Session B-4 Transnational Care

Transnational Eldercare: Filipino Caregivers Caring for Elderly Migrants in the Philippines

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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. [2]

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.

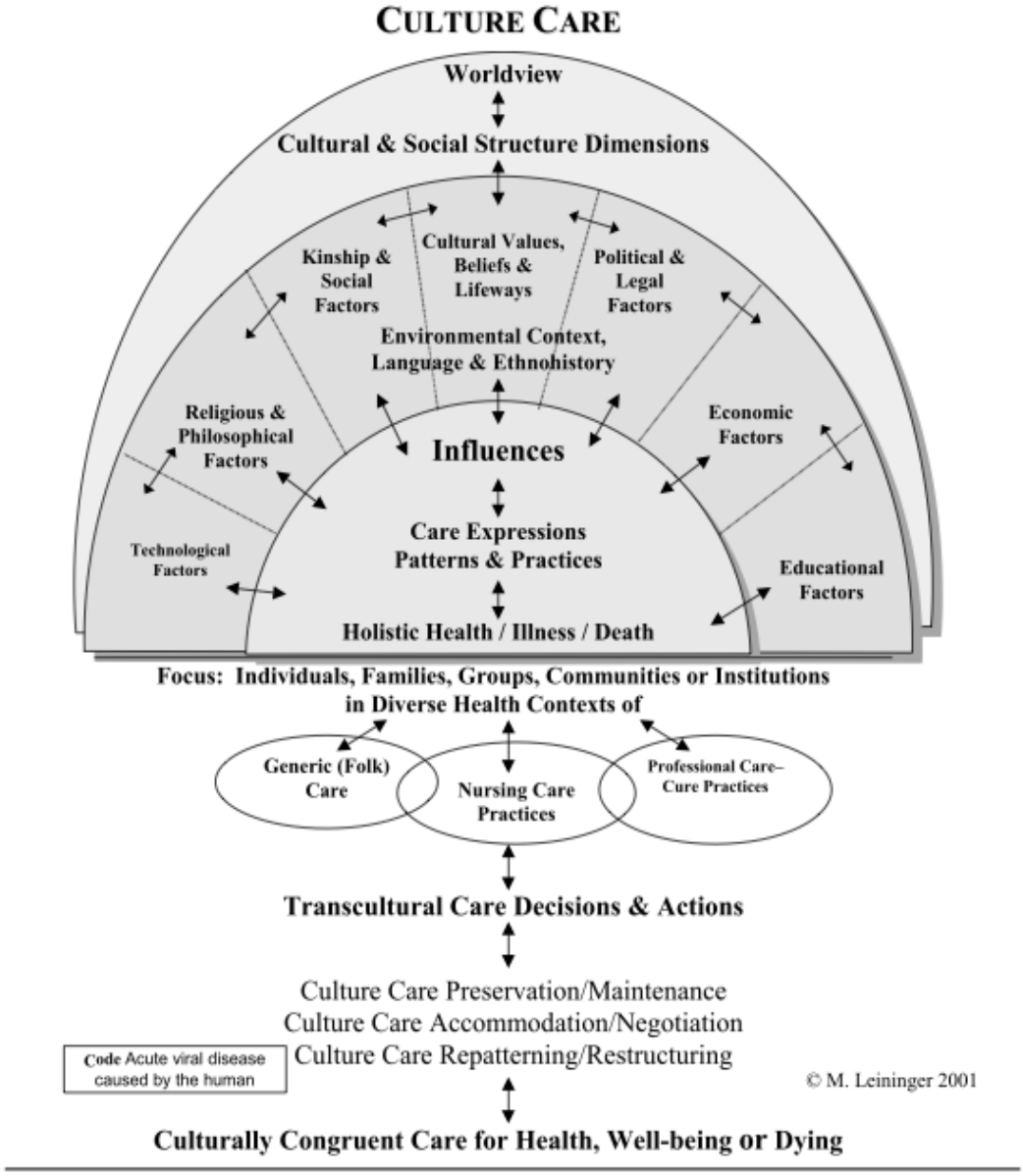
3. Cultural care universality and diversity: Understanding care from the nursing perspective

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)[3].

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

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[2] 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).

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

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.

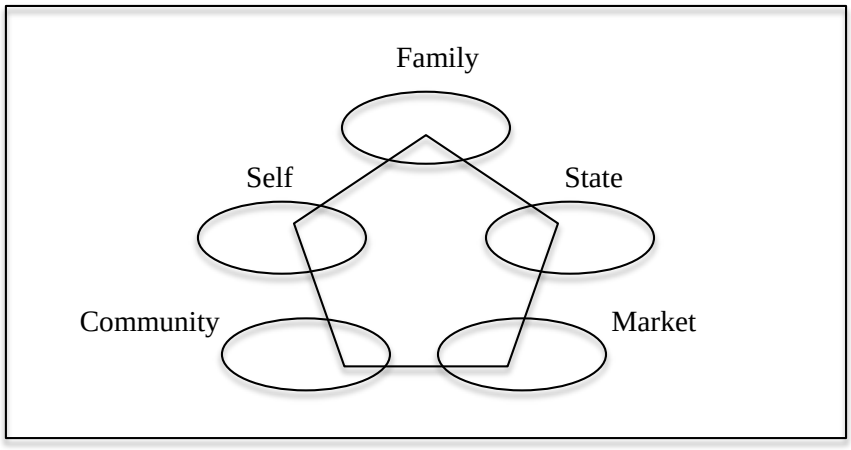
As defined by Razavi (2007: 21) the care diamond is "the architecture through which care is provided, especially for those with intense care needs such as young children, the frail elderly, the chronically ill and people with physical and mental disabilities". However, the literature's concentration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

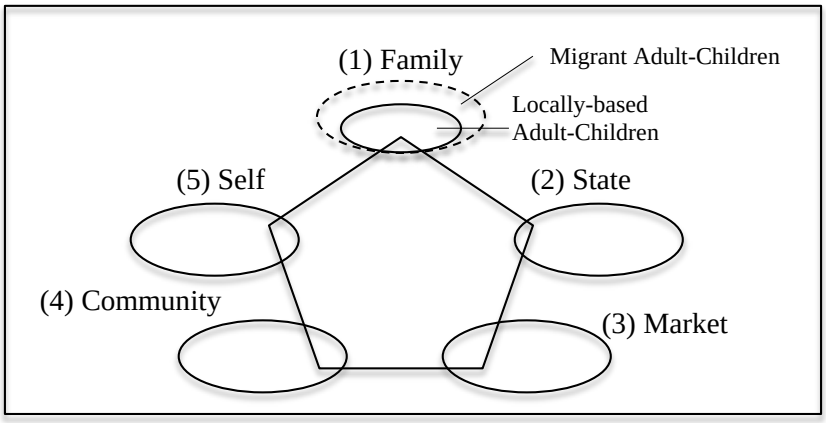
Although the care diamond is largely understood as an aspatial concept, Raghuram (2012) emphasises that the care agents can be analysed as sites of care and the relationship between these

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.

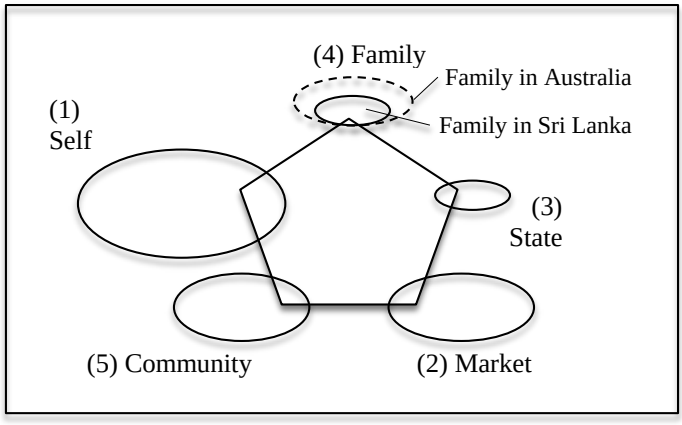
Though being self-reliant for physical care, most of these elderly employed live-in domestic workers to assist them with the general running of the household. As detailed by Nelun

(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 though 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].

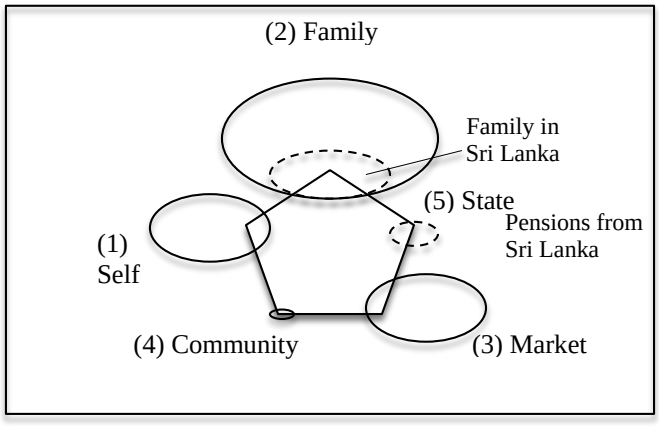
However, as observed in studies on elderly migrants living in host-countries, these elderly faced difficulties in adjusting to the foreign environment which places them in a vulnerable position of great dependence on their children for food, mobility and entertainment (Izuhara and Shibata 2002; Lamb,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

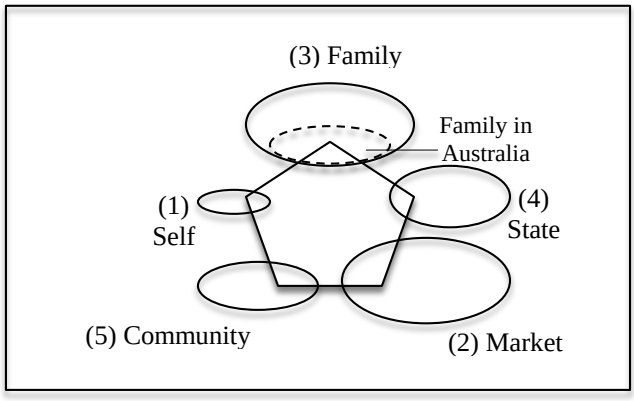
> Well he never really called that much from the beginning [of the migration], so why should I bother him with my troubles? Anyway my youngest daughter and grandson are here with me. It's to them that I turn to when something worries me.

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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Role of the State on the Care of Low-Income Migrant Workers in Qatar

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1. Introduction

International Labor Organization (ILO) classifies the international migration for employment into 2 majors; *settlement migration* and *contract migration*. Settlement migration is the one that migrant workers are involved to secure jobs and settle there. This migration is from underdeveloped economies to developed countries and identified as the "brain drain of the high skilled people" in underdeveloped countries. In the type of contract migration, migrant workers are granted permission to enter a country and a contract is issued on their behalf or between them and their employer. According to ILO, contract migration has outnumbered the settlement migration (Zachariah and Rajan, 2004). In the case of Qatar, contract migration is dominant in which migrant workers need an entrance visa and an employer's permission in order to work in Qatar.

Qatar is a country that rapidly grows in global history in terms of urbanization, citizen wealth and its integration to global economy. Migrant workers who have immigrated to Qatar through a contract and a sponsorship relationship are incorporated into economic structure of Qatar, but excluded from the social structure. This paper seeks to analyze the role of the State of Qatar on the management of low-income migrant workers. It will be argued that international labor migration to Qatar and Qatar's responses for managing the migrant workers cannot be understood only within the economic and demographic context such as revenues, investments, small population size and low labor force of Qatar. Rather, the political and cultural structure of Qatar must be taken into consideration to understand the management practices of Qatar institutions.

As well as the economic factors including the stability of the economy, trade, foreign investment, and the income distribution effects of migration, non-economic factors such as cultures, values, human capital, political affiliation, social integration, and neighborhood safety play decisive role on the migration management policies of Qatar. Throughout the years, Qatar government could not be able to stop the migration flows to their countries since there is a reciprocal dependency between them due to the construction projects of the state. Policies and practices of the Qatar government are actually based on minimizing the impact of foreign workers on local culture, values, traditions, and customs since the cultural integrity and homogeneity of Qatar has been seen as crucial for the survival of the state and considered as being challenged and threated by the migrant flows (Babar, 2011).

2. History of the Labor Migration in Qatar

In Qatar today number of migrant workers has outnumbered the Qatari citizens by more than nine to one (Gardner, et all., 2014). In order to understand the immigration flows to Qatar, pre-oil era and post-oil era need to be differentiated from each other. As Gulf Cooperation Countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and UAE) share many similarities in terms of the development of their socio-economic and political structures, immigration issues have caused similar effects on their economy and policy decisions. After the discovery of oil in the GCC countries, their economies have been identified as petrodollar economies and prosperity level of those countries rapidly rose (Khaalaf and Saad Alkobaisi, 1999).

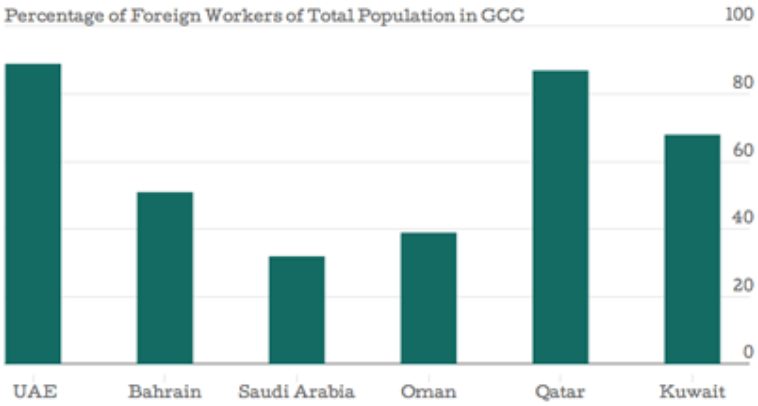

Figure 1: Percentage of Foreign Workers of Total Population in GCC (Source: Kuwait Diplomatic Institute-2011).

History of migration to the GCC countries expanded upon by the British colonial apparatus and then expanded further by the discovery of oil wealth (Gardner, et all., 2014). The discovery of petroleum wealth had a transformative impact on GCC countries' economies. A flush of oil income rapidly paved the way for modernization and changed the region's sheikdoms into modern nation states (Gardner, et. all, 2013). As rapid modernization had a significant effect on the material aspects of life, it has brought the need of the importation of labor in all level of skills. Qatar with its small population size and low level of labor participation had to seek alternative sources of labor. Since the local population is small and historically lacked the technical skills needed for modernizing their traditional societies, importation of labor at all levels of skills has been adopted as state policy (Khaalaf and Saad Alkobaisi, 1999).

On the other hand, pre-oil economy of the Gulf Sheikhdoms were described with their vulnerability since pearling industry was the only income source of the Gulf that determined the political, cultural and social institutions of the Gulf region (Niblock, 1980). The tribal structure of the region also shaped the conduct of those economic activities based on trust, loyalty and discipline. This economic structure of the region was followed by the economic dependency on the oil sources which produced importance of capital and manpower, extensive social services and a new life style of the Gulf societies. Afterwards, oil and natural gas provide a fundemental source of capital for Qatar that developed its economy rapidly and required labor forces with the rise of oil prices in 1973-74 and in 1978-1979. This development resulted in large transfers of capital from oil importing countries to oil exporting countries (Birks and Sinclair, 1982). Expansion in demand for labor and exhaustion of traditional labor supplies forced labor importers to look for additional supplies, especially in the Indian sub-continent (Schuurman and Raouf Samir, 1990).

With the 'oil boom' in 1973, the GCC countries that had been the major oil-exporting countries had to deal with a dilemma regarding investing their vast revenues. Consequently, they decided on three major economic and social fields in which to invest. The first field was the development of infrastructure, governmental ministries and services. The second field was the development of the industrial and agricultural sectors with the aim to diversify their economies. The third field was the substantial improvement in the health care and education systems as well as other social services (Winckler, 1997). Those infrastructural developments and economic growth in the twentieth century paved the way for the formation of migration industry in GCC countries and allowed them to expand their respective foreign labor forces (Gardner, et. all, 2014).

In early 1980s, labor migration had transformed the workforces of GCC countries. It rose up to 70% in Kuwait, 40% in Bahrain, 85% UAE, % Saudi Arabia and 81% Qatar (Humprey, 1993). After 1982 with the end of the oil decade (1973-1982), substantial change occurred in those countries. In 1981, the World Bank stated that migrant workers were consuming too much water, fuel, food and electricity which was costly for governments to provide wages and subsidizing public services for migrant workers (Winckler, 1997). Authorities began a rigid control over the admission of migrant workers because of the slowing down of economic development after 1982 and increase in unemployment. In 1990, the Iraq invasion of Kuwait resulted in dramatic demographic changes; for example, especially departures of migrant workers in Kuwait and Saudi Arabia rapidly increased while other GCC countries and Qatar remained the same.

In terms of the conservative and traditional form of its socio-cultural and political organizations, Qatar as a small oil exporting society is different from developed capitalist industrial societies. “Dialectical

paradox" is the term that can be used to explain this difference. Wealth and prosperity which came through the oil resources, have paved the way for the dual characteristic of rapid economic modernization. Prosperity level of the country has increased but traditional elements in the political-legal and cultural branches have remained. This affects how society react the scopes of international labor migration (Khaalaf and Saad Alkobaisi, 1999). Therefore, Qatar as a city state (Halliday, 1977) which has a few sources apart from the oil and gas has experienced the deepest impact of the migration with the Kuwait and UAE. Due to the dual characteristics of rapid economic development, since the 1970s, skilled and professional migrant workers have increased but the foreign labor force is still dominated by workers who are employed in the construction sector (Seshan, 2012).

3. Kafala System and Governance of Labor Migration in Qatar

Kafala system is the central institution in Qatar that defines the rights and obligations of the migrant workers. This system also creates a structural dependence by rooting the migrant workers to the employer rather than the state. Qatar authorities prefer individual, informal policies to broader legal policy and consider workers as economic and contract matters rather than of civil and political rights (Mednicoff, 2012). Migrant workers required to obtain their current employer's permission before changing jobs (known as a 'no objection certificate'), they are required to have their employer's permission before leaving the country (exit permit), they are not allowed to form or join trade unions and they are excluded of certain categories of workers, including domestic workers, from the protections of the Labor Law meaning that under Qatari law there are no limits on their working hours, they cannot complain to the Ministry of Labor if their rights are being breached. Moreover, the "kefeel" has ability to hold migrant's passport and tremendous power in the hands of initial sponsor (Amnesty International, 2013). In the case of GCC countries, foreign workers are employed with local contracts and they are not maintained on their home country social system (Sandrine, 2012). Throughout the time, those practices and attitudes towards the migrant workers have been normalized in the socio-cultural context of Qatar and other GCC countries (Gardner, 2014). This fact shapes the long standing norms concerning the relations between the migrant workers and employers.

The Kafala system recently has come under criticism by human rights groups, who characterize it as a modern slavery. The migration governance system of Qatar has mostly been described with its injustice practices about the migrant workers' rights. In January, *the Guardian* published a Human Rights Watch Report and described the 2022 World Cup which is the most ambitious project of Qatar as "a crucible of exploration and misery" (Gaith, 2013). This report has shifted attention to the issue of migrant workers in Qatar. Their living and working conditions have started to be investigated in terms of human

rights principles. The Qatari government has started to be criticized for exploiting migrant workers due to its infrastructure projects.

Ministry of Interior and the Ministry of Foreign Affairs are the official institutions who are responsible for the governance of the expatriates in Qatar. For the governance of the labor, the central authority that has primary responsibility is Qatar's Ministry of Labor (MOL). It implements policies for the use of labor, settles labor disputes in accordance with the Labor Law of Qatar, develop career programs and develop programs to increase the number of Qatar nationals in the workforce (Qatar Ministry of Labor). In addition, the Department of Labor Relations of the Ministry of Labor and Labor Court are two legal institutions that migrant workers can apply when they are exposed to any problems related to their employer and workplace.

Since civil society in Qatar is extremely limited, there are quasi-governmental organizations such as The Doha International Family Institute (DIFI), Qatar Foundation for Education, Science, and Community Development that are engaging with the labor migration and addressing the migrants' rights and workers' rights in Qatar (Babar, 2011). Qatar Foundation for Combatting Human Trafficking (QFCHT) is another organization deals with the victims of human trafficking. The Qatar National Human Rights Committee (NHRC) can be seen as the prominent quasi-governmental organization which was established in 2002 in order to demonstrate Qatar's commitment to prioritizing rights for all residents, and to engage with human rights as a good global citizen (Babar, 2011). The NHRC is mainly engaged with assisting the complainants and preparing annual reports every year.

All of these initiatives can be interpreted as responses for the increasing international scrutiny against Qatar regarding the conditions of migrant workers. Due to the 2022 FIFA World Cup, much attention has been drawn to the implementation of the labor law and the kafala system (Babar, 2011). Human Rights Watch, Amnesty International, and the International Trade Union Confederation regarding the treatment and conditions for workers can be seen as the institutions that showed their condemnation to the labor law implementations in Qatar. As a response to these condemnations of the human rights organizations, the Qatar 2022 Supreme Committee has started preparing a 'migrant worker charter', which has been announced to be implemented for all World Cup-related infrastructure projects (Babar, 2011). The stance of Qatar 2022 Supreme Committee can be considered as a commitment to ensure the safety, health and dignity of all workers and their welfare and rights (Babar, 2011).

In the GCC countries, the segmentation and polarization of the labor force has been drawing sharp divisions between the national workers and foreign workers (Malecki and Michael C. Ewers, 2007). The vast majority of national workers are employed in governmental jobs and do not prefer to work in private companies. Similarly, private companies tend to recruit foreign workers because they accept working in

flexible hours with a lower salary than the nationals demand. In recent years, governments have attempted to implement some strategies such as bringing quotas for the companies to make them to recruit national workers for the nationalization of the labor force. These strategies are actually named as Saudization, Omanization, Bahreinization, Emiratization, Kuwaitization and Qatarization.

As stated in Qatar's National Vision 2030 plan, rapid economic and population growth causes serious problems in every aspects of life in Qatar. Recruiting that large number of migrant workers motivated the Qatari government to take steps to weigh up the potential consequences of migrant labor. Therefore, Qatar like other GCC countries, avoided seeing itself as a destination for permanent settlement, and aimed to build a citizen workforce by alleviating ongoing dependency on foreign labor (Babar, 2011). Despite the labor nationalization strategies of the Gulf countries, national labor market is currently dominated by the foreign workers. Therefore, the kafala system can be interpreted as a process to manage the large numbers of migrant workers that are an essential component of the national labor market. Kafala system and restrictive migration management policies of Qatar reflect the fear of loss of the national identity and also as a result of the great demographic imbalance in the fabric of Qatar society and in the national labor environment.

4. Disintegration of Low-Income Migrant Workers to Qatar Society

According to Human Rights Watch Report (2012), Nepalese has the largest proportion with 39% of the low-income migrants in Qatar. Indians are 29%, Sri Lanka and Bangladesh are 9%, Philippines are 5%, Pakistan and Egypt are 3% and other nationalities account 2% of the low-income migrant workers' population. In the labor force of Qatar, nationals are mainly work in public sector and highly skilled migrant workers dominate the private sector technical jobs while less skilled migrant workers dominate the construction and domestic works. Since Qatar economy is lack of a free labor market, there is a high dependency on imports (labor, capital goods and know-how) and there is no national capital accumulation process because of the lack of national market (Schuurman and Raouf, 1990). Importing migrant workers brings costs beside benefits for supporting its development projects. As migrant workers can be brought easier and quickly for project-basis jobs and can be sent back to their country when there is no more need, cultural and political costs of the migrant workers are seen as potential threats to Qatar society which declares itself as conservative and family-oriented. Migrant workers are considered as threats to national heritage of Qatar and cultural values of Qatar and even to political stability of Qatar (Kamrava and Babar, 2012).

According to Human Rights Watch Report (2012), the most serious issues relating to the treatment of construction workers in Qatar are stated as: poor living and working conditions, low wages and failure to pay wages on time or in full, high fees charged by recruiting agents in the labor sending countries, false promises to workers about the salary, benefits and nature of the work to be performed. The life conditions of the low skilled migrant workers should be underlined in order to understand the implications of the kafala system on the migrant labor in Qatar. According to a research that was conducted with the low-income migrant workers in Qatar, the workers recorded that 40% of them was located in dormitory-style camps, followed by 25% in villa camps, apartment flats 16%, port cabins 7%, private homes 5%, and other types of accommodations 7%. Most of them share their accommodation with over six people. Moreover, the supplies of electricity, water, and the provision of air conditioning are provided in very limited standards for them (Gardner, et. all, 2013).

Low-income migrants in Qatar are mostly exploited and deprived of their main economic and social rights. Migrant workers are entering the Qatar through a sponsorship agreement and in most of the cases the contract that had offered to them does not match with the conditions such as the amount of the salary and the type of job that they encounter with in their workplace. However, workers are forced to accept those conditions because they are entering the Qatar through contacting with a labor brokerage in their sending country and if they go back to their country they need to pay those labor brokerages. In addition, they need their sponsor's authorization to leave Qatar which makes the process more challenging for them.

The separation between the higher-skilled and high income migrant workers and low-income, lower-skill workers need to be emphasized as an important aspect of the labor migration issue in Qatar. Although the cultural treats of the high skilled foreign workers towards the fabric of Qatar society are not being neglected, their supposed threat is not considered as a direct threat to the states' security. The threat of the high skilled predominantly Western foreign workers is associated with the advancement of locals within the job market. Since the Gulf countries are lack of human capital, high skilled foreign workers compete in getting the jobs which would appeal to Gulf nationals. In contrast, low skilled foreign workers who are predominantly from Asian and African countries are perceived as posing greater threat to the state security. According to the 2009 "Inter-Arab Labor Mobility Report", low skilled migrant workers tend to engage in crimes, potential to spread communicable diseases, and civic disruption through migrants' violent protest (Babar, 2011). As for the Arab workers who share the similar linguistic and cultural affinities with the Gulf countries, they have been perceived as the segments that have a politically destabilizing influence in Qatar. This perception of Qatar and other Gulf countries as well towards the

Arab migrant workers such as Egyptians, Syrians can be viewed as a traditional threat perception which has been based on the idea that they tend to disperse political ideas and ideologies threatening to the state and the status quo. While the Westerners, Asians and Africans are viewed as posing cultural threat to the fabric of Qatar society, Arab workers are considered as posing political threat to the status quo in Qatar.

Many of them are in a situation that could be described as forced labor under international law, and even quasi-slavery in some cases, particularly in the domestic sector (Molitor, 2014). The new building sites for the World Cup and the abuses that are taking place in the cases of low-income migrant workers have drawn the attention of the global media. Although the problems facing low-income migrants in the Gulf are not new, NGOs and international organizations like Human Rights Watch, Amnesty International and the International Trade Union Confederation (ITUC) have documented many reports which enlighten the situation of the workers.

As in most of the GCC countries, in Qatar migrant workers are defined as potential threats to the state security, social stability, demographic balance, and their propensity to crime and a challenge to the civic order. Since migrant workers are remained out of structured political movements, their threat to the political stability is considered as less important than the cultural and security threats. Their contribution to the state economy and development readily has been neglected by the state of Qatar. According to Babar, these threat perceptions of Qatar towards the non-nationals are part of the public mind-set around the discourse of labor migration in the Gulf (Babar, 2011). This kind of discourse has a potential for a negative treat of the state and society towards the non-nationals and migrant workers.

The result of the migration management of the Gulf countries and Qatar is the engagement of the state in problematizing migration and placing it in securitized debates. This attitude of Qatar can be explained by the political structure of the Gulf monarchies. Internal threat perception has highly dominated the state ideology and policy towards the non-Qatari segments of the society. It should be kept in mind that Qatar is not a democratic regime and participation is limited with the ruling elite. In that sense, state of Qatar's security mission dominates the discourse of the migration management as well as the social stratification based on the ethnicity and class.

5. Conclusion

Qatar as a rapidly growing economy in the Arab world has much more to do in order to cope with labor migration issue and ensure the low-income migrant workers' rights. The main reform that Qatar needs to implement is the kafala system which restricts migrant workers' life conditions. Migrant workers must be provided the right to change their jobs without the permission of their current employer and also to leave the country without the permission of their current employer. The fact that they do not have a

right to complain and change their jobs if they face with the problems in their workplace paves the way for the employees to maintain unofficial regulations.

The kafala system has been implemented at the junction between law and custom, and reinforced by legal contracts between the migrant worker and his employer (Gardner, et. all, 2013). In recent years due to the international criticism for the management of migrant labor issue in Qatar, the kafala system has been the focal point of discussions about the global human rights. Qatar as the other GCC states has long been trying to alter the aspects of this system in response to these human rights-based critiques. The critiques are mainly concerning the passport confiscation, lack of documentation, job switching, salary withholding, and problems related to labor camps and living conditions common to low-income foreign workers in Qatar and the neighboring states (Babar, 2011).

Growing migrant population in Qatar makes the management of the labor migration central point for the policy making. Beside the role of economic forces and actors in the management of migration, political factors cannot be underestimated for their role in shaping and developing migration policy of Qatar. Migration policy in Qatar is mainly identified in a broader state discourse and the anxiety of the government because of the 'demographic imbalance' present in the national labor markets and population structure (Sharon, 2006).

It can be emphasized that in recent years the GCC states have begun to take a more proactive role in addressing the issue as a bloc, although they have not succeed in harmonizing their policies regarding the migration management. The GCC states are facing similar concerns around migration and they are at the center of the international criticism for their policies related to the migrant workers. As long as the GCC countries continue to be lack of human capital in their national labor market, population growth of nationals will continue to provide a growing number of entrants to the labor force (Shah, 2012). At this point, policies that the GCC governments implement to manage the labor migration issue, remains as an important element. While they are trying to encourage the national workers to engage in labor force especially in the private sector where the foreign workers are mainly employed, they should improve the foreign workers' rights and take steps to alter the kafala agreement.

Last but not least, it is an inevitable fact that Qatar will continue facing up to the reality of labor in the following years and spatial boundaries between the nationals and non-national workers will be more crystalized. Despite of the fact that Qatar as well as the other GCC countries has been exposed an international migration flow which is not faced by any other country in the world, the constructive steps that Qatar will take in order to regulate the migrant workers' labor rights and also positive steps to diminish

the concerns of the Qatari nationals about the national identity, state security and cultural conflicts will determine the Qatar's place as a rapidly developing country in the world context.

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