

Transnational Landscapes of Care: Elderly within Sri Lankan-Australian Transnational Families and their Care Networks

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1. Introduction

Recent scholarship on migration has given attention to the integral part international mobility plays in understanding modern society especially from within the realm of the family, and the impact of migration on individuals and their families has become a central focus of transnational family literature over the past decade (Bryceson and Vuorela, 2002; Chiang, 2008; Baldassar and Merla, 2014). Although the predominant focus has been on children and spouses of transnational migrants (Asis et al, 2004; Parreñas, 2008; Yeoh et al, 2013), there is an increasing recognition that elderly parents are equally important recipients of transnational care (Baldassar and Baldock, 2000; Baldassar et al, 2007; Zechner, 2008; Merla, 2012). European transnational families are the predominant focus within this transnational eldercare literature (Baldassar and Baldock, 2000; Zechner, 2008), while the existing work on Asian forms of transnational eldercare is largely based on the experiences of unskilled migrants (Kodwo-Nyameazea and Nguyen, 2008; Adhikari et al, 2011). Wong et al (2003) observe that the transnational family structure and care strategies of unskilled and skilled migrants differ based on their access to resources and the varying circumstances of migration. Therefore, addressing this less explored aspect of transnational eldercare, the paper focuses on the narratives of middle to high-income elderly parents of skilled permanent migrants who left Sri Lanka for Australia.

The existing scholarship on transnational eldercare is largely based on the migrant's experiences in providing eldercare across transnational space (Baldock, 2000; Izuhara and Shibata, 2002; Zechner, 2008), with few studies incorporating the experiences of the care-receivers (see Baldassar et al, 2007). Since elderly parents are not solely dependent on the migrant for care but may receive care from several locally-based adult-children and have access to other forms of care, I argue that the transnational care scenario differs from that of children or spouses whose primary care-giver is the migrant. Therefore, through the perspectives of 35 elderly parents this paper first examines how eldercare is impacted by the migration of traditional care-givers, and how multiple agents of care address this care gap to varying degrees. Second, I aim to highlight the manner in which gendered notions of care and power relations shape the elderly parents' care choices.

Thus, I amalgamate the concepts of the care diamond (as proposed by Razavi (2007)) and landscapes of care (as proposed by Milligan and Wiles' (2010)) to highlight the agency that elderly parents' exert within these transnational eldercare relations. I argue that the elderly care-receiver's capacity to self-care impacts upon the care contributions made by the family, state, market and community. As such, I propose the care pentagon, which adds the 'self' as another agent of care to

the conventional care diamond, and map a transnational landscape of care that changes both temporally and spatially as the elderly parents evolve from being healthy and independent to frail and dependent.

The paper draws from dual-sited qualitative interviews that were conducted in Colombo, Sri Lanka and Sydney and Melbourne in Australia in 2010 as part of a Masters thesis research project. Although, the paper only refers to the care experiences of elderly parents, in the broader project I conducted semi-structured interviews with elderly parents, their migrant adult-children and their main care-giving adult-child in Sri Lanka to form 30 transnational family case studies. As a prelude to my argument, the following section will briefly review literature pertaining to transnational eldercare while emphasising on its gendered aspects.

2. Transnational and Gendered Aspects of Eldercare

The predominant focus within the transnational eldercare scholarship has been on the migrants' manner of providing care across borders and the issues they face in the process such as the tensions due to the distance between their family members and the limits to their ability to provide care (Izuhara and Shibata, 2002; Baldassar et al, 2007; Zechner, 2008; Merla, 2012). Transnational care-giving has many parallels to the localised forms of care where women conduct the majority of the care responsibilities, and exemplifies that gendered notions of eldercare giving are replicated across transnational space (Zontini, 2004; Huang et al, 2008). Studies also note that men tend to perform care through financial support and maintenance tasks, while women mainly provide care by addressing health and emotional issues (Baldassar and Baldock, 2000; Baldock, 2000).

Despite the emphasis on the care-giver's perspective, the existing work illuminates the issues faced by elderly. Research on elderly relatives of migrants from poor households reveals that migration reduces the financial strain on the family and promises economic and social benefits; nevertheless the migration decision also creates strained relations between the parents and the migrant which is later negotiated in order to maintain contact (Kodwo-Nyameazea and Nguyen, 2008; Adhikari et al, 2011). Ageing parents who prefer to live in the home-country despite the option to reside with their skilled migrant child usually place greater importance on companionship and support from members of their own community, while language barriers and cultural differences are added reasons for elderly parents to avoid migration (Baldassar and Baldock, 2000; Lamb, 2007). The tendency for the elderly not wishing to be a burden is a strong sentiment that has also been observed (Baldassar and Baldock, 2000; Izuhara and Shibata, 2002). A few studies have noted that parents of skilled migrants do travel frequently to visit and care for their children in the host country until ill-health restricts their ability to travel (Treas and Mazumdar, 2004; Baldassar et al, 2007).

These transnational eldercare relations alone are not adequate to fulfill elderly parents' care needs. Research on transnational eldercare observes that home-based kin such as siblings, cousins

and other relatives provide physical care while the migrant engages in emotional, practical and financial forms of care (Baldassar et al, 2007; Zechner, 2008). In addition, alternative caregivers in the form of community care-services and market initiatives generally enhance the quality of care provided within the household and on certain occasions replace the care roles of family members, e.g. Lamb (2007) notes that in India, there is a growing number of elders' homes that cater for parents of transnationals. According to Milligan (2009), elderly care-receivers' tendency to accept these alternative care options is shaped by their past gender socialization. For instance, since women are perceived to maintain stronger social connections with family and friends, it is considered they would require less formal care. Additionally, studies on formal care often assume that the transition from the home to residential care is easier for men (as care-receivers) since their experiences in military service accustoms them to communal living (Milligan, 2009).

Notably, few studies consider how the eldercare gap created by the migration of adult-children shapes care-receivers' reliance on other forms of care and the level of agency they exert within these care negotiations. Thus, I proceed to explain the theoretical framing of the paper, which aims to analyse care-networks while recognizing the care-receivers' impact on its formation.

3. Mapping a Transnational Landscape of Care

Milligan and Wiles' (2010) concept of 'landscapes of care' provides a useful starting point to examining transnational eldercare relations. As an analytical framework, it engages with a broad range of care issues since it recognizes that:

landscapes of care are multilayered in that they are shaped by issues of responsibility, ethics and morals, and by the social, emotional, symbolic, physical and material aspects of caring [...] This includes the support, services and the spatial politics of care [...] It incorporates the human and spatial relationships of care, the norms, values and relationships often inherent within care networks (Milligan and Wiles, 2010:740).

While 'landscapes of care' provides the overall framing of the paper, I turn to the concept of the care diamond to narrow the analysis of eldercare within the scale of the transnational family. The care diamond allows for a focus on how other care providers interact with the care-receiver and on the care networks between four specific agents of care that emerged from my empirical work. The care diamond is a model of the welfare mix in care services which represents the family, community, market and state (Razavi, 2007; Ochiai, 2009). Both the landscapes of care and the care diamond acknowledge that care networks are formed by the inter-relations among multiple care-givers.

As defined by Razavi (2007: 21) the care diamond is "the architecture through which care is provided, especially for those with intense care needs such as young children, the frail elderly, the chronically ill and people with physical and mental disabilities". However, the literature's

concentration on intense care scenarios tends to homogenise elderly as helpless (Ochiai, 2012; Abe, 2010), while overlooking the care needs of the relatively healthy elderly. Indeed, work on ‘positive ageing’ and ‘ageing-in-place’ from Western countries highlight the potential for elderly to remain independent until latter stages of their lives (Bowling, 2008, Stenner et al, 2011), while even during frailty mechanisms such as telecare are provided to help elderly maintain autonomy (Milligan et al, 2011). Thus, I argue that the care diamond should be extended to the analysis of care scenarios where elderly have the ability to exert agency, in varying degrees.

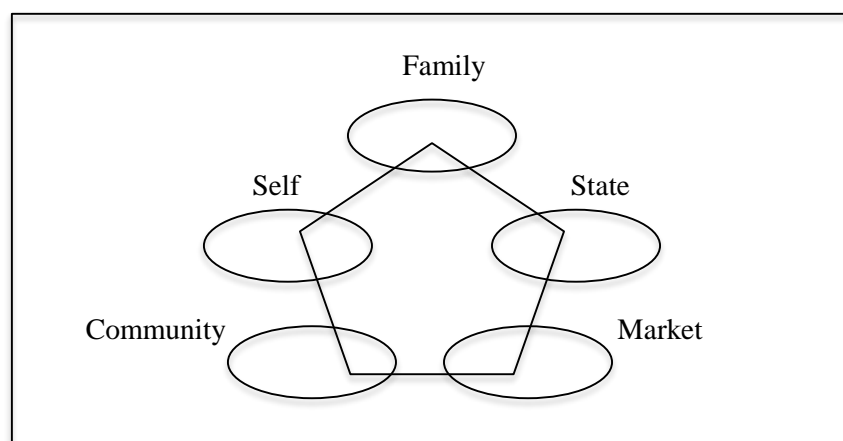
However, the care diamond scholarship gives lesser attention to the perspective of the care-receiver. Although, Ochiai (2009) acknowledges the care-receiving individual (both children and elderly) within discussions, the emphasis is on whether the care diamond accurately reflects the care-receivers’ experience, e.g. representing the state and market as supplementary care agents. Within the debate on how caring for love and money raises issues about quality of care, Razavi (2007:16) notes that for the elderly “family care can engender a humiliating sense of being dependent and a burden”. While Razavi states this concern to be beyond the scope of her discussion of the care diamond, I take issue of this point to argue that elderly strive to reduce their dependency on family care and form alternative care relations with other care agents.

Focusing on the care dyad between the care-giver and the care-receiver, Milligan and Wiles’ (2010:740) brings attention to the “embodied and situated personal and identity politics” of care-receiving (and care-giving) by emphasizing that ideals of care-receiving (and care-giving) are shaped by the availability of care arrangements and “situated institutions such as culture, home and family.” Indeed, Tronto (1993:109) propounds that “[c]are-receivers might have different ideas about their needs than do the care-givers[...]Care-receivers may want to direct, rather than simply be passive recipients, of care-giving that they receive”. Thus, I contend that a discussion on care should bring care-receiver’s expectations of care into conversation with their care-givers’ contributions. I argue that recognizing the care-receiver’s care needs as articulated by them problematizes culturally-informed notions of eldercare and intergenerational reciprocity, and questions the extent to which modernization and changing family patterns have led to an reinterpretation of these care norms by the care-receiver. Therefore, I bring attention to the care-receiver’s care-giving potential and forward the notion of a ‘self-caring care-receiver’. I posit that care-receivers’ self-caring initiatives do impact upon the contributions made by care agents at various stages of their life course and at varying degrees.

3-1. The Care Pentagon

As such, I propose the care pentagon as a framework that incorporates the care-receiver or the ‘self’ into the care diamond as another care agent whose contributions, similar to the others vary (see

Figure 1). I forward the care pentagon as a recognition of the changing demographic and care contexts, where elderly enjoy greater longevity and good health, and are capable of caring for themselves for longer periods of time. This situation overlaps with the changing care regimes where most Asian societies are shifting from a purely familistic regime to one that is gradually incorporating more liberal aspects (Ochiai, 2009; 2012).



[Figure 1: The Care Pentagon]

By recognizing the care-receiver as a 'self-caring care-receiver' I highlight the agency exerted by care-receivers in determining their care needs and negotiating their care, which is overlooked within care diamond analyses since it concentrates on the care balance between the four agents. Since care-receivers' agency does fluctuate according to their age and level of health, I do not place the care-receiver at the centre of a care diamond, indicating that they maintain control within care-relationships at all times. Similar to occasions when certain care agents have little impact on the care mix, e.g. limited state contribution towards eldercare in Thailand (Ochiai, 2009), I assert that eldercare is an evolving process where a healthy and independent elderly person may require phases of acute care due to a fall or a cardiovascular problem, or may reach a stage of frailty where their self-caring capacity would gradually diminish. Next, I explicate two more facets of the care pentagon.

3-2. Adopting a Scalar View

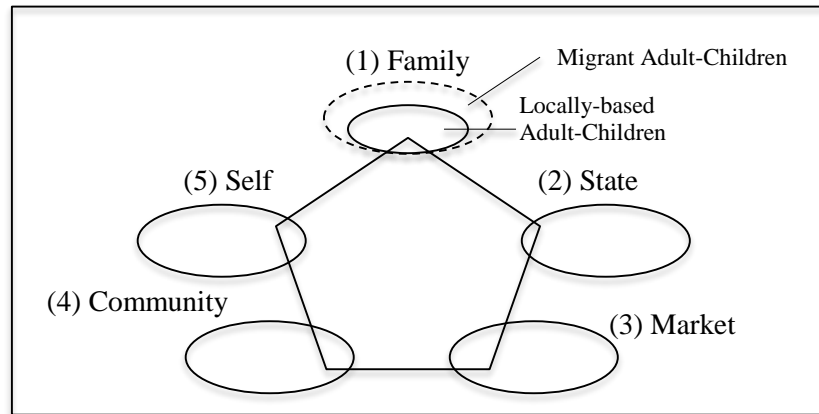
Although the care diamond is largely understood as an aspatial concept, Raghuram (2012) emphasises that the care agents can be analysed as sites of care and the relationship between these sites and institutional arrangements also need to be incorporated to better understand care arrangements. Indeed, geographers have observed how sites of care influence the elderly persons' agency and their ability to care for themselves, e.g. receiving care within the home provides the elderly with greater levels of independence (Milligan, 2006; Wiles et al, 2009). Within the context

of transnational migration where care-receivers cross international borders, the nature of the agency exerted by the care-receiver also varies according to the country they reside in. Further, through the scalar view I assert that each care agent may represent both local and transnational forms of care, e.g. family care may include emotional care provided by migrant children and physical care by locally-based adult-children (see Figure 2). Thus, by considering the landscapes of care, which emphasises that care can be achieved in both distance and proximity, I expand the focus of the care pentagon from the local to the transnational scale.

3-3. Tiers of Care-givers

According to the care diamond, the care-receiver accepts care from multiple care-givers who complement each other (Ochiai, 2009). Milligan and Wiles (2010:737) argue that caring “is ‘necessarily relational’ in that it involves on-going responsibility and commitment to an object (or subject) of care”. Bridging these two notions and extending it further, I contend that from the care-receiver’s perspective the family, community, market and state form a network of care-givers that is structured according to a hierarchy of preference. Thus, based on the care-receivers’ expectations of care and notions of relationality the manner in which they seek care from these agents forms a tiered network of care-givers, e.g. the self would be the first preference for care, while the second option may be a domestic worker and thirdly a family member. I represent the care-receiver’s preference within the care pentagon by numbering the care-providers from the first to the fifth (see Figure 2). The tiers within the care pentagon are not fixed, but vacillate according to the circumstances of both the care-receivers and their care-givers, e.g. the migrant with generally a limited ability to care, during home visits may become the main care-giver. However, the preference is not reflective of the proportions of care given by each provider, e.g. although an elderly parent’s first care preference during frailty would still be self-care, the largest proportion of care maybe provided by the family.

In doing so, I highlight the negotiations that occur at a micro-level within care relations, which is not emphasised within macro-analyses that focus on institutional arrangements and care regimes (Razavi, 2007; Ochiai, 2009). Thus, while the care diamond’s emphasis on care networks remains within the care pentagon, by engaging with care-receiving ideals and emotions I provide an analysis that extends to the intimate scale. Next, I briefly explain the migration context in Sri Lanka and subsequently the factors and trends that has lead the present landscape of care in Sri Lanka.



[Figure 2: Depiction of Care Preferences and Transnational-Local Forms of Care within the Care Pentagon]

4. Study Context

International migration has been a dominant trend in Sri Lanka for the past thirty years, and has developed along the two trajectories of labour migration and skilled permanent migration. Australia has been a favoured immigration destination for Sri Lankans due to its proximity to Sri Lanka in comparison to other developed nations and the relative ease of gaining work and study opportunities and eventually Australian citizenship. Therefore in 2011, the Sri Lankan-Australian population stood at approximately 110,000 (0.5% of the total Australian population), the majority of whom entered Australia under the skilled-worker category (Australian Government-DFAT, 2011: 60). Most professional migrants have achieved upward economic mobility and lead more luxurious lives than they would in Sri Lanka. Although there are no statistics to directly relate migration of Sri Lankan professionals to a decline in family-based eldercare of their parents, the implication of professional migration on the care of elderly is evident. Generally, the earliest age that Sri Lankans would obtain their academic qualifications and migrate as professionals would be in the late 20s to early 30s, while their parents are likely to be in their 50s. Next, I define the scope of the five care agents within the care pentagon while highlighting the manner they have transformed due to increased transnational migration in Sri Lanka. Further, I focus on the case of affluent, urban elderly instead of providing a broad discussion of the landscape of care available in Sri Lanka.

4-1. Family

The tendency to consider adult-children as the primary care-givers of elderly persons stems from culturally embedded values of reciprocating care that was provided by parents, while societal expectation and sanctions also create pressure to care for ones' parents. Recent studies on eldercare

reveal an increased strain on intergenerational relations and difficulties in maintaining family care due to the formation of nuclear families, decreased number of adult-children per family, increased labour force participation of women, separation of family members due to migration and the loss of adult-children due to the 30 year civil war in Sri Lanka (Silva, 2004; World Bank, 2008). As a result, there is a gradual increase in elderly living alone, or with their spouses, or seeking alternative living arrangements.

4-2. State

Despite the decline in family care, the state's approach towards eldercare is largely familistic. However, the state's provision of fully subsidised health care to all Sri Lankans and the concessional rates of pharmaceutical drugs for elderly in government hospitals do benefit these affluent elderly. Notably, most migrants preferred their parents be attended to in private hospitals, which allowed them to contribute in greater amounts monetarily. However, the elderly sought fully-subsidised care from the state hospitals since the doctors were deemed to provide better services and were not exploitative. Though not directly linked to care provision, I highlight that state provided social security in the form of pensions is vital for the middle to high-income elderly to afford care.

4-3. Market

Market care is available mainly in three forms: local domestic workers, home care nursing services and 'paying elders' homes', with local domestic workers being the most common type (Silva, 2004). The affluent classes of Sri Lanka have had a tradition of keeping domestic workers to conduct household and childcare activities and were not hired exclusively for eldercare. These domestic workers were employed through personal contacts and recommendations and were largely live-in workers. Recently, due to the difficulty of finding domestic workers through personal networks, 'house-maid agencies' have become more common, where domestic workers visit houses on a daily basis. Nevertheless, live-in domestic workers are still preferred due to the lack of trust of domestic workers referred by agencies and the fear of being robbed.

The past decade has also seen a gradual growth of home-care nursing services. 'Paying elders' homes' managed by religious institutions offer modest living arrangements such as separate rooms with shared toilets. Recently, the private sector has also established many luxurious paid accommodations with nursing services. These accommodations, generally charge in foreign currency and cater for affluent elderly such as parents of permanent migrants and foreigners who chose to retire in Sri Lanka.

4-4. Community

The community as an agent of care in Sri Lanka caters largely for the needs of destitute elderly, through fully-subsidised elders' homes and day centres. Although middle and high-income elderly can benefit from such services, due to media representations of its residents as objects of pity many avoid utilizing them (Sunday Times-Sri Lanka, 07/08/2011). Thus, neighbours are generally the community form of support available to the more affluent elderly. Limited studies have considered the importance of neighbours and extended family members as primary or supportive care-givers (Waxler-Morrison, 2004). However, research on Sri Lankan elders' living arrangements has observed instances where extended family members such as siblings or cousins care for their elderly relatives (Silva, 2004). Further, it is common for extended family members to live within the same neighbourhood due to ancestral land division practices. Similar to Razavi's (2007:21) assertion that 'community' is a "the heterogeneous cluster of care providers", within the study I define community care as the availability of informal support networks, which includes a wide range of people who offer various types of care at varying degrees.

4-5. Self

The urban, affluent elderly parents' tendency to rely on themselves for care is an amalgamation of several factors. The parents I spoke with are economically independent, with 83% of the respondents receiving state-provided pensions. Given the elderly parents' social background and that several (34%) of them had themselves worked abroad, these parents' notions of receiving eldercare exemplified their desire for autonomy from their children and to be provided with care only when they require it. As elaborated by Omala (female/58/widowed):

I don't want to be a burden to anyone, especially to my children. I have made arrangements for my retirement. I have enough money in the bank in case I get sick.

Recognition of the disproportionate distribution of eldercare duties among adult-children also influence parents to care for themselves. A significant proportion of care-receivers (37%) chose to live alone or with their spouse in order to ensure that their children, both migrant and locally-based, are treated equally. Therefore, while concern for adult-children motivates self-care, a sense of selfhood is also a significant factor, especially since these parents possess the resources that are essential for care.

Within the study, I apply Sri Lanka's definition of 'elderly' as persons above the age of 60 years. I define 'healthy elderly' as those who are both physical and mentally able; although they may require medical attention for illnesses such as diabetes or cardiovascular problems, these ailments do not impede their ability to care for themselves. 'Frail elderly' denotes persons who are critically ill and/or require assistance in activities of daily living. None of the 35 elderly respondents were disabled or required intense care-giving at the point of the interviews, although 13 of them had experienced health crises due to heart attacks, falls and other forms of sudden acute illnesses.

However, I use the labels of being 'healthy' or 'frail' as convenient terms purely for analytical purposes. In addition, the majority of respondents referred to care strategies that took place during their deceased spouse's or parent's illness; therefore, these experiences have been incorporated into the analysis.

The following section focuses on three transnational landscapes of care elderly parents of Sri Lankan migrants experience as they reside in both the Sri Lanka and Australia, and as their level of health and agency reduce over time. Through the discussion I will explicate on how the gendered notions of care shape these elderly parents' care expectations and relations.

5. Care in Sri Lanka when Healthy and Independent

During the early stages of migration when the majority of elderly parents are relatively healthy and independent, within the family the exchange of emotional care takes precedence as a form of transnational care-giving. This "technological management of distance" (Parreñas, 2001:130) through phone calls, text-messages, and Skype enable migrants to convey their love and concern for their elderly parents. However, the transfer of emotional care reflected gendered distinctions of caring where unlike their female counterparts, most of the male respondents failed to comprehend the emotional significance of frequent communication and tended to be satisfied with helping their parents when in financial need. Since the majority of the healthy elderly parents do not require financial support, their sons' failure to understand their emotional needs lead to discontentment as shared by Omala (female/58/widowed):

If I tell my son that I am sick he will ask how much does it cost to see a consultant and will send the money immediately. But I have the money; what I want is just to talk about my problems with him.

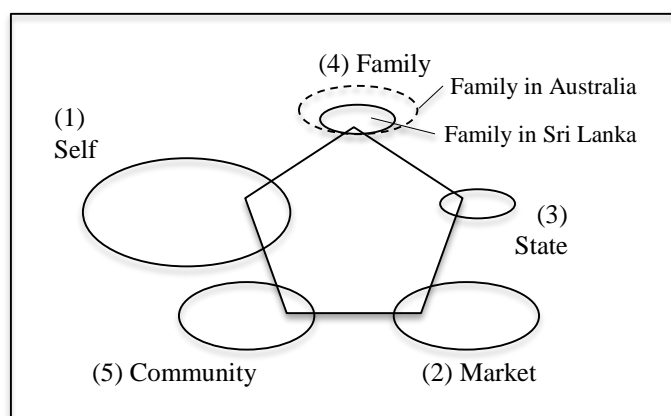
During this phase, locally-based adult-children's caring patterns did not vary significantly from their migrant siblings. They too provide emotional support and company, while occasionally offered practical care by providing their parents with transportation and help with home maintenance. Notably, despite the care-givers' gendered ways of caring, the elderly parents' expectations of care during this stage is gender-neutral where they expect mainly emotional support from both sons and daughters.

Though being self-reliant for physical care, most of these elderly employed live-in domestic workers to assist them with the general running of the household. As detailed by Nelun (female/89/widowed) a live-in domestic worker also provides these elderly companionship and a sense of security of having a person to appeal to in an emergency:

I have known Soma since she was a child, since she has been in the family she knows who are the trusted people, who to call in an emergency. It's much better than a daily [domestic worker]. You can't leave the house when they come in, they might rob you.

Further, the presence of supportive kin in the form of siblings, extended family and fictive kin such as neighbours reduced the care-receivers' dependency on their adult-children, while they were a crucial form of assistance for parents without any adult-children in Sri Lanka. For instance, Lalani (female/69/widowed) whose only child resides in Australia, depends on her two younger sisters who are both doctors to advise her on health issues and they take turns to accompanying her on monthly visits to the doctor. A tri-wheeler driver fulfills her transportation needs, while also providing her with other services such as posting letters, accompanying her to various places such as the bank and market. In the night, Lalani's neighbour's domestic worker and the worker's husband sleep in a room allocated to them to keep her company in case of an emergency. State provided care at this stage was not significant since the elderly parents' have few ailments or chose to receive private health care since their complaints were not very serious or costly.

Considering these elderly respondents' transnational landscapes of care illustrated through the care pentagon (see Figure 3), the elderly parents' first preferred to fulfill their care needs by themselves and second through market care, mainly domestic workers. Both migrant and locally-based adult-children played a vital role in providing emotional care during this stage.



[Figure 3: The Transnational Landscape of Care when Care-receivers are Healthy and Independent in Sri Lanka]

In addition, practical and emotional care provided by extended family and neighbours were important for the parents' to maintain their autonomy. Thus, contrary to the Asian family care model (Hu and Chou, 2000), the care expectations of these affluent elderly were not centred on the adult-children but were distributed among agents that represented the community and market. However, this landscape of care differs greatly when these healthy and financially-independent elderly parents visit their transnational care-givers in Australia.

6. Care in Australia during Visits

Transnational eldercare conveys the notion that migrants and their elderly parents are perpetually apart, with episodic moments when they exchange proximate care; such episodic moments are also recognized as a vital aspect of the transnational eldercare (Baldassar et al, 2007). Thus, I shift the focus to proximate forms of care exchanged between the relatively healthy and mobile care-receiver and their migrant children, when the former resides in Australia. The majority of 35 elderly parents (69%) had made multiple visits to Australia by the point of the interviews, while several of them (16%) travelled annually to reside for a period of three to six months.

The sentiment around organizing the parents' visits to Australia is triggered by the migrants' desire to show their parent that they 'care about' them. Since the elderly parents were generally healthy, care was expressed largely by taking them on trips, and going out for dinners, which as voiced by Swarna (female/85/widowed) are translated to emotional care:

Because I am keen to go to the temple... every month they go to the temple... we even went on a long trip for 14 days. Anyway once a week they take me out to see various places. They take enough care [of me].

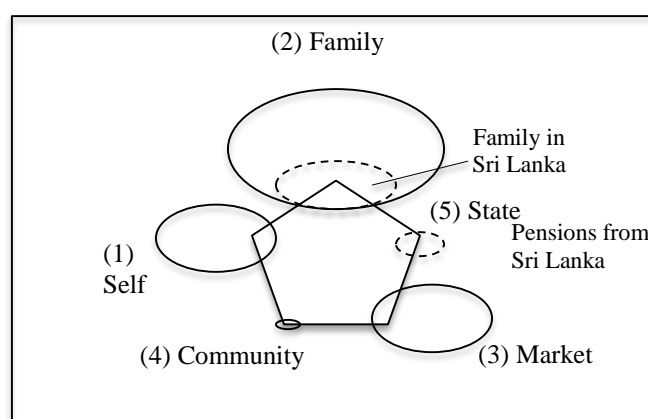
However, as observed in studies on elderly migrants living in host-countries, these elderly faced difficulties in adjusting to the foreign environment which places them in a vulnerable position of great dependence on their children for food, mobility and entertainment (Izuhara and Shibata 2002; Lamb, 2007).

Indeed, as visitors to Australia the elderly parents could not access formal community care facilities and had to depend on market care, while their adult-children had to pay large sums of money for their medical insurance. Most elderly respondents drew parallels with the sense of community they felt in Sri Lanka and how its absence in Australia and their lack of familiarity with Australian norms of living limited the agency they were able to assert in their day-to-day activities and mobility, which in turn placed them in a position of greater vulnerability and dependency with regard to care. For instance, although Lalani (female/69/widowed) is capable of taking walks alone, she explained that the streets are empty and if she should fall she is afraid that no one would hear her calls for help, and an injury would be an added burden on her daughter. While most elderly mothers' found the unfamiliar neighbourhoods restrictive to their mobility, in comparison, elderly fathers were more mobile, e.g. taking walks or accompanying their grandchildren to school or for extra-curricular activities. However, they too emphasised that the ability to rely on friends and neighbours as informal care-givers is not available to them in Australia due to cultural inhibitions and racism as elaborated by Rahula (male/75/married):

Australia is not good place for dark-skinned Sri Lankans like me; I guess we stand out as different. I go out for walks everyday, and the maximum I will get is a nod.

Although, the elderly parents' ability to physically care for themselves remained consistent in Australia, their landscape of care extended only to the family and occasionally the market because

they were taken for medical check ups by their migrant adult-child (see Figure 4). Notably, adult-children in Sri Lanka continued to provide emotional care while their parents were in Australia. Since the Australian migration policies consider the migrants as the custodian of their elderly parents, the state has no impact on the care they receive during their visits. The state care represented in the care pentagon is elderly parents' pensions that they receive in Sri Lanka. Although it is a small contributor to the care, it did contribute to the elderly parents' sense of self. The formation of community networks were limited due to racial differences, the respondents' lack of confidence in the foreign environment and their immigrant status which made them ineligible to access community care. Thus in comparison to the care scenario in Sri Lanka, the landscapes of care in Australia offers limited options and tends to thwart the elderly parents' agency.



[Figure 4: The Transnational Landscape of Care when Care-receivers are Healthy and Independent in Australia]

7. Care in Sri Lanka when Frail and Dependent

Eldercare is an evolving process where the initially healthy parent may face deteriorating health and declining financial strength. These elderly parents' increasing frailty did not result in an immediate shift to family care, but a gradual one where they realize their reducing capacity to self-care and attempt to maintain autonomy by engaging in other forms of care. Among them domestic workers were the most frequently opted source of care. Four parents who lived in paying elders' homes explained that moving into these homes was precipitated by the need for independence and personal space, since they faced difficulties in maintaining a household and also considered it a caution against possible family tensions, which in turn highlighted the gendered notions of ideal care-givers. In Kamala's (female/79/widowed) words:

My sons actually called me to [move to] Sydney, but I said no. If I had a daughter I would have considered. So I thought of coming here [to the paying elders' home]. At the moment I have no problems with my daughter-in-law, but that's because we are apart. It's when you have to live together that the problems start.

Further, the structure of the paid accommodations allowed the parents to maintain personal autonomy. The care-receivers' movements were not restricted by the management and they were allowed to have personal domestic workers who would share the room with them. This arrangement enabled the elderly parents to bring in care-givers who are familiar with their care needs into the more formal care setting. Notably, all three of these respondents only had sons and had to rely on their daughter-in-laws for intimate care-giving either in Australia or Sri Lanka. In contrast, Erandathi (female/77/widowed) who had a daughter residing in Sri Lanka opted to relocate to her daughter's house when faced with greater frailty.

Indeed, the majority of parents' decision to reside with their daughter instead of their son during frailty, not only expressed the common assumption that women are better suited for care-giving (Zhan and Montgomery, 2003; Wong, 2009) but also the significance of (non)family ties when receiving care. As voiced by Swarna (female/85/widowed),

My son is there [in Australia] he will look after me alright, but that is a son and a daughter-in-law. But I want to be looked after by my daughter. I mean how can you be naked in front of your daughter-in-law but you can be that in front of your daughter. You can't ask your daughter-in-law to wash you.

Thus it is not only the gender of their care-givers, but also the kinship and intimacy shared between the care-receiver and care-giver (Long et al, 2009; Wong, 2009) that impact whom the elderly intend to rely on for intense care-giving. Nearly all elderly mothers differentiated between the (emotional and physical) care received from a daughter and a daughter-in-law: a daughters' care is an expression of love, while a daughter-in-law would care as an obligation.

With the parents' increasing age and greater medical needs, their income becomes insufficient and they rely more on their adult-children for financial support. For most parents, financial support was readily given by the transnational care-giver as reflected in Malini's (female/81/ widowed) experiences:

When I needed to have a heart surgery, my children here [in Sri Lanka] told her about the situation, [and] she sent money immediately. So we had no problems on that front. In fact she insisted that I be put in a private hospital.

Despite the importance of the migrant child's remittances for the parent during ill health, the majority of parents expressed that it was not an adequate expression of care. Similar to Dimanthi (female/83/widowed), as parents become frailer and their social networking becomes more restricted, they relied more on their adult-child for emotional support.

We are all growing old now, most of my friends are dead and gone, or are too sick. Who do I have to turn to now other than my own children? It takes very little to upset me nowadays, and at that time I need to talk to my daughter. Just hearing her voice is enough to soothe me.

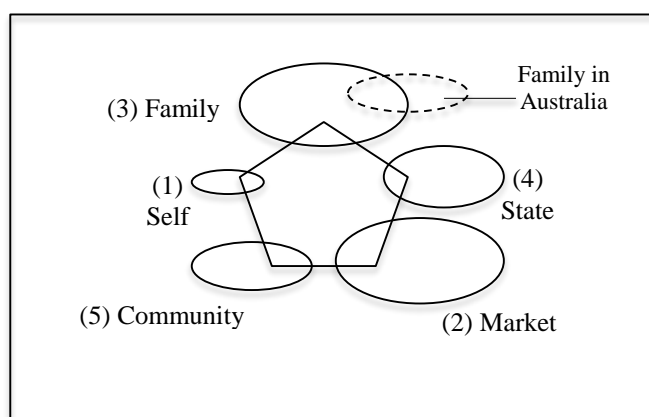
The gendered patterns of emotional support expected – and received – during the parents’ frailty did not vary much from when they were healthy; daughters were more diligent than sons in keeping contact with their parents. In addition, the failed expectations of emotional care by the migrant during the early stages of migration impacted whom the parent chose to turn to when faced with greater vulnerability. Relating to the emotional stress she felt when she fractured her hip, Vijitha (female/81/widowed) explained:

Well he never really called that much from the beginning [of the migration], so why should I bother him with my troubles? Anyway my youngest daughter and grandson are here with me. It’s to them that I turn to when something worries me.

Although family care was the option for the majority of elderly parents during these phases of ill-health, a few care-receivers explained that extended family members such as siblings, nieces and nephews, neighbours and acquaintances provided them with a wider network of care givers. Rahula’s (male/75/married) experience during his heart attack illustrates that the network of local care-givers the respondents can appeal to for help during a crisis is extensive:

The very minute I told my wife to call an ambulance, she called my daughter but also my son-in-law’s sister [whose office was near the hospital and has previously helped during emergencies]. She came immediately to the hospital straight from work and had made the initial hospital payment as well.

Contrary to studies which posit that family would be the first option of care while the market is the least preferred form of care, in the study, despite the presence of locally-based adult-children several elderly parents chose to rely on market care in the form of domestic workers and paid elderly homes. Thus, I contend that the dependency patterns of affluent care-receivers form a tiered pattern, where commercial forms of care are first preference since it enables the elderly to maintain their independence, while closer familial ties to the care-giver convey reducing autonomy for the care-receivers (see Figure 5). As such, when elderly respondents experience greater frailty, their landscapes of care expand to all four tiers of care, while the care provided is less emotional and more physical.



[Figure 5: The Transnational Landscape of Care when Care-receivers are Frail and Dependent in Sri Lanka]

7. Conclusion

Study of the care exchanges between migrants and their elderly parents discloses the manner in which transnational migration has transformed conventional notions of care. Through the care pentagon, I emphasised that the care-receivers' tendency to accept care from various agents is based on their notions of relationality and expectations of care, which in turn creates a tiered network of caregivers. In response to changing family norms, ageing parents seek to maintain their autonomy until they reach a stage where they require long-term care. Meanwhile, elderly parents engage in 'self-care', believing that by caring for themselves, they would be reducing the care burden on their familial care-givers. Family consistently plays a significant role in the elderly parents' care landscape, however the type of care they initially provide is largely emotional while as the parents' level of frailty increases it expands to physical care. However, the variations between the three transnational landscapes of care in Sri Lanka and Australia emphasises that the elderly parents' autonomy is tied to their access to other care-givers. Indeed, this group of affluent elderly highlight that market care is a preferred form of care despite the presence of family. In comparison, community care is largely supplementary to family and market care. State care is greatly appreciated but less utilised due to the elderly parents' access to private health care.

These transnational landscapes of care are also shaped by the elderly parents' gendered ideals and experiences of care-receiving. First, discontentment could be identified along gendered lines, where elderly respondents complained that sons failed to understand the significance of phone calls and considered money a substitute for care, while daughters provided emotional support through frequent communication. While these negative care experiences initially motivate parents to maintain greater autonomy regarding their care, it also creates a complex interlocking of gender and power relations as the parents reach frailty. Nearly all respondents preferred to receive care from daughters, this partiality was influenced by notions of both gender and intimacy. The preference for women over men as care-givers perpetuates the gendered understanding of women as natural care-givers and emphasised the tendency to expect intense care-giving from them (Isaksen, 2005). Further, I argue that the elderly respondents' preference for daughters over daughter-in-laws when receiving physical care associated with the naked body reveals their notions of insider/outsider when it comes to intimate care. Notably, the tendency for a domestic worker to provide intimate care over a daughter-in-law emphasises the elderly respondents' opinion that first, despite both being outsiders, the ability to pay the domestic worker for their care is preferred instead of accepting obligatory care from the daughter-in-law and second that they wield greater power within care negotiations with paid care-givers than with familial care-givers.

Thus, by including the ‘self’ as another agent of care to the care diamond, I focused on the changes that take place at an individual level within care relations, which does not get highlighted within more macro-analyses that focus on care pluralism. Further, through the paper I intended to emphasise on the dynamic nature of eldercare and offer a framework that can capture both its temporal and spatial variations.

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