The article, based largely on fieldwork in Gulf countries and in Kerala, focuses on female nurses from Kerala who have worked, are currently working or are preparing to work in Gulf countries. It examines in particular to what extent these women today aspire not only to a lucrative career abroad, but also to a new lifestyle in which traditional gender-based restrictions are replaced by increased and improved female agency and a focus on the nuclear family. The main goal of this article is to demonstrate how, after three decades of existence, the migration of Keralese nurses in the Gulf has evolved from a chance to an actual migratory strategy of these women and their families, taking into account — very quickly — various new opportunities, particularly in western countries. After two generations of nurses’ migration, evolutions which are closely linked to the emergence of an Indian — or, more precisely, a Keralese — diaspora in the Gulf countries are now taking on a much wider global dimension, with significant implications on lifestyle choices.

KEYWORDS: agency, diaspora, female agency, Gulf countries, Kerala, nurses

Introduction

When, in the mid-1970s, Indian nurses started to be hired for newly built hospitals in various Gulf countries, it was an unexpected opportunity for the most adventurous of them to gain previously unimaginable good wages. One generation later, thousands of young girls, predominantly Christians from Kerala, fill up the nursing schools all over India with the intention of migrating abroad after graduation. Now their ambitions are no longer confined to a job in the Gulf countries.

Hence, a nursing diploma is increasingly considered as a passport opening the world not only to the nurse herself, but also to her relatives. Families encourage
this female migration, since it is now consciously regarded as a privileged opportunity to increase social mobility. The migration opportunity has consequently changed the status of nurses, which used to be rather low in India. It has also been a chance for these young nurses to set up life strategies, based on the experience of older migrants. Migration to the Gulf is now considered as an intermediate step before further migration to the West, the new open line. For these young nurses today, migration not only means better status and a better economic situation, it is now also perceived as a way to secure more autonomy or agency, as women, than they can get in their own country.

This article, based on fieldwork carried out both in the Gulf (Oman, Emirates) and in South India (Kerala), deals with the evolution of this specific migration and its remarkable socio-cultural consequences during the last three decades. If, in the late 1970s, the migration of nurses was mainly an economic scheme supported by a familial strategy of social mobility, it now has more to do with the aspirations of the young Keralese women themselves to live a more autonomous life. In a certain way, the nursing diploma represents a passport to migration that helps these women to escape from traditional familial and social structures that are perceived as restrictive. I also argue that the development of a Keralese diaspora in the Gulf during the last 30 years has changed the way of life of the migrants and more specifically of the female qualified migrants, to the point that the Gulf countries cannot anymore be considered as totally foreign countries for Keralese people (excepting perhaps the special case of Saudi Arabia). Even in new migratory plans towards the West, the Gulf plays today a crucial role as a first step to the rest of the world.

Having first presented the specificities of Kerala which make it the ‘exporting’ state of Indian nurses, I then outline and analyse some exemplary cases of young migrant nurses. In the last part, I explain the evolution of this specific migration of qualified women during the past three decades and the evolution which has taken place in the life of Keralite nurses in the Gulf, as well as back home.

The Context: Kerala’s Massive Migration to the Gulf

Though there are millions of migrants living in the Gulf countries, studies are only now starting to be conducted on the different communities of people working there, from an anthropological point of view at least. It is, nevertheless, well known that South Asians, and Indians in particular, represent a large part of these migrants. Their number is even proportionally higher since the Iran-Iraq war and the first Gulf war which were followed in the different Gulf countries by the expulsion of thousands of Arab migrants, particularly Palestinians, Yemenites and Egyptians.

The number of Indian migrants working in the Gulf countries today is estimated to be around four millions and, according to South Indian scholars who have conducted a large-scale statistical study (Zachariah et al., 2002), nearly half of them come from Kerala, a small South Indian state. About 10% of these Keralalese migrants, more than 150,000, would be female migrants. Some of them
are housewives who followed their husband in migration, others are employed as a secretary or in other office jobs, some are domestic servants, but a large number, estimated between 40–60,000, are working in the Gulf as nurses. In fact, in Kerala today, to become a nurse turns out to be an objective strategy of emigration supported by the families of young women who are now very prized in the matrimonial market.

Kerala represents only 3.1% of the Indian population, but among the three to four millions of Indian migrants living in the Gulf, they are a definite majority, employed at every level of the job hierarchy, even if most are unqualified or low-qualified people. The reasons for this massive Keralese emigration and its complex consequences cannot be explained in detail here. I provide just a few elements necessary to understand the precise topic of this article.

According to the last census (2001), there were 31.8 million inhabitants in Kerala whose majority are Hindus, but two minorities are also well represented: nearly 20% of Muslims and nearly 20% of Christians. This little state has a peculiar position in India and its development has often been considered as a model: Keralese literacy rates rise up to 90.9% when it is 64.8% for the whole of India; fertility is much lower with 1.7 children per woman as compared to 3.5 for India (statistics for 2001); life expectancy is 68.8 years for men compared to 59 for India, and 74.4 years for Keralan women compared to 59.4 for Indian females in general (statistics for 1999; Tarabout, 1997: 253; Théau and Venier, 2001: 24).

In 1957, Kerala was the first state in the world to elect a communist government, the trade unions are still very active and politics continues to mobilize a large part of the Keralese people (Jeffrey, 1993: 126–40). Observers are also pointing out the high literacy rate of Keralan women (87.7% compared to 53.6% for India), their high level of education and their important role in the job market. A number of scholars (for example Jeffrey, 1993; Saradamoni, 1999; Théau and Venier, 2001) argue that this specificity could partly come from the matrilineal tradition that used to prevail in this area until the early 20th century. Yet economic development does not follow the same good lines, due in particular to the low rate of private investment in industry. Indian or foreign entrepreneurs point out systematically the ‘handicap’ of a labour force that claims higher wages than anywhere else in India and is all too ready to appeal to trade unions for any dispute. Unemployment has therefore been a structural problem in Kerala for more than 30 years and has partly been ‘solved’ by massive emigration of Keralites to other parts of India. During the same period, the labour market in the Gulf has been taking off and Keralite people have been among the first to join it. Until now, only a small proportion of Keralese people (2%) have migrated to western countries (Zachariah et al., 1999: 9). Today, the remittances of Keralite migrants are the second source of income of this Indian state after the export of spices and rubber (Zachariah et al., 2000: 21).

Another characteristic of Kerala is the importance of the Christian minority: some 20% as compared to 2.4% for India. In some districts, like Kottayam district, Christians even represent the majority of the population. The large Christian community of Kerala is not only a result of conversions induced by
colonization, as elsewhere in India, it has a much older history. The Syrian Christians claim to have been evangelized by St Thomas, the apostle, during the first century of our era (Visvanathan, 1993: vii-xiii). Actually the writings of Arab travellers attest to the presence of Christians in Kerala as early as the 7th century. Syrian Christians consider themselves rather well placed in the caste hierarchy, whereas the conversions that followed the Portuguese and Britannic colonizations have mostly been of the untouchable population, particularly of fishermen communities. Through conversions, these Catholic Christians (called ‘Latin’) or Protestant Christian groups, who represent today half of the Keralalese Christians, have been able to gain a better social status.

It is the Christian community of Kerala which gives to the state 90% of its nurses and a majority of the nurses all over India (Mohan, 1990: 16). It is worth noticing that more than a third of the Indian nursing schools are located in Kerala. The Christian specialization in nursing is quite easy to explain in the context of a country whose population is mainly Hindu. Two key notions of Hinduism are those of purity and pollution (Dumont, 1966). The nursing job, because it induces constant contact to polluting substances (blood, faeces, vomit, etc.) can be considered as particularly impure. Yet, it cannot be a job reserved to untouchable people since, according to Hindu orthodoxy, a caste Hindu must not be touched by an untouchable. The fact that Christian women took on this role has solved such questions in a certain way. For Christians, even if nursing is still not a very prestigious profession, it has at least the advantage to meet traditional values of the faith. Moreover, it is inscribed in their tradition since the first nurses in India were religious sisters (missionaries to begin with, then Indians). This ‘Christian’ plus ‘Keralalese’ aspect of Indian nurses can also be checked – or is even more obvious – in the Gulf countries, since 90% of the Indian migrant nurses I met there had these two characteristics (70% of them belonging to the Syrian Christian community, 30% to the Latin Catholic); the other 10% were either Hindu Ezhavas, or Hindus belonging to other parts of India.

Today, the professional and migratory niche of Keralalese nurses is undergoing a huge unexpected development. After the opening up of a nursing labour market in the Gulf, which started in the 1970s, western countries are now looking for and actively recruiting Indian nurses. Experts of the World Health Organization estimate that this new line should be amplified in the coming years because of the ageing of western populations, adding to the shortages of local labour in this sector. That is why, in India, the sector of nursing training is developing with an unseen rapidity, particularly in the private sector. The Indian government is very keen to expand this migratory market and is reforming the nursing school and colleges so that, within 10 years, they should meet the best international standards and the exigencies of the most difficult ‘importing’ countries. The goal is also to win the competition with the other strong ‘exporting’ country for nurses, the Philippines. This growing market of migrant nurses regularly makes news in the Indian media, which now compares them to the widely known computer workers of Bangalore as a similar source of foreign remittances and as a typical model of the capacity of India to train a highly qualified labour force for the world market.
A New Generation of Migrant Nurses

Neejee is 20 years old and is completing her third year of nursing school in Kochi, one of the big cities of Kerala. When I asked her how she imagines her future, she answered without hesitation:

After graduation, I’ll work here for two years [in India]. That is the minimum experience required for the Gulf and it will give me the time to save up for the fare. Once I am there I will work for two years and then I’ll get married [which means that she will have saved enough for her dowry]. My husband will come to work with me in the Gulf. After two years it will be possible to have children. During that time, we will have the time to save money and I’ll have the time to pass the TOEFL and maybe the CGFNS. So it will be possible for us to go to England or to Connecticut where I have some family.

One can see that her plans are clear and precise. But Neejee is not an exception: almost all the young nursing trainees or young nurses I met had the very same ideas about their future.

In an average Malayali family, there will be a brother in Saudi Arabia, another one in Dubai, a sister in Kuwait, an uncle in Canada, an auntie in the UK and maybe some cousins in the States or Australia. So, we Malayalis feel a little bit as if the world was ours and that Kerala was only the centre of it!

This was stated by Joey, another young nursing trainee, trying to explain why she was so keen to go abroad that at first she chose this profession against her parents’ will: ‘I want to see the world, I want to travel, I want to learn new things. What chances do I have to do that if I become an accountant or if I got an MBA?’.

The story of Teresa, aged 29, is another example of this new generation of Keralese migrant nurses. She has the same social background as Neejee, Joey, and almost all the nurses I met for this study and a very similar family. Her father is a farmer, owner of two acres of commercial crops, her mother is a housewife; her sister is married, a housewife herself, and her brother is working in Dubai. Older than Neejee or Joey, she has already accomplished some of her goals. She actually found a job in a governmental hospital (where you get the best salaries) in Muscat immediately after completing two years of work in an Indian hospital. Her brother paid for her migration expenses of 70,000 Rupees, given to a ‘travel agency’ which provides contract, plane ticket and visa. She then got married two years later. She is an exception, in that she married a man she met through one of her friends, undergoing thus a ‘love wedding’, while almost all young Keralese – including migrant nurses – still follow the tradition of ‘arranged wedding’. Teresa says that, after four years of work and saving, she has been the one to put aside the biggest part of the money and to buy all the gold jewellery given as dowry to the in-laws. Six months later, thus earlier than planned by the young couple, she was pregnant (she ‘forgot’ to take her contraceptive pill) and resigned after three months to come back to Kerala. She used the time of her pregnancy to prepare for the exams necessary to get a nursing job in the West, taking exams that she passed brilliantly. But since the capital of the couple was not large enough to pay for travel and visa fees (partly because they made several trips between Oman and
Kerala), she returned to the Gulf, Abu Dhabi this time, leaving behind her newborn baby to the care of a sister of her husband, who was himself still working in Muscat. Three months were needed to save the money required to repay the travel agency and four more months to save the money needed to go to the USA. Teresa was able to save the totality of her salary, since she chose to live in the hostel of the Abu Dhabi hospital and had food free of charge. The couple is now ready to leave for New Jersey, where she obtained a contract in a big hospital. This time, they will take the child with them.

It is worth noticing that Teresa's husband, Nirmal, who works in the tourism sector, is himself a pure product of the migration culture of Kerala. His parents met in Libya where both of them used to work, his mother as a nurse. Because of her profession, they were able to reach Germany in the late 1970s with the help of Protestant missionaries. During his childhood, their son was living between Germany and Kerala (where a paternal uncle used to take care of him), while his sister stayed with the parents in Düsseldorf and eventually married a German. Nirmal's parents today hold German citizenship. He thinks that he could himself get it if he wished, as he was born in that country and speaks the language perfectly. Like many Indians, he is polyglot, fluent in six languages. But Nirmal and Teresa think that it would be better for them to live in the USA, in particular when they imagine the future of their children. According to them, emigration to an English-speaking country would be a less radical split with their native country. Nirmal, who has always lived between different countries, feels particularly concerned by this question, more so than his wife, for whom these aspects of migration are still an abstraction. She admits herself that she just knows how it is in the Gulf and that 'everybody knows that it's completely different when you live in a Western country.'

In January 2004, I was invited to the wedding of Swaya, a 25-year-old nurse, just coming back from three years of work in Saudi Arabia. She had been working there in a small hospital in Damman where she got a contract at the same time as two of her best nursing school friends. Their stay in Damman had been quite difficult, involving a financial deception, since the contractor that gave them the job 'forgot' to specify, first that he was taking 30% of the salaries paid by the hospital and secondly, that there were no paid holidays for this three year contract. So they stayed in Saudi Arabia for three years without coming home. Conditions must have been harsh, since all the nurses of their hospital went on strike three times. Nevertheless, the three young girls, even if they were not entirely happy about this country and its people, also keep good memories of their job in a very modern hospital and of their life in the hostel where they used to live. They like in particular to tell stories of the happy parties that their Filipino colleagues used to organize regularly. In a certain way, these three years of migration seems to have been like a prolongation of the life they had when they were studying and living together in their Delhi nursing school. Yet, the three of them decided not to renew the Saudi contract, though it would have been possible.

Like her two friends, Swaya is a Hindu Ezhava. I first met her one week before her wedding when one of her friends invited me to visit her to see the dowry jewellery
(nearly 400 grams of gold in the form of bangles, necklaces, and a belt) and the magnificent silk saris offered by the in-laws. Swaya affirms that her family offered a dowry of 250,000 Rupees. Her father is a part-time accountant clerk in the local administration. He earns 3,000 Rupees and runs in addition a farm of three acres, but Swaya has two sisters who are still to be married and only one brother, working in an Indian shop in Fujeirah. Swaya’s groom, 33 years old, lives himself in Saudi Arabia where he has been working for the last seven years as an engineer in an American oil company. She has met him only twice, because he came back from the Gulf only 10 days before the wedding, but her friends state that:

He has a good reputation. People say that this is a hard worker and he makes good earnings. He doesn’t smoke nor drink. He comes from a good family and his mother seems to be a nice woman [. . .] His sister’s husband runs a big jewellery shop in Trivandrum, the capital city of Kerala, and there is only one sister left to marry [which means that there is no need to save a lot for dowries in this family].

Swaya worries a little bit because he was not very talkative during their two meetings, but her friends comfort her, saying that he must be shy and that a man living alone in Saudi Arabia for so many years can only have lost the habit of chatting with women. However, Swaya wants to follow him as soon as possible and to continue there to follow the courses for the CGFNS that she just started in Kerala. ‘I hope he will allow me to do so’ she says, because she would very much like to live in the West: Australia, the USA or the UK, she does not care where. Her friend insists: ‘She is right. You can’t spend your life in Saudia. Those Arabs are not good people; you have no freedom there. It’s OK to start, but after a few years, it’s better to try another place’. But they are not so sure that the future husband ‘will allow’ a move, since he has such a good job there. On the wedding day, the husband, a fat man who does not smile easily, does not really seduce the friends of Swaya and they worry a little bit: the groom’s young sister is leaving for Chennai to study and somebody would have to take care of the widowed mother; they fear that it would be the role of Swaya, since the groom has not said clearly that he intends to take his new wife with him and that he is going back to the Gulf after one week. It seems that there is no way to ask the question directly to the husband or to any in-laws.

Two months later, Swaya has left to join him in Jeddah. The in-laws did not hesitate for long to make their choice between the potential salary of their new daughter-in-law and the necessity of somebody taking care of the mother, who now lives with a nephew. According to her friends, who chat with her through the internet, Swaya has already told her husband about her plans for the West and the idea of the Green Card seems to move him, but he is still not convinced to get a job corresponding to his qualification in the West, as he did in the Gulf. A friend of Swaya comments: ‘She loves him, but he is too serious. He is not the type of man who can accept easily to see his wife earning more than him. He is too proud...Swaya is always on the net trying to prove to him that there are also opportunities for him in Australia or in America’. Yet he has accepted that his young wife goes on with her CGFNS courses.
New Generation, New Aspirations

From these three examples, very representative of the new generation of migrant nurses or candidates to migration, different important aspects can be pointed out. First of all one observes that, for all these young women, migration is a clear and evident objective. This has to be understood in the wider context of massive migration from Kerala to the Gulf countries. It has also to be seen in the global Indian context where international migration and the existence of a huge diaspora in most parts of the world (the UK, the USA, Australia, East Africa and Singapore) is accepted, by the Indians themselves, as proof of their people’s capacity to adapt and prosper anywhere. The NRIs, Non-Resident Indians, as they are called in India, are seen by most Indians as a lucky sort of citizen, who in a certain way get the best of both worlds: an Indian cultural heritage added to the material advantages of more prosperous countries. Moving to another country, at least for a few years, is therefore a goal that a lot – if not the majority – of Indians consider as highly profitable. Indian cinemas as well as literature, which depict again and again Indians in-between two countries and two cultures with all the conflicts, happiness, freedom or contradictions engendered by migration, largely reflect this tendency. The young nurses or nurses-to-be are well aware of all these aspects and consciously follow this path. For them, to become a nurse is, first of all, the passport for this way of life, a fact that all the principals of nursing schools acknowledge. One of them attests:

More than 90% of our students do choose this job because their plan is to work abroad. It used to be different 20 years ago, but there are so many migration opportunities now. It is a problem for us because we know very well that vocation for caring is not their first interest and we worry about the quality of the nurses we are actually training. It is also a problem for Indian hospitals because we have a large turnover in our staff as so many nurses are ready to leave at any moment. . . . On the other hand, this migration phenomenon has a good impact on the way this profession is now considered, socially speaking. . . . We nowadays have students from social categories that used to be very rare before these migration opportunities, like young Hindus or even Muslim girls and we think that it’s just the beginning. Nurses used to be considered as a sort of servant; now that’s the technical and modern aspects of the profession that people underline. The stigma on this profession is disappearing little by little with each new opportunity appearing abroad.

Actually, Indian nurses have been working in the Gulf, and in much smaller proportion in the West, for more than 30 years now, giving time to the new generation to set up a planned strategy based on the experience of the pioneers. In India, and more especially in Kerala, women in migration are a minority, but for the young nurses it does not seem to appear as an adventure as it can be for unqualified women, vulnerable to every sort of exploitation. As qualified recruited staff, nurses know that they will have quite good conditions of work and life in the Gulf or anywhere abroad and that bad experiences like false contracts, harassment and bad salaries, are rather uncommon when it comes to nursing. Being a nurse in India, they are sure to find a job which is already a good thing in Kerala, where the unemployment rate is very high, but they will only be earning
2.500 Rupees at the beginning, ending up at 10.000 Rupees if they are lucky enough to get a job in a government hospital. However, if they reach the Gulf, their salary may directly rise to 40.000 Rupees, a very enviable position when most of the other workers there earn only three to four times more than in Kerala.

Status, Dowry and Wedding

For young migrant nurses, saving a little bit of money and seeing other countries (which they are often eager to do) is not the only ambition which propels them to migrate. In fact their migration plans also have much to do with social status and wedding prospects, as appeared in the story of the three young girls above I gave as examples and in the quotation of the nursing school’s principal. Contrary to the Philippines, nursing used to be considered as low-status work in India. Consequently, the wedding opportunities for young single nurses or nurses-to-be were not very satisfying, particularly in the hypergamic tradition that prevails in India. Jenna, a 50-year-old nurse whose ‘just married’ niece was currently living in Dubai and preparing to leave for Australia with her husband, explained to me:

“Twenty years ago, there was no respect for nurses. People were gossiping because we have to touch men in our job and they used to give us a bad reputation. When I got married, my mother-in-law told my husband that I should resign for the dignity of the family. But today, nursing is a job where there is no unemployment and, most of all, that allows you to go to the Gulf or to America itself. So even good families are now looking for nurses as a bride. In my generation, a nurse was lucky to marry a technician as I did; today they can even marry a lawyer, as my niece did.

Shoba George (2000: 152), in a study undertaken on Indian nurses who have emigrated to the USA, partially confirms this opinion, saying that ‘girls with a good family background are in such demand that they get “booked up” while still in school’. The recent ‘attraction’ for nurses can also be checked out in the matrimonial advertisements of Indian newspapers or specialized internet sites where the phrase ‘nurse wanted’, namely ‘nurse working in the Gulf will be preferred’ appears regularly.

The chance to get a ‘good husband’, which in the Indian context means a husband chosen by the parents, coming from a well-known family and with a good education level, is an issue that came up again and again in the discussions I had with the young nurses. To be ‘in high demand’ has another consequence that all of them are pointing out: it allows to reduce the price of the dowry asked by the future in-laws because, after the wedding, the earnings of the bride, as an actual or potential migrant, will come in addition to the in-laws’ income. Actually, a migrant nurse brings not only more money, but she offers a way for her husband to migrate, as she can get a visiting visa for him at first, which ends up generally in a work permit; once in the Gulf, the husband has three months to find a job. The migration chain has thus started and other members of the in-laws’ family may follow this path. Another advantage of marrying a migrant nurse in the Gulf is her ability to borrow money if she is employed in a government hospital. This money may then be the capital which enables the husband to start a
small business in migration, a strategy that the geographer Philippe Venier reports as quite common in the Emirates. The families prospecting for a bride are perfectly aware of these advantages, as are the nurses’ families.

For the latter, generally coming from the ‘low middle class’, as they describe themselves, the price of nursing studies is nevertheless a major stress. They often have to borrow money for this, most of the time from a family member, sometimes from a bank, in order to pay for these three years of study. So when parents pay for the nursing study of a daughter, they consider it as an investment that the girl is supposed to largely pay back once she is a single migrant (nowadays during two to three years generally), either by sending money to her parents or by saving herself for her dowry and by buying in the Gulf – where it is cheaper – the gold jewellery that has to be given at the time of the marriage. To say it cynically, the ‘burden of having a daughter’, as it is often said in India, turns out much lighter if she is able to get a nursing diploma. In that sense, the decision to become a nurse cannot be considered as the result of an individual decision of the young girl alone, but much more like a collective decision of the family in its efforts to climb the social ladder.

The New Aspirations of Young Keralase Women

Young nurses take an active part in the social mobility strategies that their parents, in the sense of the extended family, are building up, but at the same time their major motivations are more individualistic. Their dreams as ‘young modern women’ follow a new model in which the traditional joint family has rather little space. Sonia, a 27-year-old nurse who has been working for three years in Muscat and got married a year earlier, comments:

In my native country, it is very difficult to have a personal life and it is worst if you are a woman. Everybody wants to decide for you, everybody knows what is supposed to be better for you. That is not that you have no freedom, but everything has to be discussed with everybody: the way you dress, the way you spend your money, the time you spend with your husband. . . . On everything not only the family members but also the neighbours may give their advice. It is something very hard to bear when you are educated, when you earn your own money and once you have even been able to live alone in a foreign country as I did. . . . That is why I imagine that it will be difficult for me to come back home one day. Familial solidarity is a good thing that you, Westerners, have too much forgotten, but it doesn’t mean that everything must be shared. I told my husband that there is no way we will live with his parents if we come back. I don’t feel either that I would be able to live again in a village with the neighbours gossiping because I put on some lipstick or wear high-heel shoes. I also don’t want to spend all of our savings to pay for the study of a cousin’s son or by contributing to the dowry of an auntie’s grandchild. ‘Small family is happy family’ as we now say in India: I want to live with my husband, and the children we will have, in a nuclear family. I think that all the decisions which have to be taken about the way we live, the country we live in or any other big decision have to be decided by both of us, with nobody interfering. . . . Of course, it is easier for a woman to give her voice when the in-laws are not around. That is a big advantage of living abroad, this couple life.
Nurses are not the only ones in Kerala to prefer the idea of a nuclear family. The majority of young people may have the same feeling. Actually, the new model has become a reality for many people, in the cities particularly and joint family *stricto sensu* may very well be about to disappear. Yet ‘large family’, in the sense of a constant interaction between the different members of a family, be they parents, brothers, sisters, uncles, or cousins, is still the norm; the potential and socially admitted interferences of all these in-laws (among them, in the first place, the mother-in-law) are more and more difficult to bear for young women who wish to get more autonomy and agency. As social pressure to maintain the traditional norms is strong, migration appears as a solution for them, since by being far away they may partly realize these aspirations without having to fight on a daily basis. It would be exaggerated to say that economic motivation has disappeared from the migratory goals, but in the case of the young nurses it is just one of them, and not the most important anymore.

**New Migratory Plans: A More Complex Circuit**

The migratory plans of young Keralese nurses, which started with a stay in the Gulf and ended up in a western country, come to reinforce this hypothesis, since the young women are not at all naive and know very well that the chances are that, by following their plans, they will never come back home. In their case, if economic reasons are still cited to explain migration, it is never a question of surviving but more of having access to the best possible things, be they housing, good education for the children, or a retirement pension. Consumerism is also a strong motivation for young women who are quick to speak about all the goods more easily available once you do not have to take care of too many other people. For them, the best place to get all of this is the West, but being realistic, they know that it is difficult to escape the Gulf option. It is indeed the easiest door opened to them, because you can work there with an Indian nursing degree and some experience. To pass the TOEFL or CGFNS exams then means an added investment of time and money. The Gulf is nevertheless still very attractive because, besides saving money for the ‘real future’, as some of them stated it, speaking of their future in the West, these first few years spent in migration will allow them to secure a nuclear family type of relation with a husband less affected by the traditional familial and social pressure. In this couple relation, young nurses are very conscious of their power, in that they can often provide the open door to migration for their husband and will be the ones to give the entry key to the most wanted western destinations. Seen as a first step and a place from where you can come back and go again if needed, the Gulf operates and is perceived as an initiation to migratory life. It is the time where you learn to live far away from your close ones, where working as a single woman for the first time you gain autonomy and self-confidence, where you get used to living in contact with foreign people, without having done a definitive break with your home country, since the Gulf is still not considered as a place where it is possible or even desirable to settle down. As a passage, the Gulf is not frightening at all for the young nurses who know plenty
about life there, through the stories of other Keralite migrants and, more especially, from the first generation of migrant nurses.

**The Pioneers: Learning Migration, Learning About the Gulf**

Bindu, who arrived in Fujairah in 1981, told me:

> It was only possible to bear this life [in the Gulf] by counting the days before coming back home. We had a one or two year contract and most of us were thinking of going back as soon as possible. Yet, as we were not spending a cent on us, we were proud to be able to send so much money to the family. I was earning 10 times more than in India, more than my husband and his two brothers put together in their business. I was even able to send some money to my own family. . . . In India, my salary was just helping. In the Gulf, it could change my entire life. But it has been so hard.

I was told the same story again and again when I interviewed nurses who emigrated before the end of the 1980s. At that time, the migrant nurses were all married women with children, who went alone, leaving their family behind. Their social background was the same as of today’s young nurses (the father a small farmer or clerk in Kerala, the mother a housewife, and belonging to the first generation in the family to have access to higher study), but for them, migration was just an economic opportunity and not, like today, an objective strategy. Their life in the Gulf was strictly confined to the compound of the hospital until, much later, husbands started to join their wives in migration, following the massive migratory waves of Indians into this area by the middle of the 1980s.

Maryama is another example. She is 59 years old and now retired, living in a large mansion with marble floors and stairs in a suburb of Kochi, to which I have been invited extensively. The house is big enough to lodge the family of her sons, in case they should one day come back from the USA, where both of them are now living with their wives and children. Maryama is a pioneer of the nurses’ migration to the Gulf since she arrived in Kuwait in 1977 and stayed there until the Iraqi invasion. She was part of one of the first batches of Indian nurses hired for this region and has been a witness of the Kuwaiti developments during her 14 years of emigration. Before leaving for Kuwait, she was already used to living far away from Kerala, since she was married to a man working in an airplane company in Delhi:

> In the 1960s, it was not very well considered to work as a nurse and since my husband had a good salary, I stopped working as soon as I got my first child. . . . But life is very expensive in Delhi and since it was easy to find a job with my qualification, I started again to work in a government hospital in 1974. Then my husband came to know that special planes were reserved in his company to transport nurses to the Gulf from Bombay. We thought about this opportunity and I started to check newspapers for information about it. Then a cousin of mine who is also a nurse and lives in Bombay told me that recruiters were offering good proposals there. She already had a few friends who had left for the Gulf and, from the news she got, salaries and conditions of life were OK. That is how we decided that I should try. . . . But nobody can imagine today how it was to go there at that time. Now it seems quite normal that a woman leaves alone to work abroad, but
for the first of us, it was a real adventure! Because, if you take the case of Kuwait, there was absolutely nothing there: Kuwait city was not even like a small town of Kerala. For me, coming from Delhi, it was like another planet. The first weeks, I was crying all the time, I was afraid of everything and I was missing my children so much. Life was also awfully boring. Besides working, there was nothing to do but writing letters and waiting for the answer.

When Maryama left for Kuwait, her idea was to stay there for three years. Her main goal was to save enough money to pay for higher studies for her three children (in the West, if possible), then it was to buy some land in Kerala to build a house one day. In fact, after three years, her husband came himself to work in Kuwait, bringing with him the two younger children. In the Gulf, a woman cannot get a family visa; only a man with a work permit can do this. From there on, she described their life in Kuwait as very nice:

Year after year it was becoming better. More and more people were arriving from India and Kerala and it was possible to have a real social life. We had good friends and a nice apartment. We were not rich but very well off. The children were attending an American school and were doing well. Since my husband was working for Kuwait Airways we had free plane tickets, so we used to come back to Kerala on holidays more often than we ever did when we were living in Delhi.

To end up, I was sorry when we had to come back because of the war. My husband went back in 1992, but I was too old to start again, so this time I decided to stay home.

She considers herself mainly responsible for the familial achievements since she was the first to migrate, opening the way to her husband, and she is proud of this, claiming that they are now ‘a very respected family in the neighbourhood’. Her only explicit grief is that the two sons may probably never come back to live in India and that her grandchildren may become too American to respect the ‘Indian traditional values’, but she concludes that ‘that’s the price of ambition’. In fact, she also finds that life is quite boring in Kerala once you have been used to a more cosmopolitan life. Now she and her husband go twice a year to the USA to visit their sons.

This boredom is common to most of the ex-migrant nurses I met. The norm is that migrant nurses do not work anymore once they have been working for more than five years in the Gulf. Indeed, the building of a house is one of the first clear indications of success: to start again as a nurse in India for 3,000 Rupees means that there was a failure somewhere. That is obviously the case, as shown by the small number of ex-migrants I was able to find in Kerala hospitals. Almost all of them were women who had met big troubles in life, like a divorce, serious sickness of the husband, or bankruptcy of a business.

It is clear that for most of the migrant women, more than for male migrants who at least have real projects to conduct once they are back, it is difficult for nurses to readjust to Kerala’s social life. The oldest see it as the problem of any retired woman, but for the younger ones under 50, it leads to building new plans of migration, whether realistic or not. This shows that, once you enter migration, it becomes very often an endless process.
Life in the Gulf: Despised Autochthons and Scorned Migrants

According to the stories told by the oldest migrants or ex-migrants nurses, this nice aspect of the ‘cosmopolitan’ life in the Gulf paradoxically appeared when the Gulf started to be very ‘Indian’ and even ‘Keralese’, roughly from the middle of the 1980s. It has to be understood that nurses in the Gulf – and Indians in general – do not have a lot of relationships either with locals or other migrant communities, except perhaps with Filipino nurses. Their feelings about Arabs of the Gulf are indeed very bad. Women who are today over 45 years old of the ‘first era’ of Indian migration to the Gulf, some of whom have remained there ever since, continue to provide this negative impression of people in the Gulf countries shared by all the nurses I met have:

You can’t imagine how it was. Only rich people knew what a hospital is because they used to go to Bombay if they needed to. But the others were afraid of everything in the hospital and, of course, they were not able to speak a single word of English. I remember a woman who was delivering and needed an episiotomy [a common operation to facilitate a difficult delivery]. She was shouting, my God, but she refused to be touched, so the baby died. (Mary, 48, who still lives in Dubai)

There was nothing. Muscat was almost a village. No highways, no high buildings, just a few shops and just a few foreigners. Today, it is possible to shop exactly as if you were in Trivandrum because Malayalis have so many shops. There are Indian schools, Indian theatres, TV and newspapers, and there are Indian churches. But when we arrived, it was just a desert. (Beejee, aged 56, who is back in Kerala)

They don’t like Indians, they are really racist. For them, we are just slaves, just good to work and nothing else. . . These people are totally uneducated, they are not even able to do things by themselves. Here it’s the foreigners who have done everything and they are still the ones to work and build and manage everything. . . Do you know how it was here 20 years ago? Nothing but a desert. . . These Arabs, they have just been lucky to have oil, otherwise they would still be walking behind their camels!. (Lethika, aged 45, back in Kerala after several years in Oman, in-between two contracts)

The Gulf is not done for family life. . . . Can you imagine having your children studying here? Who has heard of Abu Dhabi University? No, here you can maybe have your children as long as they are small children. Then they must go somewhere else. . . . One of my sons is doing a Master at JNU [Jawaharlal Nehru University] in Delhi, that’s a good university, and my daughter is completing her PhD in the UK. You can’t compare to what they offer here. (Jenny, aged 52, working in Fujeirah)

In short, the migrants, and especially Indian migrants as they are working at every stage of the job hierarchy, assume to have been the ones to ‘civilize’ the countries of these Bedouins (the most common term when speaking of the locals). There is consequently a sentiment of frustration that all the Indian nurses, from the oldest to the youngest ones, experience about being under the orders (at least administratively) and at the mercy (legally) of the natives with whom there is no social integration and for whom they do not feel any admiration or respect. All of them underline what they see as a big difference with migration to a western
country, including those who, in spite of everything, have been in the Gulf for more than 20 years, a difference that Beemole, who has been working in the Emirates since 1982, explains this way:

You can’t feel at home here, never, even after years and years, even if now we have everything to live like in Kerala. Because we have no rights: Just the right to work and keep silent.

Her eldest son, born in Dubai, has been trying in vain to get a visa to visit his parents in the Gulf from Bangalore, where he is a PhD student in economics. Moreover, Indian nurses emphasize that the only relations they have with the local people are professional relations. Only two women out of all those I interviewed had been to a local home, at the time of a wedding. Another sign of the actual lack of relation with locals is the very small number of nurses who are able to speak Arabic, even if they have to follow two months of language courses once they have been hired by government hospitals. They generally state that ‘[w]ith the doctors, one speaks English and with the patients, body language is enough’.

No way to get citizenship, no way to build a house, to be the owner of a business, no good study opportunities for the children. In brief, until now, life in the Gulf could only be thought of as a passage before coming back home. People in Kerala are indeed well aware of this difference with a migration to the West, particularly parents of young nurses. Several principals of nursing schools in Kerala have incidentally mentioned that the parents rather push their daughters to migrate to the Gulf countries:

Even if salaries are better than in the Gulf, they know that a migration to the USA or to the UK means very often that their daughter will settle there. They imagine their daughter marrying an American boy, they think that they will never know their grandchildren and they are afraid of that.

Life in the Gulf as Christian Keralase Women

While migrant nurses make it clear that they do not like Gulf natives, the evolution of the population structures over the last 20 years has totally changed their way of life in these countries. The mutual dislike of the locals and migrants does not appear as a daily problem for the nurses who, besides their duty time, live now in a quasi-Keralase environment. In most cities of the Gulf, one can now find Indian shopping areas where the majority of shopkeepers come from Kerala and where you can find exactly the same products as in Kerala. A lot of city areas have now an almost exclusive Keralase neighbourhood, as for example the district of Ruwi in Muscat. It is also possible nowadays to find Keralase newspapers (printed in the Gulf), cinemas, churches, temples and Indian schools where Malayalam is taught as well as Hindi.

All of this seems like a huge gulf between the rather austere life of the pioneer migrant nurses and the life of nurses arriving today. Even the single young women who stay in the hospital hostels may have a social life outside for shopping, meeting friends or family members or by taking part in the parish life. In some places, like Dubai, social events may be even more abundant than in Kerala itself with the frequent coming of Indian or Keralase actors or singers, premieres of
Indian movies and other functions. The liberalism prevailing particularly in the Emirates, but also in Oman or Kuwait, allows people not to change Keralese habits, be it to wear saris, to practise one's religion, or to offer alcohol to male guests. And anyway, the home country is not very far and very accessible, as is obvious from looking at a map of air connections between the three international airports in Kerala and all the possible destinations in the Gulf. For those who, like the nurses, have good earnings, coming back home for any important occasion is not a problem, even if most of them choose not to go too often in order to save more money.

Nevertheless, for these women, there is a big difference with life in Kerala on a very significant point: motherhood. Almost all of them return to Kerala for delivery, at their own parents' home, thus following Indian traditions. Thereafter, those who live with their husband in the countries of emigration return with the newly born baby; those who live alone have no other choice but to leave the child behind. Most of the time, they manage to take three months maternity leave at the time of their delivery, but I have met several mothers who had to go back leaving behind a baby hardly a month old and who talk about the heartbreak it means for a mother.

All scenarios then come up for children of emigrant parents in the Gulf. When it is possible (normally when both parents are working in the same place in the Gulf and they found a way to keep the children with them), small children live with their parents. If any problem occurs -accommodation, transfer of the father or more often guardianship problems– the children will be sent back to India. It is thus frequent that the children stay alternately on either side of the Arabian Sea. Nevertheless, as soon as they reach adolescence, the children invariably return to India to pursue their studies, often in reputed and expensive boarding schools that flourish in Kerala particularly in the regions of Christian emigration. So emigrant nurses often find themselves in a situation of ‘part time mothers’, in their own expression. This is a source of suffering, even if they do not worry about the well-being of their children left behind, trusting other women of the family who are taking care of them, most often a sister-in-law or a mother-in-law. It is nevertheless felt as a chaotic familial life, a direct result of the way things are working for migrants in the Gulf. Comparison with migration in the West systematically comes up when the topic of children is discussed. Once again, it is pointed out that there is no way to settle down in the Gulf for good, since even children born there will not easily get a visa once they are grown-up and because retirement is also theoretically impossible there.

Actually, this could very well be a period of transition, since the new trends of Gulf migrant policy could soon give more opportunities, at least for well-off migrants, to settle in a more permanent way, in particular by allowing ownership of houses. Some fears of the migrant nurses seem thus unrealistic like, for instance, concerns about ‘emiratization’. At least in the Emirates, where Indian nationals are estimated to be 5% of the whole population (Battegay, 2002: 111), there is no way that the country could be run without migrant labour, while in others countries, like Saudi Arabia, the local nursing training rate is too low to form a real competition for Indian nurses.
Besides their disdain of the locals, the feeling of precariousness and the frustration concerning the children, nurses nowadays rather appreciate their life in the Gulf. A lot of them have extended their stay for much longer than originally planned without real complaints, except for one country: Saudi Arabia. Being women and Christians, they are doubly affected by the laws of this country. To work there, ‘it’s like being in jail’, I was told all the time by ex-migrant nurses or by nurses on leave that I met in Kerala. They stress prohibitions to leave the hospital compound when they stay in a hostel, with the exception of the official shopping outing they may have, at the maximum twice a month, under the control of a male local driver and, of course, wearing the long black dress that all the women there have to wear outside (except western women, as they remark). They have many anecdotes to tell about the ‘punishment’ they get (generally a public sermon at the hospital or a deduction from their salary) by not following the rules exactly. If, for example, they speak to a male compatriot, if they are a little bit late to come back to the bus which transports them, or if they laugh in a shop. Women living in town with their husbands also perceive the prohibitions on a woman going outside alone like a feudal law. Dina, aged 36, who has been living in Jeddah for 10 years, said:

Can you imagine that you have to wait for your husband to do everything? You can’t go by yourself to pick up the children at school, you can’t go to the nearby shop if you have forgotten to buy something you need for your cooking, you can’t go to help a sick friend. . . . That’s impossible to get a real social life there because you have no freedom.

But most of all, the nurses resent interference in their religious practices. Since, being generally very religious, they cannot even imagine not to pray and not to gather to pray and to celebrate the major events of the Christian calendar, they feel like living all the time on the verge of illegality, thus susceptible to be thrown out at any moment. On this topic also, many anecdotes are circulating, like how X or Y was taken into custody because of a bible found in her suitcase at the airport or because of a small jewel cross worn under the duty uniform or also how the religious police usually patrols an Indian neighbourhood on Christmas eve, trying to find houses where carol songs could be heard. Some of these stories may be rumours, and are very difficult to check, since it is almost impossible for a researcher to officially conduct a survey on migration in that country, but these are clear signs of the frustrations that nurses experience by living in Saudi Arabia.

In brief, it is possible to argue that for the nurses at least, there are two different Gulfs. A first one is represented by the Emirates, followed by Kuwait, Oman, Bahrain and Qatar which, in that order, are nowadays considered as places where it is rather nice and enviable as Keralese to live for a certain time, altogether because of the conditions of work or life and because of the salaries you get there. A second world is Saudi Arabia, where you may have to go, if that is the only place where you have been able to get a contract when you enter migration, but where life is difficult for migrants and where you get the lowest salaries.

This hierarchy among the potential migration countries in the Gulf is well known in Kerala and there is also the biggest prestige to earn by working in
Dubai, the top place in the Gulf for Keralse people and more generally for Indians, than by working in Jeddah or Riyadh. It is thus quite frequent to see young nurses who secured a first contract in Saudi Arabia coming back home as soon as this contract ended, to look for a better contract in another Gulf country if they are still not able to try employment in the West.

Conclusion

After two generations of migration, Keralse nurses have now enough collective experience to know what they can expect by leaving their country to work in the Gulf. They know that they will have to pay a price as a mother, but considering the Gulf as a first step for a further migration to the West, they also see more advantages than possible griefs in taking that path. As women, to become a nurse in order to migrate, remains a viable way for them to secure more easily their aspiration to live as a nuclear family without the social and familial pressures that exist back home. By ‘nuclear family’, they mean of course to stay with their husband and children only, but also – more importantly – to save as much as possible of their incomes for the couple’s needs and for the future of their children, a goal that young men are not so far behind to share. This more individualistic approach to life may be a source of tensions since, like all migrants, they are supposed to contribute to the larger family’s prosperity. The fact remains that, in order to become a nurse and to pay for the initial migration expenses, young women need the help of their own family. However, by contributing largely to save themselves for their dowry, they feel in a certain way like not being in debt anymore. However, when it comes to in-laws, things are more difficult to negotiate, since the latter are often needed during the first years of a nurse’s migration, especially to take care of the children; it is indeed an obvious acknowledgment of the larger family’s necessity. The ‘remuneration’ of this service, with its affective aspects, and the feelings of debt which it induces, certainly create problems to most of the migrant nurses, which is also why the western opportunities seem so attractive to them.

Yet the West is still more difficult to reach and the Gulf, if not perfect, is nevertheless synonymous with a better familial and social status. Moreover, the evolutions, which have taken place in the Gulf countries during the last two decades, most importantly with the emergence of a sort of Keralse diaspora in Dubai, Abu Dhabi, Muscat or Kuwait City, have totally changed the life of the migrant nurses. From the rather austere way of living it used to be, enclosed in the hospital compound, it has more often now become a metropolitan experience, corresponding much more with the aspirations of young middle-class Keralse women. The Gulf is no longer seen as a hard and painful task, but as a rather nice passage to a still better future.

Some scholars (for instance Gulati, 1993) argue that male migration already gives way to more agency for the wives living back home. It can additionally be ascertained that migration of women themselves, at least when they are qualified,
induces a stronger evolution in the social and familial structure, an evolution radical enough to make it difficult for the women to readjust to traditions in their own country on return. The migration of nurses thus cannot be considered anymore as a temporary migration, but has become a lifetime process with significant implications. The Gulf line has offered initial opportunities for Keralese nurses to define new aspirations. It still plays a key role in their current life strategies and should play it for a long time, since the Gulf has become the first place of the Keralese diaspora. But increasingly, a placement in the Gulf has become a stepping stone for a whole new style of life in the increasingly global Keralese community.

Notes

1 This is an estimate which seems probable if one crosses the total number of nurses in the Gulf with the proportion of Indian nurses I met in Gulf hospitals. There are no actual statistics concerning Indian nurses working in the Gulf, so the ones I give in this article come from my own sample.

2 This research is based on three phases of fieldwork of two to three months each in Kerala and Mumbai between 2001 and 2004. In addition, six weeks of fieldwork were also conducted in Oman and in the Emirates in 2002–03. I interviewed a total of 286 migrant women and women aspiring to be migrants: 120 nurses were interviewed in Kerala (when they were on leave or back from the Gulf), 111 in Oman and the United Arab Emirates (UAE). Fifty-five nursing trainees were interviewed in Kerala. Other people, such as nursing school principals, hospital matrons and preachers were also interviewed by myself. Eighty-seven interviews with the nurses (generally at the nurse’s home in Kerala or in their hostel when in the Gulf) were conducted individually; on several occasions these amounted to at least six to 10 hours of discussion. The remaining interviews were conducted with groups of three to six women. I was also invited to spend a few days (from three days up to one week) with families of 17 migrant nurses. The women I met were between 24 and 55 years old, the majority of them between 30 and 45 years; trainees, of course, were younger (19 to 22). I used an open-ended interview schedule, but on the whole the women were also quite eager to share their stories with me. I have changed the names of all my informants, though I use actual Keralese names or nicknames.


4 Among them are a certain number of nurses who arrived in the USA a long time ago (George, 2000) or in the UK, but the massive recruitment of nurses by western countries is a much more recent phenomenon.

5 They are claiming to be equivalent to Vaishyas, and certain branches of Syrian Christians claim to descend from converted Brahmans. For explanations of the Indian caste system, see Dumont (1966).

6 Indeed, Keralese nurses frequently mention Florence Nightingale and, most of all, Mother Theresa as sources of inspiration.

7 The Ezhavas are a Hindu caste, considered as low in the caste hierarchy. They represent the biggest community in Kerala.

8 In India, it is the family of the bride who gives a dowry to the family of the groom. In Kerala, the dowry rose to huge amounts, partly due to the money coming from the
migrants. For details on the Indian dowry system and its often tragic consequences, see for example Benel (1996) or Menski (1998).

9 TOEFL is the Test of English as a Foreign Language. CGFNS is the test conducted by the Commission of Graduates of Foreign Nursing Schools, an American organization. The first diploma is needed to migrate to any English-speaking country. The second is compulsory for securing work in the USA.

10 One acre equals 0.6 hectar of land.

11 55 Rupees are equivalent to one Euro.

12 It is worth noting that these arranged weddings are not really questioned. On the contrary, the ‘love marriage’ or ‘western style’ seems very precarious, as most Indians say, including young cosmopolitan Indians. The divorce rates in western countries are said to prove that ‘love marriage’ is not a good strategy.

13 The CGFNS seems difficult, as it is estimated than only 17% of the Indian candidates pass it on the first try.

14 I observed that in Kerala, more than elsewhere in India, English is more and more widely spoken. More and more children are going to private ‘English medium schools’, where they also learn Malayalam (the language of Kerala) and Hindi (the national language), but where most of the teaching is directly in English.

15 See below for further details on how these differences between migration to the Gulf and to the West are perceived by potential migrants.

16 ‘Contractors’ are taking on the job of labour importer; the salaries are then not paid directly to the employees by the societies employing them, but the money is given to the contractor, who deducts his percentage before paying the concerned employees.

17 For details on Filipino migrant nurses, see Davison (1993).

18 I thank Philippe Venier for this information. For details on the economic consequences of the migration in Kerala and on entrepreneurship ability, see Venier (2003).

19 This competition is so high that it is now very difficult to enter public nursing schools or colleges which are free, so most of the trainees have to follow their studies in private schools whose fees may rise to more than 30,000 Rupees per year. Parents also have to pay for lodging and boarding when, like in most cases, the school is far from the family home.

20 One could say that, in Kerala, hardly anybody believes today anymore in the ‘myth of return’ after the migration of young people to a western country.

21 Social mobility is also a strong motivation: a good sign of it are the plans that all the nurses I met have for their children (or future children). When they say ‘good education’ they mean higher education such as a PhD, if possible in the best world universities. Actually, the children of the oldest migrant nurses have very often obtained this type of education, be they girls or boys.

22 Except Dubai, which is in India almost considered as an Indian town. It is even possible to argue that the Keralese now consider it as a truly Keralese metropolis.

23 For details about the segregation between locals and migrants or between the different communities in the Gulf, see the example of Kuwait in Longva (1997).

24 An evolution is on the way in this regard since the Emirate of Ajman has recently started to allow foreigners to buy land for commercial purpose with the possibility to build a house nearby. For the general system of sponsorship and citizenship aspects, see Longva (1997).

25 Nurses often have their special prayer groups under the supervision of a local preacher.

26 Even if they do not feel guilty, as western women will surely do in such circumstances, since in the West the social norm is a lot more that the mother is the only one able to take daily care of her children.
27 Yemen has more or less the same negative reputation as Saudi Arabia and the Keralese consider it as a poor country where salaries are very low.

References


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