as in the case of the men in church leadership, they may be simultaneously reproducing other dominant power relations.

The reemergence of the stigma associated with nursing in the immigrant community is a clear indication that established power structures do not easily allow for the validation of new status claims. Nursing is used as a marker of premigration status to hamper the efforts of not only the nurses but also their families to make status claims in the transnational social space. For example, in the transnational marriage market, otherwise appealing candidates can be considered unacceptable for the sole reason that one parent is a nurse. The gatekeepers of old wealth and status in Kerala — the nonmigrant elite — struggle to keep nurses and their families from joining them on the status ladder.

Even when migrants such as the immigrant church leaders are marginally successful in making new room for themselves on the ladder, they may be reaffirming established gender relations that are oppressive to immigrant women. My research shows that the transnational organization of the church allows men, at both an individual and an institutional level, to make status claims through financial donations and leadership in the immigrant church. And while the church hierarchy allows some space for the reconfiguring of status relations for men, it helps reproduce patriarchal gender relations by allowing only a selective transnational transfer of ideas, keeping out those who might challenge established gender relations and male headship of the household.

Despite marked progress in their economic standing, the fact that migrants cannot always successfully make status claims points to the importance of studying intervening factors such as class and gender. In a review article on theoretical and empirical contributions to transnationalism, Mahler (1999) points out that both gender and class are addressed rarely, if not sidelined, in current scholarship. Among the Keralite immigrants I studied, gender- and class-based stigmas against nursing were resurrected and sustained through transnational connections in order to thwart claims to social status by the nurses and their families.

By bringing gender and class to the forefront, I wish to show the multidimensional character of transnational connections. First, these connections provide invaluable assistance for immigrants and their children in their struggle for economic and social survival in a host society that is at best indifferent, if not hostile. Second, transnational connections are a source of resistance that helps reconfigure established status hierarchies and makes room for limited social mobility. And yet, these connections can also help reproduce oppressive relations of power.

CHAPTER 2

Work

Nursing, Women's Networks, and Men "Tied to a Stake"

It is difficult to get exact numbers on Keralite Christians in the United States, given that the Immigration and Naturalization Service does not break down immigration by region of origin, religion, or profession. While no accurate figures exist on the population of Indian nurses in the United States or of Keralite immigrants, a directory on Keralites in the United States indicates that 85 percent of these immigrants are Christians, whereas Christians make up only one-fifth of Kerala's population. Scholars attribute the disproportionate presence of Christians among the Keralites in the United States to the nursing professionals who tend to be from the Christian community (Williams 1988, 1996). A survey conducted in the Keralite Christian community in Dallas found that 49 percent of adults surveyed reported nursing as their occupation (Thomas 1978: 30–31). The overwhelming presence of nurses in the community points to a distinct pattern of immigration.[1]

As mentioned in chapter 1, women's migration and entry into the labor market has relatively recently become a topic of interest for scholars of migration and immigration. While scholars agree that gender relations change after migration, they disagree widely on the nature of the changes. Their discussions, which focus primarily on the question of whether women gain or lose autonomy, are predicated on an autonomous, bounded notion of the individual. In one scenario, the female immigrant is seen as strategizing to increase her autonomy when faced with the conflicting agendas of the household or the pressures of the workplace. In another scenario, her autonomy is limited by a false consciousness that

fails to reject the patriarchal structures of control. In yet another, her liberty to pursue her own ends is affected by her minority position in a hostile host society and her consequent need to make the household a bastion of resistance against racial oppression. In all these scenarios, autonomy is an unexamined concept measured by how much the woman is able to pursue her own individual goals unhampered by her relationships to others.

In order to understand how women (and men) from non-Western cultures assess their own loss or gain of autonomy, we must first recognize that their notion of personhood may be very different from notions of personhood found in Western cultures. Keralite Christian immigrant men and women perceive the self as connective — less bounded and always in relationship with others. Following the anthropologist Suad Joseph, I use the term *connectivity* to mean "psychodynamic processes by which one person comes to see himself/herself as part of another. Boundaries between people are relatively fluid so that each needs the other to complete the sense of selfhood" (1993: 55).[2] In societies such as that of Kerala, where the group — especially the family — is valued over the individual, the connective selfhood is valorized and upheld.

I use *connective autonomy* to characterize the changes that take place in the lives of the Keralite Christian immigrant nurses. Whereas entry into paid labor and emigration increase their mobility and independence — both financially and socially — they experience this autonomy only within a set of relationships and obligations. As Joseph puts it, "Connectivity entails cultural constructs and structural relations in which persons invite, require and initiate involvement with others in shaping the self" (1993: 56). While the nurses operate within these structural relations, they are also negotiating and challenging the status quo and, indeed, democratizing the patriarchal norms of their cultural milieus.

Their husbands, on the other hand, lose status and experience downward mobility in the immigration experience, both in patriarchal status and connectivity. They are dependent on their wives in the immigration process and in settlement. Many of them feel isolated without the support of family, friends, and a wider net of social relationships.

To better understand the significance of nursing in this story, I begin by looking at the sending community and negotiations over the new earning power of nurses. Second, I examine the immigration process — the aspects of demand and supply that draw these women into the nursing profession, as well as the importance of networks in helping them develop connective autonomy. Third, I turn to the experiences of nurses in the United States — the challenges of getting licensed and negotiating the racialized environment of the workplace, as well as the positive change in professional self-esteem. Finally, I look at the experiences of the nurses' husbands as they immigrate, settle, and enter the U.S. labor market.

The Sending Community and Nursing

In 1914, the first Indian nurses were recruited by the British colonial forces under the guidance of Florence Nightingale and eventually were organized into the Indian Military Nursing Service. According to the sociologist Ranjana Ragavachari, the nurses were recruited mostly from Indian Christian communities in the state of Kerala or from Anglo-Indian communities. These communities were relatively more open to allowing women to work outside the home, even in a low-status profession such as nursing. Ragavachari attributes the low status of the profession to "existing cultural norms deeply rooted in Hindu philosophy" that defined nursing as polluting (1990: 15).

The relative openness of the Christian communities to nursing had much to do with the active role that English missionaries and mission hospitals took in representing nursing as noble Christian service. Given that Nightingale's model of nursing was explicitly religious in nature, it seems probable that Christian nurses were more easily trained and therefore perhaps more aggressively recruited by the British colonial powers.[3]

Despite the religious packaging of the profession highlighting its noble aspects, nursing was seen as a low-status trade rather than as an education. In the early years, nursing schools, eager for students, were known to accept those who had failed to complete high school. After three and a half years of simultaneously taking classes and working in hospitals affiliated to the nursing schools, the nurses received diplomas rather than degrees.

Within the Christian community in Kerala, mostly young women from the less well-off families responded to the recruitment efforts of the nursing schools. Many nursing schools provided free education and a monthly stipend to the students they recruited, in return for a period of bonded service by the nursing graduate. A number of women I interviewed remarked that they really had wanted to go to medical school, but that their families had not been able to afford the expense.

As nursing opened up a window of opportunity for young women to contribute to the family income, there was a concurrent change in their status both in the family and in the wider Keralite society. These young

women were transformed from burdens and liabilities into financial assets within the family. But because of nursing's negative status in Kerala, and its gender and class stigmas, society was not without ambivalence about this transformation. Moreover, the greater autonomy of nurses was offset by their culturally prescribed dependence both within the family and in their gender and class positions in society.

FROM BURDENS TO ASSETS

The story of the Keralite nurses and their immigration is connected to another story about the transformation of women's worth in Kerala. The discourse around the female child in Kerala was, and to a great extent still is, one that designates her as a liability. In a society where arranged marriage is still the norm, daughters are often seen as burdens because the family is obliged to provide a dowry, or *streedhanam,* for the marriage of a daughter, whereas they receive a *streedhanam* upon the marriage of a son.[4] The anthropologist Susan Visvanathan argues that, whereas the *streedhanam* was ideally a premortem inheritance, it has become a means of contracting marriages into desirable families, with different rates for each economic class. In addition to the economic status of the families, the educational and employment qualifications of the bride and groom, as well as the woman's complexion, are important factors in the negotiation. Visvanathan explains, "It *[streedhanam]* expresses the fundamental severing of economic ties for a woman from her natal home, and her incorporation into the conjugal household" (1989: 1341). As one of my female respondents put it, investing money in a girl's welfare and education was seen as "watering the fruit trees in your neighbor's garden."

The more daughters there were in the family, the greater the burden, since it meant that parents not only had to pay dowry for each daughter but also had to give appropriate gifts when their daughters came back home to give birth to their grandchildren. One woman I interviewed, Mrs. Varghese, described the nature of the "burden" for her parents when she said, "I am one of nine children and one of five daughters. As we started getting older, my father and mother had the burden of getting us married. Our dowry system is very hard, because you have to give to all the daughters for marriage. I noticed when each of my older sisters got married, and each time they had children, they would come to our house for the delivery and my parents would have to give a lot of money. You have to do everything according to the custom. And it was really very difficult for my father to do it." In the face of such difficulty, Mrs. Varghese explained, she chose to become a nurse because "that is the only thing you didn't have to pay for."

Often it became a family project to scrape up enough money to send the aspiring nurse to begin her training.[5] In my interviews with the immigrant nurses, many recounted that a father or a brother had made the initial long train journey with them to register them at nursing school. As a result of such family participation in the establishment of a daughter's career, the typical family eagerly awaited completion of her training, her subsequent employment, and her eventual contribution to the family income.

In interviews, some women told me they had postponed marriage to first finish building their natal family house or help siblings complete their education. For example, Mrs. Patrose described the collective effort in her family: "My parents did not have a good house back in Kerala, and I wanted to build a good house for them. That is why I wanted to work in the military for sometime more. My brother also was employed at that time. He too wanted to help for the same cause. My parents never asked me for anything. But I wanted to help my parents before I got married." Mrs. Varghese explained her own reasons for putting off marriage: "I thought, you know, when I get married, I will be in trouble. Sometimes you don't know what kind of person you marry? Sometimes, according to our culture, they don't want to help the wife's side. I am not talking about everybody. I didn't know what kind of person I might get, and then I wouldn't be able to do my wish. When I was single, I could do whatever I wanted with the money I made."

Whereas most of the women talked about going into nursing to ease the burden on their families, some who were considered less of a burden to their families talked about choosing nursing for other reasons. One woman told me that she was inspired by the story of Florence Nightingale and had decided in second grade to become a nurse, much to her family's dismay. More frequently, I heard women talk about going into nursing because they wanted to travel. Younger women were inspired by seeing older nurses coming back from the urban areas of North India with new fashions and gifts for family members. As Mrs. Patrose explained, "When I was small I liked to see people coming from outside the country with lots of money and gifts for other people. That was in my mind, and I always wanted to go." One woman identified another influence for her travel dreams: "There were a lot of magazines, and there were a lot of stories written about them [nurses] . . . like [in] the *Malayala Manorama* [a popular weekly magazine]. They are like ideal things, not really practical

things. They come back rich, and they will bring all this stuff." But for most of these women, the focus was less on going away than on returning to Kerala with gifts and money for their families.[6]

Whether they took up nursing to ease the financial difficulties of their families or to fulfill their own dreams, these nurses challenged the traditional characterization of women as burdens. In most cases, they became assets to their families because they used their newfound autonomy to act in collective ways toward collective ends. The financial and social autonomy they gained did not lead to an individualized notion of the self, because the very definition of the self is embedded in a set of obligations and duties to others.

However, there is tension between the autonomy these women gained and the cultural prescription of dependence for women, first on their parents and then on their husbands. When parents or husbands sought control over the new earning power of the nurses, these relationships became sites of potential conflict. For the Christian community in Kerala, young women making a living outside the home was an unprecedented social phenomenon. All the mothers of the fifty-eight immigrant men and women whom I interviewed, with the exception of one, did not work outside the home.[7] For the families of the nurses, the experience of a wage-earning woman was brand new. At both the individual and social levels, this new female earning power was undefined and unnegotiated.

Control over this new power was the cause of conflict between some parents and their nurse daughters. As Mrs. Thomas explained to me, her family did not want her to marry because they assumed that her contribution to the family would be cut off when she entered the husband's family.[8] She complained that they wanted to extract as much money as they could from her, and that they are angry with her to this day despite the fact that she has sponsored all her siblings in their emigration to the United States after her marriage.

In some cases, this new earning power led to spousal conflict, as with Mrs. John, who tearfully told me about her husband's betrayal of a pact she had made with him before their marriage. Because she was the eldest child of her family, one of her main intentions in becoming a nurse was to help her family. She claims that she had told her husband before marriage that she intended to continue helping them. She found that her husband did not keep his word, and this became one of the causes for their severe marital problems. That she had to negotiate this points to cultural expectations that a married woman belongs to her husband's family, and that her natal family no longer has any rights over her. Mrs. John was aware of this expectation, but she felt that the tradition might apply only to women not working outside the home. She bitterly observed that her husband might have agreed to her request before marriage only because he wanted to come to the United States, and she was his ticket.

Conflicts such as these, between parents and daughters and husbands and wives, became the basis for the societal evaluation of nurses as too independent. While the young women and their families negotiated the implications of this new earning power, the cultural reverberations of these negotiations earmarked the nursing professionals as lower-class deviants with respect to the customary gender and class norms in Keralite society.

GENDER- AND CLASS-BASED STIGMAS

Besides their increased financial power, young women experienced other changes upon entering the nursing profession. They had greater social independence in their lives and more control over their mobility and sexuality. Yet these changes too were cause for social stigma. Being away from home and having to make choices for themselves made nurses relatively more independent. Whether or not they abided by family dictates, their increased independence and earning capacity gave them new means to negotiate control over their incomes and their lives. For example, some women talked about their antipathy toward the dowry system. Mrs. Kurien put it rather emphatically:

> I think that dowry is unnecessary. If a person is working and earning money, why should you have to give more money? I am dead against it, but who am I? I am just one person against all these other people. . . . Yeah. It is different if you are going to marry a person and stay in their home and eat their food everyday, and you have no income and you are not working. That is different. Then you give them a share of whatever it is that your parents have given you. But if a woman is working, and she is going to earn all her life, why should you give a dowry to them? I don't agree with that.

As a result of her stance, Mrs. Kurien told me, approximately ten of the marriage proposals she received did not work out for her.

The greater independence in nurses' thinking was matched by a parallel increase in their freedom of movement. Enrollment in a nursing program required that many of the aspiring nurses leave Kerala and study and work in cities far away from home. Consequently, there was a relative loss of patriarchal control over their mobility and sexuality. Whereas a young

unmarried woman was expected to live under the control of her father and older brothers, and a married woman under the control of her husband and his family, the nurses had clearly traversed these social conventions.

That nurses were breaking social norms became apparent when they came home to Kerala for vacations. Mrs. Samuel narrated an incident that illustrates the collision of her two worlds:

> When I went to Kerala on vacation, I would go to my parents' house. If I wanted to go to my sister's house or somewhere and it was dark, I would think that it was okay to walk there. One day my father said to me, "This time, at this time you are going there! No! You can go there tomorrow." I said, "No, it is okay. It is only eight o'clock. We [she and her sister] can walk there. It is not that far. How do you think I am working there in Bombay? I am doing night duty. Every night I am walking, crossing the street, and going and doing night duty. So, you didn't know that, did you?" Like that I told my father.

The greater freedom of thought and movement associated with nurses led to questions about their moral status. Mrs. Mathew, a more recent nursing graduate, told me why she did not want to go for nursing training outside of Kerala: "Also a lot of times that feeling about nursing was towards the people that left Kerala and went for their training outside of Kerala. Like even now, you hear of stories of girls who went off to do nursing training in other states, and they are never heard of again. So my parents would not have wanted to send me outside of Kerala."

As noted earlier, nurses were also suspect because their work involved constant and close contact with unfamiliar male patients and doctors. Traditionally, in Kerala it was not appropriate for young women to even speak in the presence of males who were not relatives. For instance, as Mrs. Philip explained, "I could speak to my mother and even my brothers, but not when other men were around. I was not even allowed to go in the front room when other men were around, like my brother's friends." Working in direct contact with men who were not kin gave rise to allegations of sexual immorality against nurses as a group, because, as Mrs. Kurien explained to me, people "all thought we were prostitutes. They think that once you go outside the house, you are doing all kinds of things that you are not supposed to. Maybe some of the people who went for nursing did go in other ways. But everybody put you down, and they looked down on you as if to say, 'Oh, you're only a nurse.'" When asked whether anyone said anything directly to her or her family, she replied, "Not directly, but there is always this talk, 'Oh, she is a nurse.' That means that she is nothing." And in some cases, the nurses who opted for late marriage in order to help their families were especially vulnerable to suspicions about their sexual purity.[9]

Nurses were also identified as being low-status workers from poor families, constituting a class stigma against nursing. Because nursing involved cleaning sick and diseased bodies, it was seen as dirty work. Mrs. Jacob, who went into nursing against her family's will, described why nursing was not acceptable to her family: "In those days nurses were looked down upon, especially the nurse who went to Bombay for school. They were the ones who were doing menial work." When asked what was menial about the work, she replied, "Probably the daily activities and care for other people – cleaning them, bathing them, and things like that. At home you have servants to do things like that, and in nursing school you are doing the same thing your servants do for you. . . . My father was somewhat of a prominent person, and he was a Panchayat member [local political position of high status]. So it had more to do with his dignity, that one of his daughter went for nursing and did not go to college." Thus, nurses who left Kerala were seen as doing menial work, equivalent to that of servants, because, in Kerala, family members customarily took care of the immediate bodily needs of patients. In the large cities of northern India, patients depended more on nurses for such aid.

Furthermore, the three years of schooling required for nursing was not seen as an education, especially in Kerala. Mrs. Peter explained that, before she began her training, she too had not been cognizant of the education involved in nursing: "The general public did not know about nursing, the kind of work a nurse is doing. They thought that nurses do not learn anything medically. Before I went for nursing, that was also the understanding I had. I did not know that a nurse had to study all kinds of medical sciences. I thought the nurses only give shots. It was only after joining that I learned that a nurse had to learn a lot about taking care of patients."

Consequently, the low status of nursing led to the common belief that nurses came from families in dire straits who sent their daughters away to earn money for the family. Conversely, aspiring nurses whose families were not under economic duress met with resistance, as was the case for Mrs. Philip:

> Well, in those days, nursing was associated with the option for the poor, who would send their eldest girl to help save the rest of the family. But I was not in that category, so the family said no way. . . . Then a friend of mine decided to go to nursing school. She was really secretive about it. . . . I found out that this friend got the address for the nursing school from the local doctor, so I ran to him and

said that I was interested in going to nursing school. He insisted that I not go, pointing out that my friend was the eldest child of many, and how she was doing this to save the family.

In the archetypal figure of the eldest daughter who became a nurse and put off marriage to "save her family," the class- and gender-based stigmas against nursing combined, showing that gender and class are inseparable. On one hand, when nurses attempted to achieve class mobility by putting off marriage to contribute to the family, they were seen as morally loose women. On the other hand, the greater independence gained by nurses had a declassing effect because their deviation from gender norms was attributed to their class origins.

And again, the self-sacrificing eldest daughter who became a nurse symbolized the tensions between autonomy and dependency for women in Kerala. The new earning power that she brought to the table was a disruptive force that challenged social norms of female dependence. Parents, siblings, husbands, and the nurses themselves have had to figure out what this means in the context of existing sets of ties and obligations.

The entry of women into nursing broadened their basis for negotiation within the patriarchal system in place. However, when nurses have challenged social and familial norms of patriarchy, they have not done so in a language of rights based on an autonomous bounded self. As young women working far away from home, they stood outside the norm of controlled female mobility in order to help their families. When they challenged the patriarchal authority of their husbands, it was because of obligations to their natal families. Immigration offered opportunities for even greater autonomy for nurses, who carried with them obligations to their families in Kerala.

The Immigration Process: Demand, Supply, and Networks

The history of nursing in India, especially for Keralite Christians, allowed the development of an orientation toward migration as a survival strategy. Often nursing schools were located in the large metropolitan areas of India. Typically, Keralite nursing graduates established themselves in the same area after graduation in order to complete their bonded-service commitments.[10] Many women have reported a further incentive to stay in the large Indian cities: the opportunity to sponsor siblings and other

extended-family members seeking better educational and employment opportunities outside Kerala. Saskia Sassen-Koob (1984) notes that the large-scale incorporation of women into a labor market may disrupt unwaged-work structures in a community, minimizing the possibility of workers returning to their communities of origins and, consequently, creating a pool of workers willing to migrate.

The incorporation of Keralite Christian women into the Indian labor force and the resulting pool of migrant workers became a source of supply to meet the emerging demand for nurses in the global market. As families began to depend on the incomes of their pioneering daughters, many Keralite nurses accepted the more lucrative nursing opportunities found in other countries. And just as these nurses had been the first in the family to leave Kerala and had facilitated the migration of family members, once settled in the United States they continued to sponsor family members.

The supportive role of the family during migration is anomalous relative to other female migration patterns. Scholars of migration typically find that patriarchal family systems accept and support male migration but usually act as an obstacle to the migration of women with or without men (Hondagneu-Sotelo 1992, 1994; Massey et al. 1994; Kanaiaupuni 2000). In fact, Hondagneu-Sotelo found that the single Mexican women who migrated to the United States came from "weakly bonded families that provided little economic support and lacked patriarchal rules of authority" (1994: 87). What is interestingly different about the nurses in my study is the overwhelming support they got from a patriarchal family system (and from families who were strongly bonded) to migrate alone. Perhaps this shows that patriarchal family systems can be flexible in the face of economic need.

Nurses had little control over the sale of their labor, since they depended on national and international demand and supply. Nevertheless, they exercised connective autonomy, determining where and how they immigrated within the context of a new set of relationships formed through nursing networks. Consequently, Keralite nurses were part of the transnational nursing labor force that met the demand in the United States.

DEMANDS OF A RACIALIZED LABOR MARKET

In the United States, a number of factors contributed to the demand for nurses. The post–World War II expansion of Medicare and Medicaid programs created a greater need for health care professionals. Economic

growth in the 1950s and 1960s allowed more employers to offer medical insurance to their workers. However, the supply of nursing personnel did not keep up with the expansion of demand for health care, leading to cyclical patterns of nursing shortage.

One of the main reasons for the shortage was the decline in the traditional labor pool of U.S.–born women in the nursing profession. Attractive alternate career choices for women opened up in that period. Furthermore, sex-based occupational discrimination, along with poor working conditions for nurses, resulted in not only the shortage of new nurses but also a high exit rate for those already in the profession (Jackson et al. 1989).

More important, as Paul Ong and Tania Azores explain, "the endemic and recurring shortage of nurses" in the United States "is tied to wages that have remained below market level because hospitals, which employ 70% of nurses, have colluded to set rates" (1994: 167). Since the economic crisis of the late 1970s, hospitals have been under tremendous pressure to cut costs by such means as keeping nurses' wages low. As a result, nurses typically reach their peak salaries in the first five or six years of practice. Using data from the American Nurses Association, Ong and Azores calculated that, between 1976 and 1986, real wages for nurses rose by only 2 percent.

Such low wages, along with negative work conditions, have led to severe shortages of nurses. For example, the vacancy rates for registered nurses in hospitals doubled during 1985–86, according to a study done by the American Hospitals Association (Curran et al. 1987). Staffing problems are especially difficult for inner-city hospitals, which are often under extreme budgetary pressures. In addition, they must pay higher wages to attract nurses to work under relatively more difficult conditions than in suburban or rural hospitals.

The liberalization of immigration, specifically in the form of the Immigration and Nationality Act of 1965, was an attempt to respond to such labor shortages in the United States. The third preference category in this act allowed for the entry of skilled professionals needed in the United States. Because this act also increased immigration quotas for formerly restricted areas, it helped induce immigration of Indian nurses, among other Asian nurses. By the late 1970s, immigration of Indian nurses to the United States was exceeded only by that of Filipina nurses and was closely followed by Korean nurses. From 1975 to 1979, while 11.9 percent of the nurses admitted to the United States as permanent residents were from India, 11.2 percent were from Korea, and 27.6 percent were from the Philippines (Ishi 1987: 288).

Although foreign nurses make up only a small percentage of the nursing workforce (4 percent in 1984), they are a critical source of labor, particularly for inner-city hospitals that have difficulty attracting and retaining nurses. In a guide to managing the nursing shortage, Barbara Shockley (1989) justifies foreign nurse recruitment by arguing that hospitals are able to offset the cost of foreign nurse recruitment in thirteen weeks versus the cost of temporary staffing and payment for double shifts.[11] It is the inner-city hospitals that have actively conducted recruiting campaigns in countries such as India, leading to what some have characterized as a "brain drain" (Yamanaka and McClelland 1994: 86) and what others cite as a "skill drain" (Mejia et al. 1979). Consequently, foreign nurses are most likely to be concentrated in the critical care units (high stress areas) of urban hospitals, where native nurses are less likely to work.

The United States has not been the only destination for nurses emigrating from India. In the OPEC countries, expanding oil economies in the mid-1960s led to a greater need for foreign labor, especially in the service sector, health sector, and other professional sectors. Again, Indian nurses were part of the immigrant workforce that was recruited by a number of Middle Eastern countries. In fact, among the women I interviewed, several had worked in countries such as Kuwait, Saudi Arabia, and the United Arab Emirates. Others had spent years working in African countries such as Zambia and Nigeria before coming to the United States as part of a global step-migration process.[12] Consequently, besides supplying the labor demand in India, Keralite nurses have been an important part of the labor pool supplying the global demand for health professionals.[13] To understand why the nurses left Kerala and India, it is important to examine the economic and social conditions that led to the development of a transnational labor force.

SUPPLY OF A TRANSNATIONAL LABOR FORCE

Even while the state of Kerala has been the focus of international attention for its success in achieving social well-being in areas such as education and health, it also has had a poor record in industrial and agricultural productivity.[14] Between 1970 and 1986, Kerala's per capita income increased by only 4 percent as compared to the rest of India's, which rose by 26 percent. Unemployment has been high in the state. Comparisons of survey results over nearly a decade show that unemployment rates have been twice as high for women as for men (see table 1).

TABLE 1. Changes in the Incidence of Unemployment in Kerala
(Unemployed as a Percentage of the Total Labor Force)

Year	Male	Female	Total
1977–78	14.0	30.6	19.9
1983	10.8	18.4	13.1
1987–88	12.8	26.3	17.1

SOURCE: Gulati 1996: 39.

The severe unemployment in the state has been an incentive for young people, especially women, to seek both educational and employment opportunities elsewhere. Consequently, urban areas in India have attracted young people like the nurses who sought employment in hospitals outside of Kerala after completing their education. For many nurses, the next step has been emigration to different parts of the world.

Mrs. Eapen, who attended nursing school in North India in the early 1970s, described the process to me. After three years of nursing school, graduates were obligated to contribute one year of bonded service to the hospital. While completing their terms of service, she and her classmates — some thirty-odd women — traveled to nearby cities like Delhi to get a head start on their professional lives. They registered with employment agencies, secured interviews at hospitals, and filed for visas at the American embassy.

Mrs. Eapen recalled that, soon after she got her first job, the director of nursing at the hospital jokingly asked her if she had her passport ready, referring to the extremely high turnover rates for nurses in metropolitan hospitals. As Mrs. Eapen put it, "These people thought that we were just there to use the hospital like a motel, because they knew that all of us, especially the Keralite nurses, were only going to be there for a short time. And as for my batch, nobody is left there. Everybody's gone."

For the nurses I interviewed, the question was not whether they were going to emigrate, but where. The United States and countries in the Middle East were top recruiters, but nurses were emigrating to African and European countries as well. A number of factors influenced the choice of destination. For instance, some nurses mentioned that it was much easier to emigrate to Arab countries because the process did not include sponsorship or tests. Typically, recruiters from countries like Kuwait or Saudi Arabia would hold interviews in India and pay all travel expenses for those selected to work. In fact, nurses working in a number of the Middle Eastern countries did not have to pay their own living expenses and vacation travel expenses, making these jobs extremely appealing.[15]

Many nurses used the strategy of step migration, as did Mrs. Samuel, who told me that she first migrated to Zambia and later ended up in the United States. Her friend, who had migrated to Zambia as a nurse, had sent her many letters encouraging her to come as well. In Mrs. Samuel's words: "The ticket was free. I didn't have to pay for anything. Everything was free, so I went there. . . . Then everybody started coming to America. As their three-and-half-year contract finished, they started coming here one by one. So I started this way too."

Today, Kerala still contributes nurses to a transnational labor pool, as I discovered during my trip there in 1997. In the focus group interviews I conducted with nurses, as well as in interviews with nursing school deans and retired nurses, I learned that the profession continues to offer a survival strategy for many Keralite women. As Mrs. Mathew, a nursing school superintendent in Kerala, put it, "There are about twenty-five nursing schools just in this area [she is referring to Kottayam, a small town in central Kerala]. They get certificates from one of these schools, get a passport, and go abroad. So once these girls study and go abroad, the whole house is saved."

However, even as more nursing schools sprout up around Kerala, with increasing student bodies, the profession itself is in great disarray. To meet the demand for nurses, many schools offer various short-term auxiliary health-worker courses, whose graduates often get away with using the title of nurse, discrediting the profession. Mrs. Mathew explained the cause for the disarray: "Nowadays nursing education just happens on paper — in theory. Nursing has become a business. . . . If they build a hospital, its main source of income is the nursing school they attach to it."

In addition to the poor quality of education, Keralite nurses also complained about the relatively poor work conditions inside Kerala. In a focus group interview, nurses talked about the high nursing vacancy rates in hospitals, which lead to a disproportionately low nurse-to-patient ratio and poor quality of patient care. In one hospital, nurses told me that, for every forty-five patients, there were only two staff nurses. As a result, Keralites who could afford it sought health care outside the state. Furthermore, many of the nurses who had trained and worked outside Kerala talked about the markedly different treatment they received from doctors and administrators in Keralite hospitals. Instead of being treated as equals and colleagues, they were shouted at and treated like subordinates.

Along with its relatively poor work conditions, Kerala is unique in the

lack of collective action on the part of nurses in a highly politically mobilized society. As one nurse who worked outside Kerala explained, "Here they won't strike — they won't open their mouths. The problem is that the people working here either need their bond or they have gone abroad and they are coming back and working because they don't want to just sit at home. Salary is not a botheration [consideration] to them. So only we juniors are here for the salary, and most are only here for the time being. Most of us are here on a one-year contract. This is just a temporary thing, since most of us are planning to go to different places."

And despite the continuous stream of nurses going abroad, hospital administrations do not have to improve work conditions to retain even the minimal nursing workforce. Keralite hospitals rely on the three-year period of labor that nursing schools require of their graduates. Consequently, as long as the nursing schools are filled with students, Keralite hospitals constantly have a fresh batch of employees who can be paid very little, since their labor is defined as part of their apprenticeship.

One of my subjects summed up the reasons why she wants to immigrate, given the negative work conditions in Kerala: "Why struggle here and get no money? We can go abroad, make some money, and come back. Staying here, we don't get any respect and we don't get any money." Worsening work conditions in Kerala, coupled with great financial incentive to migrate, result in a transitory transnational nursing workforce with little motivation to fight for better conditions. However, the nurses mobilize to help each other through extensive nursing networks, underlining their exercise of connective autonomy in the immigration process.

WOMEN'S NURSING NETWORKS

From my interviews with nurses, I learned that nursing networks often formed even before aspiring nurses arrived at nursing school. Most often, prospective students would find out about the application process for emigration from existing networks of neighbors, relatives, or friends who had access to such information.[16] The friendships they built in nursing school and at work often determined where they would migrate and what type of job they would obtain.[17]

In some instances, the nursing schools in distant northern India put women in touch with other prospective students, initiating a professional network among the women. This was the case for Mrs. Eapen, who ended up traveling with ten of her classmates from different parts of Kerala on their initial four-day-long journey by train to the northern state of Uttar Pradesh. It was with these women that she went to the national capital, Delhi, after graduation to seek out future prospects. Mrs. Eapen explained how each batch of graduating students depended on the previous batch of alumnae to help them:

> Our senior batches, they were all living in different hospital quarters in Delhi. So when we went for our interviews, we would all stay with them — two or three with each one, even though we were not supposed to, because they live in dormitories. It was just overnight, though. . . . When we got there, our senior batch would take us to the American embassy to file. To file, you really don't need to do anything, but they would help us. They would take us there on scooters or taxis. We [would] go and file and leave it there, and see what happened next.[18]

Mrs. Eapen used the same Delhi network in her emigration to the United States. Even though her cousin sponsored her, she chose to come to the city where a nurse friend from Delhi lived.[19]

Just as in Delhi, where the junior batches depended on the recent graduates, so those who emigrated first were invaluable to others trying to emigrate. Nurses in the United States wrote letters to India encouraging their friends to come and work in the United States. They told them how to go about applying for visas, warned them about preliminary interviews, and reassured them about finding jobs and living arrangements in the United States.

As a result, many of the women I interviewed chose, like Mrs. Eapen, to join their friends rather than relatives, even though the latter may have sponsored them. And sometimes this made it easier for relatives to sponsor nurses, because they did not always have to take on the burden of getting the new immigrants established. This was true of Mrs. Simon, who recalled that, while her husband's cousin had sponsored her, she did so on the condition that Mrs. Simon would live with her friends from nursing school. Migration scholars have found that, because migrating women depend on female-dominated networks, they are more likely to choose migration destinations where their networks are firmly established, and to choose occupations in which their networks have already established a niche (Kossoudji and Ranney 1984; Repak 1995).[20]

The help did not always go in one direction — from those already in the United States to those attempting to come here. For example, Mrs. Samuel explained how her former classmate in India helped her procure important paperwork: "The matron [nursing director] and the people in that hospital in Bombay did not like us going outside India. They were so mad that they wouldn't fill out the forms and send them back to me.

So I had to tell my friend Rosie, who was there in Bombay. She went directly to them and gave them some money and everything was done."

The strong friendships, sustained over large distances and long periods of time, sometimes appeared to become more like fictive kinship. For example, Mrs. Joseph's decision to emigrate to the United States was thoroughly influenced by one of her senior nursing schoolmates, whom she called Chechi, the term for an older sister. Mrs. Joseph recalled:

> By the time I went to Delhi, Chechi, who was already a nurse in Delhi, had gone to Kuwait. So what she did was to arrange with roommates to take care of me. They came to the railway station, and let me stay with them, even though it was difficult for them to accommodate girls from outside. . . . I finished my training in 1973, September. I had correspondence from Chechi in Kuwait. "Since everybody is going out of the country," she said, "why don't you file to go to the States?" She said this because her roommates who were helping me stay in Delhi, they were already in the process of going to the States. Even though my counselor — my so-called sister — was in Kuwait, she didn't want me to go to Kuwait. She said that is not the place for me. She encouraged me to file a petition to go to the States. She said that she would help me to do that without giving my family any burden. . . . I filed it, and within two months the tick form came. And then my mother died, and my Kuwait nurse-sister said, "Now you don't stay here anymore."

What is significant here is that the relationship between these two women took on a kinlike quality as Mrs. Joseph's friend assumed the role of the caretaking older sister and Mrs. Joseph submitted to her friend's wisdom like a younger sister. Use of the term *chechi* in this circumstance is not unusual, since formal kinship terms are used in Indian society when addressing elders, even when the individuals are not related. But clearly, Mrs. Joseph's friend took the responsibilities of this relationship seriously. She not only proactively counseled her to emigrate, but she also offered to help her financially so that the younger woman would not have to burden her family with the costs of emigration.

Such fictive kinships are not unique to the networks of immigrant nurses from Kerala. Mexican immigrant women have adapted the *confianza/compadrazgo* system to form fictive kinship relationships that help them maneuver in the alien environment of the formal workplace (O'Connor 1990). Cecilia Menjivar (1995a) learned that the Salvadoran immigrants she studied applied kin terms to members of their hometown on whom they depended for help in the process of emigration. Marixsa Alicea (1997) found that Puerto Rican migrants' fictive kinship ties, mostly the product of women's kinship work in the community, allowed people to claim they were related to almost anyone and to introduce friends in Puerto Rico as relatives to their children.

The nursing school friendships–fictive kinships that coalesced into transnational networks were sources of support to nurses but conceivably threatened others around them. Potential tension existed between the prescribed norms of dependence on husbands and extended-family members and the new pseudofamily relationships, which were strengthened by the process of immigration. Mrs. Thomas, for example, talked about how she avoided potential tension: "I obeyed my husband. My friend offered everything, but my husband wanted me to stay with his sister." Thus, Mrs. Thomas decided to stay with her husband's sister, with whom she was hardly acquainted, to maintain peace. Similarly, Mrs. Simon recalled that many women's friendships became strained when their husbands immigrated and could not get along with their friends.

In utilizing these networks, the nurses partly transformed the ground on which they stood, shifting from extended family channels of support to those developed in their professional ventures. Despite the difficult process of becoming incorporated into the nursing labor market in the United States, and the racism they faced, they continued to develop their professional identities by winning new respect for their own capacity to be better nurses in American hospitals.

Nursing in the United States

Indian immigrant nurses, like other foreign nursing graduates, must become credentialed as registered nurses (RNs) in order to work in the United States. The requirements for licensing have changed over time and vary from state to state. In the 1960s and through the early 1970s, as long as foreign graduates showed proof of a nursing education and a license from the home country, they could register to work in the United States. In the early 1970s, an increasing number of states in the United States began to require foreign nurses to pass state board exams to practice as RNs. Passing these exams became a major obstacle for many foreign nurses. The *American Journal of Nursing* reported that 84 percent of foreign nurses failed their first attempts at state boards in 1975, and that some of these continued to fail on consequent attempts ("Pre-immigration Tests Start in October for Foreign Graduate Nurses" 1978).

To respond to the dismal state board exam failure rates of foreign nurses, the Commission on Graduates of Foreign Nursing Schools, estab-

lished in 1978 in the United States, administered screening examinations to aspiring immigrant nurses in their own countries. The exam significantly boosted the rate of success of foreign nurses who took the state boards to obtain their RN licenses.

Once foreign nurses were allowed into the country, they had to jump over a number of hurdles, in addition to obtaining registration, to become recognized as nurses. In U.S. hospitals and nursing homes, especially in the inner cities, they confronted a racialized division of labor, which I discuss in a later section. However, despite the discrimination and other obstacles they faced in the workplace, they gained a new sense of professional pride from their work.

BARRIERS TO INCORPORATION AND MOBILITY

For the nurses whom I interviewed, the state board examinations presented an extremely challenging impediment for many reasons. First of all, the exams were difficult given the Indian women's educational background. Besides the challenge of language comprehension, many were not familiar with the multiple-choice format of the exams. The five sections of the exam included psychiatric nursing, which was not a part of the required curriculum in India for most nurses at the time. Furthermore, as was determined in the late 1970s, the state licensing exams were culturally biased against foreign nurses, which also contributed to their low rate of success.

It was a financial burden for the newly arrived immigrants to meet the costs of taking the exam. Most worked as nurses' aides, making meager wages with which they had to support themselves and, in some cases, children and unemployed husbands. Paying exam fees became expensive for immigrants when the test had to be taken multiple times until they passed all the sections. And preparation for the exam was expensive because it required separate books for each of the sections and completion of coursework that was not a part of the curriculum in India.

Furthermore, the requirements for the exam were confusing to the immigrant nurses, and these requirements varied from state to state. Consequently, few nurses went to Massachusetts, where the exam was reported to be very difficult, and more nurses went to Texas, New York, New Jersey, and Florida (Williams 1996: 20). In general, the requirements included obtaining verification of their educational history in particular formats, which were not always easy to procure from Indian institutions. For example, according to Mrs. Varghese:

> Even though you are a graduate from there, you have to pass the GED. I had graduated from high school and gone to college, so I did not want to take the GED, but I did not have a high school or college transcript. They don't accept the college certificate from India. They need everything in transcript form showing all the courses — physics, chemistry, et cetera. I sent a letter to my family and asked them to go and get a transcript from my college. But the rules are that they cannot send it to me. It has to go straight to Springfield. All these rules and regulations! Nobody ever told me. It took my school of nursing fourteen months to send my transcript. Somebody has to go behind the peons day after day to get them to send it. I had nobody there who could do that for me. It took some time for me to take the exam here.

In Mrs. Thomas's case, her husband had to go to India in person to round up all her paperwork before she could take the state boards.

Because of the difficulty and time involved in passing the state boards, most foreign nurses obtained jobs as nurses' aides in the meantime to make ends meet. Some states granted foreign-educated nurses interim permits to work as registered nurses if they had met the prerequisites for taking the next scheduled RN licensing exam. But in most states the only professional option for unlicensed nurses was working as a nurse's aide. (See appendix 2 for a description of different types of nursing jobs.) However, this meant that many foreign nurses ended up performing the work of registered nurses while getting paid nursing aides' salaries. Mrs. Eapen explained how this came about in her case: "I knew what to do. I knew how to change dressings. I studied in India, plus when the IV bottles were empty, I could change the IV solution for them if they were at lunch or they were busy. The things that I was not supposed to do as a nursing assistant, I was doing for the nurses. Either they asked me or I just had the free time and I used to do it." However, this practice made her very unpopular with her peers. The other nurses' aides did not like the extra work that she was doing, and they would report her to the administration, reducing the solidarity on the ward floor.

Many of the nurses I interviewed found it hard to work as nurses' aides for a number of reasons. It was emotionally difficult to do work that, in their eyes, had little to do with nursing. Mrs. Punoose told me that, in India, sweepers with no professional education did the dirty work, such as emptying bedpans. It was also physically demanding for the typically petite Indian nurses to lift heavy patients in and out of bed. Furthermore, they had to compete with American women — mostly African American nurses' aides — whom they perceived as having better language skills and physical capacities. Nursing home administrators were also less keen on

hiring foreign nurses as aides because they feared, correctly, that foreign nurses were only waiting to pass their RN exams to leave for better opportunities.

For those who passed the exam, getting a job was not very difficult, given the shortage of nurses. Once immigrant nurses are licensed, they tend to work for more years than native nurses, who experience burnout and leave the profession earlier. However, even though immigrant nurses have long careers as nurses, few rise to managerial positions. In part, this results from the discrimination that does not allow immigrant nurses to rise to positions of leadership. Mrs. Lukos was an exception among the women I interviewed, because she was a nurse manager. Yet she too spoke about the difficulties of her position: "I have to do fifteen times more than what a white person does to survive as a manager. And my opportunities are also fifteen times less. . . . In order to get the next promotion as a vice president of nursing, I have to work fifteen times more. That's the system."

On the other hand, many immigrant nurses were not in a position to focus on career advancements, given their family obligations. Because the nurses I interviewed were supporting not only themselves and their immediate families but also an extended family in India, they tended to work long hours and use many strategies to earn higher incomes. For instance, they worked evenings and night shifts, which paid a higher premium. Or they worked double shifts and holidays, which often paid time and a half or double hourly rates. Furthermore, being a head nurse means more responsibility with very little compensation in the form of overtime pay or shift differential. Consequently, most of the immigrant nurses, who were already pressed for time, were not interested in additional responsibilities while facing the challenges of a racialized ward floor.

RACIALIZED EXPERIENCES ON THE WARD FLOOR: "REAL NURSES" VERSUS "REAL NURSING WORK"

Indian Christian immigrants are no strangers to discrimination. Since in India many of them worked in the north, they were minorities on two counts — as South Indians and as Christians. Consequently, a number of them expected to find a different experience in the United States. Mrs. Lukos described her sense of disappointment on this issue: "When I looked ahead, I didn't think that my kids had the same future that I did — because [the] majority [in India is] Hindu or Muslim, and Christians are just pushed aside. So I thought I should go to some country where people are treated equally, but it is not so great over here either. I was mistaken."

On the ward floor, immigrant nurses face discrimination by patients, doctors, and hospital administration as well as from their peers. Many of the nurses spoke of being rejected by patients who asked outright for white nurses, as happened to Mrs. George: "Some patients don't like us — our color. When that happens, we tell the patient that in all the other hospitals, in the 3 [P.M.] to 11 [P.M.] and the 11 [P.M.] to 7 [A.M.] shifts, it is only foreign nurses who work. There won't be any American nurses. And some patients will insist, 'I don't want you. I want a white nurse.' Then we tell them, 'If you want to find a white nurse, go ahead and look for one.'"

While Mrs. George described the racial element of the rejection, Mrs. Eapen's story pointed to another dimension of the rejection — namely, the questioning of their professional capacity. Mrs. Eapen worked on a floor where she and two other immigrant nurses covered the weekend evening shifts. In one incident she described, which involved another immigrant nurse as well, a patient expressed his lack of faith in her professional capacity: "So he said, 'I want to see a nurse.' We both had uniforms on. We both had our identification badges. So I said, 'We are nurses. My name is Susie and this is Nanny. We are both registered nurses.' He said, 'I want to see a real nurse.' So I said, 'We have our registration. We are registered nurses. So I think we are real nurses.'" After Mrs. Eapen explained to him that there was nobody else to help him, the patient came back to them later and apologized. Mrs. Eapen was skeptical about the apology, since she thought he had realized that he had no choice and needed them to take care of him for the next twelve hours. For the immigrant nurses who had to overcome many obstacles both in India and the United States in order to become nurses, it was especially painful to have their professional authenticity questioned.

Besides rejection by patients, the immigrant nurses had to deal with the racist assumptions of doctors and hospital administrators. For example, Mrs. Lukos talked about a discrepancy in how a nurse manager dealt with her and her American colleagues regarding a test required for all employees in the intensive care unit where she worked. The nurse manager singled out Mrs. Lukos with the warning that she could not work in that unit if she did not pass the test. Mrs. Lukos found that none of her American colleagues had received similar warnings. She surmised that "the nurse manager thought I am from a foreign country and I am not intelligent enough to pass." While Mrs. Lukos passed with the high score

of 98 percent, she discovered that one of her American colleagues had failed the test and was still scheduled to work. She successfully challenged the nurse manager's double standard, and the American nurse could not continue working in that unit.

A number of nurses told me about doctors who complained they could not understand the nurses' English, even though nobody else had trouble understanding them. Although many Indian nurses have English training and English-language nursing curricula, fluency in spoken English can be challenging for many of them. For those who are fluent, their accent can present an added obstacle to communication. Unlike upper-class Indians, whose spoken English is often distinguished by a "British flair," middle- and working-class Indians, particularly those originating in rural areas, tend to speak English with accents identifiable by their particular linguistic background.[21]

Others nurses noted that doctors did not consult with them because they assumed that the immigrant nurses did not know what was going on. Mrs. Eapen complained about a number of instances where a doctor passed her by to ask her white colleague questions about Mrs. Eapen's own patients. When such mistakes happened consistently, the nurses felt that they were more than simply coincidence. Furthermore, a couple of the nurses told me that they felt that doctors and administrators were checking up on them behind their backs.

Another important group of people with whom the immigrant nurses had to get along was their American colleagues. One immediate problem for the immigrants was their lack of cultural capital, which made it difficult for them to interact socially with their peers. Despite not having a "language problem," Mrs. Philip explained, she had difficulty at work : "It takes courage to be with people and talk and laugh and joke like they are doing. I still feel the difference, being with white people, because I don't even understand them. Maybe it is my age difference with the group. Although they are at work, they talk about life at home, like their boyfriends and girlfriends, stuff like that, where I can't talk in that way with them."

This difficulty with social banter affects the nurses' integration into the workplace. Many complained of feeling isolated especially when they worked in the small private suburban hospitals of Central City. Mrs. Punoose, who worked in such a hospital talked about being the only one without any backup in a racially segregated ward floor. She said that the Filipinos there supported and helped each other, as did all the white nurses. Because she was the only Indian nurse, she felt alone. She felt that

support is especially necessary in private hospitals, where there are few nurses of color and weak or nonexistent unions.

Mrs. Punoose's experience offers a sharp contrast to that of Mrs. Samuel, who worked in a large, public inner-city hospital. She described a ward floor that included nurses from mostly Asian countries — Indians, Filipinos, Koreans, and Thai — along with black and white American nurses. There were six nurses from Kerala who worked in her ward, and many more in the hospital. She said that the immigrant groups spoke in their respective languages at times, and that the others jokingly chided them for doing so. The social atmosphere described by Mrs. Samuel seemed strikingly different from that in Mrs. Punoose's hospital, but the two cases highlight the ethnic and racial lines of division among the nurses.

When facing devaluation of their work, and social segregation of the ward floor, the immigrant nurses I interviewed resisted by defining the work they did as "real nursing work" as compared to the nursing done by American nurses. The distinction goes as follows: Indian nurses are better at doing the "actual work of nursing" — the practical work of bandaging patients, checking intravenous tubes, and inserting catheters — whereas American nurses are good at "charting, writing, and sweet talking."

A number of the immigrant nurses, such as Mrs. Simon, complained that American nurses got away with not doing the "real nursing work." As she put it, "I see, like, a couple of nurses, not everybody — just a couple of nurses — they come and they sit and they talk, talk, and talk. But you hardly see them moving around and working — I mean, the real nursing job." When asked whether theses were immigrant nurses, she responded:

> No, these are white Americans. They will flirt around with white doctors — Blah, blah, blah, blah — I mean, we don't go for all these things. We come, do our job, take care of our patients, say, "Hi, I am so and so," and we do our job. The Americans have a way of saying, "Hi, honey, how are you? Hi, sweetheart." I mean, I have even seen nurses kissing the patients. We don't go for all that. And the patient likes that — the patient thinks, "Oh, the nurse — so wonderful she is." You know what I mean? Those nurses can act a lot. They get better feedback from patients. At the same time, we may be working hard and we may not be getting that much appreciation.

In Mrs. Simon's eyes, the American nurses can do less "real nursing work" because they are good at sweet-talking the patients and flirting with the doctors. While Mrs. Simon characterizes her partiality to "real nursing

work" as a choice — "We don't go for all these things" — it is also clear that she would be less successful at kissing the patients and flirting with the white doctors. Thus Mrs. Simon and her ilk are limited to doing what she calls "real nursing work."

Second, Mrs. Simon contrasted "real nursing work" with "paperwork," which she characterized as preferred by white nurses. She talked about the ambulatory unit — where patients report before surgery — which she said was entirely made up of white nurses who mostly do paperwork. Because the patients in the ambulatory unit are not yet bedridden, they do not require much practical nursing care. Mrs. Simon described her own reticence to work in ambulatory nursing:

> I don't like ambulatory nursing because it's not really nursing — it's like more of a office-nurse type [of work]. Lot of paperwork — I really don't like doing paperwork much. I like to do real nursing. You know it's stimulating — watching the blood pressure and checking the patient's fluid levels. Things like that are more like nursing to me. Ambulatory [nursing] could be boring sometimes. Sometimes it could be so busy that it could make you confused, if you are not used to it. All the patients come, and so many people you have to send together to the OR [operating room]. You have to check everybody. You have to be careful — anything you didn't do, and they will call you. So originally the nurses were all white — in ambulatory, they are all white.

In this statement Mrs. Simon first identifies her distaste for working in the ambulatory unit as a choice. She prefers to do "real nursing," which is more stimulating than paperwork, but she then admits that doing all the paperwork in the ambulatory unit could be confusing for her. Consequently, she and other nurses like herself end up in wards where the work is physically more labor-intensive but requires less paperwork.

The notion of "real nursing work" points to a racialized division of labor that the immigrant nurses confront in the United States. If they fail to pass the state boards, they are forced to work as nurses' aides with other mostly minority women. With registrations in hand, not only are they more likely to be recruited for inner-city hospitals with other mostly Asian immigrant nurses but also they are more likely to work in wards where the work is physically labor-intensive and in areas with a high burnout rate for native nurses (Ong and Azores 1994). And despite the their limitations, the Indian immigrant nurses I interviewed, like Mrs. Simon, managed to find new empowerment in their vocation. Not only were they "real" nurses doing "real nursing work," but also they functioned as teachers and consultants on the American ward floor.

"DIRTY" NURSING REINSCRIBED: PATIENT CARE MANAGERS, TEACHERS, AND CONSULTANTS

Even though nurses were considered to be doing "dirty work" in India, few nurses, once they graduated and obtained staff positions in hospitals, had to clean up after patients. For example, many of the Indian nurses I spoke to recalled that there were ayahs or *methranis* in Indian hospitals — women who did the work of emptying bedpans and cleaning up after incontinent patients. In India, the "direct nursing work" — the dirty work — was left to nursing students, family members, and ayahs, whereas the staff nurse passed out medicine following the doctor's orders.

There is a clear hierarchy of care in Indian hospitals, where staff nurses are second in command after doctors and they maintain a distance from the dirty work as they move up the medical ladder. For women like Mrs. Punoose, it was a shock to find out that, in America, even "the nursing director will do the work of a nurse if it is necessary." The Indian immigrant nurses encounter a different philosophy and practice in nursing in the United States, as well as advanced technological resources that give them greater autonomy and a better estimation for their own capacity as nurses.

Many of the nurses I interviewed brought up "total patient care," a nursing practice that was different from what they had been accustomed to in India. As Mrs. Thomas explained, "Here nursing is about total patient care, the total well-being of the patient — mental and physical care of the patient as well as the patient's family. Back home you give medicines, that is all." The practice of total patient care requires nurses to be patient care managers. Not only must they respond to the patient's mental, physical, and emotional needs, but also they must represent the patient's needs to doctors, dieticians, pharmacists, and other caregivers in the medical team, as well as to the patient's family.

Total patient care was impossible to achieve in India, given the average nurse-patient ratio of one nurse to sixty patients. As a result, it was difficult for nurses to develop any personal relationships with patients. Mrs. Thambi observed, "I didn't know the patients' names. I didn't know who they were." Mrs. Philip noted that, in contrast, "here you have to be very polite to them and take care of them as a close friend."

Furthermore, many nurses emphasized their new role of teaching in their interactions with patients. Because U.S. law requires that patients be made aware of the effects of each medication and medical procedure, it is the duty of the nurse to keep patients informed. It is also the nurse's

responsibility to question doctors and pharmacists in case of mistakes regarding the appropriate medications and dosages.

The immigrant nurses I interviewed spoke of having to take numerous courses to keep up with the changing medical field and fulfill their obligation as teachers. Mrs. Philip talked about how much more knowledgeable she felt about nursing as a result: "I think that I know more here than the doctors in India did. . . . I have taken a lot of classes. These are all special courses. . . . Yes, they teach us here. I did not know how to take an EKG [electrocardiogram] or look at an x ray in India, but here I do."

As patient care managers, as teachers, and as students, immigrant nurses are practicing their profession in new and varied ways. Mrs. Jacob put it best when she observed that, in the United States, nurses are like "consultants" and "patients are the beneficiaries." When I asked her to compare her experience as a nurse in India to that in the United States, she responded:

> It is much better here. I have the autonomy. I can make decisions. I can make an assessment. I am not carrying out orders like a robot. I think, and I put my education into what I am doing on a daily basis. There I cut someone's nails and hair because the staff nurses told me to. Over here I know why I am doing it, physiologically. You are improving your circulation if you massage the head. . . . Even though I am told to do it here also, I can make an assessment myself. I am not carrying out the doctors' orders here; I can question if something is wrong. Lots of autonomy.

As a consultant, Mrs. Jacob felt more empowered to autonomously make decisions and assessments in a way she did not feel capable of doing in India. But along with the increased autonomy comes additional responsibility and increased tension.

The legal aspect of nursing in the United States is a new feature for immigrant nurses that has also increased stress in their work experience. Mrs. Thomas verbalized the tension that comes with having to follow the letter of the law. As she put it, "Here, suing comes to mind first, before you do anything. So you have to learn to be very smart, to know the law. If I do this, it is not right. If I write this, I will be sued or I will lose my job. Here it is easy to lose the job. That makes you stressed, whereas in India you don't lose the job unless you really did something very serious, where people died or something like that. It is very stressful here, very stressful."

Despite the added responsibilities and the lower job security, most of the nurses spoke of greater professional gratification in the United States. With the help of better available technology, they feel a sense of accomplishment at being able to "save lives" more effectively. Mrs. Peter explained her improved evaluation of nursing: "Since we have heard the negative criticisms about nursing from our childhood, a part of that is still in our minds. Very difficult to get rid of it. After coming here, there is no way we can find fault with our profession. It is as equally important as other professions like [those of] doctors, physical therapists, et cetera. I don't see any difference."

Despite structural barriers posed by the difficulty of incorporation and by racial discrimination, immigrant nurses are able to find new professional self-worth through their work experiences.[22] As managers, teachers, and consultants in the United States, they have more autonomy in their work and feel more effective. However, this is not the experience of their spouses, most of whom experience downward mobility in the immigration process.

MEN'S IMMIGRATION AND WORK

Whereas, among most other groups that migrate to the United States, the men arrive first, in the case of the Keralite Christians I studied, the women, as nurses, came first and later sponsored their husbands and families. Typically, the men waited in India with the children until they were allowed to join their wives, who by then were working in the United States and supporting their Keralite households. In other cases, single women went back to India with their green cards and found husbands, whom they then sponsored as spouses. In this immigration experience, conventional roles were partially reversed for men and women (Williams 1988).

While the immigrant nurses experienced upward mobility and an increase in general status, especially due to their ability to sponsor migrating family members, many of their husbands became downwardly mobile and lost status in the immigration experience. These men experienced loss of status in two ways: with respect to the women in the community, and relative to their social and economic positions before immigration.

Relative to their wives and sisters who are nurses, Keralite immigrant men faced the prospect of perhaps never making as much money or gaining equivalent professional status. Although in India many of the women worked and contributed financially to the household income, they were not the primary breadwinners. Consequently, after immigration, men's lives became reordered — around the their wives' employment opportunities and family obligations.

A second way that men lost status was with respect to their social and

economic positions before immigration. The difficulty in transferring Indian degrees, credentials, and work experience to the U.S. context often left the men in the position of having to start all over again. As immigrants in the United States, they had less access to the political and social structures of the wider society. Low incomes and unstable employment, usually in secondary-labor-market jobs, left many men with few opportunities for public participation and access to leadership positions. Men not only lost autonomy and patriarchal status in the immigration process but also lost their sense of belonging. They felt isolated in the United States.

NURSING-BASED IMMIGRATION

Since women were the primary agents of immigration, their husbands and male kin were dependent on them when they joined them in the United States. This dependence often went beyond the financial aspect to include social orientation in American society. Because they immigrated prior to the men, the women of the community were initially more proficient in dealing with the American society. Whereas some men married nurses with the intention of coming to the United States, others came because of their wives' initiative. For example, Mr. Peter told me that he had forfeited the opportunity to emigrate to Kuwait before marriage because he was doing very well in his bank job in Bombay and had hopes of getting a promotion and transferring back to Kerala. However, he changed his plans to follow his wife to the United States.

Two of the men I interviewed had not yet officially resigned from their jobs in India, even after twenty years of being in the United States. Mrs. Punoose described her husband's situation: "When he first got here and got into the car at the airport, he said 'I am only here for six months.' He had a salary of ten thousand rupees, and he did not want to lose that job. He wanted to go back and continue that job. But after six months, he sent a medical letter stating that he was temporarily unfit to work. Finally, he made the decision to resign, but since he could not send some paperwork, he has not yet resigned. . . . After all these years, he is still here. If he goes back, I cannot stay here." While Mr. Punoose planned to be here only temporarily, it was ultimately his wife's desire to stay that kept him here. Perhaps Mr. Punoose, who has returned several times to India, has not yet resigned because he is holding on to the hope of return.

Unlike their wives, who were much sought after in the employment market, the men had difficulty finding employment. Initially, the majority of the men were completely dependent on their wives, and then usually became only secondary providers for their households. In contrast, in India husbands and wives tended to have equivalently paying jobs.

Consequently, after immigration, the men I interviewed found that their lives were more likely to be ordered around their wives' work schedules and their children's needs. For example, both Mr. Thambi and Mr. Kurien dropped out of educational programs to take care of sick family members. In the absence of adequate child care, Mr. Papi quit a job to take care of his two children while his wife worked. Mr. Lukos spoke of his enduring remorse at not having furthered his education and career: "I got the job my second week here. That was a mistake. I should have waited and evaluated more, but I took a small job as soon as I could. They were nice people, but professionally it was damaging to me. . . . Also, because of taking up this job, I had to pick up the kids and be with the family, and I was forced to do that. That was very costly. I should have gone straight to school — does not matter what it was." The fact that Mrs. Lukos was working and going to school made it difficult for Mr. Lukos to go to school.

The men had to adjust their work aspirations to accommodate their wives' work schedules and work locations. Given that many families had only one car in the beginning, the men had to be available to drive their wives to and from work. Also, a nurse's job availability determined where the family could live. If nurses had trouble passing the board exams in a particular state, the men had to follow their wives to states where the exams were easier for them to pass.

Because women immigrated ahead of the men, they were able to sponsor family members in India before their husbands could do so. As a result, often the women's extended family immigrated before the husband's family did. Raymond Williams observes, "Tracing the network of an extended family or congregation often leads to an 'immigration matriarch' whose decision to immigrate ultimately led to a much larger community of family and friends being formed in the United States" (1996: 203). The family members required not only financial assistance for the journey but also help in getting established once they arrived in the United States. Consequently, there was some tension in the sponsoring family, as husbands felt resentful of resources being spent on the wives' families. Mr. Patrose gave his view on the cause for male resentment:

> So what happens is that, when they become citizens, these ladies try to bring their relatives. In most of the cases, they came ahead of us by two or three years. So they started to bring their relatives, and she is always supported by her small clan. The man becomes sort of isolated. Even if he brings his family, it is a little later than the wife's family. There is domination there. She has already sent money for their

tickets. . . . All the spending is done by her. So wherever relatives have come, mostly only her family has come and his family hasn't. Nobody from his family is around. Then we know that, in that family, the domination is on the wife's side and less on the husband's side. . . . The attachment from the woman to her family is still there. Normally in India they can't show it. Here they are able to show it to their own family even after marriage. In India, you are 100 percent married to your husband. That changes. The attachment is less. . . . The American society has brought this to us. Basically that neighbor of mine is not worried about whether I am eating today or not. In the same way, I am not worried about him. That sort of individuality of society breaking into pieces is going on. In this particular case, the husband and wife become separated [have separate goals].

According to Mr. Patrose, that women gain additional support from their clan further undermines the men's already weakened position and increases their isolation.

Furthermore, a number of men talked about their own obligations to their natal families. Culturally mandated male obligations to the family include marrying off sisters, taking responsibility for the welfare of widowed sisters, and taking care of parents in their old age. For example, Mr. Thomas said that the main reason he came to the United States was to make money to provide a dowry for his sister. And in a cultural milieu where women are traditionally understood to be "100 percent married" to their husbands, the married woman is not expected to financially support her natal family. The use of resources to help her family takes away from what is available to help his family. Thus Mr. Patrose interprets the women's attachment to their natal families as being individualistic in an American sense, because the couple is not unified in carrying out their culturally mandated obligation to help the husband's family.

EMPLOYMENT AND UNEMPLOYMENT: NO STATUS, NO SECURITY, AND "TIED TO A STAKE"

Upon immigration, most men attempted to find a "small job," as Mr. Lukos did. After acclimating themselves to the new social and work settings, they would attempt to find better paying employment through Keralite immigrant networks. Because their degrees, credentials, and work experience were not always recognized in U.S. workplaces, the men had to retrain themselves in new professions, take secretarial and clerical jobs, or do manual labor to contribute to the family income.

Most of the men I interviewed went from doing physically difficult jobs to easier jobs that required some training, such as electronics, respiratory therapy, and x-ray technology. Some took advantage of programs made

available by the Comprehensive Employment and Training Act, which provided job training for the unemployed.[23] Raymond Williams, in his study on immigrant groups from India and Pakistan, says of Keralite Christian immigrant men: "Most of the men who followed their wives took positions in machine shops or factories, or used the connections their wives had in the hospitals to get training as medical technicians" (1988: 108). In an informal survey and in interviews I conducted at St. George's, many men were hesitant to disclose the exact nature of their work and used such vague terms as "business" or "office" when asked about the nature of their employment, illustrating their discomfort in relation to this topic.

Whereas preexisting nursing networks established in India provided the nurses with information as well as help in getting jobs, most of these women's husbands did not have ready-made and lasting support systems such as these. For example, Mr. Elias explained the difficulty presented by not having preexisting networks when he noted, "When you come to this country, you are alone all the time. How do you make your connections? That is very hard. So our own Kerala people helped me get a job."

Mr. Elias's work history demonstrates how he depended on other male immigrants from Kerala to move from job to job. He found a job as stock boy in a furniture store with the help of an immigrant friend. After working there for three months, he got a job as a packer and messenger in another company with the help of another immigrant acquaintance. While there, he befriended another Keralite immigrant, who helped him find his third job, as a worker at a shipping dock. Although he made a lot of money at this job, he wanted to further his education and consequently left this job. Again Mr. Elias turned to his immigrant acquaintances for information, but he ran into the limits of the newly formed network. As he put it, "I wanted to go to college, but nobody knew how to do it, because there were not too many Indians there. So I, who came from India, how would I know how to go to college? It was very hard. . . . Nobody knew anything in those days — 1976. I ask one person how to do it, and he says, 'I don't know.' Then I ask the next person, and he will also say he doesn't know. . . . After two years, I figured out how to enroll in college." Mr. Elias's experiences highlight the shortcomings of the networks available to the immigrant men. Not only were the men all equally unaware of how to access resources in this society, but also they were in the same tertiary job market, floating from one unsatisfactory job to the next.

The sociologist Cecilia Menjivar, in her engaging book about Salvadoran immigrants in the United States, found a similar weakness in the networks of those she studied. As she puts it, "When all members of one's network live in highly constrained conditions, links to multiple social fields

that could create social capital are practically nonexistent. . . . Thus our attention should shift from reifying the notion that immigrants achieve benefits through informal exchanges with relatives and friends toward examining the structure of opportunities that determines if immigrants will have the means (and what kind) to help one another in the first place" (2000: 156). The "structure of opportunities" available to the men in my study channeled them into particular areas, such as technical or medical fields. For example, Mr. Mathew explained how a Keralite nurse who was a supervisor at a nursing home became the point person of an immigrant network for men: "All the Malayalees that come from Kerala first go to her for a job. . . . A lot of men would apply for other jobs in factories and places like that while they were working in the nursing home. And when they got jobs, they would quit the nursing home and go."

Because they had to accept whatever job was available to them initially, many of the immigrant men had to abandon any status-related reservations that they had about doing manual labor or other such jobs. Because manual labor paid more than clerical work, it was more lucrative for the immigrant men. Furthermore, there was a leveling of status in the beginning for all the immigrant men, since even the professionals — such as the physicians or dentists — could not work in their professions without passing their registration exams. As a result, even physicians and dentists were working as cashiers and security guards. It was while reflecting on immigration as a status-leveling experience that Mr. Samuel observed, "There is no status here, period. . . . You can't say that I don't do that kind of thing, because you have to eat and you have to pay the mortgage. There I could say, 'I don't care for that job. I don't want it. That is too cheap.' Here there is no way to say that."

While the men were willing to take any job, there was very little job security in their postimmigration employment. Over a quarter of the men I interviewed who came as the husbands of nurses lost their jobs after ten or fifteen years of working for a company because of downsizing or relocation of the company. In the recession of the early 1980s, the ebb and flow of the U.S. economy more immediately affected men in the secondary labor market. As Raymond Williams explains:

> In the early 1980s many who had gained a foothold in the lower rungs of the ladder lost their jobs in the recession that hit the northern cities in the "rust belt" and the southern regions due both to the oil crisis and the recession in the aeronautical industry. A congregation in Houston began construction of a new church building, and six months later half of the congregation had lost their jobs, primarily the men. Such job insecurity was novel for men from India because, although India and especially Kerala has a high unemployment rate, those who have jobs keep them for life without lay-offs or dismissals. (1996: 203)

As these men compared their work situation to that in India, many complained about the lack of unions or about weak unions in the United States. Mr. John, whose job was a casualty of the Reagan era, spoke about the lack of freedom in the United States:

> Even though we say America is a democratic country, really it is not. In India we have all kinds of freedom. What can you do of your own in this country? We are working here. Do you have any guarantee? We don't have any guarantees at all. However smart you are, they can fire you any time. But in India this kind of situation is not there. If you have a job in India, and you have three hundred and sixty-five days' experience, your job is secure. Nobody can do anything against it. Here unions have no validity. . . . If you look deep into the system, you can see the flow of slavery current underneath. The common masses do not realize it. They are using the people.

After working for thirteen years in electronics, Mr. John was laid off and was not able to find another job. At the time of the interview, he had not found another job and was training to become a chauffeur.

Like Mr. John, Mr. Samuel saw the lack of job security as connected to a systemic problem. In comparing his current employment position to his past in India, Mr. Samuel also underlined the lack of union strength in the United States: "There in India, once you are in the register — especially in government and factory jobs but no matter what job it is — once you are in the attendance register, you are a unionized person. No matter what you do, your job is guaranteed until you retire. Here no matter how they polish it, . . . there is no security."

Mr. Papi, who worked at a mental institution, felt there was discrimination at his workplace. Given his background in India as a union organizer, he decided to do something about it. He attempted to garner support to start a union. However, his position was terminated, and he believes that his interest in starting a union may have been a cause.

The lack of job security led a number of the men to speak of a broader sense of insecurity and isolation that they felt in the United States. For example, Mr. Samuel spoke of the absence of a safety net:

> When it is good, everything is good here. When it starts falling apart, this is the worst place. If you are in India, when you fall apart, there will be neighbors, friends, relatives there. Here there isn't anybody. That is the difference. That is my

feeling. There is no safety net. In India, with all the relatives — even if they don't help or do anything, I always mentally feel like there is somebody behind me to back me up. Always there are people with me — relatives — somebody is there. Here, I always get an emptiness in the depth of my mind. As long as you are okay, healthy, your job is there; everything will go smoothly, and you are safe.

Even if his relatives were not necessarily in a position to help him, Mr. Samuel knew that he was not alone in having to face his problems. He misses the sense of connectedness built into the basic social framework in India.

Others, like Mr. Markos and Mr. Thomas, spoke of the absence of a social life. Mr. Markos remembered his life in Kerala where, after a day's work, there was always an opportunity to relax and speak with relatives and neighbors. In the United States, his sole confidante and friend was his wife. He missed the members of his extended family and commented that, while he was better off financially in the United States, he felt that he had "lost everything." Mr. Thomas, who was a union organizer, spoke about his isolation: "I was a person who was always working with people and walking around, doing public works. So my nature was like that, and now I feel that I am tied to a stake."

My male subjects are not alone in their marked feelings of isolation. The Salvadoran male subjects in Cecilia Menjivar's 2000 study also told her about feeling depressed and lonely. Menjivar hypothesizes that gender ideologies shape the way men and women use the networks available to them. She found that men were more likely to talk about the sharing of material resources than about getting moral or emotional support from other men. Prema Kurien (1998), in her work on South Asian immigrants, similarly found that the loss of same-sex networks after immigration forced Indian immigrant couples to depend much more on each other than they had in India. Likewise, the men I interviewed were less likely than their wives to look for emotional support from their networks. Consequently, men felt alone and disconnected socially.

For men, immigration brings a very different set of experiences than for their spouses. Because they follow their wives, who have stable employment, their work aspirations must come second to their wives' employment requirements. Unlike their wives, who are supported by a network of nurse friends as well as by family members they sponsored, the men do not have such preexisting connections to help them. Unlike their wives, they experience downward mobility and a leveling of status in their search for employment. Low job security leads to a decreased sense of

autonomy and control over their lives. Furthermore, they feel alone and without safety nets in a rather precarious existence in the United States.

Conclusion

While the new earning power of the Keralite nurses was welcomed by their families, it also created some confusion in Keralite Christian society. According to tradition, obligations and responsibilities to loved ones governed all relationships within the family. Parents were obligated to pay dowries for daughters and give designated gifts to grandchildren when daughters came home to deliver their babies. Sons were responsible for the welfare of parents in their old age. Brothers were responsible for the welfare of sisters and their children, especially if they were widowed. Wives were "100 percent married" to their husbands and attached to the husband's family. And the husbands, who were sons and brothers, had culturally binding obligations to their natal families. The new earning power of the nurses was a disruptive force that challenged the given nature of such obligations to the family and, consequently, to society.

As the nurses exercised their newfound autonomy in collective ways, they also challenged gender and class norms within the family and society. Consequently, they were able to contribute to the growing democratization of the moral framework of the family and society. Within their natal families, they were pioneers in demonstrating that a daughter is not a burden. They were often selfless in their attempts to help siblings and extended-family members, underlining the value of all women. They contested the assumed rights of husbands and husbands' families over wives, using their selfless desire to help their own natal families as the moral ground for this challenge.

Their relative independence and financial autonomy placed them in a position to question societal gender and class norms. In a society where dowry is still the norm, nurses commanded a market power that allowed them to refuse to pay dowry or at least speak against the practice. It was their ability to emigrate to many parts of the world that made them desirable partners, even across class lines. Some potential suitors overlooked the "menial" nature of their work because marriage to a nurse would give these men the chance to emigrate. In this way, too, nurses pushed the envelope of given gender and class norms.

Whereas nurses' entry into the labor market, migration, and work experiences in the United States helped them gain autonomy, they expe-

rienced it within the context of connectivity — of a self fundamentally understood only within relationships and obligations. Rather than simple autonomy, they gained connective autonomy in the immigration process. As already noted, the terms of the existing debate about the effect of migrant women's labor participation on women's status assumes a narrow notion of autonomy. Migration scholars might be well served if they pay attention to the differences in the very notion of self and the fluidity of boundaries between people that motivate people to act in ways that may not be recognizable when one uses a more delineated notion of the individual.

Nurses' husbands' experiences of immigration appear to be the antithesis of the nurses' experiences. These men not only depend on their wives in the immigration and settlement process but also must play second fiddle to their wives' careers. They have neither a familial clan nor fictive kin networks to help them in the settlement process. Their work experiences highlight both their insecurity and the absence of safety nets that is inherent in a postindustrial capitalist society. The men lose both autonomy and connectivity in the immigration process. Their downward mobility raises questions about what happens in the domestic sphere and how men compensate for their loss of status.

CHAPTER 3

Home

Redoing Gender in Immigrant Households

Given the status of immigrant nurses from Kerala as primary breadwinners, and the initial financial dependency of the husbands who follow them to the United States, what changes in the household division of labor can we expect to find? With the growing participation of women in the paid labor force, the household division of labor has been a subject of increasing scholarly attention in the last two decades (Berk 1985; Hochschild 1989; Brines 1994). The intellectual debates concerning how men and women negotiate reproductive labor fall across the spectrum. While some argue that women are still burdened with the "second shift" — doing housework despite working outside the home (Hochschild 1989) — others claim that men have taken on more of the housework over the past few decades (Bianchi et al. 2000).

These divergent perspectives on male and female participation in household labor are anchored in theoretical explanations that also run a gamut, from rational choice theories to social constructionist understandings.[1] Most of the empirical research in this area points to the differing time constraints and relative resources of men and women to explain the division of labor (Shelton and John 1996). The time-constraints argument promotes the view that the division of labor is a rational process based on the work that needs to be done and the availability of the individual. The relative resources explanation points to power differentials between household partners, where the more resources a person brings to the household (such as earnings), the less domestic work that person does.

In her study on economic dependency and household work, Julie Brines points out a weakness in rational choice, economistic models (1994). She finds that "the more a husband relies on his wife for economic support, the less housework he does." Brines explains the breakdown of the logical rules of economic exchange by suggesting that dependent men are not only "not doing" housework but also are "doing gender." That is, in the face of cultural norms that equate masculine competency with work and providership, dependent men may feel as though their gender identity is threatened and therefore be less likely to do "women's work" in the home. Thus the production of gender can take precedence over the most economically efficient production of household commodities. Following Brines, one would expect that all husbands of nurses would resist housework in the interests of doing gender. But I found that the Keralite immigrant men and women in my study relied on a variety of strategies in dividing household labor and in resolving tensions between gender ideologies and lived reality.

It is important to recognize the difference between what people say is their gender ideal and the reality of gendered practices, especially in the marital relationship. The sociologist Arlie Hochschild (1989) distinguishes between gender ideologies and gender strategies to make the point that there can be contradictions between the two. A person's gender ideology has to do with his or her understanding of manhood or womanhood and how that person identifies with masculine or feminine ideal types. Gender strategies, on the other hand, are plans of action that individuals adopt to reconcile their gender ideology with lived reality.

The most common point of reference for the gender ideologies of the couples I interviewed was Kerala. Some women held ideologies that contested the Keralite norm, and they attributed these ideologies to American societal influences. Another point of reference for gender ideologies was religion. Some women talked about the importance of obeying husbands as a religious obligation. In some households, there was a fit between ideology and lived reality, whereas in others there was dissonance. But both men and women used different gender strategies to sustain the fit, or to adjust for the lack of fit, between ideology and lived reality.[2]

Given the men's initial economic dependence on nurses, how do Keralite immigrants deal with the challenge of dividing household labor? What variations exist in the ways they divide household tasks and child care? What gendered ideologies and strategies do they use in the production of gender after immigration?

I choose to define the household division of labor along three dimensions — namely, child care, housework and cooking, and financial decision making. These three dimensions correspond to the analytic categories of class and economic factors, status and sociocultural factors, and power and relations of power. Among the twenty-nine couples I interviewed in their homes, when it came to decisions about child care, economic factors such as whether the couple could afford child care or obtain shift work mattered most. Similarly, housework, especially cooking, was clearly linked to status, in that this was a gender-specific task relegated to women within the household. Financial decision-making issues — such as whether both partners had equal say in money matters — tapped into relations of power. This list of dimensions is neither exhaustive nor mutually exclusive, but rather it provides broad categories useful in examining the division of household labor.[3]

In my interviews, I looked for differences in how each couple dealt with dividing household labor.[4] In Kerala, the division is strictly demarcated. That this was so in the natal homes of the immigrant couples that I studied became apparent when I asked them to describe the marital relationship and the division of labor in the households of their parents. Because the mothers of all but one were homemakers, household chores, child care, and cooking were exclusively in the maternal domain, whereas financial affairs, breadwinning, and the disciplining of children fell within the paternal realm. I next asked them about the division of labor in their own households in the United States.

Based on their responses, I categorized the households into four types. On one end of the spectrum is the traditional male-headed household, where the men do the financial decision making and the women do the rest of the domestic labor. On the other end is the anomalous female-led household, where men are not present or active and the lion's share of the labor falls to the women. In between these two categories fall two more types. The first is the forced-participation household, which appears to be similar to the traditional household except that the exigencies of immigration have forced the men to take an active role in child care. The other category is the partnership household, where the couple shares domestic labor in a relatively egalitarian fashion.

A number of factors explain the variation in the division of labor in these households. I focus here on three primary factors that are significant in shaping the division of labor in all the households. First is the pattern of immigration — whether the husband or wife is the primary immigrant. Second is the immigrants' relationship to the U.S. labor market. Third is the couple's access to help with child care, especially from Kerala.

Table 2 shows that these three factors affected the four household types in different ways, with the approach to child care having the greatest variation.[5] It is important to note here that I am not trying to generate a tight causal model. Rather, this table represents some identifiable patterns in the household division of labor that I observed, which can be associated with certain shaping factors.

To explain the variations in the division of household labor, I present each of the four different types of households in turn. After examining the factors that explain the division of labor in the household type, I present an archetypal family who best represents it. Then I look at how the couples who fall into this category deal with the different dimensions of the division of labor — namely, childcare, housework, cooking, and financial decision making.

Traditional Households

The eight families that can be described as traditional households followed the Keralite norm of maintaining gendered domains in the division of labor. The wife was responsible for the cooking, cleaning, and child care. The husband was the patriarchal disciplinarian and had the final say in the arena of financial decision making.

Relative to the other categories, traditional households stood out in a number of ways. First of all, their pattern of immigration was opposite of the norm in the community. In only one of these couples did the wife immigrate first and later sponsor the husband. In four of the cases, the men came first and later sponsored their wives. Two of these couples came together, and in one case, each partner arrived independently, and later met on a return to Kerala when family members arranged their marriage. On average, these couples immigrated earlier than the families in the other categories, since most did not immigrate on the basis of nursing. Five of the couples came on the basis of student or professional visas not related to nursing.

What is also distinct about this category is that the men were not downwardly mobile like the men in the other categories. Seven of the eight men had a master's degree or higher from Kerala or the United States. Six of the eight men held professional jobs in the United States, and almost all of them were paid as much as or more than their wives. Likewise, while five of the eight women had at least a bachelor's level or higher education, only two held professional positions in the United

TABLE 2. Variations among Household Types

Household Types	Shaping Factors		
	Immigration Pattern	*Relationship to Labor Market*	*Arrangement for Child Care*
Traditional	· Men are the primary immigrants	· Men have high status · Women have lower or equal status	· Women stay home · Kids are left in Kerala with relatives or at boarding schools
Forced-participation	· Women are the primary immigrants	· Women have high status · Men have lower status relative to their jobs in India and to their wives' jobs in the United States	· Men are forced to participate · Couples work alternate shifts · Some child care help is available in the United States or Kerala
Partnership	· Women are the primary immigrants	· Women have high status · Men have lower status relative to their jobs in India and to their wives' jobs in the United States	· Men participate · Couples work alternate shifts · There is little outside support
Female-led	· Women are the primary immigrants	· Women have high status · Men are absent, not active, or have low status	· Women are mostly alone · Relatives and the community provide some support

States. Of the three women who had been nurses in India, only one worked full-time in the nursing field. The high level of education of the members of this category corresponded to their relatively higher-class backgrounds in Kerala. Only one of the eight couples came from an impoverished background, whereas the others had been middle class or upper-middle class in Kerala.

Finally, unlike the other households, these families had a variety of options when it came to child care. These included having the mothers stay home to raise the children, sending children to boarding schools in India, and leaving them with relatives in Kerala. Such distinctive features of immigration and background allowed these families to maintain a traditional division of labor in the household.

THE ITOOPS

The Itoop family is highly representative of the traditional household. Thirty years ago, Mr. Itoop left Kerala as an ambitious young man with a dream to continue his education. Leaving behind his young wife and three children, he came to a college in the United States in 1970 to get his second bachelor's degree in computer science and business administration and eventually a master's in business administration. While he had "money, property, and everything" in Kerala, he was not content. Earning a bachelor's education in physics had instilled a fascination with the United States, and he wanted to see "NASA and the spaceship going to the moon and things like that."

Two years later, his wife joined him, after enrolling their children in a boarding school in Kerala. For Mrs. Itoop, the trip to America was not the fulfillment of a dream. In fact, her dream had been to go to college and become a teacher. However, her father had other plans for her, especially when Mr. Itoop's family approached him with a marriage proposal. Consequently, at the age of eighteen, she married Mr. Itoop, who was eight years her senior. When she joined her husband in the United States, he was still a student. In order to support the household, Mrs. Itoop, who had never worked for pay a day in her life, found a job in a factory. After her husband completed his master's degree in business administration, she quit her job. She did not like her factory job and eventually got a secretarial job.

Despite meeting his educational goals, Mr. Itoop had a very difficult time finding a job. It took him two years to find a job as the chief administrator of a nursing institution, where he still works. After seven years of separation from their children, the family was reunited when the children permanently emigrated to the United States in 1977. However, the arrival of the children brought some changes in the workload, especially for Mrs. Itoop.

The Itoops, like many middle- and upper-middle-class families in India, had a lot of help in the management of their daily lives back home. For Mrs. Itoop, the transition from life with her natal family to life with her husband was not a big change in terms of domestic duties. Before marriage, she claimed, "at most we had to take the dirty plates to the kitchen. We had servants to do that. . . . I was lazy to do even that." When the Itoops set up their own home after their marriage, Mrs. Itoop had what she described as an easy life, despite having three small children. She credited the servants for this, especially one particularly "smart" woman who "used to do all the cooking, cleaning, and also took care of the kids. She was very capable. She used to bring me coffee in bed."

However, life in the United States was a stark contrast for Mrs. Itoop. She complained that here "we have to do everything in the place of servants. Everything! Buy groceries, get everything together, cleaning, and everything. We have to go outside and make money too." With the exception of the activity of making money, Mrs. Itoop had to do everything else for the household herself. Mr. Itoop recalled how difficult it was for his wife: "The men back in India, they don't think of such things—helping in the kitchen. So, I was continuing just like that, and she was continuing in her own way as an Indian woman. She never complained. But gradually, I realized that it is not nice to take advantage of the situation. So, I started to help her."

Mrs. Itoop admitted that her husband became more helpful, especially after the children left home and she and her husband had more time on their hands. For instance, she explained that, if her husband came back early from work, he would make tea or cut vegetables, but that she still did all the cooking. Not only did she not mind the cooking, but also she was critical of the young women of the second generation who did not cook for their husbands. As she put it, "We struggle so much to cook for them. That is how we feel. Do you think today's youngsters will do that? 'You are tired and I am tired too.' She will sit down, and if he wants [food], he has to make and eat it. That is the attitude."

She points to American culture as the causal factor behind the shaping of women who are not "subdued." When I asked her what it meant to be subdued, she pointed to some American women who worked with her, as examples of those who were not subdued: "These women consider

their own opinion to be most important. . . . All my women bosses are divorced. The attitude they show at work is the same as the one they show at home." She also mentioned nurses in the Indian community as examples of women who were not subdued, who try to control their men. For Mrs. Itoop, "classy" women were subdued, and neither the nurses nor her female superiors at work fit into this category.

Correspondingly, Mr. Itoop had what he called a "dictator feeling" that paralleled Mrs. Itoop's gendered calling to be subdued. Especially when it came to financial decision making in their household, his "dictator feeling" decreed that "I make my decisions, and that is none of her business." In practice, however, he did discuss decisions with his wife. Mrs. Itoop admitted that if there was a difference of opinion, they would talk it over and her husband would "make her agree" with him, since he was the final decision maker.

Mr. Itoop was also the final decision maker in the important decisions of their children's lives. When it came time to arrange the marriage of one of their sons, Mrs. Itoop recalled, she was keen on a particular young woman for her son. They found out later that Mr. Itoop's prudent rejection of the proposal saved them from a bad match. She used this as an example to illustrate why both she and her children acquiesced to Mr. Itoop's superior decision-making capacity. Much like the Itoops, the other families in this category followed a rigidly gendered division of labor.

CHILD CARE

Because the traditional families did not emigrate specifically so that the women could take nursing jobs, the majority of these women were not the primary breadwinners. As a result, with respect to child care they had more options relative to the couples in the other categories. For instance, four of the eight women in the traditional households did not work outside the home and thus could care for their young children. The other four couples sent their children either to boarding schools or to relatives in Kerala for periods of time. But in all the traditional immigrant families, the responsibility for the children fell on the women, whether they stayed home to raise them or worked outside the home.

The men expressed in a number of ways the assumption that their wives were the primary caretakers of their children. Explaining why his wife did not work outside the home, Mr. Mathen stated, "She is raising my kids. I shouldn't say my kids — our kids." While he very quickly corrected himself to say that the children also belonged to his wife, Mr. Mathen's patriarchal authority over his wife and children was always assumed in his statements.

Her husband forbade Mrs. Paul, a registered nurse, to work after their first child was born. Unfortunately, he lost his job soon after. When he could not find a job after three months, she decided to go to work against her husband's wishes. At the time I interviewed her, she was staying at home to care for their two children while her husband ran a real estate business to support the family.

Mr. Zachariah talked about the child care issues of their household in the past tense, since both their children were grown up. He regretted having sent their first child to daycare, saying that he and his wife should have adjusted their shifts, as was common with other two-job families. But his wife was not like the other "girls," who were able to work and take care of their children at the same time. Consequently, she quit work to stay home with the kids after their second child was born. Mr. Zachariah did not discuss his own untapped potential to help with child care but pointed out his wife's relative limitations.

Whereas the men in this category were clear about their wives' exclusive child care responsibilities, the women were more ambivalent. For example, Mrs. Zachariah's perspective on the issue of child care was different from her husband's: "I threw away my good jobs because of the kids." For Mrs. Zachariah, it was a series of career compromises that finally led to her staying home to raise the children. After she got married, she wanted to continue her education and get a master's degree in nursing. But instead she decided to let her husband continue his education, since they could not afford for both of them to be in school. When her first child was born, she "threw away" a good job to be closer to home. Finally, she stayed home after the birth of her second child and found it extremely difficult to find a job again when the children were grown.

Similarly, Mrs. Cherian, who has a master's degree in natural science from India, chose not to work outside the home because both she and her husband agreed that she should stay home to raise the children. After the children had grown up, she tried to find work but was unable to do so, because her field had changed dramatically in the fourteen years that she was away from it. She instead found a clerical position, where she did not have the opportunity to apply her education.

While the men, such as Mr. Zachariah, focused on their wives' responsibilities and limitations, most of the women talked about missing the support of family members and the servants they had had in India. This lack led some of the couples to leave their children with family members

in India, especially during the early childhood stages. Once the children were older, they were brought back to the United States or sent to boarding schools in India.

HOUSEWORK AND COOKING

Traditionally, cooking and cleaning in Keralite society has been clearly demarcated as women's work. In fact, the men I interviewed talked about being shooed away from the kitchen by mothers and sisters. Consequently, the majority of men in this category comfortably admitted to never helping their wives, resting on the assumption of a permanently gendered division of labor. For some, it was a matter of pride, as in the case of Mr. Cherian, who differentiated himself from many men in the church because he did not cook or clean at home.

There were a few exceptions, such as Mr. Itoop, who had started to cut vegetables and make his own tea and sometimes even wash dishes because he wanted to help his wife and not take advantage of her. Close to retirement and with the children out of the house, Mr. Itoop had more time to show such appreciation for his wife. Mr. Zachariah, however, had no choice in the matter. His wife became extremely ill a few years ago and had to be hospitalized for an extensive period. He was forced to learn to cook and clean, especially since she never completely recovered from her illness.

Another exception was Mr. Mathen, who claimed that he did a lot of work both inside and outside his home. In fact, he claimed not only to help his wife with the cooking but also to be able to cook anything by himself. When I asked him how many times he cooked in a week, he said that there was no fixed number. Rather, he cooked only when he felt like it. His wife, a full-time housewife until very recently, was responsible for every meal, but he might help her if he was in the mood. He did not like to clean the house, especially the bathrooms, so this was also her responsibility. It turned out that Mr. Mathen felt he did a lot relative to his father, who never entered the kitchen. Mr. Mathen, who had emigrated to the United States by himself for his college education, had been forced to learn to cook in order to fend for himself. Thus, in his marriage, while he was not responsible for the cooking, he felt that his potential capacity to do things around the house was greater than the norm in Kerala.

As in the case of Mr. Mathen, Kerala was the point of reference for most of the women in this category. For example, Mrs. Itoop used the division of labor embraced by her relatives in Kerala to explain why it was

culturally justified for women to be responsible for domestic duties in a two-job household. As she put it, "Back home, even if there are servants, things are the same. Women work too. . . . Nowadays, to live, both must work. If you compare things, the women back home struggle four times more. They are up at four in the morning. There will be two or three school-age kids. You have to bathe, feed, and dress them all. The men will be lounging around. The women do everything. They make breakfast, feed everyone, pack [lunch] for everyone, and pack for themselves, and run. Often, they have to catch a bus to get to the school or the bank." The memory of her own family's experiences as well as the present lived reality of her female relatives that she witnessed on her trips back home prompted Mrs. Itoop to make the statement "This is our culture. It has always been like that."

While all the women in this category would identify with Mrs. Itoop's cultural credo, a few of them articulated awareness of alternative ways of thinking. For instance, Mrs. Stephen, a medical doctor, told me that her workload increased tenfold after immigration, especially without servants. When I asked if her husband had helped her, she said, "Not enough. Not according to the standards here, but then back home we never had to think about it. He didn't have to help me there." While she accepted her husband's failure to help her, she was also aware of a different set of American standards that she could use to assess his failure.

Similarly, Mrs. Paul, a full-time housewife, was aware of how difficult it was for some of her professional friends who got no help from husbands in the domestic arena. She speculated that, had she gone to work, she might not have had the same peaceful atmosphere at home. She was grateful that she did not have to work in order for the family to get by, since she did not think that her husband would have helped. While she recognized that the men in the immigrant community were used to the Keralite norm of not helping, she reasoned that they needed to help out more, given the different circumstances in the United States.

FINANCIAL DECISION MAKING

Unlike the child care and housework, the decisions regarding finances are traditionally in the male domain. All the men in this category saw themselves as the final decision makers, much like Mr. Itoop. Mr. Mathen, however, felt that, even though he made all decisions, he was better than his father because at least he discussed decisions with his wife.

Mr. Cherian had a different perspective on such spousal participation

in decision making. He complained of feeling compromised: "In India, men control everything. Here it is impossible. . . . Here both husbands and wives work. Over there the ladies stay home, so they don't know what the hell is up. So here we have to discuss with them. Otherwise they don't feel that equal." For Mr. Cherian, immigration brought a sense of loss of control over his children and a loss of the social status in the community that should have been his, based on his family's status in Kerala. Having to discuss financial decisions with his wife was another instance of loss of control, despite the fact that he made the final decisions.

Like Mrs. Itoop, the other women in this category deferred to their husbands when it came to financial decision making. They offered religious, cultural, and practical justifications for why men should be in charge. They seemed to believe that things had improved, given that they were better off than their mothers. But ultimately, as Mrs. Stephen explained, when she disagreed with her husband about financial matters, "he laughs and says that he will think about it, but that is the extent of it."

For Mrs. Paul, her husband's leadership was mandated by her religious beliefs. But she was aware that other alternative conjugal models could be the source of marital discord: "I was a religious type, so what I learned was that I should not challenge my husband's authority, but learn to live under his authority. Life unlike this would be hell. We know many people in America who have quite a bit of money. . . . When they are registered nurses, then they earn more than their husbands, and there are problems in the household. They lose their peace."

Mrs. Itoop believed that her husband should be in charge, even though she claimed that she understood and could handle all their financial affairs very well. This was because she believed that women should be "subdued," since it was both culturally appropriate and a practical tactic. As she explained, "We should be subdued, and want the family to be successful. Men feel that we should listen to them. That gives them satisfaction."

In Mrs. Itoop's assessment, women are stronger than men. In fact, she believed that many women play the traditional role to keep their men happy: "I know a lot of women in our society; many of them are very capable, more so than the men. Some don't show it that much. . . . They [the women] are very smart. They give more importance to their husbands."

In conclusion, families like the Itoops sustained their traditional division of labor after immigration because of a number of factors. The primary immigrant status of the male, and his positive relationship to the U.S. labor market, maintained the considerable status gap between husband and wife. The various options that these households had for child care, including that of having the women stay home full-time, further supported the traditional division of labor.

For these traditional households, there was a fit between their gender ideologies and postimmigration lived reality. As the Itoops portrayed it, the "subdued" woman and the man with a "dictator feeling" complemented each other. It was relatively more difficult for the women of the traditional households, who relied on a variety of gender strategies, to sustain this fit in the face of postimmigration changes. Without the additional help of servants or relatives in the United States, women in traditional households "threw away" good jobs or chose not to work, because they felt exclusively responsible for the domestic realm. And while immigration and entry into the U.S. labor market may have made them more ambivalent about the traditional division of labor, many of these women continued playing a traditional role to keep their men happy.

Kerala became the reference point by which they justified their level of participation in household labor. For example, Mr. Mathen felt that relative to his father, he did a lot of work around the house, while in actuality his wife was still doing the lion's share. Or Mrs. Itoop, reflecting on the current "second shift" struggles of her female relatives in Kerala, postulated that immigrant and second-generation women should accept their cultural obligations to do likewise. For these traditional households, Kerala was the measure by which they assessed and adjusted to the changes in their lives.

It is important to note that, with only one exception, none of the women in the traditional households were full-time nurses. When wives are nurses, and men have lower status in the U.S. job market, there is a reluctant accommodation in the household. When men have to participate in child care, forced-participation households occur.

Forced-Participation Households

As in traditional households, in the eight families who fell into the forced-participation category the wife did the cooking and cleaning, and the husband was in charge of the finances. Where they differed was in the area of child care. In these households, the husband was forced to share child care duties because the couples did not have the choices that were available to the traditional householders.

The women in this category were the primary immigrants, and all of them immigrated to work as nurses. Unlike in the traditional households, these couples experienced a gendered reversal in their relationship to the U.S. labor market. All the women in this category were registered nurses, except for one who was in the process of taking her board exams and another who did not pass her boards and who worked as a medical technician. The men in this group ranged widely in their educational and occupational backgrounds. Four of the eight men had college degrees from India, although only one, an engineer, was able to get a job suited to his credentials in the United States. Most of the men were doing technical or clerical work. The majority of them had uneven job histories, with periods of unemployment and moderately successful attempts to start their own businesses.

These couples subscribed to the traditional division of labor in the household, but the men were forced to contribute to child care because they had few other choices. They were not able to survive on a single income, and in some cases, despite leaving children for periods of time in Kerala, the men still have had to participate in child care in a substantial way. The Thambi family exemplified the challenges faced by the forced-participation households.

THE THAMBIS

Mrs. Thambi's emigration to the United States was the fulfillment of her father's dream and the fruit of his planning. She became interested in nursing as a ten-year-old after she got her first vaccination. As she recalled, "You know, when you get vaccinated, you get a bump. Well, my sisters would do the poking [they pretended to give shots], and I would bandage it up. From then on, they said I should be a nurse, and I agreed." After her nursing training, it was her father who "talked a lot and thought a lot about America." In fact, it became a family enterprise to find a way to send Mrs. Thambi, the eldest of eight children, to America. Her brother searched newspapers and magazines for advertisements put in by American hospitals and sent inquiries to them concerning job openings for his sister. Her father found a friend in America who was able to sponsor her, and she emigrated to the United States in 1975.

A year after her arrival, she went back to Kerala for an arranged marriage. Mr. Thambi, who was working in the United Arab Emirates, had two bachelor's degrees, in physics and education. He had been a high school science teacher in North India and had emigrated to the United Arab Emirates as a bank employee. A year after their marriage, he joined his wife in the United States. Unhappy with his first two jobs here, as a security guard and a cashier, he tried to study respiratory therapy but had to drop out of the program because of the illness of one of his children. Finally, after working as a data processor for a period, he found a new job as a computer operator.

The birth of their first child, Julia, brought a critical change to the lives of the Thambis. Julia was born with life-threatening problems. Treatment included multiple surgeries and eventually a kidney transplant. Julia needed care and attention twenty-four hours a day. The Thambis worked out their schedules so that one of them was always home with the children. They could not afford to have Mrs. Thambi quit her job, since she was the primary breadwinner. But Mr. Thambi told me that it was really important to him that his wife be home when the kids came back from school. Consequently, he chose to work an evening shift to allow his wife to be there for the kids in the evening.

The Thambis worked out a seemingly traditional division of labor in their household. However, there was a self-conscious and forced nature to this arrangement. Both were aware of the shift of power in the relationship and made concerted efforts to match their practices to their traditional ideology. For instance, Mrs. Thambi asserted that she was exclusively responsible for the cooking and cleaning because her husband "does not know how to cook or clean." Because he did not know how to make coffee, she had to wake up earlier to do this for him before she left for work at five-thirty in the morning. She had given up on trying to teach him, since he refused to learn.

Yet there is a corresponding way in which Mrs. Thambi also refused to learn something. She told me, "He does not know the ABCDs of cooking. On the other hand, I don't know anything about billing." When asked if that was by choice, she replied, "Maybe I don't want to learn." When pressed further, she responded, "I don't like it. . . . I just go to work and get my paycheck. I don't even know how much I make a year. I don't want to know anything about money."

Later in the interview, as we discussed the different experiences of men and women in the immigration process, Mrs. Thambi's comments illuminated the reason for her self-elected ignorance regarding money matters. She said, "I think they [the men] feel a little insecure when they don't have jobs. If they don't have jobs — If they have jobs, I don't know. . . . If he [her husband] makes much less money, he may [feel insecure]. I never give him a chance to feel that way." When I asked how she thought she did

this, she replied, "I mean — I don't know — in the first place, I don't talk about salary — 'You make this much?' or 'I make this much.'" I asked if her husband took care of all the money issues, and she said, "Yeah, I don't ask him about that. I don't tell him about that. When the income tax comes, I ask, 'So how much did I make?' I don't know exactly how much I make. I don't know where the bank accounts are. Like sometimes I say, if something were to happen, I don't even know where the bank is. I don't think he feels that way [insecure]." When I asked whether she consciously made an effort to not make him feel that way, she replied that she did.

Despite Mrs. Thambi's concerted effort to not participate in financial matters, her husband was aware that his wife's working outside the home had changed the balance of power relative to how it would have been in Kerala. He said that he was trying to run his household like his father ran his natal household. Perhaps this is why he said, "I really like it that I don't think that she has any idea about financial matters. . . . I don't know if she ever paid any attention. I really never heard her." He was not sure how much his wife knew about financial matters, but he liked to think that she did not know much. However, Mr. Thambi struggled to articulate why he felt the need to be in control of their finances: "Ours is a male dominated society, right? I always like to get a little more money than her. I don't know why I like it. . . . It's not the money itself. When she makes more money, I feel a little inferior. I don't know why. . . . I want to manage the home in a comfortable way. I want to be the head of the household. I like it that way. I don't know why. I am not sure about it." Mr. Thambi's desire to be the head of the household is much like Mr. Itoop's "dictator feeling." But Mr. Thambi is a lot less comfortable with it, especially given his awareness of male domination and his wife's bigger paychecks.

Mr. Thambi's headship is something that Mrs. Thambi accepts. Before marriage, her father was in charge of her life and she sent all her money to him to help the family. After marriage, she was not able to send as much money as she wanted because, "once you are married, they own you." While her husband supported her in sponsoring the immigration of her seven siblings, it became a problem when she wanted to send money every month to her parents.

Her relationship to her natal family and her desire to keep sending them money was one of the issues they had to confront. She resolved it by deciding that all women had this problem after marriage, and that it was not right on her part to want to do more than other people. She accepted that framework because she believed that women should always

be subservient to their husbands. This belief is similar to Mrs. Itoop's notion that women should be subdued, but Mrs. Thambi had to deliberately change her behavior to match her ideology, especially regarding financial decision making. While she believed in the traditional division of labor, she was not able to maintain the traditional ideals when it came to child care. Her husband confirmed that looking after the kids was the main change for him relative to his father's role in the natal family.

CHILD CARE

While some of the traditional families immigrated at a stage when their children were older and could take care of themselves, all of the forced-participation families had to face the problem of child-care arrangements for their infant offspring. The most typical solution employed by these couples was to juggle their work schedules so that one of the parents was always home. Because shift work is available to nurses, many women I interviewed worked evening or night shifts while their husbands worked during the day, or vice versa.

Three of the eight families opted to take their infant children to India, where grandparents or other relatives took care of them for a few years. For instance, Mrs. Joseph left her kids with her husband's parents for two years while she studied for her nursing license exam. A couple of people talked about how relatives they had sponsored were able to help out with child care, as was the case for Mrs. Peters. However, a majority of the couples, especially the men, complained about the difficulty presented by child care.

Couples lived like strangers for years — hardly seeing each other, as one handed off the child care baton to the other between work shifts. But sometimes rearranging schedules did not take care of overlapping periods when the children needed supervision. Mr. and Mrs. Papi found themselves in such a predicament. For a while they relied on the generosity of neighboring Malayalee immigrant families who were in the same boat. Eventually, because they could not work out their scheduling overlap, Mr. Papi had to quit his job and look for one that would accommodate their child care needs.

It is interesting that the overwhelming majority of the families in my sample did not use nannies, housekeepers, or day care centers. In my observation, financial considerations and discomfort at allowing outsiders in their homes, caring for their children, were reasons for their not relying on such help. Furthermore, as one commentator contends, "Religious, cul-

tural and linguistic traditions thus prevent such South Asian families in the United States from using McDonald's, European nannies, or microwave ovens as comfortably as a white family, even if they can afford it" (Shah 1998). Consequently, they got around these obstacles by adjusting shift work or by leaving children with family or friends in Kerala or the United States.

These are not uncommon strategies for immigrant communities. Studies of West Indians in the United States indicate that these immigrants often leave their children behind in the home country with relatives or friends, relying on what Isa Soto calls "child fostering" and Christine Ho refers to as "child minding" (Soto 1987: 131; Ho 1993: 36). Among Latina immigrant women, Pierrette Hondagneu-Sotelo and Ernestine Avila (1997) found a pattern of "transnational mothering," where women leave their children behind in their home countries and work as nannies in the United States, taking care of other people's children.

The men I interviewed talked about their involvement in child care as one of the biggest changes relative to their own fathers' roles in the household. Mr. Elias exemplifies their view when he yearned for a past where mothers were the exclusive caretakers of children: "Back home, taking care of the kids means, when they get back from the school, ask them to go and study. That is it. Here you have to change diapers, give them bath[s], help them dress, and the day is gone. Back home, even if the father and mother are there, mother stays at home and father works outside. Mother takes care of the kids. Mother is the one who forms the character of the kids. Here, the mother works outside the home, and so that is left to the father. That is the biggest difference here. Back home it is the mother's sole responsibility. Isn't it? . . . Here it is the opposite."

Additionally, in Kerala, the role of the disciplinarian was the jurisdiction of the father. It appears that the mother may have taken over some of this role in the U.S. setting. In an informal discussion I had with four immigrant nurses, children's disciplining became a topic of discussion. All the women agreed that the kids came to them for permission to do things, but that this was the cause of conflict with husbands, who were consistently more conservative, especially when it came to daughters. Mrs. Varkey theorized that perhaps mothers were better able to relate to their American-born children because they studied American psychology for their registered nurse licensing exams, which enhanced their understanding of American culture.

Living in a culture where children are encouraged to question authority, the immigrant first generation has to tolerate attitudes and behaviors

in their own children that are disrespectful by Indian standards. It is especially poignant for the fathers in this category, who not only lose their unchallenged patriarchal status but also become partially responsible for forming the character of their children. This raises a question: if child care is forced upon the husbands, what is the consequence for the other dimensions of the household division of labor? Does it mean that the men reassert their authority even more emphatically in the areas of housework and cooking and financial decision making?

HOUSEWORK AND COOKING

For all of these families, cooking and housework was clearly designated as female labor. The most popular standard of measurement when it came to male cooking skills was the ability to make a cup of coffee. Many of the men claimed coffee making as the sole item in their repertoire of cooking skills. Whereas Mrs. Thambi asserted that her husband refused to learn to make even a cup of coffee, Mr. Thambi, like his contemporaries, claimed coffee making as his only cooking skill. While the truth about Mr. Thambi's coffee-making abilities may never be established, it is clear that his wife, along with all the other women in this category, was responsible for the cooking.

Like Mrs. Thambi, most of the women accepted their role as the food preparation specialist in the household. They gave different reasons for their exclusive expertise in this household task. For example, both Mrs. Varkey and Mrs. Elias cited their husbands' busy work schedules as the main cause for the men's lack of interest in cooking. As Mrs. Varkey explained, "Engineering association meetings. He is very busy with this."

Mrs. Peter gave a number of reasons for her husband not knowing how to cook. At first she said that he had no interest in or talent for cooking. I asked if it was true that she would not let him into the kitchen as he claimed. Finally, she expanded on her resistance to her husband's presence in the kitchen: "It makes me uncomfortable to see a man cook. He is not used to doing it. I don't think he has any experience doing it."

Mrs. Papi was more forthright about her reasons for not wanting her husband to cook: "Everyday I have to cook something. If I am sick, he will cook. Otherwise, I will do everything. I don't like him to do it on a daily basis. . . . When I am not here, for the kids he makes [meals]. This is not the way men in our country behave." She believed that, to keep up tradition, she could not let her husband cook. But she was sometimes forced to ask him for help, given the lack of auxiliary support from relatives or servants in the United States.

Mr. Papi was unique in this category because he liked to cook. He often cooked with a group of men for church functions. But he recognized that his wife did not like him to cook every day. Furthermore, he claimed that she enjoyed cooking as creative release from the tension of work. Consequently, he limited himself to helping her on special occasions.

Whether it was because men like Mr. Thambi refused to learn to cook, or because others like Mr. Papi had to restrict themselves, in this category of immigrant households, cooking was a female preoccupation. However, other types of housework seemed to be less rigidly cordoned off in these households. Washing dishes and laundry were examples of tasks with which some of the men acknowledged helping women. Mr. Joseph explained why this might be the case: "When she has to work, she has to go. I have to take care of the home, and take care of the kids. Some of my friends, they have to cook. Some of the ladies work two jobs. . . . The man of the house may not have a job. So they take care of the kids. They even cook. I didn't have that kind of hardship. When my wife was away at work, I used to change the diapers, wash the dishes once in a while. These things are not acceptable back home, but there is no choice." Relative to some of his friends, who had to cook, Mr. Joseph felt that his lot was not so bad, which perhaps made it easier for him to occasionally wash dishes.

FINANCIAL DECISION MAKING

Like cooking, financial decision making was a clearly gendered task among the forced-participation households. Both men and women noted that women would bring home paychecks but that their husbands endorsed the checks. They claimed that the women did not even know how much they made. This pattern was consistent with Mrs. Thambi's claims about not knowing anything about financial matters.

What was striking about the women in this category was that, with one exception, they did not talk about disagreements with their husbands regarding financial matters. Mrs. Peter was representative of the women when she described how she and her husband dealt with financial matters. After her marriage and his arrival in this country, "everything shifted to him. He had the responsibility to become the head of the household. That is the way that I thought. So I handed over everything to him. . . . He thinks that he is the man and he should take care of me. That is the way he thinks."

While the women in the traditional household category, like Mrs. Itoop, also adhere to the model of male leadership, they talked about disagreements and critiqued their husbands. They seemed aware of alternate, American, standards of spousal involvement and compliance by which they could judge their husbands. They justified their own behavior as owing to religion, culture, or practical strategies. In sharp contrast, the women in the forced-participation category consistently resorted to espousing what seemed like the party line: " I don't know how much I make. I don't even sign my paycheck." It seemed as if they, like Mrs. Thambi, had self-consciously decided on a hands-off policy when it came to finances.

Some of the women expressed their good fortune at having found trustworthy and cooperative husbands who were also good money managers. For these women, the measure of the goodness of their husbands was the extent to which they let the women help their natal families. For instance, Mrs. George observed, "I am really lucky. I have no complaints. If I need to do something for my family, if they are in trouble or something, he helps them. My sister needed some money, and he gave it to her. You know, some Indian men, they don't do anything for the wife's family. He is not that type."

The one exception was Mrs. Elias, who seemed to be frustrated by her husband. Even though she felt he gave her what she needed, she was dissatisfied with the unilateral decisions he made regarding the investment of their money. Mr. Elias agreed that he made all the decisions and did not take his wife's opinions into account, partly because she did not have the confidence he possessed in financial matters. She complained that he regularly sent a lot of money to his relatives in Kerala and even constructed a house there without consulting her. She felt that he loved his relatives in Kerala more than his own children. But even she presumed his headship in the conjugal relationship.

For the men in this category, forced involvement in child care and to some extent in housework undermined their sense of themselves as men and as heads of their households. Additionally their headship became even more vulnerable when their wives earned more than them on average. Consequently, the men compensated by exerting their patriarchal privilege in refusing to do household labor other than child care.

Mr. Papi attempted to justify a tenuous ideology of male headship when he said, "In family life, my thinking is always that the man should be the leader. That does not mean that he should flaunt his power. She is equal to him, but still, you know, that man should be 'first among the equals.' Somebody has to take leadership, and in the ancient world, his-

tory shows that man has always had this role." On one hand, Mr. Papi relied on historical tradition to argue that men have always been the leaders in the home, yet he was faced with the reality that his wife was equal to him. Like Mr. Thambi, he struggled to establish a justification for his leadership, leaning on the weak proposition that he was first among equals as a result of his gender privilege.

In conclusion, for the forced-participation households, the primary immigration of the women, their relative success, and the stability of their jobs challenged the traditional power dynamic in the household. The men's difficulty with finding jobs and maintaining stable employment in the United States underlined the precariousness of their positions as traditional heads of the household. Their position was further jeopardized when they were forced to get their hands dirty doing child care instead of doling out doses of patriarchal discipline from a symbolic distance.

Whereas there was a fit between ideology and practice in the traditional households, there was dissonance in the forced-participation households. Mrs. Thambi and others like her responded to the dissonance by adopting the gender strategy of ignoring the reality of their relative economic success. By not knowing how much they made and by not signing their paychecks, these women consciously chose to play down what threatened their traditional ideology and their husbands.[6]

Despite such efforts on the part of their wives, men such as Mr. Thambi and Mr. Papi were ill at ease as head of household. They struggled to articulate why they should occupy the position. Some, like Mr. Thambi, had to give up plans for education, and others, like Mr. Papi, had to work out child care arrangements for their households. Faced with the reality that their jobs or career goals were secondary to those of their wives, and that they consequently became responsible for child care, these men had difficulty articulating their positions as head of household.

The reversal of status between husbands and wives in the forced-participation households compelled both to make adjustments against ideology, but the tension between ideology and practice remained unresolved. There is another response to the reversal of status between husband and wife — namely, that the ideology itself shifts to egalitarianism.

Partnership Households

The eight households that make up this category took a different approach to the division of household labor. Each couple shared the housework and cooking, the child care, and the financial decision making. They talked about this sharing as a necessary and logical adaptation made in the face of changes in lifestyle resulting from immigration.

The men were very involved in raising their children, and they did not complain about it. In a couple of cases, the men seem to cook more frequently than their wives. None of them claimed headship of the household, despite their being raised with this prevalent ideology in Kerala.

As in the forced-participation households, the women in this category were the primary immigrants, and these couples also experienced a reversal in status with respect to the labor market. All the women were registered nurses. Two of the eight had bachelor's degrees in nursing from India. One had gone on to get a master's degree in public health. On average, they were positive about their professional status. In contrast, almost all the men felt extremely negative about their occupational experiences in this country, and most experienced a loss of status at work.

The majority of these families did not leave their children in India or get much help from their relatives. In fact, only one couple left their children in Kerala with their parents. Consequently, the men did not have much choice but to contribute to child care. Perhaps as a result, these couples were more dependent on each other and seemed to be better friends with each other, as in the case of the Eapens, who exemplified the compromises of the partnership household.

THE EAPENS

Unlike Mrs. Thambi, who began by playing nurse in childhood, Mrs. Eapen harbored a different dream. She wanted to become a teacher, but financial obstacles prevented her from pursuing this career. Even had her parents been able to manage the fees for the teacher's training course, they did not have the huge sums of mandatory "donation" money required for her to obtain a job in Kerala. Consequently, she made a practical decision and chose a nursing education in North India, where a job was guaranteed upon graduation. But even before she and all her fellow graduates looked for jobs locally, they filed for employment immigration visas at the American embassy and other embassies. In a little over a year, she got a job in the United States, and she arrived here in 1976, after being sponsored by her cousin.

Three years later, she was back in Kerala because her marriage had been arranged with Mr. Eapen, who was himself waiting to emigrate to Kuwait. Because he could not find a job in Kerala despite a bachelor's

degree in mathematics, his sister had promised to take him to Kuwait. After marriage, he emigrated to the United States and tried his hand at a few jobs, and ended up doing manual labor in a factory.

Mr. Eapen had a difficult time with this transition. His wife, who had not yet passed her licensing exam to become a registered nurse, was working as a nursing assistant. She became pregnant soon after his arrival, and he had to continue working to help make ends meet. When she finally got her license two years later, Mr. Eapen was able to quit the factory job. He was unemployed for a few years while he studied respiratory therapy part-time, but ultimately he got a job as a respiratory therapist.

Despite some improvement in his work conditions, he was unhappy with the quality of life in the United States, which he described as being full of tension. The biggest points of tension were child care and family life. Like many couples, he and his wife arranged their work schedule in alternating shifts so that somebody was always with the children. But, as he explained, this arrangement left him unsatisfied: "When the husband is at home, the wife is at work. When the wife is at home, the husband has to work to adjust to the kids and their child care. So where is the family life?" They did not like the option of giving their children to a baby-sitter, so they managed themselves. In fact, Mr. Eapen claimed that he enjoyed taking care of the children, but that the quality of their family life suffered.

Another point of tension for Mr. Eapen was the work that he had to do around the house. As he explained, "Here I had to do cooking. I had to do the cleaning — I don't mind doing that. I know some Indian men are thinking they don't do this work. I do it. . . . If she will end up having to do everything, she cannot do it, right?" Here, he expressed his discomfort at being caught between the prescription that Indian men "don't do this work" and the practical reality of the limitations of his wife's time and energy after working nights.

His wife elaborated on the "tension" that her husband experienced: "Here life is more frustration, more tension. . . . Because my husband, he had three sisters and he was the one son — I think he found it more difficult here. He said he made a mistake. He should have never come here." In spite of the fact that Mrs. Eapen understood her husband's tension, her assessment of the conditions of work in the United States led her to expect a democratic division of housework:

> In India, you leave the dishes in the sink; the lady comes and washes. Here you can't do that. Because you work — everybody works, so everybody has to help. Before I go to work, I leave everything neat and tidy, so I expect the same thing when I come back from work too. Because I don't want to work eight-hour [evening] shifts [3 P.M. to 11 P.M.]. . . . That is really hard; the floor where I work, it is so damn busy. Sometimes I don't get out even [at] midnight — two o'clock in the morning. So I don't want to come [at] two o'clock in the morning to find out [that] the whole sink is full of dishes.

Just as they shared child care and housework, the Eapens were democratic in their financial decision making process. Mrs. Eapen said she was fortunate in finding a responsible man who did not waste any of their hard-earned money. She did, however, complain about Mr. Eapen's penchant for being overly generous. She was concerned that others might take advantage of him. He knew that she disapproved, so he did not always tell her about his openhandedness.

As a result, she had to set limits concerning his spending habits: "Couple of incidents happened, so I told him, 'I don't like the way you do that. If you are going to do that, it's not good for our family life.' I straightforwardly told him, so after that he didn't do it again. I said, 'I work hard, you work hard. It's our money, not only your money and my money. We have a combined account and everything. If you want to do something, even though I may not like it, you can still always tell me before you do it.'"

Mr. Eapen planned to go back to Kerala after saving money for five or ten years. But his wife and children were less keen to go back. In his truly democratic way, he said that they could do whatever they wanted, but that he hoped his wife would eventually go back with him to a less tension-filled life in Kerala.

CHILD CARE

While the couples in the forced-participation category had some support from Kerala as well as some baby-sitting help here, most of the partnership-household couples had no help. The exceptions were two families who received intermittent help from family members that they sponsored. Most families resorted to alternating their shift work to provide child care themselves. Like the Eapens, some did not like the idea of using baby-sitters, and others could not afford baby-sitters, as was the case for the Samuels. After working the night shift for seven years, Mrs. Samuel switched to the day shift when their younger child reached school age. Because both parents left very early for work, they had to depend on their seven-year-old to look after herself and her younger sibling. As Mrs. Samuel put it:

I didn't have any baby-sitting for them. We didn't have money for that, and besides, there was no baby-sitter available. My daughter was very responsible. If you gave her the key and showed her how to open and close the door and how to go to school, she would do it. She used to wake my five-year-old up, get him dressed, and drop him off at the kindergarten. . . . They would go to school, and come back at three o'clock. Sometimes when we came back, the door was left wide open as if somebody was inside. My God! We would take a step inside and call out to them "Are you in there? Did you lock the door?" And they would say, "Oh yeah!"

Like the Samuels, the Punooses relied on an older sibling to look after younger ones. The Punooses emigrated to the United States when their first two children were very young. They left the children with grandparents for two years. Eventually they had another child, fifteen years after the oldest child was born. Even though the older children helped take care of the baby, the Punooses still worked alternating shifts.

A number of the couples were used to having a lot of help in India, as is the case for most middle-class families. For instance, in the Lukos family, neither husband nor wife was used to doing any work at home. Mrs. Lukos described their life before immigration: "Each of my kids had a nanny, and the servants were there to cook. He never did anything. He just went to work and came back. I never did anything personally. . . . That changed tremendously. He started doing child care. It was important that he participate, and I learned too." Mr. Lukos agreed with his wife's assessment of the change: "In India, I never did any child care. . . . Here I used to help in every way. Since she had to work the night shift, I had to do plenty of work, and she had plenty of time with the kids."[7]

The Markoses were another family who had had servants and baby-sitters in India. Moreover, Mrs. Markos's mother, who was in Kerala, offered to take care of their children after the family's emigration to the United States. But Mrs. Markos had refused her mother's offer. As she explained, "We have solved our problems ourselves. Never bothered anybody." Mrs. Markos's desire to not trouble anyone and manage their own problems was an underlying theme expressed by some other couples in this category.

HOUSEWORK AND COOKING

Juggling cooking and cleaning along with work and child care was a challenge for all these couples. But cooking was easier for two of the men than for the others. These two had lived away from home in their bachelor days

and had some experience fending for themselves, and even admitted to enjoying cooking.[8] For example, Mr. Thomas, who left home at sixteen for technical training in North India, maintained that he did most of the cooking in the house. His wife concurred that he not only cooked but also did most of the heavier cleaning.

Mr. Samuel also asserted that he enjoyed cooking and did it on a daily basis for his household. Because he had to live on his own in North India for about six years, he learned to cook for himself. He was glad to have this skill because he could use it for the benefit of his family and friends. As he put it, "I don't think it is degrading myself, or cheap, to do housework and things like that." Rather, he assumed a leadership role in communal cooking efforts at church functions and other community events.

While his wife appreciated his talents, she complained that he cooked and entertained too much. She observed, "All the time, he has a lot of company here. Cousins, friends, and everybody. He cooks and invites everybody everyday. Chicken fry, fish fry, chicken curry—something everyday. So I don't cook too much." According to their division of labor, Mr. Samuel did the cooking, and Mrs. Samuel did most of the household cleaning.

Mr. Thomas and Mr. Samuel were exceptional in their love for cooking. Most of the men in this category learned to cook against their preimmigration instincts. For instance, Mrs. Philip described the initial shock and consequent adjustment in her household as her husband started to help her with the housework:

> I came first, and after eleven months my kids and my husband came. O God! That was the time I was studying for the psychiatric courses [for the licensing exams] and we had little kids. My husband did not do any work. By 4 A.M. I had to get ready, get the milk ready. At that time, I had a newborn baby. Then I went to work. At noon I needed to go to classes at [the] hospital. I took the bus there. By 10 P.M., I would come home and see all the dishes, the kids sleeping in dirty clothes. My husband then was not used [to it] and did not know how to do the work. I managed for about two weeks and then burst out crying. I was like a mad woman. I told him that I get up at 4 A.M. and, between work and school, get back at 10 P.M. . . . If I have to cook and clean till 12:30 A.M. at night, how long do I have to sleep? This is when he realized how I was doing all the work. So he slowly started to help and do the chores around the house. Things started to get better after a month.

Similarly, Mrs. Markos reminisced about the metamorphosis of her husband: "He was not a very good cook. He only knew how to make rice.

Now he has learned everything. In the beginning he was not very good. . . . He never washed plates after eating. After some time of marriage, he has changed. He is a very understanding person."

The Punoose's worked out an arrangement where Mr. Punoose did everything but the cooking. Mrs. Punoose admitted that she did most of the cooking, but that her husband helped her whenever necessary. She stated, "From the day he came here, he was doing all the cleaning. We both work together, and in emergency situations he helps me." Mr. Punoose also did all the grocery shopping for the household. He and the other men in this category recognized that their wives needed help, and they were able to adapt to the exigencies of postimmigration life.

FINANCIAL DECISION MAKING

What was striking about the partnership households was that, as they spoke about financial decision making, both men and women presumed a democratic process. The women were especially straightforward in their affirmation of a shared ownership and responsibility for financial matters. Mrs. Eapen put it best when she said, "I work hard. You work hard. It is our money." Thus she felt justified in setting limits on her husband's generosity with their money. Why are these women so different from some of their contemporaries despite having very similar backgrounds? Why do their husbands go along with the changes despite coming from traditional homes?

The women pointed to the postimmigration cultural and structural contexts to explain why their households were democratic about financial matters, especially relative to men's behavior in Kerala. For instance, Mrs. Thomas explained why she was primarily in charge of the finances in their household:

> Most of the things are still under my name — it did not change — phone bill, credit cards, and all other things. He is not good at checking and writing, but he used to do it when it was necessary. He managed. When he had some problem and he could not do it, he would give it to me. I am better at talking in English. When you come from a rural area of India, there is a problem in talking. There was only Hindi in that part of the country where he was working. So I took the responsibility of dealing with all kinds of matters. He has picked up a lot now, so it is less of a headache for me.

Having immigrated before her husband, and having acquired better linguistic skills, she was in charge. The new conditions shifted financial responsibilities to her, so she was not only participating in their financial affairs but also in charge of them.

Immigration also brought changes for these families because of their contact with American society. As previous research among immigrants reveals, the social organization of work exposes women to middle-class American values and gender roles. Scholars have found that, among Central American immigrants (Menjivar 1999a) and Caribbean immigrants (Grasmuck and Pessar 1991), women's work as nannies and domestics exposes them to the private lives of their employers and what they think is the American model of relationships, which leads women to alter their own relationships, making them more egalitarian.

In a similar vein, Mrs. Philip noted that many of her nurse friends had changed as a result of interaction with their American coworkers.

> They learn more. They are not the servile women, and they talk back to their husbands. They are not like slaves. They have more freedom. The country has changed them. . . . An example: I give my paycheck to my husband, and he gives me ten dollars to go and spend. Then they [American coworkers] ask you, "Why? You are working. You make the money. Why do you have to go and ask him?" Then the women think about this, and they start to feel that they should have more freedom, and they start living that way. . . . I have eight family friends here. All of them are aggressive and different from when they came here. . . . But husbands have changed also. They realize that the women are working like them, and take this into account.

Not only had the nurses changed, but also their husbands had been forced to change when faced with their newly "aggressive" wives. Like the Korean immigrant women in In-Sook Lim's study, the women in such households seemed to depend on "psychological resources such as pride and honor" — which the Korean women gained after immigration, as they became aware of the magnitude of their contributions to their families (1997: 49).

In addition to interactions with American cultural practices, structural conditions of American financial transactions also encourage democracy in a couple's financial decision making. Mrs. Punoose gave one example when she explained why she argued and fought with her husband about financial matters in a way very unlike her mother: "My father deals with everything. My mother does not know anything. She knows just cooking only. My father, whatever he does, he does not even tell to my mother. . . . Yes, she never argued. But here we have to. Here you can't do anything yourself. If you buy, both of you have to sign. Both are working and both are

responsible for the payment. Everything should not be in one person's name. It won't happen anyway. Everything is shared." When asked if she thought that was better, she replied: "I think that's better. If everything goes to one person, you end up with nothing. Everything is not controlled by one person. Everything is equal. Equal responsibility. If I need money, I have money. If he needs money, he has money."

Mrs. Punoose pointed to the structural conditions of financial transactions in the United States that allow for the participation of both husband and wife. While a woman may choose not to sign her own paycheck, she has to participate in all major credit-based transactions, such as the purchase of a home or car. Especially because her salary may be the larger and more stable of the two, in most cases her husband would need her to cosign for all loan applications related to major purchases. Thus, Mrs. Punoose could confidently assert, "Everything should not be in one person's name. It won't happen anyway." Consequently, she underlined the fact that both members of the couple became responsible for payments. The new structural conditions of postimmigration finances imposed equal ownership and equal responsibility on the couple, which contributed to the required participation of the women in the financial matters of the household. While some women, like Mrs. Thambi, might choose to just sign on the dotted line, women such as Mrs. Punoose liked the fact that they and their husbands had equal responsibility for and control over their shared financial investments.

In conclusion, the partnership households were very similar to the forced-participation households, given the women's primary-immigrant status and relative employment success and the men's difficulty in the U.S. labor market. These households received very little help from Kerala relative to the traditional and forced-participation households. Unlike in forced-participation households, the husbands' participation in child care in partnership households did not lead to the reassertion of their patriarchal status in the other areas of the household division of labor. Rather, they responded to the changes in postimmigration life in an egalitarian manner by extending themselves and sharing in all the responsibilities of domestic life. Often following the lead of their wives, husbands in the partnership household transformed their gender ideology to fit with the new reality. Consequently, as in the case of traditional households, ideology and practice were once again synchronized in the partnership households.

The Eapens exemplified this process of ideological transformation. While both Mr. and Mrs. Eapen probably started out with traditional

expectations of marital roles, their starkly different postimmigration circumstances led them to adopt egalitarian ideologies to match their new reality. Certainly Mrs. Eapen and the women of the partnership household cohort were more forceful than their husbands in their espousal of egalitarianism. As Mrs. Philip recalled, the women of the eight couples she knew closely became "aggressive and different," leaving behind their "subdued" selves. But their husbands, like Mr. Eapen, changed despite being haunted by the knowledge that "Indian men don't do this kind of work."

But whereas Kerala was the main reference point for traditional and forced-participation households, the partnership family seemed to be more immediately influenced by the cultural and structural conditions of life in the United States. For example, while all the households faced similar changes in the postimmigration structural and cultural context, the couples of the partnership households referred to these new circumstances as factors to explain the changes in their lives.

Female-Led Households

The five households in this category fall on the opposite end of the spectrum relative to traditional households. For one reason or another, responsibility for the housework, child care, and financial decision making fell disproportionately on the shoulders of the women. No one family represented this category, given the various reasons this anomalous type of household existed. Of the five households in this category, one merited inclusion because of the literal absence of the man, two were included because of the unreliability of the men, and two because of the extreme dependence of the men on their wives.

The women in this category were the primary immigrants, with the exception of one who was sponsored by her immigrant husband after their arranged marriage in Kerala. As with forced-participation households and partnership households, the women were better situated than their husbands in the U.S. labor market. All of the women were registered nurses. Of the three employed men, two worked in the nursing field but in auxiliary positions, and one worked in a factory. The fourth man was unemployed, and the fifth had passed away.

In four out of the five households, relatives in Kerala helped care for the children. In two cases, grandparents had come for extended stays. In another case, a sibling immigrated with the explicit intention of providing child care.

These households' pattern of immigration, relationship to the labor market, and access to extraconjugal child care made them similar to households in the forced-participation category. However, the differences in how the men in these families responded to postimmigration conditions resulted in female leadership in all aspects of household labor.

ABSENT MEN

Mrs. Jacob was an extremely unusual person in the immigrant community, not only because she was a widow, but also because her deceased husband was a white American. From the time she was a young girl in her village in Kerala, Mrs. Jacob had different ideas about what she wanted to do with her life. She was enamored of the consumer items she saw people bring back from the city — items like sweet-smelling soap.[9] As a little girl, she used to sit in a corner and pretend to talk in English to herself. Her desire to speak English and find the sweet-smelling soap inspired her to pursue a career in nursing, a decision intolerable to her father, a prominent politician in their village. So she ran away to Bombay — a journey of three days and nights — to look for educational opportunities.

Eventually, she got a bachelor's degree in nursing, which placated her father, since it was a college degree. She first emigrated to Kuwait, where she worked for three years before traveling on to the United States. Unlike most other immigrants, she did not connect with the Malayalee community. She eventually met her husband through a roommate, and they married against her parent's wishes. Unfortunately, three years after the marriage, he was diagnosed with a terminal disease; he died a few years later. Left with two young children to raise, Mrs. Jacob went on to get her master's degree in community health and supported her family as a single mother.

When I interviewed Mrs. Jacob in her home, I noticed a plaque on her bathroom wall that represented her position on marital gender relations. It said something to the effect that, if God had meant for Eve to rule over Adam, he would have used a bone from Adam's head to create Eve. If God had meant for Eve to be ruled by Adam, he would have used a bone from Adam's foot. That God used a bone from Adam's rib signified that God wanted Adam and Eve to be equal partners. From what Mrs. Jacob said about her marital relationship, the third scenario best described her marriage.

When I asked her to compare her relationship with her husband to her parents' relationship, she said, "My mother was very subdued. She went

along with whatever my dad said. . . . She did not have anything more, and there was no gratification. My husband and I, we would discuss and plan. If I wanted to do something on my own, I did not feel like I had to ask him for permission. Whenever I was going to be late, . . . I did not have to get permission." Mrs. Jacob told me that one of the main reasons she ran away from home to become a nurse was that she did not want to end up like her sister and her mother. Her sister had been forced to get married at a very young age because a dying grandmother wanted to see one of her grandchildren get married. Mrs. Jacob thought that it had been "cruel" that her sister, who had wanted to attend college, had been deprived of the chance to do so because of her early entrance into matrimony.

After her husband died, Mrs. Jacob was left with the difficult task of caring for her children. While she was able to handle the financial and household responsibilities, she found that she needed help raising her children. Consequently, she sponsored the emigration of her sister and family to the United States to help her. She also joined the immigrant Orthodox Church and had her children baptized there. She described this experience as "very hard. That is when I knew the meaning of swallowing your pride. I didn't want my girls to not have any identity at all." Without her husband, she felt less comfortable among his friends and sought support from the more familiar immigrant community to bring up her children.

Unlike most of her contemporaries, Mrs. Jacob left home with the explicit intention of finding a more egalitarian option than being in a marriage like that of her parents, where her mother was "very subdued." She started her family life in a partnership household with her husband; but with his death, she was left to head her household on her own.

UNRELIABLE MEN

Unlike Mrs. Jacob, neither Mrs. John nor Mrs. Kurien had to run away to become nurses. They went with the full knowledge of their families and with the intention of helping their families. Both were the eldest daughters of their families, and both had multiple younger siblings. Coming from poor families, they told their husbands before marriage that their intention was to continue helping their natal families. That they had to negotiate this matter points to the cultural expectation that a woman, once married, belongs to her husband's family. In both cases the husbands failed to keep their end of the premarital agreement, and this contributed to spousal conflict.

Mrs. John tearfully told me about the betrayal of their pact: "When the proposal came, I told him, 'I am the eldest in the house. I have to support my family.' He said it is okay. He can do everything for me. After marriage, he changed totally." She bitterly observed that he might have agreed to her conditions before marriage only because he wanted to come to the United States.

Similarly, Mrs. Kurien thought her husband had agreed to help sponsor her family members' emigration to the United States. However, although she was able to bring them over, he made it very difficult for her to support them once they had arrived. For instance, her sister had to pay him to be able to live with them. However, his mother and a number of his sisters, whom they also sponsored, stayed with them at no charge. One of her husband's nephews got in trouble with the law, and her husband took the nephew's side against Mrs. Kurien because of his loyalty to his family.

This was the last straw for Mrs. Kurien. She decided that she would take a different strategy in helping her brother emigrate to the United States: "I was determined to help my brother, no matter what my husband said. I became more outspoken then. My husband made me more outspoken. So I told him, 'If you want to say anything, say it to my face, because I am going to help my brother. If you agree with it or not, I don't care a bit. You can go to hell.' And he was more cooperative."

In addition to reneging on their preimmigration pacts, both Mr. John and Mr. Kurien were unreliable financial managers and did not participate in child care and household duties. Mrs. John constantly had to work double shifts in order to earn overtime money, since her husband had been unable to hold down a job after he was laid off eleven years earlier. She told me that her husband would not even use the microwave to heat up food she prepared for him. She used to do that for him but recently had become too tired to continue it. She remembered the days when she would have to cook for his many friends, who were always over at the Johns' house drinking and playing cards.

What irked Mrs. John even more was the way her husband had mishandled their money. He was prone to making expensive purchases on their credit cards without consulting her. Once he put the house up for sale, and she had found out about it only when the real estate agent called to ask if he could come by with a potential buyer. Another time Mrs. John's husband bought a car and called her from the dealer's office to ask for her signature. She refused, but when the car dealer showed up at her door, she relented and signed. Without contributing anything to the household, her husband used to burden her with his whimsical purchases. She told me that she used to believe she had to obey her husband, but that she no longer believed this.

Mrs. Kurien had a similar litany of criticisms about her husband. While he may have taken care of the immediate needs of the children when she was at work, he did nothing else in the house. She complained, "Very seldom did he ever cook. I still remember when I went away for a couple of days and came back, all the dishes were in the sink. . . . He doesn't even know where his own clothes are. . . . I go and do my night shift, and then I have to cook breakfast and wake up my husband and feed him. . . . He won't even make a cup of coffee."

Likewise, when it came to financial affairs, Mrs. Kurien had to change her ways in order to deal with her husband's incompetence. She said that she used to give him her paycheck and had not even known how much money they had. But he invested in the stock market, lost a lot of money, and never told her about it. This prompted her to take greater control over their finances. Interestingly, she sees his losses in the stock market as an answer to her prayers. As she put it, "When his family came, all these problems came with them and I just couldn't take it. I had to work. I had to take care of him. I had to take care of the kids. It was all just too much. I just wanted to kill myself. And then I prayed like I used to do as a child. I asked God to make him more understanding. And I think that's how he lost his money."

Both Mr. John and Mr. Kurien were aware of the difficulties their wives faced. For instance, Mr. John noted that it was difficult for his wife to work both inside and outside the home, yet he admitted that he helped her only occasionally, and only when she asked for help. He observed, "Nowadays she is tired—getting sick. Otherwise there is no problem. I am thinking that I should do a little more work for the house. It will be good for her. . . . But since I don't have that kind of routine experience, I don't do it. Something else will come up, and I will go for it." Mr. Kurien also observed that, because his wife took care of all the cooking and household labor and then went to work, "it is very stressful for her. I know, but there is no choice." When I pointed out to him that there was another choice, that he could help her, he said he had very limited time.

Apparently, both these couples began with the traditional division-of-labor paradigm, in which the men were in charge of decision making and the women did most of the other household labor. Along with feeling betrayed by their husbands' failure to honor their preimmigration agreements, these two women were also dissatisfied by their husbands' failure

to properly manage their common finances. As a result, the women had to take greater control over household finances, as well as be responsible for the child care and the housework.

DEPENDENT MEN

Similarly, Mrs. Simon and Mrs. Mathew had to assume a disproportionate share of the household labor, but for different reasons. Their husbands were present in their households, and both were employed. However, both were extremely dependent on their wives, and the latter did the lion's share of the household work.

Mrs. Simon was working in India as a nurse when many of her neighbors and coworkers started emigrating to the United States. She wanted to see if she could make it here, and she felt that her children would have better opportunities in the United States. However, her husband did not have the same ambitions and did not want to leave India. Eventually he relented. After immigration, Mrs. Simon established herself as a registered nurse, and her husband secured a blue-collar job.

Mrs. Mathew immigrated after her arranged marriage with her husband, who was already in the United States. His brother and sister-in-law — a nurse — had sponsored Mr. Mathew, who, in turn, had returned to Kerala to look for a nurse to marry. Even though Mrs. Mathew had not liked him, she had married him for the opportunity to come to the United States. His significant limp, a result of childhood polio, probably contributed to Mrs. Mathew's dislike of her husband's looks. However, she wanted to help her parents, who were not financially secure. Mr. Mathew, who had graduated from high school in Kerala, became a nursing assistant upon immigration. His newly arrived wife also started as a nursing assistant, but she soon passed her exams and became a registered nurse, while he continued as a nursing assistant. His limp did not allow him to try for other jobs that would require greater physical capability.

Both these women were responsible for all the cooking and housework. Mrs. Simon worked two jobs, which meant that she worked every day of the week. She cooked for her family in the evenings, after work. She described her struggle with her husband, who expected her to be with him at all times when she was not at work:

> Saturday mornings are the only mornings I get to sleep in, but he expects me to get up at 6:30 in the morning and make an Indian breakfast — get up and move around. He doesn't want me to sleep once he gets up — that's always his nature. He says women should not sleep in the daytime — it's bad, and you know. And finally he got tired of telling me. . . . I said, "No matter what you say, I have to sleep in, and I have to sleep in the morning. . . . If you are that hungry, you can have bread or hot cereal." So he doesn't bother me nowadays too much.

Likewise, the labor of child care was the responsibility of the women. According to their wives, both Mr. Mathew and Mr. Simon were not very patient with their children. Mrs. Mathew had taken over child care because, as she put it, "He gets upset with the kids easily. I don't like it when he starts yelling at the kids, so I do most of the child care."

Mrs. Simon found that her husband was authoritarian and tried to control his children like his father had controlled him. But Mrs. Simon intervened in his disciplining, because she believed that such an approach did not work. Consequently, he accused her of spoiling the children. I overheard the Simons' college-age daughter announce to her mother after church that she would be going to see a play with her friend. When her mother told her to ask her father about it, the daughter quipped, "As if he wears the pants in the family." Both Mr. Simon and Mr. Mathew were unable to adapt to circumstances where the patriarchal authoritarian role did not work with children. Consequently, their wives had to take on a greater responsibility in the care of their children.

Finally, both women felt they had the greater responsibility in making and carrying out the day-to-day decisions in their households. In talking about her household, Mrs. Mathew said, "I do feel that I can do many things now, whether it is going places or making decisions about taking the children to the doctor or anything. In fact, he tells me to do everything on my own, so I end up doing it all on my own." I had the opportunity to witness what she meant when I was at the Mathews residence. She decided against his wishes that they would go to church after my interview. I watched as she told him what to wear and what clothes the children should wear. And she drove them to church — which is extremely unusual for most of the families, since the men usually drive. Mr. Mathew's physical disability may have made it more difficult for him to drive.

As for Mrs. Simon, she felt burdened by her husband, who needed her presence for most activities. She stated, "My husband always makes decisions with me. He doesn't want to make decisions by himself. Like even if I tell him, 'You go and do it,' he won't do it. He still wants me to go with him. Even if he wants a T-shirt, he doesn't know how to go and do it. He wants me to go with him, and I have to say, 'This is good for you — take it.' That's the type he is." Perhaps this was the reason he evaded my

multiple attempts to set up an interview with him separately, even though he seemed happy to talk to me whenever he saw me at church or during visits at his home.

Whether unreliable, dependent, or absent, the men in this category left the women with the larger share of household labor. For the most part, these families emigrated to the United States with traditional expectations concerning sharing the work of their households. The exception was Mrs. Jacob, who immigrated with the express intention of finding more egalitarian options than those available to her in Kerala. For this group of women, their domestic experiences in the United States with unreliable and extremely dependent or absent men created a dissonance between ideology and practice.

The dissonance was severe in the case of the unreliable men because it was caused by the complete breakdown of the "patriarchal bargain" found in traditional households (Kandiyoti 1988). Both Mrs. John and Mrs. Kurien were in tears as they told me that their husbands had failed to honor the bargains they had made at the time the women emigrated. Furthermore, not only were these men unable to do their share of household labor, but also they became obstacles in the way of their wives, who were trying to do it all on their own. As a result, Mrs. Kurien recounts, she told her husband to go to hell because he made her assume such a burden.

Rather than adjusting to ideology, as in the forced-participation families, the women of the female-led households, for the most part, rejected the ideology that did not correspond to their lived experiences. In the face of dissonance between ideology and practice, they realized that the dictate to obey one's husband no longer applied. However, these women were unable to adopt a new ideology that that would fix the dissonance, as did the couples in partnership. They continued living with the contradictions of female-led households, where they were not socially supported and not rewarded for their headship as were the men in the traditional families. Yet as pioneers, they had to come up with strategies that worked for them, all the while carrying the burden of husbands who were unreliable, dependent, or absent as domestic partners. Some of these women turned to relatives in Kerala or the Keralite immigrant community for help, especially with raising their children.

Conclusion

One of the biggest changes that Keralite immigrants in general face upon arrival in the United States is the change in the domestic sphere. All

the couples have to find a way to deal with a new set of circumstances without the accustomed and readily available help from relatives and servants. Dividing labor and child care issues presents a challenge, particularly for the families of nurses, given the men's initial economic dependence on nurses. The husbands of nurses find it difficult to "do gender" in their customary ways, as a "routine, methodical and recurring accomplishment," given the vast changes they encounter after immigration, both in their work and home lives (West and Zimmerman 1987: 126). Because household tasks often become occasions for the "reaffirmation of one's gendered relation to the work and to the world," the already "dependent men" have trouble doing work that labels them as women (Berk 1985: 204). And since doing gender is not an individual performance but an interactional process, many nurses have to overcompensate by "doing gender" in the home to counterbalance their breadwinner status.

Yet among the couples I interviewed, I found variations in how families negotiated this challenge. As I noted earlier, the postimmigration gender relations in these households were shaped by such factors as the couples' immigration pattern, relationship to the labor market, and access to child care. But gender relations were also the result of the couples' level of success at resolving the tension between gender ideology and practice in their lives. I found that the choices these families made from those available to them put them in four categories.

In the traditional households, couples like the Itoops had a larger set of options available to them, which allowed them to maintain a traditionally gendered division of labor. Half of the women did not work outside the home, especially when their kids were younger, which relieved their husbands of child care and household duties. Other couples left their children at boarding schools or with parents in Kerala to alleviate the pressures of housework and child care. In all these households, men continued to be the primary breadwinners and to be in charge of financial decision making. If men felt compromised, it was relative to the ideological standards in Kerala. In practice, their lifestyles were not very different. Women voiced awareness of alternate standards by which they could judge men; however, they did not demand change. Overall, there was little inconsistency between the gender ideology and practices employed by these couples, as seen best in the Itoop household.

In the forced-participation households, like that of the Thambis, men experienced the greatest change in the area of child care. Some families received help from Kerala, but in most the men had to fit their work schedules around child care. Not only were they actively involved in forming the character of their children, but also they had less patriarchal author-

ity in the United States. In most cases, the men had to share some of the housework, although they drew the line at cooking. Because all the women in this category were upwardly mobile nurses, and the majority of the men had become downwardly mobile after immigration, husbands and wives had to face disparity in their paychecks and job status. It was with unsteady voices that Mr. Thambi and the other men claimed headship over the household; their wives claimed ignorance in financial matters. In this category, the fit between gender ideology and lived experience was tenuous, although the women, like Mrs. Thambi, made concerted efforts to create a fit.

In partnership households, men and women shared the domestic labor, and they saw this sharing as a logical and necessary adaptation to postimmigration circumstances. None of the men complained about having to take care of their children, and Mr. Eapen even claimed to enjoy it. Most of these men could do much more than make coffee — the standard threshold for men's cooking skills. However, although some men said they enjoyed cooking, most did it because they had to.

What was striking about the partnership category was the democracy presumed by both men and women when it came to financial decision making. There were many possible reasons for their egalitarianism. The women in these households spoke of being influenced by American society and noted that it had, in turn, led them to aggressively demand changes from their husbands. The men were all downwardly mobile. As families, they had less help from Kerala and consequently fewer connections. As a result, these couples were more dependent on each other. Perhaps this explains why the men were more willing to follow their wives' leads and to alter their traditional gender ideologies to fit with the new realities of postimmigration life.

The final category consists of female-led households, where women had the disproportionate burden of responsibility for household labor for a variety of reasons. Men were absent from these households because of death, were partially present but unreliable, or were extremely dependent on the women. As a single mother, Mrs. Jacob was able to handle the financial and household responsibilities by herself. However, she needed help with child care and followed the same strategy as most of the other immigrant families. She looked to relatives in Kerala and was able to sponsor her sister's emigration to the United States. She also looked to the immigrant community in the United States, which was a type of extended pseudofamily for most of the immigrants.

The wives of the unreliable men started off within the traditional paradigm, but their experiences of betrayal by their husbands and the breakdown of the "patriarchal bargain" changed them, making them more assertive women. As a result, they had greater financial control. Their desire to help their families — their connections to Kerala — acted as the impetus behind their immigration and the changes in their marital relationships.

In the case of the dependent men, the women would have liked for their husbands to participate more actively and autonomously. But the men continued to take a backseat in the day-to-day decision making, leaving their wives no choice. When the men did participate, they acted as patriarchal authoritarians with their children. When this parenting strategy did not work with the children, these men were unable to adapt to the different circumstances. As a result, their wives had to take over for them. In all the female-led households, the women had to let go of their traditional ideologies in the face of absent, partially present, or incompetent partners. There were no clearly viable resolutions to the tension between ideology and practice for these households.

On a spectrum of change, the traditional households had made the fewest changes and the partnership households had made the most changes, in terms of the fit between gender ideologies and lived experience. All the immigrant men were forced to do at least some work that their fathers would not have dreamed of doing. Furthermore, they faced the loss of patriarchal status in relation to their wives and children, coupled with a general loss of status in the wider U.S. society. With the new circumstances of postimmigration life, most of these families were forced to make some changes in the domestic sphere. Of particular interest are the ways that changes in the household were translated into a greater need for male participation in the communal sphere of the church.