotional support, help with homework etc?)
- How do you keep in touch? (skype/email/phonecalls/texts – tell me about the last time?)
- How do you feel this works?

➤ For all respondents with children in UK and India

c) your caregiving arrangements

So I would just like to ask about how you came to the current arrangement for looking your children;

i) the decision

- how was this decision made?
- who participated in the decision?
- How did it feel at the time? How is it working now?

ii) what works about this arrangement/what doesn't work so well?

iv) what would be the ideal solution for you?

(parents/grandparents/state/market/community?)

**PART 4B: CARING FOR ELDERLY PERSONS– TRANSNATIONAL & UK
NOTE: APPLY ONLY IF THE FAMILY HAS A DEPENDENT ELDERLY
PERSON. IF NOT, GO TO NEXT SECTION**

➤ If respondent has elderly family member living in the UK

I'd just like to follow up with you about the arrangements for looking after XX if that's ok. Can you tell me a little bit more about these arrangements?

Probes:

a) times when elderly person needs care

- Caring for elderly during the night (if applicable), the weekend, holidays, when he/she is ill
- Gaps – are there some days/some hours when there isn't anyone to look after XX?

b) help with looking after XX

- Who helps with looking after XX?
(partner/grandparents/friends/community/formal support)?
- What are your reasons for choosing this person/provider?
- Are you satisfied w/this arrangement?

c) Time of crisis

- How do you think your current arrangements with looking after XX compare to what would be the norm in India? How do you feel about this?

➤ If the respondent has elderly parents/relatives in India

I'd like to ask you about your elderly relatives in India if that is ok. You've mentioned that they live in India and you obviously live here. I've spoken to a lot of nurses with similar circumstances and they have different kind of arrangements with family members or they pay people to look after their parents or in-laws. Can you tell me some about what kind of arrangements are in place for your parents/in-laws?

- Who looks after them on a daily basis? What do they do?
- What about your siblings?
- Do you pay or help out this person financially for this?
- Can you tell me a bit about what kind of support you give to XX? How do you do this? (probe – do you send them money, gifts, emotional support, etc?)
- How do you keep in touch? (Can you tell me about the last skype/email/phonecall/letter)?
- How do you feel this works?

➤ For all respondents with elderly/sick relatives

So I would just like to ask about how you came to the current arrangement for looking your parents/in-laws/other family member;

i) the decision

- how was this decision made?
- who participated in the decision?
- How did it feel at the time? How is it working now?

ii) what works about this arrangement/what doesn't work so well?

iv) what would be the ideal solution for you?

(parents/grandparents/state/market/community?)

PART 4C: TRANSNATIONAL FAMILY (EXL CHILDCARE/DEPENDENT ELDER CARE)

I'd like to follow up on something else if that's ok with you. You've mentioned that you keep in touch with family in India.

- Can you tell me some more about this, like how often you are in touch with them and why, whether this has changed since you first left India? How do you show them that you care or are there for them? Support them?

➤

Probes:

- Some people I have spoken to have talked about skype or text messages being a good way to keep in touch and to support family members when there's something going on, or just even in daily life. Can you tell me about the different ways you would usually keep in touch with family? And how do they keep in touch with you?
 - *Prompt: Some people I have spoken to have talked about skype or text messages being a good way to keep in touch and to support family members when there's something going on, or just even in daily life.*
 - Can you tell me a little bit about the last skype/email/phonecall/letter?
 - Do you communicate with your family in any other ways?
 - Do you send money or gifts to anyone in your family, or do you support any business back in India? How much? What is this for?
 - What about visits, have you been able to go back to India? How often?
 - What about emotional support?
 - How do you show your family that you care?
- Can you tell me a bit about what it is like looking after your family in India? What works and what doesn't work?

Prompts:

- Since you've left India, do you remember a time of crisis in your family in India, like a sickness or a death, that might have required you to go back?
- how easy was it to return to India?
- Did you return home? How did you manage this (i.e. able to take time off work? Visas? Flights? Etc)

Other relationships

- so we've talked about family in the UK and other family members; is there anyone else that we haven't talked about?

PART 5: WORK-LIFE BALANCE

- So I've asked you lots of questions about managing work and family. Can I ask if there is anyone that looks after you in your family, friends or community?
- Do you remember a time when you were sick or ill – who looked after you? Who helped you out?

Is there any voluntary work you were engaged in when you were in India? Are you still doing that now?

PART 6: REVIEW AND FINAL QUESTIONS

So this is the last section of the interview. I'd just like to ask you a few questions about your overall thoughts on working and looking after family, especially since you have done a lot of these activities in two different countries over the past number of years.

- So you have been in the UK X years now, and there's been a lot of change throughout that time, in both work and family life. What do you think your work and family life would have been like if you had stayed in India?
 - As a nurse?
 - Would your family duties be different? As a woman/man? How would that make you feel?
 - As a mother/father?
 - As a daughter/son?
 - As a daughter-in-law/son-in-law?
 - How does this make you feel?

- How do you compare caring for children between India and the UK? Can you give me an example?
- How do you compare caring for elderly people between India and the UK? Can you give me an example?

- What would you be doing differently if you were back in Kerala working and looking after family?

- Lastly, how do you imagine yourself and your family in five years from now?
 - do you plan to go back to Kerala?
 - Where would you like to work?

Is there anything else you would like to say that you think might be important? Do you have any questions?

Appendix C: Short Interview Topic Guide

- 1) Background details: name, age, country, place of origin, religion and marital status. Family background

- 2) Nursing history: Tell me about how you became a nurse? Where did you train? Tell me about working in India? Have you worked in any other places? Tell me about working there? Similarities/differences between working there and India?

- 3) Migration history: When and where did you migrate first? What were your reasons for migrating? How did the actual migration take place, how was it organised and how much did it cost? How did you pay for it?

- 4) Finding employment in the UK: What was your first employment and how did you find it? Did you have any help from agency? Tell me about your adaptation period?
 - Work: Tell me about all the jobs you have done in the UK. What kind of work have you done? (For each job - What were your duties? What are the working hours and the pay? Do you enjoy your work? What do you enjoy about the work? What don't you enjoy about your work? How is your relationship with your managers/colleagues/patients?)
 - Changing work: Reasons for changing jobs? How have you found new jobs in the UK?

- 5) Family: Who is your family? Where do they live?
 - Children in UK/India: are your children in UK? Have they always been in the UK or have you been separated from them at any point? Can you tell me about this? How did you manage?
 - Family in UK: How do you manage childcare? Do you have any help? What's difficult? How do you manage? Any emergencies?
 - Family in India: How do you keep in touch? How often? Do you send gifts or anything else back home? If so, how do you do it? Do you visit? Do they visit the UK? Have there been any emergencies since you left?

6) Is there anything else you'd like to talk about i.e. Church, Community etc?

7) What are your plans and hopes for the future?

Appendix D: Memo – Gender and Becoming a Migrant Nurse

It is difficult to talk about work without talking about migration as the two are so intertwined – family is another aspect which seems to have a significant impact on both work and migration amongst the participants, particularly because parenthood (especially for female participants) marked a significant change in their working lives.

On completing their four-year nurse training programme in nursing schools in various parts of India, all five interviewees spent approximately one year working in private and governmental hospitals in India. Most spent this year working and simultaneously getting their documentation and English language test requirements ready in preparation for moving to other countries for work. Two of the female nurses returned to work in India after long periods of time working in the Gulf. The story of working as a nurse in India that participants describe is one of low wages, generally bad working conditions, low status and little power for decision-making in work. On the other hand, when describing the main differences between working in India and the UK, most nurses emphasised how the UK's emphasis on an evidence-based nursing means that patients can sometimes be left for long periods of time without treatment whilst waiting for tests to come back to confirm the course of treatment required. In contrast, Indian doctors just have to 'click their fingers' and the patient is immediately put on a course of medication that the doctor sees fit. The nurses expressed this as a benefit to working in India, but aside from this difference in medical approach, nurses were overwhelmingly negative about their experiences working in India.

The most cited reason by participants for their negative experience of working as a nurse in India is the extremely low pay and the difficulty in setting up a family life on this level of pay. The male nurses particularly emphasised the difficulty in setting up a family on this type of wage. The female nurses interviewed mentioned the low pay, but did not place as much emphasis on it nor on how the low wage might impact upon family life. From a gender perspective, this is interesting in terms of the male breadwinner narrative emphasised by the men in the study and how nursing is seen as a route to achieving this status in an economy where it is difficult to earn a decent wage. On the other hand, the women interviewed emphasise the economic advantages alongside the career opportunities, and the freedom from living with extended family.

Although participants have not discussed explicitly the lack of status related to nurses, the demanding complaining and sometimes sexist patients and the lack of respect from doctors can be seen to be signs of a profession that is not much valued by the public and medical profession. The male interviewees tended to emphasise how they worked in other professions, such as medical sales and IT, before committing to working as a nurse as part of an explicit strategy to migrate from India. The increased opportunities to migrate in a world where a nursing qualification is increasingly seen as a passport

can be argued to be contributing to a change in status of nurses in India. This may be a reason for the increased participation of men in this overwhelmingly feminised sector.

Although there is little empirical evidence of the increased numbers of men in nursing schools in India, figures from the RCN show that there has been an increase in the number of overseas male nurses over the past ten years working in the UK. This might suggest an increase of male migrants coming into the nursing profession on account of its migratory potentials – however, I will need to do more investigation on this.

Appendix E: Information Sheet



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Experiences of Care: Indian Nurses in the UK Can I talk to you?

Are you from India & working in the UK? Have you trained as a nurse? Are you working in nursing, health and/or social care? Do you look after or care for family who are here and/or abroad? Do you find yourself trying to balance work with family life?

If you answer yes to all of these questions, I would be really interested to talk to you and hear about your experiences. I am a PhD student in the Department of Sociology at the University of Edinburgh and am carrying out research on nurses from India currently living in the UK. The research focuses on the migration, work and family lives of migrant nurses and will be a part of my PhD thesis.



If you choose to take part in an interview, I would like to talk to you about your work, your family and your experience of migrating to the UK.

This will be completely **confidential, and anonymous**, which means that your name and any other details will be replaced so you cannot be identified. Only the researcher and her supervisors will have access to any information you give. Taking part is also **voluntary**, which means you do not have to participate in the study and you will not be disadvantaged in any way if you choose not to take part. Any information you give me will be used for the purposes of this study only. The interview will last up to 1.5 to 2 hours at a time and place that suits you. The interview can be split over two visits if you prefer. With your permission, the interview will be audiotaped. After the interview, I may contact you by phone to answer a few brief follow-up questions or to clarify certain parts of the interview. *The follow-up telephone call is not expected to last more than 15 minutes.*

If you think you might be interested in taking part or you know anyone else who may be interested, please contact me as soon as possible at:

Nikki Dunne

E: nikki.m.dunne@gmail.com OR m.n.dunne@sms.ed.ac.uk

T: 074 49312234 (you can text me and I will call you back if this is best)

If you have concerns about this research and the way it is being conducted, you can contact **Prof. Lynn Jamieson** at the University of Edinburgh at lynn.jamieson@ed.ac.uk or by phone +44 (0)131 650 4002.

I HOPE YOU CONSIDER PARTICIPATING AND THANK YOU VERY MUCH FOR YOUR HELP!

THIS RESEARCH COMPLIES WITH THE UNIVERSITY OF EDINBURGH RESEARCH ETHICS GUIDELINES

Appendix F: Informed Consent Sheet

CONSENT FORM: THE CARING EXPERIENCES OF INDIAN NURSES IN THE UK

Researcher: Nikki Dunne, PhD student, Dept. of Sociology, University of Edinburgh

Purpose of the study:

This research focuses on Indian nurses in the UK and their thoughts, experiences and feelings about leaving India, working as a nurse and caring for their families. The purpose of the research is to look at the caring experiences of migrant nurses both in work and in their families.



What will the study involve?

I am requesting face-to-face interviews lasting about 1.5-2 hours at a time and place that suits you. After the interview, I may contact you by phone to answer a few brief follow-up questions or to clarify certain parts of the interview. The follow-up telephone call is not expected to last more than 15 minutes. I will ask for your consent to record the interview(s). This is to help me recall what you have said after the interview. If you are not comfortable with being recorded, you just have to say and we can stop recording.

You do not need to do any preparation for the interview. It's not a study where there are right answers. I am just interested in hearing about your experiences.

Do you have to take part?

No, taking part is entirely voluntary and you will not be disadvantaged in any way by not taking part. If you decide to take part you will be given this information sheet to keep and will be asked to give your written consent before the interview. If you do decide to take part you are still free to withdraw at any time and you do not have to give a reason. You do not have to answer anything that you are uncomfortable with.

Will your participation in the study be kept confidential?

The information you give me will be strictly confidential. The only people who will have access to this information are the researcher and her two supervisors. We will not discuss anything that comes out of the interview with others in ways that might identify you and will not disclose what you have said in an interview. You will remain anonymous in the study. All personal information (such as the

name of your workplace or any family member names) will be removed from the transcript, so that no one will be able to identify you.

What will happen to the information which you give?

All data will be collected and stored in accordance with the Data Protection Act 1998 and will be kept confidential for the duration of the study. All recordings will be securely stored in a password protected computer and/or locked drawer. Responses will be securely destroyed at the end of the project.

What will happen to the results of the research study?

The results of the research will form my PhD thesis, which will be completed in 2016, and may be presented at conferences and meetings and published. You will not be identified in any publications.

What are the possible disadvantages of taking part?

I don't envisage any negative consequences for you in taking part. It is possible that talking about your experiences may cause you some distress, but it is up to you what you want to share and the interview can be paused or stopped at any time. If you do not want to answer a question or would like to take a break, just say so and we can move to the next question, take a break or finish the interview. At the end of the interview, I will discuss with you how you are feeling and I will give you the names of some migrant advocacy organisations. If you have any concerns or complaints about the nature of the research, you can contact **Prof. Lynn Jamieson** at the University of Edinburgh at lynn.jamieson@ed.ac.uk, or by phone +44 (0)131 650 4002

Who has reviewed this study?

All studies of this kind must pass the University of Edinburgh's School of Social & Political Science ethical review process.

