Centre on Migration, Policy and Society

Working Paper No. 90
University of Oxford, 2011

Nepali Nurses in Great Britain: The Paradox of Professional Belonging

Sondra L. Hausner

WP-11-90

Abstract

When they migrate to England for the sake of earning higher wages and gaining additional training in professional fields they enjoy, Nepali nurses have to overcome obstacles posed by UK employers, Nepali agents, and both the British and the Nepali governments, as well as contend with separating from parents and children. In the face of these many challenges, the aspiration to belong takes place not primarily in a social sphere but in a professional one. Prohibitions experienced *against* belonging are not reluctance from 'host country' nationals to allow integration, but state barriers to professional advancement, which do not tally with the actual dynamics of either labour needs in the UK nor the charted patterns of health care migration.

Keywords

Belonging, labour migration, elderly health care, nursing in Britain

Author

Sondra L. Hausner, Faculty of Theology, University of Oxford

sondra.hausner@compas.ox.ac.uk

Acknowledgements

A version of this paper will appear as 'Belonging and Solitude among Nepali Nurses in Great Britain' in *Facing Globalization in the Himalayas: Belonging and the Politics of the Self*, Joanna Pfaff-Czarnecka and Gérard Toffin, eds. New Delhi: Sage Publications. My thanks to both Joanna Pfaff-Czarnecka and Gérard Toffin for patiently encouraging the development of this piece, as did colleagues at COMPAS and the anthropology group at the University of Oxford. Radha Adhikari graciously explained the finer points of the subject to me; I also benefited from comments on earlier versions of the essay when presented first in St. Raphael, and then in Providence, Rhode Island at Brown University's Population Studies Training Center. David Gellner provided contacts and Bhim Laxmi Sakya offered first-hand knowledge. Martin Kaminer reminded me that professionals outside the academy might be interested, and Ben Eaton offered much care. All errors are mine alone.

The indicators of belonging are not solidly prescribed in any social science discourse, and perhaps they should not be. Belonging is a fluid and palpable experience that will by definition vary by subject and over time. With caveats about the dangers of rigid taxonomies in place, however, attempts to establish broad parameters of the experience of belonging – whether in the specific cases we describe here or scaled up to be considered possibly true of the human condition more generally – might be useful.

When they take on the formidable task of defining belonging, Pfaff-Czarnecka and Toffin argue that the experience encompasses (1) "performances of *commonality* … (2) a sense of *mutuality*… and (3) material and immaterial *attachments*" (2011:2). This essay builds on their project by suggesting that recognizing the exigencies of *location* – or locations – for these parameters grounds us not only in place but also points us toward what is invariably a transitive process between places. Seeing the global as rooted in the local – and then refracting outwards again – is a method recommended by Tsing (2000), who recognizes that our studies necessarily 'take place,' be they singly or multiply located.

The case described below charts local networks (or the relative absence thereof) in the global marketplace of healthcare providers, specifically nurses. Based on fieldwork with Nepali nurses in Britain and their families in Nepal, it regards how the fields of identity and belonging, singularly and collectively, are experienced and expressed in at least two sets of nation-state places. Each may be assessed as a distinct domain in a particular site, but there is also a fluid exchange and interplay between these categories across hemispheres.

Just as two locations of belonging are considered in this essay (Britain and Nepal), two methodologies are invoked: first, ethnographic observation offered material on the conditions of migration and work for Nepali nurses in the UK, and the kinds of challenges they faced as they tried to settle in – *belong to* -- a country that might *become* home (if they were lucky enough to jump through the administrative, financial, and personal hurdles they were to face), but that was not initially their own. Second, the piece contains a policy critique, in that an account of actual people's lives is shown to be at odds with government policies in both Nepal and the UK.[1] Policy landscapes genuinely aim to find the best solution to social concerns, but in this case, they do not tally with the real-life situation, and in some senses have made people's efforts towards "commonality… mutuality… and attachment" all the more intractable.

In demographic terms, Britain has an aging population pyramid, whereby a growing elderly population is projected to need increased geriatric care. But since the 1970s, fewer 'native' women have

[1] Both methods of research for the paper were limited: the ethnographic fieldwork for the paper is in some sense still preliminary, in that it consists of two years of occasional participation in Nepali community events in London and Oxford, a weekend in Norfolk, two visits to Kathmandu, and numerous visits to hospitals. And the policy landscape (for both migration and health care) is extremely fast-changing; the research for the article was done in 2008-2009, and the information was current in October 2009.

trained as the nurses and health-care providers the elderly need. Nepali women are among the top five nationalities who have migrated to Britain to provide this care. The point of the essay then, is to interrogate the experiences of belonging among Nepali professional women (and suggest that professional belonging should be included among relevant scholarly categories of identity, which in turn need to be multiplied by place), but also to demonstrate a sometimes damaging disconnect between well-intentioned efforts by the British government to enable a multicultural or pluralist society whereby we all belong, on one hand, and national health care personnel recruitment policies that precisely prohibit belonging, on the other. Nurses' accounts and experiences cannot easily be reconciled with the well-meaning goals of the UK public health services, however: ostensibly under the protection of nation-states on both sides of the globe, it is Nepali professional women who appear to bear the greatest burden of all.

Nepali Migration to the UK

In August 2008, the Runnymede Trust reported that 2001 UK census data counted almost 6,000 Nepalis in Britain (Sims 2008). At the time, community organizations estimated the number as close to eight times the census data, to number around 50,000. In July 2010, the Centre for Nepal Studies (UK) estimated over 80,000 Nepalis in the UK. Undocumented migrants from Nepal or anywhere will likely avoid those asking questions, but these figures may still give us a ballpark number of Nepalis in Britain; although the earlier figure clearly was underreported, we may also have some indication of the rate at which this figure has grown over the past eight years.

UK Nepali communities differ from the Nepali diaspora in other locations, as well as from other diaspora communities in Great Britain, in that UK citizenship was offered to retired Nepali Gurkha soldiers and their families in 2004. Many thousands of Nepali families have migrated legally to England, Scotland, and Wales. Some have been able to buy housing, one significant marker of belonging in any location. Gurkha communities continue to actively discuss fair and equal access to British government benefits, which are sometimes but not always forthcoming (Sims 2008); one successful lobbying campaign saw two new Buddhist lamas arriving to serve as chaplains alongside Hindu pandits. Battles continue in the British media about Gurkha pensions and retirement benefits and in the Nepali media (especially among expatriates living in the UK) about the possibility of dual citizenship – a campaign that should be understood as an insistence that some Nepalis belong in more than one place.

Nepali nurses – all women – migrate to the UK under difference circumstances than do Gurkha family members or university students: they are professional women seeking higher remuneration than they would receive in Nepal or India, and additional training and experience in a career for which they

are passionate. Close to 500 nurses from Nepal have joined the UK nursing register in the past five years (Nursing and Midwifery Council 2006, 2007, 2008); Adhikari estimates that a total of between 700 and 1000 Nepali national nurses are registered and working in the UK (2008b); many hundreds more have migrated to Britain and await full accreditation. All the nurses referred to in this paper were trained and qualified in Nepal.

In 2007-2008, nurses from Nepal made up the fifth largest number of foreign registrants with the Nursing and Midwifery Council (2008). Despite restrictions in foreign nurse recruitment, the number of Nepali nurses joining the Nursing and Midwifery Council's register annually has remained steady or even continued to grow.[2] When, in 2008, the total number of foreign nurses registering in Britain plummeted to half[3] the previous year's total for political reasons described below – and the number of registrants from other top-ten countries decreased by up to two-thirds – the number of Nepali registrants remained nearly steady (Nursing and Midwifery Council 2008). Given the dearth of professional nursing opportunities – and the salary levels for health care providers – in Nepal, there is no doubt that migration is the most appealing option for a Nepali nurse. In an interview last year with two nurses in west London, I was told that more than half – 26 out of 45 – of their graduating class from one of Kathmandu's most respected nursing schools (attached to Tribhuvan University's Teaching Hospital) had made their way to Britain.[4]

Although absolute numbers are small, the proportional representation of Nepali nurses in the UK Nursing and Midwifery Council register has dramatically increased in the past five years. Nepal did not appear in the top twenty countries of foreign registration until 2003; it is listed at number 15 in 2005-2006; jumps up to number six in 2006-2007; and was number five in 2008 (Nursing and Midwifery Council 2006, 2007, 2008). Apart from Australia, from where nurse migration is fully legal, and India and the Philippines, which have "government-to-government" agreements with the UK, Nepalis are second only to Nigerians as foreign nurse registrants in the most recent register (Nursing and Midwifery Council 2008). The number of new registrants from almost every other country has decreased during this same period. The cachet of migration in Nepal – along with the push factors of almost no work opportunities and extremely badly remunerated jobs – was such that Nepali nurses continued to come in higher numbers even though opportunities for foreign nurses to practice in Britain at the level of their skills and training were decreasing.

[2] 73 nurses from Nepal joined in 2004-2005, 75 in 2005-2006; the number doubles in 2006-2007, when 148 joined (Nursing and Midwifery Council 2006, 2007).

[3] This figure is still more significant when one bears in mind that the total workforce of qualified nurses, midwifery, and visiting health staff had increased by 25% between 1997 and 2007 (Bach 2010:93).

[4] Such a trend has justified the mushrooming of private nursing colleges in Nepal, who have an eye to training nurses for a global market (Adhikari 2008b), despite the legal and administrative obstacles detailed here.

Professional Belonging on a Global Scale: If you can't export your age pyramid, import global labour[5]

In Britain as in most of the world, nursing is an overwhelmingly female profession; in Nepal, it is exclusively so. Since the US and Europe's women's movement in the 1970s, other professional options have become available to working women in the West,[6] and the so-called "native" British nursing corps has diminished significantly. In addition, the United Kingdom, like every other state in Euro-America and Japan, has, for the past twenty years, projected a population that would age at a faster rate than it could likely support with its then-current number of elderly carers – especially since the same women who used to care for elderly parents at home were now usually working full-time, and not as nurses.

Looking at this wide demographic gap in the projected number of needed nurses, in 2000 Britain's National Health Service announced a recruiting drive for 20,000 foreign nurses, to be hired by 2004, which it subsequently met (Buchan 2007). The recruitment policy was astoundingly successful: within one year, more than 50% of new nursing registrants in the UK were foreign. Foreign nurses were the perfect answer to a demographic problem of fewer carers and a proportionately larger (and older longer) elderly population: migrant nurses appeared to be an unlimited labour force of already trained, often hardworking, professional women who would care for an aging British population; sometimes they were attractive and gentle to boot.

However, policies like those explicit in the Philippines – where the most talented nurses aimed not to work at home but abroad and were supported by their government to do so, in light of the remittances they would send back – gave way to public debates that exporting health care providers as global labour might jeopardize the provision of health care in home countries. The argument was, and rightly, that economic remittances in the south could not be considered sufficient compensation for the provision of health care in the north if it meant worse health care in the south. In those cases where a sizeable fraction of health care provider remittances was spent on family members' medical expenses in the home country,[7] the whole system would be shown up as for the exclusive benefit of the north.[8]

Concerns about ethical recruitment were such that the British government did not want to be seen as poaching global health care labour at any cost.[9] In 2004 (once its recruiting drive had been

[5] See Kingma (2006) on nurses in the global healthcare economy and Bach (2010) on migrant healthcare workers in the UK.
[6] Whether we refer to Europe and the US as the West or the North is a matter of convention.
[7] We know this to be the case for 80% of remittance recipients in Mexico, for example (Ray et al. 2005).
[8] See Portes (1976) for early work on brain drain.
[9] The Journal of the American Medical Association reports that a similar policy was under consideration by the American government recently (Gostin 2008); anecdotal reports suggest that it has already been largely implemented (personal communication with Nepali technician, NYU Medical Centre, New York August 2009). The US Department of Health and Human Services projected in 2002 that the government would need to recruit

completed), the Department of Health laid out clear "benchmarks for international recruiting" unequivocally stating that "[d]eveloping countries will not be targeted for recruitment" (2004:7).[10] The government also restricted the ability of employers to pay the travel or visa costs of health care professionals:

> "No active recruitment will be undertaken in developing countries by UK commercial agencies…or by any overseas agency sub-contracted to that agency, or any healthcare organization unless there exists a government-to-government agreement that healthcare professionals from that country may be targeted for employment" (Department of Health 2004:10).

The list of developing countries from which nurses were ineligible for recruitment was first published in 2001 and revised in 2004, after which the estimated number of nurses needed in the national health care system was significantly downsized (Buchan 2009). In 2006, nurses "were removed from the Home Office shortage occupation list" (Bach 2010:99). As of early 2009, every "developing" nation in the world was on the list, which included 151 foreign countries and exactly mirrored the member roster of the United Nations' list of developing countries. Exceptions – where bilateral Memoranda of Understanding between governments are in place – allow for recruitment in China, India, and the Philippines (except in certain areas and special cases).

Perhaps unsurprisingly, however, foreign nurse immigration to and registration in the UK has continued apace since 2004: quite apart from Nepali nurses, approximately 1000 new African nurses have registered in the UK every year since 2005.[11] In a span of three years (2005-2008), Britain registered more than 30,000 foreign nurses from all over the world. Once a call for labour migration is in place, a network of migrants routed on particular pathways (such as from Kathmandu to London) may be harder to stop than policy makers may realize.[12] Seven of the top ten countries from which newly registered nurses came in 2006-2007 were on the list of banned states (Nursing and Midwifery Council 2007). The only way a nurse could now come to Britain was "of [her] own volition" – meaning, in other words, if she paid for it. In most cases the costs would have to include the help of a private migration

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800,000 additional nurses by 2020 for elderly care in hospitals and in nursing homes (Gostin 2008:1827, based on HHS projections).

[10] Once again, Britain was the first country to lay out these guidelines, but the US may soon follow. Worried articles in the New England Journal of Medicine (Chaguturu and Vallabhaneni 2005) and the Journal of the American Medical Association (Gostin 2008:1829) call for "surveillance" of migrant health care workers, in the name of "human rights and global justice."

[11] The New England Journal of Medicine reported that 7000 nurses from Africa registered in the UK between 2001, when the list was first published, and 2005 (Chaguturu and Vallabhaneni 2005:1762).

[12] See Tilly (1990) and Massey et al. (1998) and for clear expositions of network theory in migration.

agent. In one swift move, the National Health Service downsized, privatized, and outsourced the costs of elderly care onto health care providers themselves.

So it is not exactly illegal to come as a nurse from a less developed country; you just can't be recruited by or work for the UK government or the British NHS. You're on your own. Or rather, you have to come on your own dime, pay your own way, remunerate the agent that places you, work in a private nursing home (or in palliative care rather than in a hospital at skill levels much beneath your experience), and be paid lower wages than your skills would merit. As citizens of states whose currencies are much weaker than the pound you will likely be willing to work for very little – especially as there may be almost no job prospects in your home country. You have to go through the market rather than the government, even though health care is nationalized. You want to work in a hospital, but you are limited to employment in a private nursing home because the hospitals can't hire you – and there is actually more need for palliative care for an elderly population, which, being brown and female, you are considered well suited to, although you may be a trained nurse with decades of experience.

The great irony of nursing migration is that professional women pose as students, and pay agents to facilitate their move, even though their skills are needed – solicited – by the British government. This construction, surely, constrains a foreign nurse's hopes of belonging. Indeed, according to the British government, she does not belong, either to the country in which she now lives, or to the national health care system in which she now works. All in her own best interest.

Departure and Arrival: Permission, Agents, and Visas

Unlike in the Philippines, where the government has intentionally trained and exported nursing labour, the government of Nepal has worried that sending women overseas might compromise their purity or endanger them. Nepali women could not travel abroad for work until 2001; the ban on travel to the Gulf was not lifted until 2006. Nepali nurses must seek permission from the Nepali Nursing Council to emigrate. In some sense, Nepali nurses have been stymied by both their sending and receiving governments, who appear to want neither to send nor to receive them in the name of their own protection.

Nepali nurses come to the United Kingdom as professional women, but they come on student visas, already a patronizing gesture. Nurses cannot come on labour visas: as we have seen, the UK government cannot formally or informally hire a cadre of Nepali health care professionals and labour visas to the UK are thus unavailable to them. Skilled labour visas (Tier 1 or Tier 2 visas in the UK; H1 visas in the US), administered through the central government, do not include nurses from third world

countries.[13] Other kinds of labour visas (such as for unskilled labour, including domestic workers) are tied to individual employers, who cannot directly recruit foreign nurses if they wish to be seen as complying with government regulations, and who in turn use not always responsible migration agents to find and place their staff. Agents provide a service to institutions who wish to appear compliant, and they cost their clients – the nurses, not the bureaucracy – a lot of money.[14]

Because only "professionals… who volunteer themselves by individual, personal application, may be considered for employment" (Department of Health 2004:7), most nurses who have migrated to the UK for work since these guidelines were put into place have paid private agents to enable their migration. But these facilitators are not always ethical: the formal ban on recruitment has left the field open for agents whose practices are not properly monitored and who often charge people exorbitant rates to migrate. Networks of private agents, adaptation colleges, and nursing homes have cropped up to fill the gap that government recruitment used to fill: agents now manage the migration, placement, and employment processes of a necessarily isolated individual nurse, who will pay high fees in order to be able to render services that are actually needed of her. Here, as in other cases, legislation designed to protect those seen as less fortunate does not remove barriers but in reality supplements hardship.

Nepali private agents who arrange nurse migration can remain the link to British government structures too intricate for the average layperson to negotiate even after several years living in Britain: for example, the gradual progression from student visa to work permit requires guidance and facilitation. It might seem odd that we are mired in a discussion of visa categories and migration management as they refract against belonging – visas seem so administrative, not related to questions of experience at all. And yet this is what my conversations with Nepali nurses focused on: where they had arrived into their professional worlds, as well as local hierarchies, and what obstacles remained to be overcome before they truly fit into – belonged in – the British health care system.

Belonging among Nepali Nurses in Great Britain

Let us create a matrix of belonging through three categories of experience: identity, network, and professional standing. We may consider these elements to indicate one's perception of self, one's links to others, and one's aspirations; they broadly represent what we know of social life and migration processes but they are heuristic variables or categories that are not intended to be exhaustive or fixed.[15] When broken down in this fashion, we see that belonging – or the attempt to belong – does

[13] See Sassen (1988) and, later, Vertovec (2002) on transnational skilled labour migration.
[14] See Ruhs and Anderson (2010) on the notion of semi-compliance to immigration regulations.
[15] The list is endlessly malleable: financial status, for example, could be an additional marker of belonging in a given location, or it could be folded into one of the three categories here. Mutuality, attachment, and commonality

not take place in a singular location but in multiple ones. That is, all three factors in Britain still operate in Nepal, and sometimes impact or are impacted by people farther afield too.[16] Belonging in each place affects belonging in the other. A belonging matrix for UK-based Nepali nurses thus poses three categories of experience – identity, network, and professional standing – in each of at least two places.

Identity/Britain

To start with, identity, that most elusive of categories, and in Britain: Nepali nurse identity in the UK seems first and foremost about being a… nurse. That my informants were Nepali, and in particular, Newar, was never in question, but the reason for and the focus of their migration to the United Kingdom was to practice nursing, their chosen profession. All were trained at well- regarded Nepali nursing colleges in the 1990s or earlier, and had worked in South Asian hospitals for extended periods of time, a decade or more. They travelled not to train nor to find work in the first instance, but to advance their professional experience and earn wages in hard currency doing so.

To say that their profession was uppermost in their minds does not denigrate other values or attachments. Being Nepali almost always meant attending Nepali diaspora communal events (such as Nepali New Year or *Dasain* celebrations), usually religious in nature; being Newar meant collectively celebrating *Mha Puja*, if at all possible. This pattern reflects our traditional understanding of belonging: a person's participation at such events can reify and reinforce a Newar communal identity, or a Gurung or a Buddhist or a Hindu one, even in a diaspora context. Participation, however, was dependent upon professional commitments: nurses often had to forego the social and culinary pleasures of collective *bhoj* or *bhway* because they were on "duty". Events were attended when a nurse could plan her work schedule accordingly, by negotiating leave on a particular day (or longer, for a ten-day festival like *Dasain*).

Natal families of unmarried nurses were sometimes viewed as support, but sometimes as the source of unwelcome pressure to return to Nepal and be closer to home. Marital families were also a core part of women's identities: for UK-based nurses with husbands and adolescent children in Nepal, part of the point of migration was precisely to give their children an opportunity to grow up in the West.[17] Sometimes a nurse might succeed in obtaining visas for her husband and children and the

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would at first glance fall within the collective or network category, but of course one's view of oneself (identity) or where one wants to be (aspirations or in this case professional standing) will impact which networks (family, religious, professional, regional) one cultivates or belongs to.

[16] One nurse's brother's migration to a European country other than Britain enabled her travel to Scandinavia.

[17] Partly for the sake of their children, women with jobs and well established in Nepal move away from their own natal families at a time when elderly parents might need care but for demographic reasons that are the opposite of why developed countries have projected aging populations – high fertility rates – women from Nepal and other

nuclear family might be reunited, even though the assimilation process would have to begin all over again for her dependents. To unmarried informants, the prospects of meeting an eligible Nepali man abroad appeared slim (we offered the idea of *shahdi.com* as one possibility but online dating did not appeal). One nurse did by chance meet and subsequently marry a Nepali man in Greater London.

If belonging depends on integral identity, one's category of citizenship or legal status (residence or permission to work) may also be important, as a way to ensure livelihood if nothing else. For all these professional women, identity ultimately appeared linked to structure: the National Health Service and the Home Office in Britain remained the obstacles to belonging in the UK. Between one and three years into a nurse's stay in Britain, she may graduate from a student visa (when she is permitted to work half-time) and qualify for a work permit whereupon she is legally allowed to work a full week.[18] This transition – from student status to formal work permit was described as an enormous relief – a significant lifting of "tension" – when a burden comes off the shoulders. Not only can she earn full-time wages but she can legitimately claim her status as a professional nurse in Britain, by registering with the British Nursing and Midwifery Council. Once a nurse is registered, she properly belongs.

Identity/Nepal

Nursing is a fairly recent professional vocation for women in Nepal; in the '50s and '60s a nurse's white uniform might have been considered foreboding and the profession impure for Hindu women (and being a professional woman was probably neither valued nor seen as entirely appropriate in the first place). Nepali nurses were recruited from the Darjeeling diaspora during this period (Adhikari 2008a). After *Jan Andolan I*, an increase in private institutions in Nepal's newly liberalized economy meant that training nurses, formerly a state-only regimen, could be privatized in the 1990s. Since 2000, there has been an unregulated mushrooming of private nurse training colleges.[19] Creating new training institutions even when there are not enough jobs is a standard capitalist pursuit, but in this context, nurse training

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LDCs are usually able to leave elderly parents in the care of siblings. One woman's migration does not usually jeopardize the home care of one's parents.

[18] Migration scholars' interest in networks (see below) has of late focused on remittances, in order to track where and how foreign-earned capital is sent "home" to sending states. But for Nepali nurses in the UK, years pass before a woman is in a position to earn full-time wages. In the early stage of nurse migration, it is possible that financial returns actually flow the other way in the sending-receiving network (the receiving state receives not only the migrant but also the financial inflow), to help establish a beloved daughter in a new and expensive country. Out-of-pocket expenses to hire agents, buy visas and plane tickets, and pay for the courses that are required prior to UK nurse registration simply cannot be paid by the half-time work that is permitted on a student visa.

[19] Complaints have started in Kathmandu hospitals that wards "were becoming seriously overcrowded with trainees," Adhikari writes. "Professionals started commenting that training standards were compromised, and some hospitals in the Kathmandu valley had more students than the number of hospital beds and patients occupying them" (2009:22). Given the desirability of an overseas nursing career, however, rates of admission to contemporary Kathmandu nursing colleges are very low. We can gather that talented women are being trained, even in private colleges, such that they could be well qualified for elderly care.

campuses arose at least partly in response to global demand, and with a growing awareness of the potential of economic remittances. The lure of migrating to Great Britain specifically (second only to the US in the global hierarchy, and with a large Nepali population in place) is such that other forms of identity and belonging – to both people and place – might be voluntarily withheld or suspended among women aspiring to nurse migration.

If, in Britain, primary identity is as a nurse, in Nepal, one primary identity of emigrant nurses is as an Overseas Nurse. A great deal of honour and pride rests on being able to succeed overseas professionally: despite the undeniable hardship of *not* belonging, no nurse I have met returns before she makes it. If a married nurse temporarily puts her professional identity over and above her identity as wife and mother (and invests all available time, money, and energy to facilitate the subsequent migration of her family), an unmarried nurse was concerned not to give in to parental pleas for her return, even in the face of heavy financial burdens, limited work opportunities, and uncertain prospects for the future. Professional identity becomes the way a woman claims herself overseas, far from family.

Once a nurse is professionally established, however – able to afford a plane ticket, and holding a visa status that will not be jeopardized by leaving the UK – she may visit Nepal. Being able to return to the place where she *really* belongs is a source of enormous relief and delight.[20] (Sometimes parents eventually visit Britain, too; being visited by family in a new location may also enable a greater sense of belonging.) The need to demonstrate having made good, though, can be experienced as pressure: the material objects a woman will bring back to Nepal with her as gifts or as show can cost a good portion of her wages. I have travelled with migrant men and women carrying televisions, phones, cameras, handbags, lipsticks, and coats, in enormous suitcases or in tightly wrapped boxes, intended as gifts for close or extended family members, or for whole households or villages. Commodity capitalism, too, has become a kind of remittance in Nepal.

Networks/Britain

Networks pose a theoretical problem in a matrix demarcated by location because they do not occur in one specific place but by definition are active in multiple sites at the same time: networks transcend and are not confined by space. We can, however, scale them up or down, or move them laterally, to consider Nepali networks in Britain, for example, or to think about how an individual nurse's personal network incorporates both family members in Nepal and group gatherings in Europe. Networks

[20] One nurse I spoke said she could not return to Nepal until she obtained her work permit: the money required for the plane ticket didn't seem worth it. (Also, I suspect, she felt she couldn't go until a certain hurdle had been jumped and a certain measure of success achieved.) Another nurse, who had already obtained her work permit, opted not to return because the cost of the ticket would cut so far into the savings for which she had come to Britain in the first place.

reverberate outward to form overlapping sets of kin, ethnic, and professional circles in Kathmandu, London, Nepal, and the UK, to name a few locations. And networks change depending on a person's circumstances: a nurse who comes to the UK on her own, leaving family behind, will forge closer links with other single or solo women like her than she would if she comes with her husband and children to begin with, or successfully negotiates their migration at a later date.

Whether a nurse is alone or with her family, she will likely belong to or participate in religious or ethnic group organizations that reflect her identity. But Nepali nurse networks appear small in Britain because the population is relatively widely dispersed – nursing homes for the elderly are all over the country. The attempt to accrue a steady income (and achieve a degree of belonging) requires women to spend more time in the small towns where they work than in central or urban locations where Nepali community and festival gatherings are likely to occur.[21]

British Nepali nurse associations do exist, but it can be difficult to attend collective events: a nurse might be on duty, or work a night shift and need to sleep during the day. Online network possibilities for migrant Nepali nurses are not particularly well used, either (*pace* Castells 1996): zero posts were listed for most of the possible discussion groups on *www.nepalinurses.com* in August 2008 (one event of note was a Teej festival celebration to be held that month); the website has since expired. The Runnymede Trust also reported that the Siddhartha Nepali Samaj, an organization established for overseas trained nurses, had not had too much success with social events (Sims 2008): work schedules are heavy and elderly health care is a profession that requires the dispersion of a workforce. Nepali nurses do sometimes attend London celebrations of *Mha Puja* and *Buddha Jayanti* even if they are located some distance from the capital, but especially in the early stages of settling, work comes before anything and transport is expensive – elaborate attempts to gather can sometimes fail. There is not a lot of time to build or reap the benefits of networks.

Still, anyone who knows about Nepali social connections will not be surprised to hear that they are tight in Britain (and that they are active in and connected to family and neighbourhood networks in Nepal, which is really in our second tier of indicators – those experiences of belonging that "happen" in Nepal, but again, networks are difficult to pin down in any one place). Even if registered professional organizations are not the dominant mode or location of interaction, nurse networks in the UK do exist among nursing college alumnae, and between friends of connected or neighbourhood families back in Nepal. Professional colleagues in elderly care homes also comprise a network, especially as some institutions are dominated by Nepali staff (in a classic example of 'snowball hiring', possibly combined with employer assumptions that certain nationalities are better suited to specific kinds of work).

[21] Nepali Nursing Association UK

Nursing college alumnae networks provide camaraderie and support in the UK: two young nurses who lived together in a small flat in west London knew each other from their Teaching College nursing training days in Kathmandu (they also grew up in the same neighbourhood as little girls, they noted, and used to see each other, although they did not personally know each other). Their families were acquainted although they were not from the same *guthi* (one of their families did not belong to any *guthi*, in an unusual case). The two lived together in a family house in London before they moved to a small two-room Hounslow flat, which they kept immaculate, the fridge stocked, at a rent of 500 pounds a month. They much preferred the "freedom" (and presumably the independence) of their own place, and took a great deal of solace from each other, although one had graduated to a work permit and the other remained at the frustrated status of student, her hours of work limited and her prospects, for the moment, bleak.[22]

As in any social setting, unanticipated – and transnational – networks may develop. For one informant, sharing accommodation with non-Nepali co-workers (first in London and then in a small English seaside town) meant the novelty of living with nurses (sometimes female and male) of other nationalities, such as Filipinas, Nigerians, or Bulgarians, each with her own culinary tastes and personal style, and the fun of a night out together in a setting new to all of them. Finally, as the carers of elderly people who may not have other social connections, some nurses may find themselves in complex personal or emotional encounters with patients. These circumstances can lead to more intimate social bonds with implications for the inheritance of objects or property. Whether they facilitate or bring about a sense of belonging or attachment will depend on the nurse, the patient, and the specific case under consideration.

Networks/Nepal

Nursing school friendships form one basis of professional and social links for nurses working in Britain, but diaspora sociality remains very closely linked to family and kin in Nepal. Family networks in Nepal – parents, uncles, husbands, children, and fictive kin – remain the closest ties, even for a woman in Britain. Families probably financed the ventures of migration to begin with and agreed to the child care that would allow the long-term absence of a nurse mother of young or teenage children. If a nurse's family has contacts in Britain, she may not have to rely on an agent for early-stage migration processes, such as being met at the airport or finding a place to stay, and this hospitality can make a big difference in foreign terrain. Networks in this instance are not so much a motivator for migration (Massey et al. 1998), but simply make transitions easier.

[22] She did, in due course, obtain a work permit and relocate to an elderly care home in Essex.

Other kinds of networks also need to be considered in the mechanics of migration and the layers or types of belonging they reveal (or inhibit): agents pose their own network about which we know little. Subsidiary networks of agents are partly responsible for maintaining a high (and increasing) flow of nurse migration in the face of significant policy changes (to which agents must adapt, as they did in 2004 by facilitating professional migration through student visas). Agents' fees, however, might counter what Portes calls the "diminishing costs of migration" (2008:13): classical theory argues that social networks mean lower costs for migrants, and thus explains the endurance of migration flows even when policies change. But in this instance agents diminish the costs of migration not for the migrant but for the state. In shifting the burden of health care migration from the state to the migrant, agents become the mediators of professional status.

Navigating the course of belonging in a "receiving" or "host" country means that ties to a private agent may remain active even when a nurse is most eager to sever them. The Nepali community in Britain is not large: on one occasion, a gathering of Newars in England included both a nurse who had paid an agent to enable her migration, and the agent she had paid (and for whom, years later, she did not have the warmest of feelings). Belonging, then, may be inhibited in British professional settings, and also within Nepali diaspora networks. As isolated women, far from natal or marital families, in awkward social circumstances during ethnic or community religious events, a nurse may at times feel that she does not belong at all.

Professional Standing/Britain

As "student" nurses, a new arrival must take English language classes and cultural "adaptation" courses in which all migrant nurses are required to enrol during the early stages of their tenure in Britain. They are also (re-) trained in basic nursing skills. Some sessions appeared to assume no nursing experience whatsoever, as when nurses were trained to draw blood. Informants were generally remarkably good-natured about the number of hours they had to spend in training sessions, except in the domain of nursing. Given the depth of their training and experience in Nepal (and sometimes India), they took offense at the level of skill they were presumed not to have: one nurse exclaimed: "I used to take blood every minute!" Living in England is a desirable goal for many Nepalis, so experienced nurses will migrate there (thus the moral concern on the part of the UK government). But lower levels of skill are required for the work they will likely do.[23]

[23] A long-term labour migration policy oriented towards elderly care might consider the recruitment of more recently trained nurses or nurses with less training given that (1) lower skill levels may be required for palliative care than for tertiary care and (2) new health care professionals in the UK are required to undertake basic levels of training in any event.

The two young London-based nurses were not satisfied with their work in a nursing home, and this is a frequent refrain among Nepali nurses working in the UK; Adhikari calls it a "dream trap" (2009). They are too well-trained. Of the two, one had worked as a nurse in a major Kathmandu valley hospital for seven years, and the other had worked in a number of large hospitals in South India. They were frankly bored in a place where their work lives centred on administering pills and monitoring patients. Palliative care did not inspire their passion for work: they would rather be in action. One said her favourite place of work in Patan Hospital was the Intensive Care Unit (although she had also worked in gynaecology and maternity); the other had specialty training in a dialysis and kidney transplant unit. Medical treatment in elderly care homes is very limited: there are no IV lines, for example, and doctors – with whom nurses gain additional technical knowledge -- visit only once a week. If migration to Britain is partly about advancing knowledge and skills, nursing home work stymies this objective.

The work arrangement itself for the two women was not bad: they worked in a nursing home nearby (only about 5 minutes away by bus), but it was not satisfying nor properly remunerated work. The nurse who remained on a student visa after years of experience in both Nepal and India had no clear signal when her work permit might come through, or why it was taking so long. Her parents sometimes encouraged her to come home: they would implore her to forego the endless administrative trials she faced and return to Kathmandu to marry. But she was determined to stick it out – so much effort, so much money expended so far – in order that she might have something to show. She wanted to succeed as a professional, and obtain higher levels of training or experience, or at least enough money so that it was worth the loneliness and also the enormous sunk cost of visas, migration, and language and adaptation courses. And there was the question of honour: she could not go back before she could prove herself or before she could take enough away to compensate for the sacrifice she felt she had made.

As for any profession a bureaucratic hierarchy exists regarding which place of employment or institution one finds work with, and at which level. In the UK, working at an NHS hospital is the Holy Grail, the reason for migration to the UK but now entirely unattainable. Over a meal with the two West London nurses, a third, a veteran NHS nurse from Nepal, recounted the difference in application statistics from the time she applied, in 2000 – she was the only applicant when the NHS was hiring five nurses – and a recent hire, in 2008, when 45 people applied for a single position; the news was bad enough to kerb the appetite of our two young friends, who appeared crestfallen.

A nurse at an elderly care facility in Norfolk took some pride that her title was a nurse, not a carer. She was the lone Nepali staff member in a remote elderly care home in a tiny town far from London and quite isolated. When I went to visit, we met some of her co-workers from Eastern Europe; later she explained that she was "Nurse-In-Charge" (unlike the two other categories, Carer and Senior

Carer). Her rank as a nurse meant that she belonged professionally and she could demonstrate her seniority in new terrain.

Professional Standing/Nepal

In Britain, being a nurse from Nepal usually implies financial and personal hardship, the near impossibility of finding a job with the National Health Service, and the indignities of working on a student visa and being retrained in basic nursing procedures. In Nepal, there is at least a status associated with being an overseas professional. Interestingly and inversely, a degree of national pride about Nepali hospitals remained palpable among overseas nurses in Britain, who claimed, for example, that Nepali public hospitals were much better than those in India and who marvelled at the amount of bureaucracy involved in a profession that they saw as being hands-on. They could not fathom how in Britain there was an elaborate 4-step bureaucratic procedure to summon an ambulance, while "in Nepal we called ambulances all the time".

Still, nursing is not seen as a particularly worthy profession in Nepal: new jobs have not been created and government support is limited. Nepali nurses also must obtain formal permission to go abroad [from the Nepali Nursing Council]. Of course they also must seek implicit permission from or an agreement with husbands and family members. But it is the state, not a husband or father, who occupies the patriarchal role in this instance; support (or resistance) from families has already been solidly established by the time a nurse begins nursing school and a professional career. What the evidence suggests is that being a transnational migrant means that a professional nurse will be patronized by two governments (Britain's and Nepal's), instead of one.

It is hard – perhaps something akin to shame – to return to Nepal short of one's goal, no matter how much parents or children may miss a daughter or mother. Personal and family sacrifices in Nepal were made in order to facilitate a nurse's migration abroad: being able to make good on those hopes and dreams is a matter of individual if not family or even national pride. Marriage – the presumed life trajectory for both working and non-working women in Nepal – is either deferred or suspended in order to be an overseas nurse. A married nurse who initially migrated without her husband and children told me that her friends teased her: why hadn't she come home to Nepal? Did she now have a boyfriend? (Her family eventually obtained visas to join her in the UK.) Did single nurses plan to marry, eventually? Yes, of course, they told us. But not right now. Right now we're working.

The Possibility of Non-Belonging

But what of the possibility of not belonging? Those arenas of life we most easily associate with the collective – religious events, for example, or *pujas* – seemed for some nurses to be a private matter, tucked in around the edges of professional aspiration. When I asked a nurse which temple she went to, her response was: "Whichever," and when I asked who else attended rituals at the temples in the neighbourhood, she said, "Indians." Religion has not exactly been demoted in this new, migrant context, but its practice has become an individual or solitary pursuit.[24]

Can someone worship alone and still belong? Most certainly; most people do. Does belonging only take place in collectivity? Solitary practice might be considered the inverse of belonging, but there is something to be made of the idea of belonging in oneself, or being comfortable in one's own skin, such that you belong anywhere. This too may be belonging, even if it is solitude.

Solitude may not preclude belonging; nor may belonging be a singular experience. People have a way of finding social connections wherever they might be, and creating bonds for themselves to survive. Belonging to Britain – or being part of Nepali circles in the UK – can happen in a number of ways. Nepali religious events among immigrants may serve a Durkheimian purpose, for example, by bringing together diverse strands of a single national migrant population (and arguably fostering a common Nepali identity) for Dasain and Nepali New Year. Families may visit from Nepal, or migrate in due course; new generations of Nepalis are born in the UK, and feel connected to more than one place. Identity and networks determine and are determined by those with whom we connect: mutuality, commonality, and attachment arise in recognition of where and with whom we belong, and these spheres may be multiple.

Policies of Non-Belonging

Nepali nurses voiced their yearnings to belong not in terms of people or places (although distances could contribute to sometimes lonely migration experiences) but through professional aspirations. In their narratives, we see that the concept of belonging must accommodate not only ethnic, kin, and religious identities and the networks that enable and ascribe those identities, but also professional status and a woman's capacity to generate livelihood for her family. Assimilation, to use the sociological policy language that has accompanied studies of migration in the US (e.g. Guarnizo et al. 2003) would then depend upon religious, kin, and cultural identity networks, and also upon bureaucratic institutions within which professional women aspire to work. As Bach writes, "nation states continue to exert a powerful influence over the mobility of health professionals" (2010:95). But British law shifts the burden of

[24] Whether this shift resembles the work ladder she and her fellow nurses have started to climb *a là* Weber's rationalization thesis is something we may wish to pursue.

recruiting international labour for health care provision onto the immigrant herself: the state absolves itself of the obligation to finance the cost of importing a labour force to care for its elderly.

Does migration fracture social networks? No. Personal experience? Not necessarily. Financing health care is perhaps one of the more critical issues of our time; let us ensure that already marginalized migrant women of colour do not bear the overhead costs of professional migration to provide global elderly health care provision. In the interest of fair and equitable working conditions – and the goal of enabling the feeling that they *do* belong – perhaps we can adjust the system slightly, such that women who provide care are themselves benefited rather than burdened. Just because they are arguably the most vulnerable population in the system (migrant women) does not mean they should bear the financial and administrative costs of providing Britain's elderly care.

A system that inhibits belonging does not arise out of malice but out of ignorance. The current or default global market for health care provision is poised to reproduce the same inequalities all over again, whereby poor women from the south do the least valued work, receive the lowest wages, and are the least supported. The final policy recommendation of a recent report on migrant health care states we need to "[f]oster public recognition of the … contribution of care workers" (Cangiano et al. 2009: 208). After all, they are doing our collective work. We would do well to shift our focus and monitor a little more carefully visa, accreditation, and migrant management agents, rather than migrant women themselves.

The question has become not only where is belonging found – in what alternative modes or locations, through which social or electronic organizations and networks – but also how can it be facilitated. If Nepali nurses continue to provide nursing care in the face of increasing needs but fewer nurses trained in Britain – as trained nurses willing to work beneath their skill levels – can we not ensure that travelling as a migrant nurse be a global honour, not an instance of poorly paid and poorly treated women immigrants who must struggle to make ends meet and justify their presence in foreign terrain?[25] This is where the question of belonging belongs.

[25] Before we end, let us note that by "migrants" both scholars and policymakers are referring to laborers who have moved from non-OECD states (Organisation for Economic Cooperation and Development) to OECD ones. Put simply, this construction means people who travel from poor countries – those places that used to be known as Less Developed economies and are now collectively known as the South, although in some cases they are further north than the North – to rich ones, not the other way around, whose structurally analogous migrants are called "expats," "development workers," or "volunteers." Migrant is not a value-neutral or a geography-neutral term: no Peace Corps doctor would ever be referred to as a "migrant health care worker". Indeed, we might consider using the Peace Corps as a model to facilitate an expatriate Nepali Nursing Corps that could provide elderly care needs all over the world.

References

Adhikari, Radha. 2008a. "If you have to clean up shit, then it's best to do it for greater personal profit!": the Expansion of the Nursing Education Industry in Nepal and International Migration. Paper presented at Scottish Centre for Himalayan Research, March 1, Edinburgh.

--------. 2008b. 'The Business Nursing Complex': Understanding Nursing Training in Nepal. *Studies in Nepali History and Society* 13(2): 297-324.

--------. 2009. The Dream Trap: Nepali Nurses in the British Health Care System. Paper presented at School of Oriental and African Studies, Centre for Diaspora and Migration Studies Seminar Series, February 18, London.

Bach, Stephen. 2010. Achieving a Self-Sufficient Workforce? The Utilization of Migrant Labour in Healthcare. In *Who Needs Migrant Workers: Labour Shortages, Immigration and Public Policy*, Martin Ruhs and Bridget Anderson, eds: 87-118. Oxford: Oxford University Press.

Buchan, James. 2003. *Here to Stay? International Nurses in the UK.* London: Royal College of Nursing.

--------. 2007. International Recruitment of Nurses: Policy and Practice in the United Kingdom. *Health Services Research* 42 (3): 1321-1335.

--------. 2009. Achieving Workforce Growth in UK Nursing: Policy Implications and Options. *Collegian: Journal of the Royal College of Nursing Australia* 16 (1):3-9.

Castells, Manuel. 1996. *The Rise of the Network Society: The Information Age Economy, Society, and Culture Vol. 1*. Oxford: Blackwell.

Cangiano, Alessio, Isabel Shutes, Sarah Spencer, and George Leeson. 2009. *Migrant Care Workers in Ageing Societies: Research Findings in the United Kingdom.* Oxford: ESRC Centre on Migration, Policy, and Society (COMPAS).

Chaguturu, Sreekanth and Snigdha Vallabhaneni. 2005. Aiding and Abetting: Nursing Crises at Home and Abroad. *New England Journal of Medicine* 353 (17):1761-1763.

Department of Health. 2004. *Code of Practice for the international recruitment of healthcare professionals.* December. www.dh.gov.uk/publications

Global Nepali. 2008. Care and Share. October/November: 56.

Gostin, Lawrence O. 2008. The International Migration and Recruitment of Nurses: Human Rights and Global Justice. *Journal of the American Medical Association* 299 (15): 1827-1829.

Guarnizo, Luis Eduardo., Alejandro Portes, and William Haller. 2003. Assimilation and Transnationalism: Determinants of Transnational Political Action among Contemporary Migrants. *American Journal of Sociology* 108(6): 1211-1248.

Kingma, Mireille. 2006. *Nurses on the Move: Migration and the Global Health Care Economy*. Ithaca: Cornell University Press.

Massey, Douglas S., Joaquin Arango, Graeme Hugo, Ali Kouaouci, Adela Pellegrino, and J. Edward Taylor. 1998. *Worlds in Motion: Understanding International Migration at the End of the Millennium*. Oxford: Clarendon Press.

Nursing and Midwifery Council. 2008. *Statistical Analysis of the Register: 1 April 2007 – 31 March 2008.* http://www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=5730

--------. 2007. *Statistical Analysis of the Register: 1 April 2006 – 31 March 2007.* http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=3600

--------. 2006. *Statistical Analysis of the Register: 1 April 2005 – 31 March 2006.* http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=3593

Pfaff-Czanecka, Joanna and Gérard Toffin. 2011. Introduction: Belonging and Multiple Attachments in Contemporary Himalayan Societies. In *The Politics of Belonging in the Himalayas: Local Attachments and Boundary Dynamics*, Joanna Pfaff-Czarnecka and Gérard Toffin, eds. New Delhi: Sage Publications.

Portes, Alejandro. 1976. Determinants of the Brain Drain. *International Migration Review* 10:489-508.

--------. 2008. Migration and Social Change: Some Conceptual Reflections. Keynote address presented to COMPAS Annual Conference, July 1, Oxford.

Ray, Kristin Michelle, B. Lindsay Lowell and Sarah Spencer. 2005. *International Health Worker Mobility: Causes, Consequences, and Best Practices*. Roundtable paper from working discussion at Institute for the Study of International Migration. Washington DC.

Ruhs, Martin and Bridget Anderson. 2010. Semi-Compliance and Illegality in Migrant Labour Markets: an Analysis of Migrants, Employers and the State in the UK. *Population, Space, and Place* 16: 195-211.

Sassen, Saskia. 1988. *The Mobility of Labor and Capital: A Study in International Investment and Labor Flow.* Cambridge: Cambridge University Press.

Sims, Jessica Mai. 2008. *Soldiers, Migrants and Citizens: The Nepalese in Britain.* London: The Runnymeade Trust.

Tilly, Charles. 1990. Transplanted Networks. In *Immigration Reconsidered: History, Sociology, and Politics*, Virginia Yans-McLauglin, ed., pp. 79-95. New York: Oxford University

Tsing, Anna. 2000. The Global Situation. *Cultural Anthropology* 15(3):327-360.

Vertovec, Steven. 2002. *Transnational Networks and Skilled Labour Migration.* Transcomm Working Paper Series online at www.transcomm.ox.ac.uk: http://www.transcomm.ox.ac.uk/working%20papers/WPTC-02-02%20Vertovec.pdf