Empowered Wives and Frustrated Husbands: Nursing, Gender and Migrant Nepali in the UK

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ABSTRACT

Since 2000, increasing numbers of Nepali nurses have crossed national borders to participate in the global healthcare market. The most common destination countries are the UK, US, Australia and New Zealand. In particular, educated middle-class women are attracted to nursing with the full support of their families. There have been profound changes in women’s position in Nepali society. As a female only profession in Nepal, nursing provides an excellent focus on how and why these changes have occurred.

Based on a multi-sited ethnography, including in-depth interviews with nurses and their families, conducted in Nepal and the UK from 2006–2008, this article discusses the changing nursing profession within the broader context of gender dynamics. Between 2000 and 2008, around 1000 Nepali nurses migrated to the UK. International nurse migration hugely affects nurses’ immediate family dynamics. This article illustrates how migrant nurses’ husbands have to accept a compromised social position, from being family bread-winners in Nepal to dependent husbands in the UK.

POLICY IMPLICATIONS

* Since the late 1990s, a new women-migration phenomenon has emerged in Nepal. The Nepal government’s current women migration policy has created a serious controversy, which requires urgent policy attention.
* Because of British work permit regulations, Nepali nurses migrate to the UK on their own. Typically the UK government gives little consideration to how its international nurse recruitment practices and work permit policy affects migrants’ family life. There is a need for a family-friendly immigration policy.
* Female / nurse migration has a profound impact on nurses’ families’ lives in the UK. This area requires further enquiry.

INTRODUCTION: NURSING AND GENDERED MIGRATION FROM NEPAL

Nursing in Nepal is currently a female only profession and international migration of Nepali nurses is a new and rapidly growing phenomenon. Female migration in Nepal, also particular to the Asian context, began mainly in the late 1980s after the Asian Economic boom and the consequent feminization of migration (Lan, 2006). Before this, international migration opportunities for Nepali
women (of any profession) were very rare. Most women stayed at home, raised children and engaged in domestic and agricultural work, and some helped run small family businesses. A small number of educated women had jobs in the formal sectors as teachers, nurses and civil servants. Those few who moved internationally did so mostly to India, usually accompanying their husbands and family members. The same could not be said for Nepali men who have been working in foreign countries for centuries.1

International migration of Nepali women coincided with profound socio-political changes in the country. The beginning of this change was the replacement of the three decades old party-less panchayat system by multi-party democracy following the 1990 Jana Andolan (people’s movement). After this event, increasing numbers of young women with secondary school education began to find jobs in foreign countries, becoming increasingly active economic agents in a range of sectors, including working as maids and care-givers. For women’s rights activists these women are now seen as family economic saviours, and education and migration opportunities are viewed as possibilities for women’s freedom and independence (UNIFEM and NIDS, 2006; Sancharika Sumuha and UNIFEM, 2003).

Consequently, a new generation of women (particularly private-school educated girls from middle-class families who, being socio-economically in the middle of the social hierarchy, can afford to pay for their children’s education) started securing places in extremely competitive technical training institutions, particularly in nursing (Adhikari, 2010; 2008). After obtaining nursing qualifications and a few years of work experience in Nepal, many young nurses aspire to go abroad. From the turn of the millennium, this new nurse-migration trend has emerged with North America, the UK, Australia and New Zealand being particularly attractive destinations.

Paradoxically, since the 1970s, international nurse migration has become one of the most debated global public health policy issues (Mejia, 1978). It has raised some serious ethical concerns as increasing number of low-income countries in the global south started losing their valuable health workforce, including nurses, to affluent countries in the global north. This has compromised developing countries such as Nepal’s capacity to deliver effective healthcare services to its own people. This phenomenon is known as the “brain drain”.

Globally, nursing is a female-dominated profession, and nurse migration is also considered predominantly as female migration and as “care drain”. Feminist scholars argue that there is a growing need for more nurses (and care workers) globally, but developed countries are affected the most. As women in affluent countries gain broader career choices, the attractions of domestic and care work, including nursing, have declined. As a consequence, long-standing care systems have collapsed and created a “care vacuum”, particularly at the most basic level of looking after young children and the elderly (Zimmermann et al. 2006). From the 1970s, as Ehrenreich and Russell-Hochschild (2002) argue, increasing numbers of women from low-income countries have been hired to take up these nursing and care work jobs and fill this “care vacuum”. This creates a “care deficit” in the nurse-sending countries as women migrate to affluent countries in the global north to provide care to others, leaving behind their own children, elderly relatives, and sick people. Feminist scholars argue that the care drain only creates a “care deficit” in the sending countries view it as an unethical and unsustainable solution.

Affluent countries in the global north are also facing major demographic changes such as declining birth rates, an increasingly ageing population and a greying (ageing) nursing workforce. Countries in the global north have also been criticized for “commoditizing” nursing and care work in this manner, and not investing in their own resources and making preparations for this urgently needed workforce. Rather, they employ cheap labour from economically disadvantaged countries. This has turned nursing and care work into a commodity that can be bought and sold in the contemporary global care market (Kingma, 2006; Zimmerman et al., 2006; Herdman, 2004). Critics view this trend as picking staff off-the-shelves, and argue that employing healthcare professionals becomes like supermarket shopping (Smith and Mackintosh, 2007).

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As well as global ethical and political issues, international nurse migration has raised a number of professional and personal concerns. As noted above, women, including nurses in 21st century Nepal, are becoming increasingly independent and empowered, and becoming the family breadwinner. As ‘female only’ professionals, and with increased international job opportunities, Nepali nurses are not just becoming more mobile, but are becoming “economic agents”, as well as facilitators of family migration. They can open up opportunities for the rest of the family as they are in the unique position of making an international move possible.

Once in the UK, however, they also have to face new challenges. Most migrant nurses end up in a completely different professional position. Migrant nurses have to accept jobs below their educational qualifications and clinical skills. In the UK, migrants of various types are invited to fill vacancies for jobs commonly known as the 3 Ds: dirty, dangerous and degrading (Castle, 2000). Nursing and care work jobs are the hard-to-fill vacancies, usually the undesired or the least desired, by the local workforce. Migration scholars for example Smith and Mackintosh (2007) argue that this reinforces a further division within social and professional classes. The increasing commercialization in the healthcare service in the UK has created a professional class, where a white British workforce occupies the managerial level and the most desired positions, and migrant nurses increasingly provide front-line hands-on care.

In this article I discuss professional nursing and nurse migration as an example of a complex issue and female migration has both positive and negative consequences at various levels – some of the consequences are the increased attraction of nursing as a profession in Nepal, nurses’ international aspirations and the consequent changes in family and gender relations. I do this by firstly examining the increased attraction of nursing as a profession since the 1990s, within the context of the Nepal’s changing socio-political situation. Secondly, I look at the migration process itself and how this effects gender relation – illustrating how nurses are increasingly valued as a family asset and also how their migration enhances family’s lijjet (honour and social standing). Finally I discuss how the men married to migrant nurses have to accept and adapt to their new circumstances – from being the head of the family and the main breadwinner in Nepal to dependant husband in the UK and learn to live with a compromised social position.

RESEARCH METHOD

This article is based on a doctoral research which looked at the nursing education system in Nepal and Nepali nurse migration to the UK. I chose a qualitative ethnographic style research method for this study. The research is multi-sited and fieldwork was done in Nepal and in the UK, between July 2006 and December 2008 with a follow-up in 2009. In Nepal I studied the socio-cultural context for women/nurse migration with a particular focus on how young women are trained to become nurses and how they prepare for their international move. There I met and interacted with over 100 nursing students, visited 20 nursing colleges and interviewed senior nurse managers, campus chiefs and nurse teachers. I also explored how nurse migration is facilitated by the brokering agencies. Then I followed over one hundred Nepali migrant nurses to the UK and conducted 22 in-depth interviews with Nepali nurses who were living and working in the UK. As well as nurses, I spent a considerable amount of time and interacted with nurses’ husbands and other family members. Interview samples were gathered by snowballing techniques, using multiple sources to identify informants and to diversify the interviewee base. I met and interviewed Nepali nurses in Aberdeen, Dundee, Edinburgh, rural Northumberland, Lancashire, Buckinghamshire, Oxford, Swansea, London, and Hastings.

In both countries, I met research informants in their everyday, institutional or “natural settings” (Ritchie and Lewis, 2003; Brewer, 2000; Gellner and Hirsch, 2001). I personally gathered all the
research information, using multiple research techniques including observation, in-depth interviews, and – where appropriate – focus group discussions. In addition, I had numerous informal discussions, countless telephone conversations and multiple meetings with a number of informants. I also reviewed available relevant records and policy documents.

Data analysis started in the early stages of the research fieldwork and continued until the end. Findings presented in this research are the result of long-term engagement and interaction with my research participants in Nepal and in the UK during the process of data collection and interpretation - a process commonly described as “immersion” by ethnographers. This iterative immersion results in the research findings being constantly cross-checked by reading and re-reading the interview records and ethnographic notes, and repeatedly listening to the interviews. Apart from some public figures, most of the research informants have been anonymized to protect their identity.

WOMEN AND NURSING IN CONTEMPORARY NEPAL

Particularly since the new millennium, there has been an unprecedented shift in how nursing is viewed by society in Nepal. Currently, nursing is perceived as one of the most desirable female professions by young middle-class women and their families. This has been regularly highlighted by the Nepali media (Ghimire, 2007; KC, 2004). During the course of research fieldwork in Nepal, most young women I interacted with, who chose nursing as a career, indicated that they saw the nursing profession as a means of getting jobs in the global healthcare market, particularly in the developed west. This is a new social phenomenon, and quite different from when the first professional training began only half a century ago.

Let us briefly look back to how nursing was perceived when the professional training was set up in Nepal in the late 1950s. Two nurse training programmes were set-up; the first one in 1956 and the second in 1959. Both programmes had a very challenging start with finding candidates for training. Amongst others reasons, women’s mobility in those days was a major social issue, so the first generation of professional nurses had very different experiences of enrolling into the training, and working afterwards. For decades, very few Nepali women and their families were attracted to this profession. There were a number of reasons for this, including a strong family resistance towards allowing young women to take up nursing.

Firstly, there were only small numbers of suitably educated women in the country. Education for women was a luxury for a very few urban elites and affluent families and almost no family wanted to empower or prepare women to work outside their domestic sphere and become economically independent. For the vast number of ordinary women, education was not available and was not a priority in society.

Secondly, women’s mobility and safety outside of the family home was also perceived to be a major issue. The vast majority of parents were not accustomed to the idea of their daughters leaving home and moving to somewhere else for training or to work as a nurse. As a consequence, in the early days of the establishment of nurse training, training authorities regularly had to actively look for suitable candidates. After spotting a potential candidate for nurse training, the trainer then had to negotiate with the woman’s parents and guarantee their daughter’s full safety during the training period (Maxwell with Sinha, 2004).

Thirdly, for many rural people, nursing and a modern western-style healthcare service were alien concepts. For example, almost two decades after the establishment of nursing training in Nepal, in the late 1970s, the failure of the Auxiliary Nurse Midwife (ANM) programme to deliver Maternal and Child Health services in rural Nepal was related to poor socio-cultural acceptance of modern healthcare workers. Justice (1986) explains that traditional healthcare systems had existed there for centuries and so people trusted the local Sudeni (Traditional Birth Attendants or TBAs). They
would normally be mature local women, married with their own children. In contrast the ANMs were usually young, unmarried, and urban-educated with no personal experience of raising families and very little familiarity with rural people’s lives (Justice, 1986).

Finally, caste, cultural purity and pollution were major issues, and hospital-related jobs were considered culturally polluting for many high-caste Hindus (KC, 2004; Fletcher, 1965). Accepting food cooked or prepared by any outsider and transporting cooked food around was, and still sometimes is, considered ritually unacceptable for many Hindus. After any length of hospital stay, or spending any length of time outside their community, many people would perform a ritual cleansing ceremony at home, and at least have *sun-pani chharne* (sprinkling of gold-dipped water) to become socially and religiously acceptable again (Harper, 2009; KC, 2004; Liechty, 1997). Additionally, nurses from the early days recount that nurse training in Nepal did not attract many candidates, because nurses wore white uniforms, the colour worn by Hindu widows. This further highlights the complex socio-cultural context that made finding training candidates a major challenge for the training authority. Not only were hospitals considered inauspicious, but the nursing profession was considered ritually unclean, so very unsuitable for high-caste Hindu women from affluent socio-economic family backgrounds. Mrs L. Amatya, who was one of the counterparts for the World Health Organization (WHO) nurses at the beginning of nurse education in Nepal, shared her experience. She told me:3

I was born and brought up in Darjeeling and went to Calcutta Medical College for nursing training. I met my husband there; we got married and came to Kathmandu. My husband was then working in the Royal Palace. When there was a chance for me to work with the WHO nurses, my mother-in-law said no, I should not work as a nurse and I should not wear a white uniform. White is a colour worn by Hindu widows. My husband was still alive, and so it seemed very inauspicious. My mother-in-law was very unhappy, she said “my son is alive and you should not wear a white Sari.”

But this attitude towards nursing changed gradually over the next two decades. In 1972, nursing became a university level education in Nepal. A few years after that, in the mid-1970s, Her Royal Highness Late Princess Prakchaya was enrolled into nurse training. Although she never took up any clinical nursing role, her entry into the profession acted as a good advertisement. As nursing gradually became socially acceptable, a few more staff nurse training programmes started in the late 1980s.

Professional nursing has transformed more rapidly since the 1990s. The new democratic government adapted a policy to expand nurse training capacity by involving the private sector in technical education provision in Nepal. The idea of privatization emerged in the late 1980s, and the establishment of the Council for Technical Education and Vocational Training (CTEVT) in 1989, introduced the private sector into technical education provision, including nursing. As a result of the escalated privatization, there has been a rapid increase in private colleges since the late 1990s.

The main reason for this rapid growth in training capacity is the increased demand for more training places for qualified nurses. In 2007, for example, BP Koirala Institute of Health Science in Dharan received over 1900 applications for 40 staff nurse training places. Similarly, the Bir Hospital Nursing Campus in Kathmandu received over 3,000 applications for 40 places, while one of the Tribhuvan University-run colleges in Kathmandu received 548 applications for 45 training places. This increased attraction towards nursing is primarily because this profession can offer international migration opportunities for the new generation of nurses, as demonstrated by these quotes written in English by a group of BSc nursing students, whom I met in one of the training programmes in Kathmandu in the summer of 2007:

To get good opportunities to go abroad in order to hold job in better position and continue my studies further in Master’s level.

One student explained as her reason for joining nursing training.
After having experience for about 3 to 5 years, I prefer to go abroad as this profession is directly linked with abroad…

Yet another explained:

I wanted to join B.Sc. Nursing because from childhood only I had dreamt of being a health worker… Besides this because of the flourishing scope [for nurses] worldwidely and since society has accepted it as now respectable profession, I joined BSc. nursing.

Many of the students I interviewed echoed this idea of international opportunities. Clearly these students and many new generation nurses see their future opportunities abroad.

NURSING AND MIGRATION: INCREASED FAMILY IJJET (HONOUR) IN MODERN NEPAL

International migration of educated youth and skilled professionals for further education or for work, particularly to the UK, North America, Australia and New Zealand has been seen as a sign of real progress particularly for the growing middle-classes in Nepal. International nurse migration is a part of this new phenomenon and is seen as career progress, a major professional achievement as well as increasing family social standing. The vast majority of nurses I interviewed and interacted with had thought that migration to the UK would mean they would be able to work in a modern and most advanced healthcare system using highly sophisticated medical technology. Almost all nurses I interacted with in the UK stated that they were influenced and encouraged to make their international move by their families, friends, and professional colleagues. Affluent countries in the global north are perceived as lands of opportunity.

Between 2000 and 2008, around one thousand Nepali nurses have migrated to the UK, and the majority of them are married and have children (Adhikari, 2010). Nurses make their journey to the UK, on their own first, and eventually their husband and children join them as dependant family members. Nurses’ family and relatives also can gain further education and enjoy higher living standards. Nurses and their families would then have potential for better earning too. Many of my research participants in the UK indicated that they migrated with the hope of achieving these major life opportunities both for themselves and for their families. For example, a Nepali nurse working in the UK explained to me:4

…it is our society in Nepal; one has to migrate to be successful in one’s career and as a sign of progress.’’

The experiences and stories of the 22 nurses I interviewed in the UK, and the countless conversations and social contacts I have had with nurses in Nepal, and in the UK, had some common elements. Migration is about fulfilling their own, in addition to their families’ material desires, and about uplifting their social status and ijjet (honour standing). Family, friends and even extended relatives agreed to lend some money to cover their initial expenses. It has been seen as a collective family investment. None of the nurses I interviewed said they felt any resistance to, or restriction on, their migration, in fact quite the opposite. Migration to Europe, North America and Australia is seen as real progress and success in their lives, which crucially can be shared later by family and relatives. As Liechty (2003: 51) suggests, in contemporary Nepali society having friends or relatives living in a foreign country provides a window into another cultural world, and looking for international opportunities is a “must-do thing”, a sign of being modern and successful.5 Here is an example of a migrant nurse who felt fully supported by her kin to meet her international aspiration.5
...for the first time in my life I felt that I was so important in my family, everybody, all my relatives were trying to help me in their own way. My sister-in-law lent me so much money [to pay the migration agent in Kathmandu]. I felt that I was special.

International nurse migration thus casts some light on women’s changing position in Nepali society, and how educated women are seen as a family asset. Only one generation ago “chhori bigryo nurse-le, chhora bigyro commerce-le” (“daughters get corrupted by being a nurse and sons by studying commerce”) was a common saying in Nepal. Nursing was then a relatively new profession and was still to gain social recognition and respect. Although nurses at that time were from relatively educated and mostly high caste families, the saying was commonly heard across many classes and in many social groups. Evidently, nursing was not the most desirable job for women as it was not socially acceptable for a young woman to move away from home, as this could potentially ruin family ijjet.

One arena where we see this change is around marriage. Namrata, a Nepali nurse I interviewed in England explained to me that when she went into nursing training in the late 1980s, her father was very reluctant to allow her to take up this profession. His main concern was “who would agree to marry her, a nurse.” She said that she had to persuade him hard for weeks and eventually, he agreed to let her apply for staff nurse training but in one condition that he would arrange her marriage soon and she would need to accept this. She accepted this situation and got married during her training. These types of family/social pressures for educated women, including nurses have gradually eased off in the last two to three decades. Now there is no need for most nurses’ parents to worry about finding a suitable husband for their nurse-daughter. The younger generation of qualified nurses are much in demand for marriage, because their qualification is not only seen as guaranteeing a job in Nepal, but also seen as a job licence to work internationally in developed countries. This then provides an opportunity for husbands to migrate as well. Nurses thus have considerably more bargaining power, symbolizing the shifting gender relations.

INTERNATIONAL NURSE MIGRATION: CHANGING FAMILY AND GENDER DYNAMICS

This shift in gender relations is also seen in those nurses who have successfully migrated. By migrating to the UK, many nurses have enhanced the education opportunities for their children, husbands and other close kin. Most professionals in Nepal could never afford to send their children to the UK for schooling. Migrant nurses’ children, in 2012, were studying in the UK universities – some studying medicine, engineering and Information Technology. These professions are considered at the top of the career hierarchy in Nepal. For these nurses’ families, these opportunities would have been impossible if they had not left Nepal. At the same time, however, the improved opportunities for nurses (and families) have made some men feel compromised in their social positions. Men, who have migrated to the UK as dependent husbands, feel demoralized and frustrated because they do not have the same social position they would enjoy in Nepal, and they have little bargaining power in the UK job market. Nurse migration has a profound effect on traditional male roles. For the Nepali diaspora in the UK, not all men are the head of a family and the breadwinner, and they do not seem to enjoy being dependent.

I have witnessed some of these men facing major challenges with social adjustments that resulted from changes in gender roles and traditional Nepali family dynamics. Generally, men are perceived as being the heads of their houses and the main bread-winners, take the main financial and other decision-making roles and enjoy higher social positions than their wives. After their arrival in the UK, they become migrant nurses’ dependent husbands. Their wives have better job opportunities, often speak better English and have better earning potential. Many men have given up their respectable jobs.
in Nepal only to find themselves moving into undesired, low-paid, ‘supermarket-shelf-filling’ jobs in the UK and experience extreme frustration – experiences shared by South Asian men who make an international move as a dependent husband (Gallo, 2006; Charsley, 2005; George, 2005).

Table 1 illustrates the professional situation of Nepali Nurses husbands’ in the UK as compared with Nepal.

The men in Table 1, whom I met and got to know better, shared their frustrations and humiliating experiences informally. I present two nurses’ husbands’ stories to illustrate how some Nepali men experience their lives in the UK as dependant husbands, with compromised social positions.

I met Prakash in Spring of 2007. He told me that before moving to the UK he was running a small but successful business in Kathmandu. When his wife expressed her desire to migrate, he agreed with her and fully supported her wishes. They sold his business and used the money to pay the migration broker in Kathmandu. After a period of negotiation with this broker, they agreed to pay the top amount, which would guarantee her a work permit for four years. They wanted to have this guarantee after selling their business, so that she would not face any problems with finding a job. All went well and she migrated to the UK first, found a job and completed her adaptation training in a nursing-home in the South East England. She found a full-time job, worked hard, saved enough money and invited her husband and six year old daughter to join her. Prakash told me, however, that after his arrival here he had great difficulty in finding a suitable job. After all possibilities were exhausted, they moved to the northern part of Britain hoping that it might be easier for him to settle there. After spending the day with his wife and his six-year old daughter, Prakash insisted that he would walk with me to the train station. As we walked, he revealed that he felt bored as he had no job: he had nothing to do and no social life. He said:

I started drinking, I was just too bored and felt isolated, I did not realize how much I had been drinking every day, and it made me feel bad

Another nurse’s husband, Deepak, is a well respected professional man, with an MSc in Sociology from Tribhuvan University in Nepal. After he completed his degree, he joined an International Non-Governmental Organization (INGO) in Nepal. He worked for many years in the rural development sector, had been involved in Action Research, worked as an international expert, and had been involved in many key positions, earning well in Nepal. His wife worked in an INGO-run Hospital in the Kathmandu valley. There was a great deal of hawa (wind) and hall (noise, rumour) about going abroad in 2004-05 and she was “caught by this bug”, Deepak told me. As she was not completely satisfied with the management structure at her work, she wanted to move to the UK and so started the migration process. She paid an agency £5,000 and migrated to Britain.
as an adaptation student. Over a year later, she applied for a permanent position in a private nursing-home. She saved some money and invited her husband to join her. He obtained a dependant visa and arrived in England in January 2007. I met him in the South East of England in the spring of 2007, and on many occasions afterwards. He shared his frustration with me.\(^8\)

I get so stressed and frustrated, there is no intellectual engagement in the village, nobody to talk to, and my wife has to go to work. I feel that I only use 1–2 per cent of my brain, and the skills and knowledge I had acquired in Nepal is useless here. Sometimes I feel that this will drive me mad, I need to get out of it. I cannot live like this for much longer.

A group of Nepali men I met in Hastings in 2007 joked about living in Raniko Des (Queen’s country) or a country ruled by a woman. Their women would be in the positions to make major financial and family decisions. Thus when the women lead the migration process, this can have huge impact on their husbands. Men become dependent on their wives for sponsorships and visas. This affects men, particularly those from South Asia, in complex ways. Nurses’ husbands have to share childcare responsibilities which would be normally done by extended relatives and kin and also have to participate in household work such as cooking and cleaning, which is generally perceived as women’s work in Nepal. Nurses’ husbands not only end up doing child care and housework but, as illustrated in Table One, they also have to take up jobs as carers in care/ nursing homes. This type of work has been perceived as women’s work throughout nursing history in the west (Abel-Smith, 1982; Dingwall et al., 1988). These types of changing circumstances create major challenges in conventional gender dynamics (Gallo, 2006; George, 2005; Charsley, 2005).

INTERNATIONAL NURSE MIGRATION FROM NEPAL: CONCLUDING REMARKS

In this article I have highlighted a major transformation in nursing in Nepal within the broader context of changing women’s position in society. Ideas of education for ordinary Nepali women started in the 1950s. Gradually female literacy started to improve. Social attitudes toward women’s education have changed from “if women are educated they become witches” in the 1950s (Tuladhar, 2007: 97–109) to “daughters’ education is a family asset”. Mainly from the time of the ‘multiparty democracy’ of the 1990s, a new generation of women in Nepal, in urban centres and in rural villages, has been able to participate and enjoy growing opportunities for education.

As more women become educated, social perceptions of women’s equal rights to mobility have changed. Roads, television networks, phone connections have reached wider remote districts and women have become more exposed to the outside world and see new images. Educated young women now aspire to modern lifestyles and seek modern paid jobs. Consequently, aspiring young women, including nurses have started to look for opportunities beyond their social and national borders. Increasing numbers of women are more mobile than ever before, working away from their homes.

The socio-political transformation however, has not been quite so smooth. Women in 21\(^{st}\) century Nepal are encouraged to engage in full economic participation by taking jobs in Nepal and beyond. At the same time, women’s mobility has received mixed reactions. A new set of state-prescribed rules and policies, somewhat contradictory to women becoming independent, have emerged in the 1990s to monitor and control women’s mobility. After a high-profile death of a woman named Kani Sherpa in the 1998, the government of Nepal put a ban on women going to the Gulf to work, which lasted for two years, from 1998 to 2000 (Sancharika Samuha and UNIFEM, 2003). The mobility of Nepali women, including nurses, is still closely monitored at the Tribhuvan International Airport in Kathmandu and along India-Nepal border check posts.\(^9\) Women are regularly harassed by immigration and border control officers in Nepal. Critics view this as the state becom-
ing increasingly patriarchal; the responsibility for monitoring women’s mobility has gradually shifted toward the state from families and societies in Nepal (Tamang, 2000).

Despite the stricter emigration regulation, female migration from Nepal is on the rise (Brusle, 2010). Also, the most recent World Bank data suggests that women make 68 per cent of total migrants from Nepal (WB, 2011). In Nepal, women working in developed countries such as the UK and North America and Australia appear to be more respected in society than those working in the Gulf (UNIFEM and NIDS, 2006). Nursing, as we have seen has become central to this. It has become one of the most desired professions for women, and in particular, nursing migration is seen as a golden opportunity for women (and their families). A nurse’s white uniform is no longer considered an inauspicious colour, but is a source of family pride. From the mid 1990s onwards many middle-class parents are no longer anxious about allowing their daughters into nurse training. There is no lack of interested candidates for training, and nurse daughters are seen as family assets. This changing attitude is directly related to a growing demand for nurses and care workers internationally. While the need for more nurses and care workers is increasing in the affluent countries of the global north, attraction towards these jobs is decreasing there. So women/nurse migration from the global south is going to continue as long as there is a long-term nursing labour need in the global north (Kingma, 2006).

This is, however, not without its ambiguity, professional nurses enter into lower status jobs in the UK, even as they (and their families) gain higher social status back in Nepal. Their husbands also suffer role reversals, which impact on gender relations in the family. When a young generation of women gain economic independence, and enjoy increased earning potential, as my ethnographic evidence illustrates, their dependent husbands have to accept their downward social and professional mobility and compromised social position.

NOTES

1. Men migrated to work as seasonal labourers in India, or took up jobs with the British and Indian armies, and Singapore police. Some of their wives and children followed them as dependant family members. It was from the mid 1980s, that migration destinations expanded, as new job opportunities starting to emerge in newly industrializing countries in the Asia, the Gulf and the Middle East. This was further facilitated by the government of Nepal introducing a new Labour Act in 1985 (Seddon, et al. 2005).

2. The first programme was set up in 1956 under the ministry of Health and the second in 1959 by the United Mission to Nepal.

3. Interview with one of the first WHO nurse counterparts, 10th August 2008, in Kathmandu, Nepal.


5. There is a new emerging economy that supports this modern aspiration.


8. Interview with a Nepali nurse’s husband in Scotland, 2007

9. Nepali women going to India have been heavily linked with women and girls trafficking to India to work in sex industry, but these women did not normally move to take up jobs in the formal sector.

10. How this data was collected and validity of this is not clear, but it does reflect the feminisation of migration from Nepal.

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