Transnational eldercare: Filipino caregivers caring for elderly migrants in the Philippines

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Abstract

The aging population and changing family structure and dynamics in Asia have caused significant developments in the familial processes in some, if not most, Asian societies. The increasing mobility and dynamics of carework across nations and cultures has come to bring about new frameworks that motivate the rethinking of care (Huang, Thang, Toyota 2012). This mobility is not limited to the migration of skilled health labor from developing to developed countries, but also of individuals acquiring health, medical, and retirement services in countries outside of their own.

International retirement migration, in this paper, refers to the case of foreign elderly retirees migrating to the Philippines for long-term eldercare, presents an interesting study for the intersection of care-giving and care-receiving between different cultures and states. As an emerging area of study, the international migration of retirees in Asia presents challenges that evolve from the differences in the nature of care concept, provision and expectations, reciprocity of care, level of health and welfare systems, and migration and feminization of care work, among others. This involves looking at the issue in two ways: from the perspective of care-givers and that of care-receivers.

This paper is a byproduct of an earlier preliminary study on the issues concerning the care of Japanese elderly in the Philippines.[2] It yielded findings that identified language and cultural concepts of care as main challenges in the provision of transnational care. This study looks deeper into the caregiving aspect of transnational care through the narratives and experiences of Filipino caregivers working in a private nursing home that cater to foreign elderly migrants in the Philippines. It presents case studies of Filipino caregivers and identifies the meanings and practices they attach to the care of foreign elderly migrants. It also explores the stresses of transnational caregiving, which emanate from cultural and language barriers, differences in cultural meanings and expectations of care. It presents a narrative of their responses to these factors and how they adapt in these situations. The study draws from the perspective of transcultural nursing (Leininger's Culture Care Universality and Diversity theory) in understanding eldercare as the provision of culturally congruent care vis-a-vis the social, cultural, economic, and political milieu where care is provided between individuals of different race and culture.

Keywords: *transnational care, international retirement migration, Filipino caregivers, elderly migrants, nursing homes in the Philippines, Leininger's Culture Care Theory*

1. Introduction

Filipino nurses and caregivers are not new to the phenomenon of transnational care. Choy's *Empire of Care* (2003) documents the earliest migration of Filipino nurses to the United States at the beginning of the 20th century and emphasises the movement of health professionals across borders to perform care work to individuals in more developed countries. Transnational caring, for Filipino nurses in particular, has been a familiar phenomenon, one that has been promoted by the state and the nursing profession in the Philippines.

Meanwhile, Parrenas (2003) explores aspects of a global care chain through her analysis of migrant domestic workers and nannies in Italy and California, mostly migrant Filipino women who perform 3D (difficult, dirty, dangerous) jobs, while leaving a care deficit in their families in their country of origin. This chain has come to include not only those who perform domestic work, but also those whose work involves the production and (re)production of care (Yeates 2011), and that involves health professionals and caregivers.

Understanding transnational care involves looking at the many layers and intersecting spheres of the intimate and the public, of the national and the international. In analyzing the concept of care work, it should be contextualised within the larger perspective of state policies, globalization, and economics, which reflect a multitude of factors that contribute to how care work is facilitated between and across countries, and between individuals. It goes beyond the direct contact between care-giver and care-receiver, and invites one to see the other factors that govern and shape the caregiving landscape in the global context. This study looks at the phenomenon of transnational caring using three different layers: *macro* (globalization, labor migration, global care chain), *meso* (state-sponsored migration policies, care markets), and *micro* (individual caregiving and care receiving experiences). However, this paper focuses on the micro layer and delves into the human stories of individual actors with direct experience of transnational caregiving, that is the Filipino nurses and caregivers.

Another important highlight of this study is on elderly migration. The case of elderly migrants moving into the Philippines (and other countries in Southeast Asia) to receive care reflects a reversal of the dominant trend where movement usually involves care-providers from developing countries migrating to developed ones. Using data gathered from interviews of Filipino nurses and caregivers in a local nursing home caring for foreign elderly migrants, this study answers the following questions: What are the eldercare values and caregiving practices of Filipino nurses and caregivers? How do they adjust to the differences in the culture, language and care expectations with their foreign elderly care recipients? What are the stresses experienced by Filipino nurses and caregivers and how do they adapt? Does it really prepare Filipino nurses and caregivers for transnational eldercare work?

2. The globalisation of care

The concept of global care chain (Hochschild 2001; Parrenas 2003) was first used to depict a series of care deficits and transfers, that involve individuals, mostly women, from developing countries who migrate to developed countries and perform domestic and care work for richer families. The resulting absence in caring for the migrant individual's family is taken up by another individual, usually by another woman—paid or unpaid—and replaces the care deficit left behind by the migrant individual.

The idea of the transnationalization of care is emphasised by Yeates (2011) as having "backward and forward linkages," unlike in internationalisation which merely involves the geographical dispersion of practices across borders. She defines care transnationalization as the "processes of heightened connectivity revolving around consciousness, identities, ideas, relations and practices of care which link people, institutions and places across state borders" (1113).

Caring as a form of work embodies "activities and orientations to promote the physical and social (re)productions of 'beings' and the solidary-affective bonds between them" (1111). Eldercare as a form of care work is more specific to the physiological, emotional, and psychological care of elderly individuals, and also includes the whole range of highly intimate and less intimate activities. [3]

This paper argues that the idea of global care chain (Hochschild 2001) extends to the case of Filipino caregivers who care for foreign elderly migrants in Philippine nursing homes. However, it

represents a significant shift in the movement of care providers and recipients, but continues to perpetuate the series of care chains that is inherent in the global care chain framework. The creation of eldercare markets in the Philippines does not impede the outflow of care workers, but temporarily keeps them while waiting for opportunities to migrate and work outside of the country. These markets serve as temporary pockets of care work where caregivers and nurses acquire skills needed for transnational caregiving, but will eventually migrate to developing countries.

This study agrees with Huang, Leng & Toyota's proposition that the idea of global care chains should be viewed, not only as a "single productive chain," but as "multiple and intersecting" (2012, 131). In international retirement migration, it is the elderly migrants who cross national borders, and are cared for by Filipino caregivers, who need not leave their country, while being able to provide care for a culturally and racially different set of care-recipients.

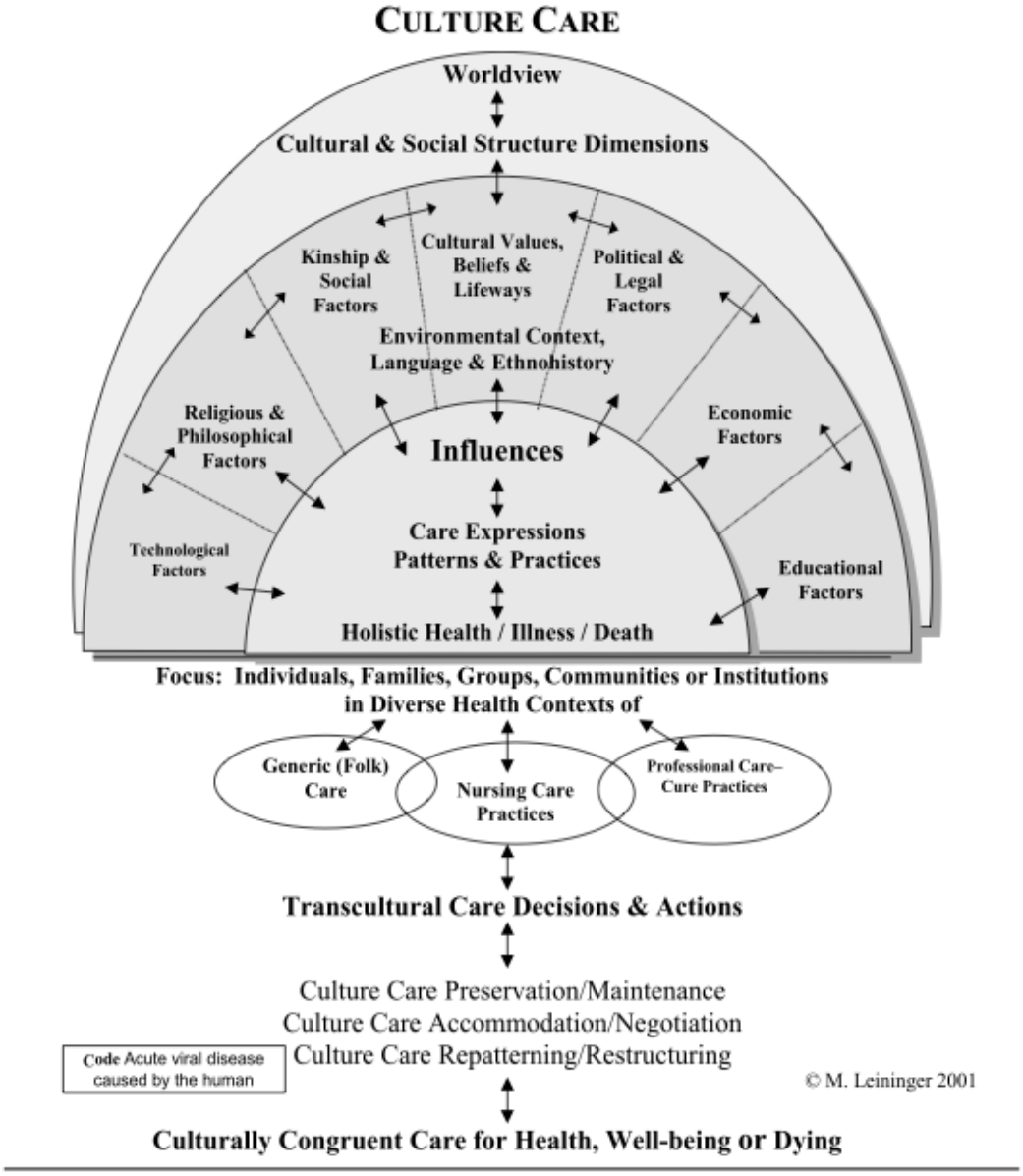
3. Cultural care universality and diversity: Understanding care from the nursing perspective

How does nursing, both as a science and as a profession, view transnational care? There is one nursing theory that has looked at the aspect of care across cultures. Madeleine Leininger's culture care universality and diversity theory looks at the convergence of care and culture in understanding and providing culturally congruent health and care practices (2006, xi). It begins with the recognition that the concept and practice of care differs across cultures, and that a nurse must be able to recognise this distinction in order for her to adjust to and provide a culturally appropriate care. More importantly, the theory views care and care practices within the continuum of life (that is, from conception to death). The theory also recognises that there are aspects of care that may be similar across cultures (universality) and also differing depending on the socio-cultural milieu (diversity).

Culturally congruent care refers to the appropriate caregiving that is based on an understanding of the cultural, social, economic, political, and religious/philosophical, familial, technological, and educational factors that influence the health belief and practices of an individual. These factors shape an individual's meanings of health, illness, wellbeing, and thus influence his/her concept and expectations of care. Moreover, these concepts and expectations translate into the actual process of care practices. Thus, a Filipino caregiver and a Japanese elderly, for instance, may have differing conceptions of care, which is based on their individual exposure to their cultural and social norms. The convergence of these factors is the point where transnational care, or eldercare, becomes visible.

The figure below shows the factors identified by Leininger as influencing health and care beliefs and practices.

[Figure 1. Leininger's Sunrise Model that shows the dimensions of Culture Care Universality and Diversity.]



Source: Leininger, Madeleine. 2002, 191.

Drawing from this framework, this paper focuses on the experiences of care held by the Filipino nurses and caregivers, that translate to the caregiving practices in the care of the elderly. Through interviews and participant observation, this study aims to understand the Filipino nurse and caregiver's concepts, meanings, and practices of transnational caregiving. Furthermore, this mindset of caring has also been included in the nursing curriculum in the Philippines, and to a significant extent, influences the concepts of care developed in nursing students and practicing nurses in the country.

However, this study is limited in providing only one perspective: that of the caregivers. A more holistic understanding of the human aspect of transnational care should include the perspective of care recipients, something which could be looked into future researches and studies on the topic.

4. Methodology

The author conducted participant observation and key interviews of Filipino nurses and caregivers in a private nursing home in Quezon City, Metro Manila. There are a total number of 16 nurses and caregivers, but interviews were made among the 5 nurses and caregivers (one male, four females) who had direct care experience with the foreign elderly migrants in the nursing home. Observations and interviews were conducted over a period of one month. Informed consent from the nursing home owner and interviewees was sought prior to the beginning of the interviews and participant observation.

The nursing home is situated within Quezon City, in a private and secluded residential area. It currently houses a total of 14 elderly individuals, with four (4) foreign elderly migrants (3 Chinese, 1 American). In the previous year, it had 2 Japanese elderly migrants, but one of them had gone back to Japan in July 2013, and the other had died within the same year. Data collection were gathered in June 2013 and updates were taken in October 2014.

5. Research findings and discussion

The five (5) interviewees' ages range from 23-25 years, all unmarried. Most of them have 1-3 years of care work experience in the same nursing home, and have this as their first professional caregiving experience. The interviews were open-ended and the questions asked were about their ideas of eldercare and transnational care, difficulties and challenges in transnational eldercare, stresses in carework, satisfaction in carework, and future plans. The common themes that came out of their responses are identified:

- respect and treatment of the elderly migrant as a family member
- patience and communication as important aspects of eldercare
- physical and emotional stresses of eldercare
- low economic value assigned to caregiving work
- caregiving work as temporary and as a transition to hospital work or working abroad

5-1. Respect and treatment of the elderly migrant as a family member

One of the most prominent aspects of the responses include the interviewees' familial treatment of the elderly individuals they care for, both local and migrant. Two female nurses share,

> I see them not only as patients, but similar to a kin. Of course, since they are old, they have no family and relatives to accompany them, and we serve as their "second family" here in the (nursing) home.

> Caring includes emotions because we have come to be with them longer, we begin to think of them as we would our own grandparents.

One male nurse expresses respect of the elderly as paramount to his responsibility in eldercare, and shares an important Filipino insight on growing old:

> On eldercare, it involves taking responsibility of the patient and respecting the elderly. Our main learning here is the value of life. We have a different culture compared to them, and usually, Filipinos take care of their own family members,

> while in foreign cultures, it is common to bring them to nursing homes. This makes me think if I become old, do I suffer the same fate?

Another female nurse adds,

> Because we tend to be with them most of the time, I am bound to think of my own family and what happens if I, or my parents, reach that age…I am beginning to realise the possibilities when they age someday.

This may seem to indicate an overlapping of the familial and professional spheres when it comes to caregiving, but it is also important to note that filial piety is an important tradition in Filipino culture.

A traditional Filipino household includes the nuclear family, but also commonly includes grandparents and other kin, thus becoming an extended family living under one roof. Caring for the elderly members of the family is considered a familial responsibility, and it was only in 1987 that elderly welfare as a state responsibility was first stipulated in the Philippine Constitution (Natividad 2000). Given this expectation on the family, many Filipinos tend to provide care for their elderly parents and grandparents by accommodating them in their own houses. They either hire a live-in caregiver, or provide the care themselves, depending on their ability to do so. The idea of nursing homes is still in the process of becoming accepted in the country as an alternative form of eldercare due to the reluctance of some elderly individuals based on images and stories of abandonment and lack of care. In addition, the cost of care in institutional or nursing homes is relatively expensive (average monthly cost is Php30,000-40,000, roughly US$665-890) and only those families who can afford to pay are able to send elderly family members in nursing home care.

The elderly migrants in the home care tend to stay for years, as some are to be cared for until their death. Hence, the caregivers spend a long time with them, and with the daily interaction with the elderly, it is inevitable to develop some degree of close bonds with them. One respondent relates how she has come to treat some patients as "grandmother" or "grandfather" and accords him/her the kind of concern and care she would normally give to a family member. However, she emphasises that she remains conscious of her role as a nurse, and although she becomes attached in some degree to her patient, she is able to perform her nursing duties. She states,

> We have to be firm, and cannot give in to all their demands. We have to explain the reasons for our caring rules, and establish our authority as nurses—as those who know what is good for their health. Age no longer becomes an issue, that despite being younger than them, they have to follow our advise. I can maintain my authority over them. Sometimes, they test the lines, but I have to be firm by repeating the rules for them and establishing boundaries.

The sense of respect and responsibility to care was particularly evident and common among the responses of the interviewees. This was also cited in Sprangler's study of the care values of Fil-American nurses in the United States. Sprangler (1992) revealed an "obligation to care" sentiment among her respondents that was reflected in the nurses' expressed dedication to work, attentiveness to giving physical care as comfort, and respect and patience to their patients.

5-2. Patience and communication as important aspects of eldercare

All the respondents agree that the nature of their work involves providing holistic care to the elderly migrants—care ranging from assistance to daily living, providing companionship, listening to

personal stories, relating to the demands of the family, ensuring provision of medical care and needs. They emphasise the value of communication as part of the care. One of them shares,

> Having long patience is important, as patients tend to be testy; also to have love for them, as similar to your love of the family. Talking with patients is an important aspect of caregiving.
>
> We talk with them on a daily basis. Some are not responsive, that is the problem, but you still have to communicate them, you orient them everyday.

Communication is important in maintaining the caregiver-care receiver relationship. The interviewees share that initially, language is a barrier. Some of the patients can no longer respond verbally with coherence, and they have to resort to nonverbal communication to assess how the patient feels. In the case of the Japanese elderly resident who lived there last year, one of the caregivers can speak Nihongo and she was assigned to care for that one patient. When she is not on shift, the other caregivers communicate by using pen and board, hand gestures and other nonverbal signs, and by learning a few basic Nihongo words for body parts.

In the case of transnational eldercare, care becomes the language of communication. Because some of the patients cannot verbally express themselves, or have differences in language, the caregivers had to adapt by knowing their patients' nonverbal expressions and cues. Touching and other nonverbal cues become a way of expressing care to the elderly despite the differences in language to overcome the barriers of communication.

5-3. Stresses of eldercare

On the stresses of eldercare work, the interviewees have differing responses, as some find physical work more tiring than others, while some find emotional care more stressful. These are the responses from four of the five interviewees:

> At the beginning, physical tasks are hard, but you tend to develop the techniques for doing these easily. Like turning patients, especially those who are big and heavy. Now I am used to it, and am able to do them with ease.
> It is physically stressful, especially when a patient becomes agitated and they hit you sometimes, you still have to be affectionate to them…one needs to be more understanding.
>
> I had to learn how to provide physical caregiving, since we have to do all kinds of care for our patients, we have to adjust physically. It is especially tiring, but since we do this for the care of the patient we have to do it anyway.
>
> The work requires seldom idleness and rest, we have to always see that the patient is okay.

Aside from the physical and emotional stresses of care work, relating to the elderly individual's family and relatives also adds to the care burden. An interviewee shares,

> It is challenging, most of them have attitude problems, one would easily see that. But as you meet them longer, you come to understand their attitudes and you learn to adjust. You are now able to relate to them and talk about the patient's condition.

> Some of them visit patients every week, some every month, while others, every year.

One nurse noted that they knew it was the lack of available family members who could provide care to their elderly members, that they are being sent to nursing homes to be cared for. Hence, most elderly migrants being cared for in the nursing homes are those who can afford to pay for professional eldercare services, because of unavailable caregivers in the family and at home. Those who do so usually have family members who are living or have migrated abroad and the elderly member is transferred in the Philippines to be cared for. Most of the elderly migrants in the nursing home are being cared for until they expire. The terms of their care require palliative care in the event that their conditions worsen and death is inevitable. One nurse shares,

> Some relatives say they can't handle the care. Some have no time, so they depend on nursing home.

In a way, some of the nurses feel that they "fill in" the family roles for these individuals, since visitation of relatives are not constant and frequent. Furthermore, they become exposed to their individual stories, and their pains as they continue to stay in the nursing home. Since most of the elderly patients being cared for stay in the nursing home for years, the respondents are able to build lasting relationships with them.

One of the recurrent stresses of care work is the unexpected change in attitude in their patients. They all emphasise how important patience is in the nature of care work, since most of their patients exhibit signs of senility, some even have Alzheimer's and dementia. There are times when a patient becomes agitated, and it takes a whole lot of energy and attention to this one patient, while they delegate or delay the accomplishment of other routine work.

Building a routine helps, instead of burdens, care work. Because of the multifaceted nature of providing physiological, social, and emotional care, establishing a routine helps in managing the caregiver's time. They work for a 12-hour shift, and because they typically handle 6-8 patients daily on rotation, following a structure of tasks and activities allows them to accomplish the important ones immediately. Nature of care work in the morning includes bathing, feeding, medication intake, and taking of vital signs (consciousness, temperature, pulse rate, breathing pattern, blood pressure). All these take up the first 3 hours, with a window time between 10am-12nn, after which it is again time for lunch feeding. The most "restive" period is between 2pm to 4pm when the patients take a rest or nap, or watch TV. During this time, the caregiver has enough time to do paperwork and document the activities and patients' conditions for the day.

Management of caregiving-induced stresses involves the use of different stress-relieving techniques. However, all interviewees agree that good relationships with the other staff members makes the work lighter, and they are able to share stories and woes with each other. The following are some of their experiences:

> When I go home, I leave all the stress in the workplace. I play with my dogs, which help me take my mind off. I also have a boyfriend, and we both attend church activities as members of Singles for Christ.

> I distance myself or do many things to keep my mind off the stress. I just enjoy the work, when work is done, we keep it out of mind, and do other things. I also psyche

> myself at the beginning of the day by thinking happy thoughts…I also don't bear too much burden for a long time, I can easily dismiss my emotions.
>
> Upon going home, I establish communication with my mom. We exchange stories about my day at work, my patients, unique situations, etc.
>
> Our schedules are open and flexible, we maximise our days off. We go out together with other members of the staff.
>
> We are able to balance (work and life) since we have days off. We really have to find time…My stress at work is confined here, I don't bring it at home, I leave them here.

Social relationships at work and at home become important avenues or outlets for the caregivers and nurses to release work-related burdens and stresses. Filipinos are generally known for being friendly and perhaps this adds to their ability to handle stress relatively easily.

5-3-1. On gender and caregiving roles

One respondent was a male nurse, who has been working in the nursing home for 2.5 years. He states that performing intimate care to a patient is an important task and that which calls for professionalism at work. He relates his experience of providing intimate care—it is easier to perform intimate care on male patients, than on female patients, who needs more sensitivity and care. He said that since he has no choice but to do the work, he has learned to adopt a professional stance on every thing he does at caregiving, and sees these as part of the care he provides his patients. He states,

> When you accept the nature of this work, you are able to adjust. For me it is easier to care for male patients, compared to female patients. First there is an initial discomfort. However, there is no issue, no malice, when we think of everything as purely work, as a sign of respect also. When we begin to show malice, the patient will become uncomfortable.

He also does not perceive an inherent difference in the effectiveness in caregiving between male and female caregivers. Instead, he thinks that long experience in caregiving contributes to efficiency, since one develops mastery of the activities needed in eldercare.

There are only 3 males on the whole staff of the nursing home, factors concerning why there is a low number of male staff has not been explored. However, factors which could be considered may include the low volume of male applicants, and the availability of slots upon their application, that could probably influence the gender of employed caregiving personnel.

5-4. Low economic value assigned to caregiving work in the Philippines

In the Philippines, the Bureau of Local Employment under the Department of Labor and Employment pegs the average monthly basic salary of an entry-level caregiver at Php10,000-12,000. This is relatively higher compared to the salary of entry-level nurses working in private and public hospitals (Php5,522 and Php9,939, respectively)[4].

In the case of the nurses and caregivers in the nursing home, they all entered as volunteers paid with a daily allowance of Php100/day (~US$5), while promotion to regular status normally depends on the availability of slots. Due to a significant lack of available hospital work opportunities for newly-passed nurses and caregivers, most of them strive to work as volunteers in the nursing home despite

the meagre allowance. Most of them worked for a year as volunteers before they were promoted as regular volunteer staff, which received a base salary without benefits, and whose contract is a no-work-no-pay basis.

When asked about their economic satisfaction in their work, the respondents express an initial hesitation to discuss their salary, but afterwards, they all seem to share the sentiment that as long as they are making good with what they earn, they are happy. Four of the interviewees state,

> I don't know why I stay (in caregiving), at first I did not like it, I preferred to work in a bank. But as I go on, I came to love the profession, what I do. I think I have acceptance now, that this is what I am really meant for.

> (My salary) is always just right for my monthly needs. I still enjoy what I am doing right now. Besides if I do not do this, I will not be doing anything since hospital work is not available for us right now.

> As long as the salary is not so low, or that we have enough to get by, that is okay with me. I even started as a volunteer, being paid with Php100/day, so we value our position now as regular staff.

> We make ends meet, unlike when we were beginning—we were only paid Php100/day. I worked just to be able to do something. After boards, it took me a year without work, just staying at home. This work has become my way to escape from the pressures at home, where my mom pushes me to work abroad.

This reflects the low perception about care work, despite the commodification of care. Yeates (2011, 1110) explains that care work is "essentially oriented to the reproduction of beings and do not necessarily 'add value'," which are commonly performed by most women in families and in the domestic sphere. This important feminine idea about care work diminishes its value, hence in the economic ladder, it is regarded as a low-paying job.

Despite the low economic value of care work, some of the interviewees tried to look beyond the financial aspect of their work and see non-material rewards as a means of satisfaction in their work. One male nurse states,

> I am satisfied in a way that it feels different knowing you can help others, somehow. Especially when you have a testy patient thanking you later on, that is something. So we really just enjoy what we do.

5-5. Caregiving work as temporary and as a transition to hospital work or working abroad

However, the lure of better economic prospects abroad continue to be a promising factor for them. All five interviewees have expressed plans to work abroad in the future either as caregivers or hospital nurses, because of the inherently higher pay. When asked how long they continue to see themselves in eldercare in the Philippines, their responses varied from 1 to 3 years.

Because of this state, most of them have been working in the nursing home for the last 2-3 years, and when asked whether they see themselves staying long in eldercare, some have voiced varying sentiments:

> I have plans to work abroad if I find a chance. Hopefully in Dubai, because some of my family members are there.

> I also plan to go abroad someday, maybe work in New Zealand, if there is a chance. Initially, I was planning to work in Saudi Arabia, but the news (about working there) has not been very positive. Maybe I'll try in Canada (someday).

Most of them also voice out maximising their opportunities to learn about nursing procedures they can perform in the nursing home, such as insertion of nasogastric tube, giving of intravenous medications, catheterization, feeding through PEG, cleaning of ostomy, among others, while waiting for opportunities for hospital work to become available.

For some, they view eldercare as a valuable training ground and experience needed for care work abroad. Most of them have plans to work abroad, but they all know that they need at least 3 years of hospital or caregiving experience in order to qualify, hence, they think that being in eldercare is better than not acquiring any work experience at all. One nurse has just resigned from the nursing home and will be leaving for Canada this December to work in the live-in caregiver program.

6. The realities and challenges of transnational eldercare: Perspectives of the Filipino caregiver

These narratives provide an important glimpse into the personal experiences of Filipino nurses and caregivers on transnational eldercare in the Philippines. Their experiences of caring for elderly migrants show that the meanings and practices of care are influenced by the cultural and social background of the caregiver. The tradition of filial piety and respect for the elderly are the most prominent cultural meanings of care held by the Filipino nurses and caregivers in the care of elderly migrants. Although differences in language proved to be an initial challenge, they were able to make use of other modalities to communicate, and use care as a language to communicate their response to the needs of the elderly migrants. Gender issues at work did not seem a prominent issue in this case, but in care work, professionalism is important in providing efficient care.

The physical and emotional stresses experienced by the Filipino nurses and caregivers in eldercare are perceived as manageable because of the good social relations they have with their co-workers and with their families. Although other stressors like relatives add to the challenge of eldercare, they accept it as part of the holistic care that they should render to the elderly migrants.

An important finding is on the low economic valuation of caregiving in the Philippines, which perpetuates the perception that it "does not necessarily 'add value'" (Yeates 2011, 1110). Because of the inherently low pay scale given to nurses and caregivers, care work is seen as a transition to work abroad—where they can gain caregiving experience while looking for opportunities to migrate and work outside the Philippines.

As this paper argues, the creation of care markets in the Philippines perpetuates the series of care deficit in the global care chain. International retirement migration changes the dynamics by making a significant shift in the dominant trend—where movement involves care-providers moving from developing countries to developed countries—and creates new areas for research that explore the impact of elderly migrants being cared for in developing countries, such as in the case of the Philippines.

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Notes

[1] The author is a registered nurse in the Philippines and is currently finishing Master in Asian Studies at the University of the Philippines Diliman.

[2] This paper entitled, "Japanese Elderly in Philippine Nursing Homes: Opportunities and challenges in Transnational Care" looks at the care of Japanese elderly migrants in a private nursing home in Metro Manila, Philippines. It was presented in the 18th Young Scholars of Philippine Studies last July 7, 2013 at Kobe Catholic College in Kobe, Japan.

[3] Yeates makes a distinction between the two as: highly intimate work involves personal, social, health and sexual care; while less intimate work involves cooking, cleaning, ironing and general maintenance work (2011, 1111).

[4] Data taken from the Department of Labor and Employment, 2004.