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'Repaying the Suffering' in Transnational Families from Kerala, South India

Tanja Ahlin

INTRODUCTION: MIGRATION AND TRANSNATIONAL FAMILY CARE[1]

In middle-class Indian families, it has become quite common to have some family members living abroad. Indians have been migrating to countries which have historical links to their motherland, such as the United Kingdom (Rutten & Patel, 2003) and the countries of the Middle East (Vora, 2013), as well as more recent destinations such as the United States of America (George, 2005) and Australia (Voigt-Graf, 2005). Migration, however, rarely splits these families between 'home

1 The research project on which this contribution is based has been made possible thanks to the Erasmus Mundus Doctoral Fellowship, Specific Grant Agreement 2013-1479.

country' and 'migrating country' in any sharp manner. In the past, migration might have been experienced as a kind of "social death" (Baldassar & Merla, 2014, p. 54), but today information and communication technologies (ICTs) and the possibility of frequent travel enable migrants to keep a constant connection with their family members and thereby remain involved in everyday family life, creating the so-called "transnational social spaces" (see also Basch, Schiller & Blanc, 2005; Herrera Lima, 2001). In contrast to some other communities studied under the paradigm of transnationalism, for example Latin American and Caribbean migrants in USA, Indian transnational social spaces have been described as particularly dependent on small-scale kinship networks rather than state-based political and economic ties (Voigt-Graf, 2005).

In anthropology of migration, Laura Merla and Loretta Baldassar (2014) have introduced the notion of "care circulation" to explain care in terms of various kinds of support that fluctuates over the life course of family members and across countries and continents through which they are dispersed. According to this conceptualization, the circulation of care is (1) reciprocal, as it flows, for example, not only from adult children to their parents but also the other way around; (2) multidirectional, as it is exchanged also with other relatives and non-relatives outside of this dyad; and (3) asymmetrical, as it tends to be exchanged in uneven ways on different occasions (Baldassar & Merla, 2014). Family, household and home are not seen as static social structures, but as ideational and structural processes built around everyday practices of caregiving, emotion work and intimacy. What counts as good family relations and care in "global households" (Kofman, 2012) does not depend strictly on physical proximity between family members. In care circulation, the emphasis is not on how migration disturbs family relations, but on how family members, despite large geographical distances, manage to effectively "do family" from afar (Zentgraf & Chinchilla Stoltz, 2012).

In this contribution, I explore how family and intergenerational reciprocity are practiced in transnational families originating from the South Indian state of Kerala. I explore this topic on the basis of long-term fieldwork which I conducted in 2014-15 in Kerala as well as in Oman, a Middle Eastern country which has historically been one of the major destinations for Keralite migrants (Irudaya Rajan & Percot, 2011). My fieldwork also included some Keralites who migrated to other countries around the world and whom I interviewed by phone or via internet-based webcam communication platforms. I focused particularly on those who migrated as nurses, a profession often taken

up in Kerala as a migration strategy *par excellence*. As such, the phenomenon of migrating nurses from Kerala can be described in terms of "global care chains", a notion referring to "a series of personal links between people across the globe based on the paid or unpaid work of caring" (Hochschild, 2000, p. 131). Care is here conceptualized as moving in a unilinear way as women from the global South and East migrate to care for children of fully-employed women in the global North and West, and at the same time leave their own children behind and provide for them through remittances. This theory highlights globally structured inequalities of class, race, ethnicity and gender, as well as illuminates commodification as the central norm of care, which in the context of labour market exchange and the wider frame of political economy becomes embodied in the migrant domestic worker (Lutz, 2002; Parreñas, 2008; see also Van der Geest, Mul and Vermeulen 2004). Additionally, Nicola Yeates (2009b) emphasizes that the carers involved in care work are not only unskilled domestic workers, such as nannies and maids, in household settings, but also professional carers such as nurses.

In continuation, I first describe the colonial history of the nursing profession in Kerala and how its practice changed under the influence of worldwide socioeconomic changes as described in the framework of global care chains. I then explore how for Keralite families of nurses, migration in itself became a form of reciprocating care. Finally, I look at some examples of how the migrating adult children continue taking care of their parents at a distance by using ICTs, and I show how also the parents who remain in India actively participate in the caring process by means of ICTs.

NURSING IN KERALA, NURSES FROM KERALA

In India, Kerala is known for its nurses and, conversely, the nurses from Kerala are known to be especially good nurses (Nair, 2012). The reasons why most nurses originate from this particular state are related to the Indian colonial history as well as to the strong presence of Christianity in comparison to other states. Indian women were first educated as nurses under the guidance of Florence Nightingale in 1914 when the British settlers needed nurses to attend to their military forces (George, 2005). At the time, women who would become nurses were recruited mostly from Kerala, where about 20% of the population is Christian (Philips, 2003). Compared to Hindus, who see any work re-

lated to bodies as polluted, the Keralite Christians perceive nursing in a different light, as a service to God. As George (2005: 41) writes, the "relative openness of the Christian communities to nursing had much to do with the active role that English missionaries and mission hospitals took in representing nursing as a noble Christian service." But nursing has also been related with lower economic classes: one woman I talked to remembered she wanted to become a nurse in order to "serve God," but her father refused because this profession was below the status of their family (see also Nair 2012).

After the Second World War, and after the Indian independence of 1947, the dynamic of need for Indian nurses changed, as Keralite nurses started entering the global labour market in significant numbers. This was triggered by the political and economic conditions that had created severe shortages of nurses in USA (George 2005: 50). Coupled with the liberalization of immigration, this induced immigration of Indian nurses to the USA, and nurse migration also increased to the United Kingdom and the Persian Gulf countries (Nair 2012: 13). Their relocation was facilitated by the Syrian Christian Church, which provided a social network abroad, and by embassies of the destination countries and employment agencies which provided sponsorship and guidance in practical and official aspects of the migration process. In line with the theory of global care chains, the international migration of Keralite nurses has thus been fuelled by the global socioeconomic inequalities that pushed nurses into searching employment abroad while leaving their non-migrating family members behind (Walton-Roberts, 2012).

In Kerala, poor working conditions have continued to serve to this day as a strong incentive for nurses to look for employment abroad (see also Chua, 2014). As my informants told me, nurses' salaries remain among the lowest in the country, with the monthly payment up to 12,000 Indian rupees (Rs, roughly 160 EUR), thus well below the average monthly expenses of about 16,000 Rs (220 EUR). It is therefore of little surprise that Keralite nurses strive to work and live around the globe. This is illustrated by the diversity of destination countries for the nurses in my study, which included USA, UK, Oman, United Arab Emirates, Saudi Arabia, Italy, Ireland, the Netherlands, South Africa, Australia, New Zealand, the Maldives and Guyana. The choice of country mainly depended on its current migration policy, labour market and the nurses' knowledge of English; if they were able to pass the required English language test, they would migrate to an English-speaking country, while those with a poorer knowledge of English generally moved to the Middle East or other non-English speaking

countries. Additionally, nurses often migrated to countries in which members of their extended families and friends from nursing schools had already moved; these personal and professional networks were indeed crucial for prospective migrants in planning their journey (see also George 2005: 54-57). Once abroad, the nurses thus remained well connected to their Keralite roots, and the Christian Church, strongly present in many of the destination countries (USA and Oman included), helped significantly in sustaining the networks of the Keralite diaspora of nurses.

Besides global economic inequalities, the theory of global care chains emphasizes gender inequalities integrated in care work, as most of those who migrate to provide care labour are women. According to global care chains scholars, this phenomenon is built on the long-lasting local patriarchal social and welfare structures and even supports them (Yeates, 2009a). While Keralite nurses are still predominantly female, the benefits of this profession in terms of migration prospects have become so alluring that even men have started entering into it. In my study, seven out of twenty-nine families had sons rather than daughters working abroad as nurses. One male nurse even told me he was "forced" into nursing by his cousins so that he could move abroad and earn well. He continued to complain, however, that he regretted his decision to become a nurse after having difficulties in passing the English exam and seeing the demand for nurses plummet in some countries, like USA, in the recent years. While the impact of female nurses as the main breadwinners on the family dynamics has been explored (Gallo, 2005; George, 2005; Percot, 2012), how family power relations are subject to transformations as men enter into nursing, a highly feminized field, still calls for further exploration.

MIGRATION AS AN ACT OF INTERGENERATIONAL RECIPROCITY

In Kerala, the increasing entering of women as professional carers into the local and then global economic market has had a significant impact on family dynamics, including intergenerational reciprocity. The expectations the parents have towards their daughters have altered, as the daughters' status shifted "from burdens to assets" (George 2005: 42). Before women started taking up the nursing profession, they represented a burden for their parents who had to assemble the dowry for their wedding. Especially in large families

with many daughters this could be a painstaking process, pushing some families into further poverty. The parents were also reluctant to invest in the education of their daughters who would marry soon after finishing their studies, and so whatever income they earned would land in the hands of daughters-in-law. But with nursing, this changed. Excellent prospects for migrating, earning significantly better salaries abroad than in India and sending remittances home have made nursing a desirable profession not only among youngsters but also among their parents.

As Sheba Miriam George (2005: 43) writes, migration in Kerala became "a family project" rather than a decision of an individual nurse. Among the families I encountered during my fieldwork, migration was planned for years, and some parents, especially mothers, started pondering about educating their daughters as nurses when the latter were still little girls. While the nursing education was relatively inexpensive in the past (Nair 2012), it later became a significant investment in time and resources, leading some families in acquiring loans to pay for enrolment fees, dormitories and food for their studying daughters. Furthermore, money was needed to pay for the English language classes and exams required by the migration and labour laws of English-speaking countries recruiting Indian nurses. However, families considered these investments worthwhile, if the daughter(s) eventually succeeded in passing all the tests and obtaining a visa and employment abroad.

Migration of children also entailed emotional and other costs, as the children would move far away from their parents; this is significant in a country where co-residence of elderly parents with one of their married children is considered key to good elder care (Lamb, 2000). However, one mother explained her feelings about her three daughters becoming nurses and migrating to three different countries (UK, South Africa, and United Arab Emirates) in this way:

> Interviewer: Since you are away from your children, do you feel sad?
>
> J.: Don't we all have to live? Things wouldn't work (they wouldn't get a job) here … I can't ask them to be here with me. How can it be possible? Don't they have to lead their life ahead? Then, when we are sick, if they want to take care, then it's ok (to accept their support).

This mother saw it would be selfish of her to demand that her daughters remain in Kerala, as she was well aware they had better employment prospects abroad. Additionally, she recognized that having lucrative employment abroad enabled her children to also help her in times of need. As my informants told me, the parents in Kerala could

not demand support from their children, especially from married daughters whose income would belong to her family-in-law. But if the daughters offered their help, either financial or any other, the parents could accept it. The nurses I talked to, however, never saw any dilemma in this: while they knew their parents would never require help explicitly, these nurses took it as their duty to help their own parents to reciprocate the parents' efforts in educating them and thereby opening important life opportunities for them.

The remittances provided by the nurses were generally spent on repaying loans, renovating the family house in Kerala, paying for younger sibling's education, saving for a dowry, and buying a car. Additionally, the aging parents could count on having financial resources in times of health crisis. This is particularly important in India, where despite some recent efforts to introduce various health insurance schemes, there is no universal system to provide for health care related costs and also no pension for a large majority of the elderly (Ahlin, Nichter, & Pillai, 2016; see also Rutten & Patel, 2003; Mazzucato 2008).

For the nurses I interviewed, migration was a way of 'repaying the suffering' to their parents who "suffered a lot," as they said, in order to bring them up and especially to educate them in the nursing profession. For example, during my visits to a private school, run by one of the Christian factions in a town in central Kerala, I learnt about the difficulties and challenges of the nurses studying to pass the English language exam, IELTS (International English Language Testing System). The young nurses attending the classes saw it as their duty to succeed in these tests and to migrate, as only then they would be able to reciprocate their parents for all their "suffering."

Successful migration thus represented a form of intergenerational reciprocity, particular to Keralite families of nurses. Such understanding of migration was related to religion and class. However, some of my Hindu informants in Kerala disproved of nurse migration, saying that it was "not good" to leave one's parents behind to age on their own. In the Hindu context, elder parents should live with one of their children, usually the eldest son and his family, in the same home, since this was the best way for the children to also provide seva, or service, to them (Cohen, 1998; Lamb, 2000, 2013). Furthermore, both Hindu and Christian informants of higher classes noted that many of these nurses were "nothing but milking cows" for their families, suggesting that family exploitation was the main force behind their migration efforts. Christian nurses and their families, however, saw their own endeavours very differently. As one of the mothers, whose daughter was

a nurse in Australia, said, "If (my children) lived here and had no jobs or earned a very poor salary, would we all be happy? No!" The nurses I interviewed agreed with this observation, and recognized in migration an improvement of the quality of life for both themselves and their aging parents, despite the fact that it introduced distance between them. From my field notes:

> B., a nurse working in the UK, has two younger sisters who can take care of her parents if needed, as they still live at home, while she can give financial support, and "that's the basic thing everybody wants." Nobody has to look after the parents because they are in good health; she could stay here (in Kerala) and support them physically in case of illness, but "for that also money is needed". ... Even if you are "sitting nearby" but don't feel for your parents that doesn't help – care depends on your personal engagement. She says, "(It's about) having a feeling for your parents from the heart ... a genuine feeling ... Basically, we should be near, I know the importance of that, but they should feel that I care for them, there's a mutual understanding, that's a good relationship, it won't go away even in many years."

Thus, in Keralite families of nurses, solidarity and reciprocity was practiced differently from Hindu families in which co-location were of prime importance (Lamb 2000). For Keralite nurses, intergenerational reciprocity was not linked as much to physical proximity, which is not possible in the case of international migration. Rather, coresidence became gradually replaced, at least to a certain degree, with practical and emotional engagement at a distance. In practice, besides remittances and regular yearly visits home, this increasingly included keeping in touch via information and communication technologies (ICTs).

PRACTICING INTERGENERATIONAL RECIPROCITY AT A DISTANCE

For Keralite transnational families, living together in the same house or at least in proximity became impossible due to international migration. However, everyday ICTs, such as landline and mobile phones as well as the Internet, have become crucial in maintaining relationships between family members at a distance. For the nurses abroad, calling their parents frequently and regularly became a norm, the next best way of reciprocating care to doing so in person. Keeping in touch over ICTs often included working out a schedule around the nurses' work obligations as

well as around the parent's activities, such as attending social events and prayer. If the nurses failed to contact their parents for a longer time, or did not follow the implicit schedule of calling regularly, this was a sign for concern. As one mother with three daughters abroad explained:

> Interviewer: When you talk on the phone, what feelings do you have?
>
> J.: I'm very delighted. If they don't call for a day, I won't be able to sleep even that day. If everyone calls, I sleep peacefully.
>
> Interviewer: How many minutes do you talk to them?
>
> J.: At times we talk for one hour, if it is from the UK, though computer (internet-based calling). With the daughter in Dubai, we talk for about half hour, if it is through the net, if it is through mobile about 10 minutes.

Calling home regularly and frequently thus became a way of providing care at a distance (Ahlin, 2018). The goal of this ICT-enabled interaction was often to exchange small, mundane details of everyday life, and this kind of paying attention was perceived as an expression of continuous care across distance. The children provided care by ICTs also in more explicit ways, for example, by giving advice on treatment when the parents in India fell ill or had a sudden health emergency. For example, they monitored carefully the treatment that was given to their parents in hospitals, such as by asking for pictures of healing wounds after surgeries.

The parents, however, were not only passive recipients of care in these relationships. They, too, used ICTs to continue taking care of their adult children abroad. For example, a young nurse working in Saudi Arabia, told me that she was in touch with her mother daily, using the landline phone, mobile phone and Skype. As she explained, talking on Skype, and especially seeing scenes from daily life in her family, such as the food prepared by her mother, had a good impact on her wellbeing when she was missing her home and was having a hard time being so far away. Thus, a webcam can be helpful for parents to support their children abroad emotionally and morally in times of homesickness. Additionally, P.'s mother told me she used the webcam to check on P.'s health by closely inspecting her physical appearance: "Does she look thin? Does she look pale? Is she eating enough? Is she smiling enough? Or is her face sad and worried?" In P.'s case, such parental concern was also related to the challenging living conditions that unmarried Christian women experience in a largely Muslim Middle Eastern countries (Percot, 2006).

For Keralite parents, the care they provided for their children through upbringing and education was reciprocated in several ways. To 'repay the suffering' of their parents, the children strove to complete their nursing studies and successfully migrate abroad. Later on, they provided for their parents financially through remittances, paid regular yearly visits to them and gave attention throughout the rest of the year by calling home frequently. The parents, too, used ICTs to continue caring for their children, for example by offering emotional support in moments of homesickness. The level of support between the parents and their children varied between families as well as between siblings within the same family. Generally, however, the family relations after migration mirrored the quality of relations that existed before it. The case of transnational families of Kerala nurses thus illustrates how migration can re-shape the notions and practice of intergenerational reciprocity of care.

According to the theory of care circulation, the main underlying principle of intergenerational care is moral (rather than just monetary) economy. Thus, the generalized reciprocal exchange is based on the expectation that the giving of care of various kinds (financial, practical, emotional and so on) will eventually be reciprocated. One of the key characteristics of such care is that it is asymmetrical, meaning that "the quality, quantity, direction and presence or absence of the circulation of care is highly variable, constantly negotiated and deeply influenced by factors both within and outside the family" (Baldassar and Merla 2014: 31). But how could the quality and quantity of care ever be measured? When Keralites talked about parents' "suffering a lot" to educate their children as nurses and help them in the migration process, this was meant as an expression of the significance of the invested care rather than a quantitative evaluation of care to be eventually reciprocated in equal quantity and quality. Suffering, like caring, is much too complex to allow for any sort of measurement. The question of how much care, exactly, would suffice to reciprocate the parents' suffering is therefore impossible to answer.

Still, as a sort of practice of family power relations, emphasizing the 'great amount' of care that the children received from parents can be a powerful way to remind them of their (more or less near) future obligations towards their parents. Indeed, in Kerala there was little subtlety about this, as the parents constantly recounted to their children of their own efforts and involvements in helping them succeed professionally. At the same time, the act of

migrating and leaving their family in India incurred suffering for the children, too, and this was generally noticeable from their feelings of homesickness. Moreover, the migrants made sure to convey the importance of parental suffering to their own children, and this became a way of securing reciprocal care in their own old age. As one middle-aged nurse Anna, working in Oman by herself for almost two decades while her husband and two daughters lived in Kerala, put it: "If my parents didn't educate me, I would be nothing, I would not earn any money ... Now I am in Oman, I am struggling for them (my whole family, including own parents). (My daughters) too, have to remember, 'See, my parents struggled for me, so I cannot forget them.'" Anna recognized the suffering of her parents, but also pointed out the suffering she had to endure by living in a small desert town without her family, only to work, and she made sure her own daughters would understand the meaning of her actions: an illustrative tale of how in Keralite transnational families care, and the feeling of obligation to reciprocate it, moves from one generation to another through the invocation of suffering.

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