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Journal of Family Studies

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rjfs20

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To cite this article: Sanjaya Aryal & Ayse Guveli (2023): Flying families between the UK and Nepal: compromised intergenerational care amidst a restrictive migration policy context, Journal of Family Studies, DOI: 10.1080/13229400.2023.2218842

To link to this article: https://doi.org/10.1080/13229400.2023.2218842

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Published online: 01 Jun 2023.

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JOURNAL OF FAMILY STUDIES
https://doi.org/10.1080/13229400.2023.2218842

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Flying families between the UK and Nepal: compromised intergenerational care amidst a restrictive migration policy context

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ABSTRACT

Studies on the global care economy rarely focus on the implications of migration policies in maintaining informal intergenerational care among transnational families of care workers in the global South to the North migration context. Our study addresses this by exploring how migration policies influence the exchange of care transnationally. We pose two research questions: how do migrant families manage intergenerational informal care in origin and destination countries, *and* what are the roles of migration policies in shaping these arrangements? Our study presents the perspectives of Nepali migrant care workers in the UK and their family members. We generate novel data on the care practices within Nepali families and compare Nepali *Gurkha* and non-*Gurkha* families to illustrate the role of migration policies in exacerbating or reducing care inequalities. The research reveals how these inequalities force migrants to become 'flying families' to maintain care in proximity through cross-border mobility. We also show grandparents as active agents in maintaining intergenerational care. We propose a policy recommendation to enable the mobility of extended families and extend welfare provisions to reduce care inequalities created through the supply and recruitment of the care workforce from the global South to the global North.

ARTICLE HISTORY
Received 6 September 2022
Accepted 23 May 2023

KEYWORDS
Intergenerational care; global South–North migration; migration policies; transnational families; global care chain; care circulation; regimes of (im)mobility; displaying families

Introduction

> Before going there [the UK], getting a visa was not that easy. Our visa [application] was rejected first time and we only got it on the second try. In addition to a huge application cost paid by my son, we had to travel to Kathmandu twice for the interview [and biometric] and had taken several months to make papers [produce supporting documents]. We had applied a second time as we knew from many friends that they had received the visa in their 2nd or 3rd attempt.
>
> (Urmila, grandmother from a non-*Gurkha* family)

I have my *buwa* [father-in-law, aged 71] and *muwa* [mother-in-law, aged 57] staying with us here [in the UK]. They take care of my two sons, and the sons also love being with their

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> grandparents the most. Since I do not have to worry about the childcare and household work, I am working [a paid job] at the same time taking some courses at a college.
> (Gopini, female nurse from a *Gurkha* family)

Large numbers of migrants from the global South are filling the increasing shortages of care workers in the global North (Ehrenreich & Hochschild, 2003; Lutz & Palenga-Möllenbeck, 2011; Parreñas, 2001, 2005). This has inevitable consequences on intergenerational informal care within these migrant families. Here, intergenerational informal care refers to the family members providing care across generations, which does not include public or commercial provisions of care. Nepali migrants are using these international opportunities in the health and social care sectors and their share is growing rapidly (Adhikari, 2020). As the opening quotations demonstrate, Nepali migrant families maintain intergenerational care transnationally. However, within this same group of migrants, some families (*Gurkhas*) can come and go or stay longer in the UK, whereas others (*non-Gurkhas*) can struggle to get a visa or come and go for a shorter duration based on their immigration status.

Migration research on care workers usually focuses on their roles as paid care workers with less attention to the ways they manage care transnationally within their families as caregivers or receivers (Kilkey et al., 2018; Locke, 2017). Likewise, the possible implications of the global North's restrictive visa policies in maintaining and shaping care within transnational families are still largely under-explored (Merla et al., 2020). Hence, one of the research concerns in this paper is the gap in knowledge on intergenerational care connections among migrant families in the transnational setting, either locally, in the origin or host country, or transnationally. There is a limited understanding of the role of left-behind grandparents and the perspectives of care providers and receivers from different generations within these care connections (Chiu & Ho, 2020; Ducu, 2020). We address these gaps in the literature and offer insights into intergenerational care exchanges within transnational families through the study of Nepali migrant care workers' families in the UK and Nepal.

We pose two research questions: how do migrant families manage intergenerational informal care in origin and destination countries, and what are the roles of migration policies in shaping these care arrangements? Answers to these questions demonstrate and contribute to our understanding of the complexities of maintaining intergenerational care among transnational families located in the global South and the North. This extends the understanding of the global economy of care to show how different migration regimes shape the exchange of intergenerational care transnationally and minimize or exacerbate care inequalities among transnational families.

In the next section, we first present a brief background of migration and care work migration from Nepal and family practices on intergenerational care. Then we present the changes in the UK's policy on family migration. For the conceptual framework, we use four different yet closely related concepts within the study of care and migration: the global care chain (Hochschild, 2000; Parreñas, 2001; Yeates, 2012), care circulation (Baldassar & Merla, 2014), regimes of (im)mobility (Glick Schiller & Salazar, 2013), and displaying families (Ducu, 2020; Finch, 2007; Walsh, 2018). These concepts enable us to demonstrate how migration creates inequalities of care among migrants' families, how family members exchange intergenerational care and its associated motivations and

emotions, and how immigration regimes impact the exchange of care. We review these concepts after the background section. Then we present our research design and methods, followed by findings and discussion and conclusion.

Background

Care work migration and intergenerational care practices within Nepali families

Migration within and outside the country for labour work and household livelihoods has a long history in Nepal dating back to the eighteenth and nineteenth centuries (Sharma, 2018). Political change in 1990 led the nation to adopt a democratic system and increased integration with the global market economy enhanced people's access and aspirations to mobility. It accelerated and diversified migration in the 1990s, which further dramatically increased in the 2000s to countries such as India, the Gulf states and Malaysia and also to regions in the global North such as Australia, USA, UK, Europe, and Japan.

One of the new forms of migration that emerged since the late 1990s was the international migration of nurses, mainly women, which helped reverse the trend of men as leading migrants from Nepal (Adhikari, 2020). The migration of Nepali nurses is also unique as it is not linked to either historical, colonial or religious ties with the countries they frequently migrate to, such as Australia, UK and USA. Rather, it is mainly based on the demand for nurses and targets the countries with relatively easy migration processes that are taking more migrants. It is further based on the support available from private service providers or through social networks and connections facilitating the process. In the case of the UK, more than 1,000 Nepali nurses migrated between 1997 and 2008 when the UK was actively recruiting nurses and healthcare workers internationally (Adhikari & Melia, 2015). The trend slowed down after 2008. An estimate in 2021 accounts for more than 3,000 Nepali nurses working in the health and social care sectors and residing with a total of 10,000 dependent family members in the UK (NNAUK, 2021). Since the 2000s, the migration of other groups of Nepali to the UK also increased. This included the migration of skilled workers in different fields and their dependents through the Highly Skilled Migrants Programme (HSMP); ex-*Gurkha* and their family members through the resettlement programme; and migration of students and their dependents.

Gurkha is a special brigade of Nepali soldiers in the British army that has existed for the last 200 years. It was established to expand the British Army with men from ethnic groups classified by the British authorities as the 'martial race' (Caplan, 1995; Gellner, 2013). These ethnic groups derive from the hilly regions of Nepal, such as the Magar, Gurung, Rai and Limbu. Due to a massive recruitment drive since World War II, a small number of people from other caste and ethnic groups also joined the force (Kansakar, 2001) and this expansion continues. However, before the mid-1990s, the majority of the Brigade of *Gurkhas* was comprised mostly of these four ethnic groups (Gellner, 2013).

The *Gurkhas* have been in continuous campaigns for years with demands for settlement rights and equal pensions as a recognition of their service to the British Crown (Gellner, 2013). Since 2004, the British government has granted settlement rights to those who have served as *Gurkha* for at least four years, as well as their families

(spouse and children), on a compartmental basis. Those who served before 1997 were granted the same rights in 2009 and additional rights regarding settlement for adult children were added in October 2018. Since men born into *Gurkha* families often follow their fathers' legacy of working in the British Army, the resettlement scheme allowed many of these families to migrate and settle in the UK across three generations. There is no updated official figure on the number of resettled *Gurkha* families or overall Nepali population in the UK apart from the 2011 UK census, which recorded more than 60,000 Nepali residing across the country. Laksamba et al. (2016) estimated there to be around 100,000 Nepali in the UK. However, there are no more contemporary estimates.

Care workers for this study consisted of Nepali men and women working in health or social care settings in the UK as nurses, care assistants, health care assistants, support workers, and assistant nurses. This group is diverse in terms of route of entry, visa status and entitlement to residency in the UK. For instance, nurses, spouses of nurses or other skilled workers or students, and members from both *Gurkha* and non-*Gurkha* families are involved in the care work profession. *Gurkhas* are migrated through re-settlement visas and non-*Gurkhas* through student, labour or other types of visas. Hence, this study also compares the role of the UK's migration policies on grandparents' mobility in the UK and on the transnational exchange of intergenerational care in *Gurkha* and non-*Gurkha* families.

Nepali family members see themselves as responsible for providing care to other members, especially to the elderly, children and other dependents. Though the Nepali state provides a monthly allowance to the elderly (THT Online, 2021), it is not sufficient to cover their needs. Other state welfare provisions are weak, and so are the conditions and services of elderly homes. Moreover, staying in elderly homes is perceived as abandonment and the neglect of elderly people by their families and is a subject of taboo (Pun et al., 2009). Hence, Nepali try to maintain care of elderly family members within the household as a filial responsibility rather than seeking care from the state or private care institutions (Pun et al., 2009; Speck, 2017). Due to weak welfare provisions and familial care practices, elderly members expect care (in the form of hands-on physical care or emotional care) from younger generations and older generations perceive care of children/younger generations as their major responsibilities.

We found that among the non-*Gurkha* families, most of the migrants came to the UK first and their spouses and children joined them after a few years, but their parents were left behind in Nepal. Hence, the migrants provided care to their children locally in the UK and exchanged care with their parents transnationally while living apart. Because of this practice of family support in maintaining care within the household, they expected care from family members despite living in different transnational locations. Therefore, the elderly left behind in Nepal expect care from their migrant family members, whereas the migrant couples in the UK expect support for childcare from their children's grandparents (we have used grandparents to denote care workers' parents throughout the paper). However, in the absence of the grandparents, the migrant couples are bound to manage the care of their children alongside the responsibilities of paid work in the UK. While performing this dual role, they seldom use paid childcare services either because of the familial practice of care or financial constraints. This further increases their expectations to receive help from the grandparents, especially during childbirth,

to support the mother and baby and to continue childcare when the mother returns to her job after maternity leave.

In turn, grandparents try to visit the UK to care for their grandchildren. However, even though grandparents are becoming increasingly mobile in caring for their families transnationally, research on the grandparents' role in providing care to the younger generation transnationally is rare. Moreover, migration literature on Nepal depicts Nepali households as 'empty nest[s]' (Subedi, 2005, p. 11), with elderly lone grandparent/s as passive recipients of care and are often left behind on their own.

Hence, this study also makes a key contribution by exploring grandparents' roles in the transnational exchange of intergenerational care within families. Likewise, we will focus on the role of family migration and visa policies in enabling or disabling the transnational exchange of care in Nepali *Gurkha* and non-*Gurkha* families in the UK and Nepal.

UK family migration policies

Through its selective migration policies, the UK has introduced several measures either to restrict or provide controlled access to migrants and their family members. Family migration is always tough and has been viewed as a problem since the colonial period (Turner, 2015). Furthermore, the restriction on family migration and entitlement of residents to accompany dependent family members is also based on several factors including the migrant's country of origin (Kilkey, 2017) and skills sets they can bring to fill gaps in human resources in the UK. Kilkey (2017) defines these as utilitarian migration policies, which create barriers and conditions to family migration and settlement to facilitate the required human resources in the country. For instance, migrants' elderly relatives from the global South are targeted the most and their settlement in the UK has become complicated and limited. These restrictions and conditions are integral in migration policies dealing with family members' entry and settlement in the UK (Anderson, 2014). While looking for the reasons, we can see the British government's restrictive policy towards migrants' elderly dependent family members are designed to avoid the 'burden' of taking care of them. The UK Visas and Immigration policy (2016, p. 1) describes that 'The main aim of the new ADR [Adult Dependent Relatives] rules is to reduce burdens on the taxpayer, in view of the significant NHS [National Health Service] and social care costs to which ADR cases can give rise'. The ADR visa route includes many conditions, including that the migrants who are inviting dependents to the UK need to hold British citizenship or permanent residency permits. The ADR must show evidence that they are coming to the UK to receive care from or provide care to family members. They must also show social/health care needs, which may include evidence that care is not available in the country of origin, and that the family member in the UK can support, accommodate, and care for them without claiming public funds for at least five years (Kilkey, 2017). These provisions limit the elderly's access to state welfare provisions. Because of these conditions, the number of applications for family visas and their success rates is low (Walsh, 2020).

Other rules on family visas have been tightened as well. For instance, the requirement for English language proficiency was introduced in 2010, and a minimum income threshold was introduced in 2012. Visa fees have increased: it costs approximately

£7,000 for a family member's entry and settlement application (Walsh, 2020). Given the restrictions, tougher conditions, and higher costs, the care workers' partners and children in our study entered the UK through the family visa route, whereas the parents had generally used a standard visitor visa, valid for up to six months. Even the application process for the short-term visitor visa was reported as complicated, as applicants were required to present paperwork to show they were likely to return to their country at the end of the visa period and have good income or savings. We explored how these restrictions, conditions and complications had implications on the exchange of intergenerational care by comparing *Gurkha* families, who do not have such restrictions, can travel and settle in the UK, and have access to state welfare provisions, with non-*Gurkha* families who face more restrictive policies.

Theoretical framework

Defining care

Care is a broad term. It is defined as work supporting others or as a relationship involving love and emotion (Milligan & Wiles, 2010). It is also defined as social relationships between a caregiver and recipient in familial or professional settings (Lloyd, 2000). Feminist scholar Mary Daly defined care specifically as ' … looking after those who cannot take care of themselves' (Daly, 2002, p. 252). However, Glenn (1992, p. 1) defined care as ' … purchasing household goods, preparing and serving food, laundering and repairing clothing, maintaining furnishings and appliances, socializing children, providing care and emotional support for adults, and maintaining kin and community ties'. Hence, it includes a broad range of activities of reproductive labour.

Care is also defined as both physical labour in 'caring for', which is possible only through proximity, and emotional labour in 'caring about' others, which is also possible from a distance (Fisher & Tronto, 1990; Zechner, 2008). Families exchange care among their members across different generations, including care for the elderly and children. Therefore, in line with Glenn's (1992) broader understanding of caregiving as labour, we consider intergenerational informal care within the transnational setting to consist of physical (hands-on) care, emotional care, and any other support to family members. It involves caregiving either in physical proximity and co-presence or from a distance, including hands-on physical support, material and monetary support, remittance and gifts, emotional support, love, and guidance, both locally in physical co-presence and from a distance among different generations of family members. We focus on how Nepali migrant care workers in the UK and grandparents maintain intergenerational care within their families either locally in the UK or Nepal or transnationally between the UK and Nepal, and how this differs between *Gurkha* and non-*Gurkha* families based on the UK's visa policies on family migration.

The Global Care Chain (GCC)

The global care chain (GCC) refers to the globalization of care labour and the creation of an international network of families based on social division and inequalities and the further creation of inequalities of care. The GCC, coined by Hochschild (2000), focuses on how globalization processes (Sassen, 2002) impact the giving and receiving

of care at local, regional and global levels. It deals with how the increased workforce participation of women in the global North expands the care market, which attracts women from the global South to take up care work in richer countries, as well as how this affects families who are involved in the chain. The migration of care workers in order to participate in the care market in the global North creates a chain of care between migrants' families and others who provide care to migrants' families in the global South and service users in the global North.

The GCC shows the transnational linkages within the transfer of care, as well as the social division and inequalities between the service providers and recipients. In this chain, richer households contract members of poorer households, whereas richer countries hire migrants from poorer countries. Though Hochschild's initial concept of GCC deals with the inequalities of care, emotion and love among the families involved in the chain of care, it targets migrant mothers involved in unskilled domestic work and childcare at the transnational level and its impact on the children who are left behind.

Parreñas (2015) defines the phenomenon of women passing on their reproductive labour or care labour as paid or unpaid work to other women in a global context, both in the sending and receiving country, as the 'international division of reproductive labour' (IDRL). The IDRL is also involved in the 'racial division of reproductive labour' (Glenn, 1992) and the 'international division of labour' (Sassen-Koob, 1984). It reveals the transfer of reproductive labour to less privileged women both in the sending and receiving countries.

Hence, the GCC or the IDRL shows the global economy of reproductive labour and the political-economic foundation of reproductive inequalities among women or families involved in care work at the local, regional and transnational levels (Yeates, 2012). These inequalities are based on class and racial hierarchies between providers and receivers of care and also on the political-economic ties between nations (Parreñas, 2015). This is especially relevant since our study deals with families migrating from a poorer country in the global South (Nepal) to a richer country in the global North (the UK). These countries also reached a bilateral agreement in 2022 to initiate the recruitment of Nepali-trained nurses in the UK health sector (GoN, 2022; GOV.UK, 2022). We further explore the concept of regimes of (im)mobility to link these global care inequalities to migration policy regimes, which we will discuss in detail in the remainder of the article.

The GCC's initial concept, which is focused on domestic workers leaving behind their children, has been elaborated and used in broader contexts to analyse the impact of care work migration beyond women and their left-behind children. Since the care workforce and care sectors are diverse, the GCC concept has been extended to cover the heterogeneity of migrant care workers beyond unskilled domestic work, care contexts and care connections. This encompasses care work in institutional settings, including skilled workers such as nurses in health and social care settings, and non-reproductive care labour (Yeates, 2009, 2012). Yeates (2012) proposes new directions for research on care transnationalisation. Some of these include paying enhanced attention to the sex arithmetic of care migration, the inclusion of a wider range of care occupations, sectors, and historical contexts, and power relations and inequalities within care networks spread across varied geography.

Our study follows these recommendations by including both men and women, considering diverse professions within the health and social care sector, and the role of

power relations between the UK and Nepal in creating care inequalities. Other suggestions for further research have been to consider care exchange within the care workers' family networks (Locke, 2017). However, in the expansion of GCC literature, care relations within migrant care workers' families and the role of state policies and regulations in maintaining these care relations are studied less. Hence, in addition to care inequalities, we consider looking at informal care within the family network in the transnational setting and the implications of migration policy regimes.

Care circulation

Care circulation focuses on caregiving based on kinship ties and a moral economy of care. Hence, it views migrants and other family members as providers and receivers of care, considers the care exchange within the family as a moral responsibility, and deals with the role of each family member in transnational care exchange processes and practices. Care circulation also acknowledges that transnational families exchange care both in the origin and host countries (Baldassar & Merla, 2014). As such, it refers to:

> The reciprocal, multidirectional and asymmetrical exchange of care that fluctuates over the life course within transnational family networks subject to the political, economic, cultural and social contexts of both sending and receiving societies. (Baldassar & Merla, 2014, p. 22)

It considers the obligation to maintain reciprocal care as a binding force among family members located transnationally. It is based on Finch's (1989) recognition of caregiving among (local) families as a resource in the family, which is exchanged in diverse forms. Unlike the care chain and inequalities between the care provider and receiver families, care circulation involves the family care connections and takes caregiving and care receiving as entities that circulate within family networks which either remained together physically or in different locations transnationally.

Care circulation, therefore, focuses on the mobility of care within families and takes care as a moral obligation of family members, whereas the GCC focuses on care mobilities as the commodification of care and uses the frame of a political economy of care to assess the inequalities between care providers and receivers. Though care circulation considers care as a moral economy or obligation, in practice the family members may negotiate with each other to circulate care, which is influenced by individual factors such as power relations, gender inequalities, birth order and economic status (Baldassar & Merla, 2014). Therefore, the care circulation concept could provide a complementary perspective to the global care chain concept by considering how transnational families exchange care to help minimize care inequalities.

Care practices among transnational family members are asymmetric and involve the exchange of care either from a distance or hands-on care with physical co-presence. Migrants and family members can remain in their country of residence while exchanging care from a distance. Care from a distance involves 'caring about' family members who are living apart transnationally, which includes remittances and gifts, and emotional support and cooperation through regular contact and communication. The care circulation literature accentuates the role of new communication technologies in maintaining 'co-presence across distance' (Baldassar, 2016, p. 145; Madianou, 2016) through easy access to the use of video calls and social media platforms. However, 'de-demonising' care exchanges over a distance has been criticized, as although

communication technology plays an important role in exchanging care across distances, it cannot always substitute the need for hands-on care in physical co-presence (Merla et al., 2020, p. 16). This was relevant in our study as although the Nepali families were well connected through communication technologies, they also made efforts to remain together or make transnational journeys to exchange informal care in co-presence.

Physical closeness is especially crucial in certain life events, such as births, marriages, illness, and death (Ryan et al., 2015). It is also important to physically care for dependents such as children and the elderly and to sustain social ties. Weaker state welfare provisions further increase the need for care from family members (Ryan, 2007) and social norms and values on familial care can also lead dependents to expect to receive care from their (extended) family members despite geographical distance. For instance, reciprocating care to older parents, especially among Asian families, is seen as a duty of sons and daughters, which is sometimes referred to as filial piety (Sun, 2012). Likewise, the well-being of the younger generation is often seen as a responsibility of the grandparents (Chiu & Ho, 2020; Ducu, 2020). In our study, though the families were trying to maintain intergenerational care, non-*Gurkha* families travelled during important life events in response to weaker state welfare provisions together with the social norms and values surrounding familial care.

Exchanging hands-on care is an important aspect of the care circulation, which is possible only by maintaining physical co-presence and visiting family members transnationally. However, since physical co-presence is possible only through the mobility either of the caregiver or the care receiver, the ability to travel to receive or provide care becomes an important resource. This opportunity again depends on individual/family factors including age, health status, and the ability to invest the costs and time (Sun, 2012). Both grandparents' and migrants' roles become crucial in maintaining hands-on care among different generations within migrant families.

Providing and receiving care within transnational families also depends on external factors such as migration regimes which could facilitate, restrict, or control the mobility choices of international migrants (Kilkey & Merla, 2014). However, excluding a few recent studies, the roles, contributions and perspectives of the family members and especially of the grandparents in making international visits to provide care and their perspectives on the care are largely under-examined. For instance, some studies explore the roles of grandparents visiting host countries to care for grandchildren, presenting them as 'international flying grannies' (Plaza, 2000), 'Zero Generation or G0 grandparenting' (Wyss & Nedelcu, 2018), 'flying grandmothers' (Baldassar & Wilding, 2014; Bjørnholt & Stefansen, 2018; Kilkey & Merla, 2014) or grandparenting migrants (Chiu & Ho, 2020). The policy of free movement, especially within the European Union (EU), has further enabled European migrants to travel between destinations for both short and long visits, thereby becoming 'flying grandmothers' (Bjørnholt & Stefansen, 2018; Hărăguș et al., 2021; Wyss & Nedelcu, 2018). These studies helped reinterpret the role of left-behind grandparents from passive care receivers to active agents in the transnational exchange of intergenerational care. Our study fills the gap by focusing on the perspectives of grandparents and migrants and by bringing perspectives from both the origin and host country on how transnational families manage intergenerational care.

Regimes of (Im)mobility

In recent years, richer countries in the global North have increasingly introduced restrictive migration policies, especially for those from the global South, and have portrayed certain groups of people as a threat and developed policies to constrain their movements. This is said to ensure national security and preclude potential exploitation of the national economy and the creation of a burden on the welfare state's provisions. Turner calls this exercise of surveillance and control over migrants, refugees, and other aliens an 'immobility regime' through which states create 'modern enclavement' with the emergence of 'gated communities (for the elderly)' and 'ghettoes (for migrants, legal and illegal)' (2007, pp. 289–290). He presents this as a paradox where in the wake of the increasing flow of goods and services, restrictive migration policies –'immobility regime[s]'– are parallelly emerging and becoming increasingly stringent. Care as a commodity is in high demand in the global North but the migration of care workers' families is strictly controlled. These restrictive policies curtail the movement of migrants' elderly parents and are driven by the dual motives of expanding access to care (workers) as a commodity while controlling the mobility of their families. Bonizzoni (2018, p. 230) claims that the richer states consider the elderly as 'dangerous dependencies' and restrict their ability to cross borders and keep the care responsibilities a private, transnational, family matter. Merla et al. term the current state of care-related mobility regimes as 'immobilizing regimes' as they 'block the physical mobility of some, while granting highly conditional mobility to others, resulting in situations of enforced and permanent temporariness and ontological insecurity' (2020, p. 15).

Hence, in terms of intergenerational care among the care workers' transnational families located in the global South and North, restrictive migration regimes of the North specifically control the mobility within family networks and create negative impacts on the capacity to exchange hands-on care through visits. However, nation states do not treat every migrant and their families equally. Rather, the regimes of (im)mobility create restrictions for some and mobility for others in a stratified way based on the categorization of migrants according to nationality, occupation, economic status and demography (Glick Schiller & Salazar, 2013). This framework calls us to ask on what basis the migration policies and procedures at the state and international level categorize migrants and their family members (Block, 2015) and how those regimes affect individual mobility differently.

The regimes of (im)mobility framework is useful in understanding how richer states' migration policies aim to maximize economic benefits but, in creating hurdles and conditions for family migration based on country of origin, socio-economic status, age and gender, limit the chances of maintaining proximate care in transnational families. We use the regimes of (im)mobility framework to examine the consequences of the UK's policies on the migration of family members, specifically Nepali grandparents' visits to the UK to care for their grandchildren. We compare the family care arrangements and experiences of the *Gurkha* who have migrated to the UK under a resettlement programme and non-*Gurkha* families, who have migrated under different visa categories. We also explore how restrictive visa policies complicate international travel between countries with unequal power dynamics and discuss the phenomenon of 'flying families' in the context of Nepali family members' visits and stays in the UK.

Displaying families/grandparenting

Transnational families often try to maintain family practices such as intergenerational care either transnationally, through remote contact and communication, or through physical co-presence. Both of which are seen as practices of 'doing families' (Ducu, 2020; Morgan, 2011). However, the geographical separation, together with other complexities such as visa restrictions, the ability to travel, and language differences create barriers. When family members' roles are under question, this further leads them to act to maintain family roles (Ducu, 2020). Hence, they tend to display their efforts as part of family practices. Finch (2007) defines displaying families as a process through which the family members convey to others that their acts are a product of family relationships. Both doing and displaying families are important activities, as in addition to maintaining family relationships, displaying demonstrates to others that the relationships are working effectively and makes 'family-like' qualities visible (Finch, 2007; Morgan, 2011; Walsh, 2018).

'Displaying families' has been used as an analytical framework to examine the motivations and emotional experiences behind the actions of doing and displaying families (Ducu, 2020; Walsh, 2018). Ducu (2020) used the notion of 'displaying grandparenting' to examine the motivations of grandparents among transnational Romanian families. Her findings suggest that in situations where grandparents are one of the major contributors to childcare, separation due to migration encourages them to display grandparenting.

Doing and displaying grandparenting can be motivated by an individual's desire to pass on their language, culture and religion to their grandchildren. Visits are taken as one of the major family practices of doing and displaying grandparenting and are likely to involve providing care, engaging in family activities, and ultimately renewing existing ties (Ducu, 2020). However, the ability to travel is again influenced by visa policies and therefore the categorization of migrants. For instance, research on intergenerational care shows that free movement within the EU facilitates the doing and displaying of families for European migrants and excludes non-European migrants (Hărăguș et al., 2021). Hence, the motivations and emotions attached to 'doing families' can be affected by travel restrictions, demonstrating how the UK's categorization of migrants can influence the exchange and display of informal care across generations.

This review shows that the GCC, care circulation, regimes of (im)mobility, and displaying families concepts are closely related. However, they have different approaches and areas of focus while dealing with issues related to the mobility of care and its implications for family members. GCC, coming from a political economic perspective, considers the mobility of care as a commodification that creates a chain of care and inequalities between the care provider and receiver families in increasingly dependent societies and economies (Hochschild, 2000; Parreñas, 2015; Yeates, 2012). Viewed from a family perspective, care circulation is seen to be guided by a moral economy (Baldassar & Merla, 2014) where care exchanges within families are taken as moral obligations and a contemporary form of family practices. The concept of displaying families considers how family practices are maintained, their motivating factors and the associated emotions. The (im)mobility regimes perspective (Glick Schiller & Salazar, 2013) explores the role of migration policies and procedures in influencing

peoples' abilities to cross the border, exchange informal care, and address care inequalities.

Hence, we expect that these concepts complement each other in exploring and broadening the understanding of the complexities of maintaining intergenerational care among Nepali transnational families. Our analysis utilizes the GCC perspective's strength in dealing with how the migration for care work creates inequalities of care among families. It uses the care circulation perspective to shed light on how families exchange care at the local and transnational level, including both care from a distance and hands-on care, and the perspectives of different generations of care providers and receivers within the family network. It uses the concept of displaying families to present the motivating factors and emotions associated with intergenerational transnational care. It also uses the conceptual understanding of regimes of (im)mobility to consider the consequences of migration policies and procedures governing global South to North migration contexts, exploring, in particular, the extent to which the restrictive or enabling migration policies and mechanisms are shaping care exchanges and exacerbating or reducing care inequalities.

Research design and methods

Data was collected through in-depth semi-structured interviews with migrant care workers and their family members between April 2018 and January 2019. The care workers for the study were selected purposively in the UK using the snowballing technique through multiple sources, including Nepali organizations and individual networks, to ensure diversity of the population in our sample in terms of (i) profession (working as care assistant or nurse); (ii) care settings (working in social care or health care); (iii) gender (men and women); and (iv) *Gurkha* and non-*Gurkha* families. Despite the sampling being non-purposive in terms of caste and ethnicity, possibly because of the selective recruitment of the *Gurkha* in the British Army as mentioned earlier, our respondents from *Gurkha* families mostly belonged to the ethnic groups. We will come back to the possible impacts that caste and ethnicity may have had on care practices in the Results and Discussion section.

After the interviews in the UK, family members were selected, traced and interviewed in Nepal using the contact information provided by the respondents in the UK. 49 people, including 35 Nepali migrant care workers (27 women and 8 men) in the UK and 14 grandparents in Nepal, were interviewed. In one case, a carer (migrant's sibling) was interviewed in place of a grandparent who was unable to respond adequately because of their age. Table 1 shows the demographic profile of the respondents and their family members including the age distribution of the migrants, children and grandparents, their family category, marital status and job position. Among the respondents, 12 families were visited by the grandparents before or after a child was born in the UK. The main residence of the grandparents in seven families out of the 35 was the UK. These were mainly from the *Gurkha* families.

The interviews were conducted by SA in Nepali, digitally recorded, and transcribed into English. The names of the participants were changed to maintain anonymity. The University of Essex Ethics Committee has approved the research project and ethical standards were maintained in the whole process. The positionality of the researcher and

Table 1. Characteristics of the respondents: care workers and their family members.

Particular	Number (%)
Gender	
Female	27 (77)
Male	8 (23)
Family category	
Non-*Gurkha*	27 (77)
Gurkha	8 (23)
Age	
21–30	7 (20)
31–40	13 (37)
41–50	9 (26)
51–60	6 (17)
Age on arrival	
Below 21	4 (11)
21–30	17 (49)
31–40	9 (26)
41–50	5 (14)
Marital status on arrival	
Married	30 (24 women, 6 men)
Unmarried	5 (3 women, 2 men)
Migrant's children	
Migrants having children before the migration	16
Migrants had baby in the UK	17
Age of children	
Below 5 years	9 (19)
5–10 years	13 (28)
11–17 years	9 (19)
18 and above	16 (34)
Age of parents	
Below 65	43 (46)
65–74	32 (35)
75 and above	18 (19)
Job title	
Nurse	13 (37)
Health Care Assistant	2 (6)
Care Assistant	10 (29)
Support Worker	3 (8)
Nurse Assistant	2 (6)
Other	5 (14)

power relation was considered, and reflexivity was used in the collection and interpretation of data (Gatrell, 2006).

The computer software NVivo was used to systematically collate and analyse the data. The data analysis used thematic methods proposed by Saldaña (2011). This included a process of familiarization with the data; the construction of patterns by organizing and ordering the data into categories and broader themes within NVivo through the descriptive and interpretive coding process (Watts, 2014); the exploration of interrelationships among the categories by noting patterns and themes and making comparisons between the clusters (especially between the *Gurkha* and non-*Gurkha* families); and interpretation of the data. We selected some extracts from the fieldwork data to exemplify key findings and used these in the analysis.

The small number of men and *Gurkha* families compared to women and non-*Gurkha* families was one of the limitations of this study. We restricted our sampling to only those who work as nurses or paid care workers in the health and social care sectors. This helped provide insight into diversity within the homogenous group of

health and social care workers requiring similar credentials and skills. It may not represent care workers in every position or sector, but it provides meaning, experiences and perspectives on the nexus between migration, intergenerational care and migration policy contexts.

Findings and discussion

The interview data showed that the care workers in this study were eventually accompanied by their spouses and children in the UK, whereas the grandparents in the non-*Gurkha* families were mostly left behind in Nepal. As working parents with childcare responsibilities, the migrants encountered childcare deficits in the UK. Likewise, grandparents lost care, company, and grandchildren to care for in Nepal due to the migration of family members. Hence, for our respondents, migration created a care gap both among the left-behind family members in Nepal and the migrants in the UK. The families utilized different strategies to manage intergenerational care within their family networks and exchanged care to meet their needs as far as possible. This occurred both locally in Nepal and the UK and transnationally between the two locations.[1] Here, locally refers to how the family members who were physically staying together exchanged care between each other, whereas transnationally refers to how the family members who were staying in different locations exchanged care either remotely or by coming into proximity through transnational visits. The families exchanged care either in the form of finances/remittances, material goods, and communication while staying in Nepal or the UK, or through physical and emotional care in proximity through visits.

Our aim is to show how the families managed informal care across generations in Nepal and the UK, and how the migration policies of the UK influenced care exchanges. Hence, we present our findings and discussions according to the major themes as below: families providing childcare support during transitions; changing care responsibilities; grandparents missing their grandchildren; visa and travel complications leading non-*Gurkha families* to become 'flying families'; resettlement rights allowing *Gurkha* families to become 'flying families'; and welfare provisions facilitating care. Our findings and discussions are presented according to these major themes and further split into subthemes. We focus on the implications of the UK's regimes of (im)mobility on family migration and how the regimes lead either to negotiations and compromises for some (non-*Gurkha* families) or facilitations for others (*Gurkha* families) in the care connections. Following this we present the reasons why these care exchanges resulted in the creation of 'flying families'. The regimes of (im)mobility had limited impact on the transnational exchange of care that took place across distances, for example through finances/remittances, material goods, and communication. Hence, despite having major roles in maintaining intergenerational care, we have left them outside of our research scope.

Families providing childcare support during transitions

Care of the left-behind family members in Nepal was managed locally and complemented transnationally either through visits from the UK or whilst remaining in the UK. Because

of the UK's restrictive policies on family migration and reintegration, children in non-*Gurkha* families remained in Nepal during the initial years following the parents' migration until they had either secured residency or had reached a minimum pay threshold to apply for family reintegration. During the period of transition, the care of left-behind children shifted to grandparents, spouses, and other members of the extended family and kin network. For instance, a female nurse had left behind her husband and two daughters in Nepal while coming to the UK. Her husband was able to come to the UK after a year and her two daughters after two years. Jina (the female nurse) recalled the care arrangement for her daughters while they were in Nepal as below:

> My elder daughter who was nine years old was admitted to a hostel [boarding in a school] whereas the younger daughter who was only two years old was left with my *didi* (elder sister). I used to miss her a lot and spent most of my income in calling her and sending money to my *didi* to look after my daughter. The funny incidence was that in spite of my frequent calls, my daughter started calling me aunt and her aunt as mum.

Although the care of the children was covered by extended family members and complemented by transnational communication, leaving their children behind took an emotional toll on the migrants. They were scared of losing intimacy and family bonds, especially with their children, which led them to display care by sending gifts and making frequent calls. Likewise, the migrants felt guilty for leaving the children and increasing the care burden on the left-behind grandparents or other family members. For instance, Sita (a female nurse) commented:

> While I was coming here [to the UK], I requested my mother [aged 75] to come and stay with my husband and daughter in my rented room in Kathmandu to look after my daughter. Despite her illness, as she had gone through repeated operations, she had come and looked after my daughter.

Even in the cases where grandparents were healthy and of working age and (extended) family members were ready to support, the migrants tried to bring their children with them and displayed their role in the childcare by sending *koseli* (gifts) and remittances, though not out of necessity or demand. As in the case of Taiwanese migrants in the USA (Sun, 2012), this was influenced by the social norms and values of filial piety that expect adults to care for their parents and not vice versa. Hence, bringing children to the UK was an immediate priority once they became eligible and able to afford it. This mostly ranged from two to four years.

Grandparents' motivations in supporting the family

The left-behind grandparents who participated in the study were diverse in their health conditions and age (their ages ranged from 38 to 89 years with more than half of them above the age of 65 years), as well as in terms of care needs and the ability to provide intergenerational care. For instance, younger grandparents more often had new-borns and younger grandchildren with care needs, whereas older grandparents were often themselves in need of care and were less likely to have young grandchildren. The grandparents who were healthy and of working age were able to look after themselves by staying on their own in Nepal and tried to provide care to the younger generations. These grandparents, contrary to the migrants, perceived caregiving to grandchildren and the wellbeing of the younger generation

(including adult migrant children) as their obligation. For instance, Ram (a left behind grandfather, aged 49) described how:

> We are able to look after ourselves and on top we have one daughter with us who assists in household chores. Hence, rather than expecting care for us, we assist in caring for grandchildren in need, either visiting them in the UK or inviting them here.

These grandparents, being middle-class, healthy and of working age, did not expect to receive care. Rather they were concerned with fulfilling their responsibilities towards younger generations. This mainly depended on available resources due to their class status, age, and health. This finding was in line with other studies such as Chiu and Ho's (2020) on Chinese grandparents, Sun's (2012) on Taiwanese migrant families, and Ducu's (2020) on Romanian grandparents. However, despite the Nepali non-*Gurkha* grandparents' material ability to travel, because of visa restrictions hands-on grandparent support was only possible for a short term, often a maximum of six months at a time. Likewise, grandparenting was possible through transnational visits of either them to the UK or the migrants and grandchildren visiting Nepal.

Changing care responsibilities

Care of elderly grandparents by non-migrant family members in Nepal

Unlike the healthy and working-age grandparents, the left-behind elderly and ill needed hands-on physical care. This role was shifted to other members of the extended family and kin network and supported by hiring care workers. The following comments from three separate respondents illustrate this:

> Since I was the elder *buhari* (daughter-in-law) in the family, I was the main [person] responsible in the family to look after everyone … My *deurani* [younger sister-in-law] used to support me at home so we used to do the household work together. When I came here [to the UK], our family kept [hired] a girl to work as domestic help to support my *deurani* in household work and to care for my son and father-in-law [aged 84] as my father-in-law needed special care due to his illness … But after working for five years, she [the domestic help] also migrated to Saudi Arabia. So now, my *deurani* is looking after each and everything on her own. (Bijaya, female care worker in the UK)

> During my husband's hospitalisation and illness, I had thought that if all my sons would have been here [in Nepal], they would have shared the care responsibilities together. But since only one son was with us [as three are migrants], he [the left-behind son] had to go through a lot of burden. He had to take a leave from his job for more than a month and almost lost the job that time. (Mina, left-behind grandmother in Nepal, aged 70)

> Our mother [aged 89] used to live with my sister. But when my sister went to the UK, I had to leave my job at a Health Post [government run primary health care facility] in [a village] and started living in Kathmandu … I looked after my mother and since she is getting older, I have become her full-time carer. I am getting financial support from my sister though. (Manita, migrant nurse's younger sister in Nepal)

As in GCC literature (Hochschild, 2000; Parreñas, 2001), we identified a shift in care responsibilities towards the remaining family members and an increased role of paid care workers was necessary to fulfil care needs. The comments also show the diversity

of care roles and those roles were assigned and/or negotiated and compensated based on individual factors such as power relation and gender expectations, birth order and economic status (as articulated by Baldassar & Merla, 2014).

Non-Gurkha migrants managing childcare in the UK or sending children back home for care

In the UK, migration brought a substantial change in terms of maintaining care locally among non-*Gurkha* families. It created a double burden: they had to provide care for their children whilst performing a paid job in the absence of extended family members. The first thing they missed after migrating was the support of parents and extended family members. Poshan (a male care assistant and husband of a registered nurse) stated:

> We [husband and wife] used to work in the same nursing home full time but in different shifts. Our elder daughter used to go to the school on her own whereas I had to drop off and collect the younger one from her school. So, we had to manage the household chores, caring for the kids and doing the care job all together on our own.

Likewise, Sita (a female nurse) described how:

> After coming here, my daughter missed her grandparents so much so that she had temper tantrums, not eating anything or obeying us. So while I was at home, I was just taking all my time with her. I had night duty and he [my husband] used to work in a restaurant. As I had to go to my work at 7, she used to cry since the afternoon asking me not to go to my work. Then my husband left his work for some time to stay with her at home.

The migrant couples tried looking after their children either by managing rotational work shifts or compromising and reducing their working hours. Alternatively, they could try to keep the same hours of work, but they would then face increased pressure in retaining a work-family balance. Hence, their unsettled financial situation required them to work longer hours. This led some migrants to have a hard time managing paid work and childcare together. On rare occasions, migrants received support from fellow Nepali neighbours and networks or transnationally through the grandparents' occasional visits or in situations of dire need. Some also sent their children back to Nepal to be looked after by their grandparents or relatives for between a few months to three years so that they could concentrate on their jobs. Sewa (a female nurse) mentioned:

> We really had very difficult time after having our son. So we had taken him to Nepal when he was one year old and left him for two years [with his grandparents] as we were not able to manage time. We brought him back to join him to a school.

Hence, their inability to afford paid childcare, the absence of the family members who they used to rely on while in Nepal, and the state's weak childcare provisions worsened care inequality among the non-*Gurkha* families in the UK.

Grandparents missing their grandchildren

Regardless of whether the grandparents required physical care, were healthy and of working age, were elderly, and whether their care needs were being covered or

whether they were accompanied by other children/caring family members, they commonly commented on how much they missed the company of the migrant children and grandchildren and also the emotional toll of living apart. For instance, Lila (a grandmother, aged 89) stated that:

> Though I live with my younger daughter, I always think of the elder daughter and grandchildren [living in the UK]. I always count on them on when they would come and worry whether I can meet them again.

Likewise, Hari (a grandfather, aged 65) mentioned:

> We [the couple] live here, whereas all our children are in the UK, but we are in good shape to live on our own. Though we talk to them regularly, we miss their presence and specially miss looking after and spending our spare time with the grandchildren.

These comments indicate that grandparents expected not only physical care but also emotional care in the form of the company. Likewise, they missed their role of grandparenting by looking after the grandchildren and spending time with them. It not only shows their desire to do things together as a family (Morgan, 2011), but also the associated emotional burden they experienced due to their inability to perform their usual role (Ducu, 2020).

Visa and travel complications leading non-Gurkha families to become 'flying families'

Migrants and grandparents in non-*Gurkha* families were mobile either through short-term visits or flying back and forth to Nepal or the UK respectively to maintain physical co-presence and exchange hands-on care.

Non-Gurkha migrants travelling to Nepal to provide and receive care: doing and displaying families

The migrants reported travelling to Nepal on short-term visits. The aims of the visits were diverse and included either caregiving for grandparents or receiving care themselves. They also involved sending children to access care from their grandparents in Nepal, travelling for leisure and holidays together, celebrating special life events, or combinations of these. We will deal with these in detail below.

Elderly grandparents who were dependent on other family members expected their adult children in the UK to visit them to cover their care needs or spend time together. Shila (a female nurse) reported that:

> We talk regularly and share everything going on in our family. Though I am here now [in the UK], my father [aged 70] still seeks advice from me especially regarding health care. Once he had to go for a *minor* hernia operation, he called me to come to Nepal for the operation and waited for my visit. After I managed a month-long holiday from my work, I travelled to Nepal. We booked the operation date, he had the operation, and I took care of him till he was completely healed. Then only I returned here. Hence, despite having other family members in Nepal, I have to be there if any health conditions or emergencies occur for my family.

In addition to maintaining care from a distance through communication and other exchanges, the migrants therefore also travelled to Nepal to provide care for grandparents when needed during special health care crises or family emergencies. This again suggests

that the left-behind grandparents' expectations to receive hands-on care from their migrant children were heightened when they became incapable of managing independently or had special and urgent health care needs. This supports Merla et al.'s (2020) claim that co-presence through improved communication cannot replace physical co-presence for physical and emotional care, which are instrumental in certain life events, such as childbirth or illness (Ryan et al., 2015).

It was also common for migrants to make short-term visits to Nepal every two to three years. The relative infrequency of these was mainly the result of the long distance between Nepal and the UK and the cost of these journeys. They also described travelling for leisure and holidays or special life events such as weddings to be part of family activities and maintain family bonds, which Morgan (2011) calls 'doing family'. These visits helped strengthen their ties with the grandparents and broader family circle and to display effective family relationships (Ducu, 2020; Finch, 2007). The migrants were not just care providers during these visits – they could also be care receivers. For example, Sanu, a female nurse who travelled to Nepal with a new-born baby to receive care during maternity leave, described how:

> My mom and dad had come and looked after me while I had [my] daughter. They stayed here for five months. As they had to go back, I also went together with them and stayed for another three months. Even after having my son, as my parents were not able to come, I went to Nepal and received good care from them.

Since grandparents were not able to stay in the UK for more than six months at a time due to visa restrictions or were not able to visit the UK at all, migrants also travelled to Nepal to receive care for extended periods. Inviting grandparents was also associated with visa complications and additional costs, and the uncertainties involved in getting a visa could cause emotional stress on both sides. Hence, to reduce complications, the migrants planned to visit Nepal themselves to receive and/or provide care, causing them to fly back and forth between Nepal and the UK and become 'flying families'.

Short-term visas leading non-Gurkha grandparents to become members of 'flying families'

Meanwhile, the grandparents from non-*Gurkha* families also travelled to the UK to provide hands-on care to their migrant family members. These visits, especially those made to provide care, were also linked to other activities of 'doing' and 'displaying' family such as visiting major landmarks in the UK and enjoying leisure activities and taking holidays together with the family. Visits made by grandparents before or after the birth of a grandchild in the UK were the most common practices. This was mainly due to familial care practices and a lack of state support. During those visits, the grandmothers looked after the new-born babies, 'mothered the mothers' (Wyss & Nedelcu, 2018), and helped with household chores. They tried to maintain the Nepali practice of providing intensive care to the new-born and mother, whereas grandfathers cared for other grandchildren by supporting in daily chores and taking them to and from school. Durga (grandmother, aged 60) stated:

> After the birth of our first grandson, both of us [she with her husband] had travelled to the UK and stayed for six months. Then I had gone a second time [after a few years] and stayed for another six months during the second grandson's birth. Afterwards, I had visited them

> twice and stayed for six months each time to support in looking after the grandsons. In earlier days visiting *sasurali* [the parents' home] was common but now visiting *chhoriyali* in *bidesh* [daughter/children's home abroad] is a common practice among the Nepali.

These visits to the UK were made out of necessity for short-term childcare support, which also helped migrant women re-enter the workforce after maternity leave and reduced childcare responsibilities for the migrant couples. Longer visits would have provided additional necessary support. However, given the complications and high chance of visa rejection, the participants did not risk applying for an expensive long-term family visa. Rather, they opted to visit with a short-term visitor visa, which did not allow them to stay more than six months at a time. We can relate this to how unequal relationships between nations influence mobility and care inequalities (Parreñas, 2015; Yeates, 2012) through regimes of (im)mobility. British nationals receive short-term visas on arrival in Nepal, whereas Nepalis need to go through a lengthy, stressful and expensive visa application process with a chance of rejection. Because of the restrictions, these families were limited either to staying put in Nepal and exchanging care among local family members or trying to exchange care transnationally between the two locations on a short-term basis.

Hence, to re-arrange further hands-on care for grandchildren, they had to re-apply for a visa and travel back and forth between Nepal and the UK or invite them to Nepal. Even the visitor visa was not easily accessible because of the complicated visa application process and high application costs and rejection rates, which brought additional emotional stress. Man Bahadur (grandfather, aged 68) described how:

> While our grandson was left with us [he lived for seven months with them], we [he and his wife] applied for visas so that we could take him to the UK and also look after him for some time there and return back. However, our application was rejected for the first time. It was a real *tension* for the whole family on what to do and why it happened. But later on we applied for the visa again by adding more papers and got it on the second try.

As mentioned by Urmila earlier in this article and by Man Bahadur, the migrants and grandparents had normalized the complications involved in the visa process, including its costs, risk of rejection, and associated stress, and were prepared to keep reapplying until they gained a visa. Furthermore, as in the case of Chinese (Chiu & Ho, 2020) and Romanian grandparents (Ducu, 2020), the Nepali grandparents also viewed the support and care they provided to their children and grandchildren as an obligation and so were prepared to travel between Nepal and the UK. However, their preference was to get a longer-term visa so that they would not need to apply for each journey and travel repeatedly. Some of the grandparents also compared their UK visas with the five-year visas they had gained to visit family in the USA. Ram (a left behind grandfather, aged 49) stated:

> One of our daughters lives in the USA and one in the UK. We [he and his wife] got five years visa to the USA. Hence, whenever needed, we can just buy the ticket and go. Whereas it is only for six months to the UK. Though the UK is nearer, when we need to go there we always feel more *tension* applying for the visa.

The frequent journeys made by grandparents to the UK to provide intergenerational hands-on care were not, therefore, made arbitrarily, but rather were prompted by the UK's restrictive policy on family migration. As a result, the short-term visits to cover care needs in the UK amidst restrictions forced these grandparents to become

members of 'flying families' and created emotional stress for the whole family due to the uncertainty of getting a visa, the increased financial burden of travel, the time needed to apply for the visa each time, and the inability to continuously maintain care for a longer period of time. We showed that the restrictive migration policies cost money, time, and hardship for these families, forcing their members to make expensive and difficult visa applications and frequent travel.

Resettlement rights allowing Gurkha families to become 'flying families'

Mobility and settlement rights enabling elderly care and grandparenting among Gurkha families

Migrants from *Gurkha* families received long-term support from grandparents as they were able to settle in the UK through the *Gurkha* resettlement programme. The comment by Gopini, a female nurse from a *Gurkha* family, which is quoted at the beginning of this article, reflects on how they were able to share childcare responsibilities among extended family members. Extra hands for sharing informal care responsibilities in the UK even enabled the migrant couples to continue their paid jobs and personal/professional development activities. Because of the settlement rights afforded to the ex-*Gurkha* families, i.e. enabling mobility regimes (Glick Schiller & Salazar, 2013), the grandparents had no travel or length of stay limitations and they could settle or stay in the UK as long as they wanted or were needed to. This facilitated and enabled intergenerational care within these families, for example sharing the childcare roles, household chores or care and providing company for the elderly grandparents. Maya (a female migrant nurse from *Gurkha* family) stated that:

> We are living all together with grandparents [aged 72 and 64, and in-laws aged 73 and 67], they sometimes go to Nepal or visit other children as they like or as per the need. The positive thing of living together is that we have no more worries on how the grandparents would do on their own in Nepal. It has strengthened our family and we are able to look after our daughters as well as grandparents. We are even getting the grandparents' support in childcare and household chores.

Here, the resettlement rights facilitated freedom of movement between Nepal and the UK, blurring the boundary between the exchange of local and transnational intergenerational care and reducing emotional strain. This is in contrast to non-*Gurkha* families, where restrictive and controlled access to mobility made the exchange of care more difficult and complicated and increased the emotional burden. Hence, we argue then that enabling migration policies facilitates transnational mobility and blurs the boundary between local and transnational care.

The UK's enabling migration policy for *Gurkha* migrants, therefore, positively affected the maintenance of care both locally and transnationally, whereas the restriction on family migration exacerbated care inequalities in non-*Gurkha* families. This also shows the influence of the regimes of (im)mobility in either facilitating or disrupting mobility and transnational care connections.

Freedom of mobility enabling the Gurkha to become 'flying families'

In contrast to the non-*Gurkha* families, the settlement rights of *Gurkha* families facilitated their freedom of movement. On their part, they did not have to worry about the

visa application process and fees or chances of rejection. It enabled them to exchange the needed care through co-presence as their right. Dewaki (a grandmother from a *Gurkha* family, aged 57) whose main base is in the UK, reported that:

> My daughter lives in Nepal and my son lives in the UK. As all children are considered equal for any parents, I travel between Nepal and the UK to be with my daughter's family for some time and my son's family for some time. During the stay, I support them by looking after the grandchildren, but basically it is giving love in the family as much as you can, isn't it? So, I visit between son or daughter whenever I like or when they call me.

Whenever they were able to cover the travel cost, bear travel-related difficulties, and manage other responsibilities, they could travel between Nepal and the UK and maintain intergenerational care. For both generations in these families, access to travel freely between Nepal and the UK based on their settled status enabled them to cover informal care needs in the family and displaying grandparenting. Hence, the freedom of movement facilitated their transnational travel and enabled them to become 'flying families'.

Nepali care workers' families, both non-*Gurkha* and *Gurkha*, had therefore become 'flying families'. However, the reasons for this were different. Restrictive migration policies and controlled access to visits or long-term settlement for the non-*Gurkha* families worsened intergenerational care within transnational family networks. Hence, to maintain intergenerational care, the grandparents and migrants made circular visits on a short-term basis between Nepal and the UK. Fulfilment of the intergenerational care obligations amidst the restrictions caused them to become 'flying families' in transition between the two countries. These families fly between countries as a coping strategy to avoid complications and restrictions related to longer-term entry and settlement associated with the family visa route. *Gurkha* families with two generations in the British Army, meanwhile, had greater freedom to stay for longer periods or fly back and forth between the two countries. Hence, in contrast to the non-*Gurkha* families, the freedom of movement afforded to the *Gurkhas* also caused them to become 'flying families'. The *Gurkhas* becoming 'flying families' is similar to families in the EU travelling back and forth for short visits or staying for a longer term and becoming 'flying grandmothers' or 'flying kin' (Bjørnholt & Stefansen, 2018; Wyss & Nedelcu, 2018) because of the policy of free movement within the Union (Hărăguș et al., 2021). Whether due to the pressure of maintaining intergenerational care despite restrictions (among the non-*Gurkha* families) or the freedom of movement facilitating international travel (among the *Gurkha* families), they had both become 'flying families'. Hence, we argue that both enabling and restrictive migration regimes can produce 'flying families'.

Our concept of 'flying families' is based on the concept of 'flying grandmothers' (Baldassar & Wilding, 2014; Bjørnholt & Stefansen, 2018). However, the term 'flying families' demonstrates that migrant families in the destination countries also fly to their origin countries to provide and receive care. Hence, it presents the family as a whole (both the migrants and grandparents) as active in managing informal care through international travel. It also shows that these flying families can become internationally mobile due not only to enabling visa policies, but also to the need to provide care amidst restricted access to visas or residency permits. Hence, the term 'flying families' broadens the earlier concept of flying grandmothers.

Welfare provisions facilitating care

Another aspect that influenced care dependencies and care inequalities was access to state welfare provisions. The left-behind family members in Nepal were unable to rely on public services. Nepali care migrants in the UK depend on family support and care provisions because of the expensive personal care and childcare in the UK. Hence, these transnational families need to provide and/or receive care from their family members both in the UK and Nepal. The non-*Gurkha* families tried to maintain intergenerational care responsibilities through short-term visits, which are much more expensive because of the visas and private health insurance fees while flying from Nepal. Moreover, with the UK's restrictions on the use of public funds (Kilkey, 2017), including health care services for visitors, the grandparents' visits from the non-*Gurkha* families to the UK can often only involve providing, as opposed to receiving, care.

However, elderly grandparents in the *Gurkha* families (being ex-*Gurkha*) were entitled to free health care, a pension, and other support such as state benefits in the UK if they were on a low income or out of work. Moreover, many of the *Gurkha* families chose to migrate to the UK and live together once the resettlement option became available in 2004. This helped them maintain intergenerational informal care in the family. Bidhya (a female health care assistant) mentioned:

> All of my family members [male] are *Gurkhas* – my father, grandfather. It is the same with my husband's family. Hence, my father is in the UK and he sometimes lives with his son and sometimes with me. Similarly, my husband's father and mother also live sometimes with us and sometimes with their other son. Hence, we do not need to go to Nepal to look after them, and in addition when they come to us, they are of great help in household chores. Since they also get 'benefits' here, they only visit Nepal for a shorter period of time.

Hence, the opportunity for family resettlement and their ability to access state welfare provisions motivated the elderly to settle in the UK, which further helped reduce transnational care inequalities.

Comparisons between intergenerational care exchanges between the non-*Gurkha* and *Gurkha* families in the same migration context depict the role that 'regimes of (im)mobility' (Glick Schiller & Salazar, 2013) have in care inequalities. Similarly, in line with Sun's (2012) work on the role of welfare provisions, age and ability in influencing family dependencies, we found that weaker welfare provisions fuel family dependencies. Controlled access to mobility further restricts the non-*Gurkha* families in maintaining intergenerational care continuously for the elderly and children. Hence, in line with Glick Schiller and Salazar (2013), access to mobility was different among the *Gurkha* and non-*Gurkha* families and affected intergenerational care differently. The unrestricted movement possibilities for the *Gurkha* families enabled them to provide and receive unrestricted care, albeit with expensive flights to Nepal. However, the restrictive and controlled movement options for the non-*Gurkha* families generated care inequalities, emotional sufferings and increased dependencies within the families. This comparison between the *Gurkha* and non-*Gurkha* uniquely illustrates the intergenerational care inequalities between comparable migrant groups that exist due to differences in the way individuals are categorized. The increased care responsibilities, difficulties in maintaining intergenerational transnational care, and the resulting emotional toll, are not the results of migration or participation in the global care economy in themselves, but of the

restrictions on family migration. Based on these differences, we argue that migration policies influence the exchange of intergenerational care and can either minimize or exacerbate care inequalities and emotional hardship among migrant families.

The *Gurkha* families were able to maintain intergenerational care due to their resettlement rights. However, in contrast, we note that whilst non-*Gurkha* families were heterogeneous in terms of caste and ethnicity, they faced similar hurdles to secure entry and settlement in the UK. Hence, mobility and care were affected based on whether these families' entry and residency in the UK were facilitated or restricted rather than on any factors specific to caste and ethnicity. It is also important to note that intergenerational care was facilitated in the exceptional cases of non-*Gurkha* families whose grandparents were settled in the UK. Therefore, the comparison between the experiences of *Gurkha* and non-*Gurkha* families shows how the categorization of migrants affects mobility and intergenerational care.

Our empirical findings therefore demonstrate how the use of the concepts of the global care chain, care circulation, regimes of (im)mobility and displaying families in combination is useful in understanding the complexities of care migration from the global South to the North. They also show how migration policy regimes play a major role in facilitating or restricting the mobility of family members and intergenerational care exchanges among migrant families.

Conclusion

Our study on Nepali migrant care workers and their families in the UK and Nepal explored intergenerational informal care connections and exchanges within transnational families and the implications of migration and migration policies. We found that migrant families both in Nepal and the UK manage intergenerational care either locally or transnationally. The UK's restrictive policies on family migration for non-*Gurkha* families had a huge impact on exchanging hands-on physical and emotional care locally and transnationally in proximity through cross-border mobility. The uncertainty of receiving a visa created emotional stress, insecurity and an inability to plan care, whereas the restrictive access to short-term stays forced them to travel back and forth between Nepal and the UK, ultimately leading them to become 'flying families'. In the same context, however, the UK's resettlement policy for *Gurkha* families facilitated long-term stays and transnational mobility for the grandparents in the UK and hands-on care when in proximity to their families. In both family groups, we also found that grandparents were active agents in the care circulation and provided care to the younger generation either by travelling across borders or by staying in their country of origin. Both grandparents and migrants saw the care of other generations as a filial obligation and tried to circulate it by using any possible means. On the other hand, the expensive personal care and childcare, and the absence of a family network in the UK, made migrant care workers' families more dependent on their families in Nepal. Similarly, the left-behind family members in Nepal depended on their children's support because of the poor public health and elderly care services in Nepal. These dependencies also fuel transnational care provisions and circulations. This demonstrates that the concept of regimes of (im)mobility, together with the global care chain, care circulation, and displaying families concepts, complement each other in building an understanding

of the complexities involved in maintaining intergenerational transnational care exchanges, the resultant emotional experiences, and how migration policies can reduce or increase care inequalities.

Our contributions in this article are fourfold. Firstly, our study focuses on care workers' families and addresses the lack of study on their family care relationships (Locke, 2017). It reveals the care inequalities among transnational families both in the origin and host countries. It highlights that they try to cover the care needs within the family network through informal care exchange among different generations both locally and transnationally. Further, the study contributes to novel data on care practices within Nepali transnational families. It also represents the findings based on Nepali care workers, who are a new group of migrants and a minority group in the global South to North care migration context.

Second, it contributes to the literature by presenting data about family members in both origin and destination countries and the perspectives of migrants and grandparents. It shows that migrants are concerned about their care responsibilities towards parents due to filial piety, whereas the grandparents are concerned about their obligation to care for their children and grandchildren. The lack of public welfare provisions further fuel family dependencies and informal intergenerational care provisions and circulations transnationally. It establishes grandparents as active agents in the intergenerational care exchange through international mobility.

Third, the unique comparison between the *Gurkha* and non-*Gurkha* families illustrates that care inequalities are created not due to the families participating in the global care economy in itself, but because of the restrictive migration regimes. It reveals two different reasons for the emergence of 'flying families'. For the *Gurkha* families, this is due to their freedom of movement and the possibility of longer visits to the UK, whilst for the non-*Gurkhas*, 'flying families' represent a workable compromise to maintain intergenerational care by travelling repeatedly on a short-term basis amidst the restrictions.

Fourth, the right to resettlement eases both transnational travel and longer-term stay and brings *Gurkha* families together. It facilitates intergenerational care locally or transnationally or in combination. However, restrictions on mobility force the non-*Gurkha* families either to stay put in Nepal and exchange care locally in the UK or Nepal or become 'flying families' to exchange care transnationally between the two locations on a short-term basis. The restrictions constrain intergenerational care both locally and transnationally, create emotional burdens, and set a distinct boundary between the two modes of support. Hence, it again shows the role of migration policies in setting diverse boundaries between the ability to exchange intergenerational care differently among families locally and transnationally and in increasing or reducing care inequalities.

In the context of Brexit, the healthcare workforce in the UK has been decreasing and public services are exponentially increasing recruitment and relying on workers from outside of the UK and the EU (Homer, 2022). Likewise, the governments of Nepal and the UK signed a bilateral agreement in 2022 to recruit Nepali nurses in the UK health sectors (GoN, 2022; GOV.UK, 2022). As a result, it is the right time for the UK to reconsider its restrictive migration policies on family members. Labour-sending countries like Nepal can utilize the opportunity to negotiate with the UK to address

the concerns of potential migrants, including the ways to minimize care inequalities as mentioned above. To minimize inequalities in the provision of care for the families of the migrant care workers, we recommend that migration policies should enable the free movement and access to public welfare provisions for extended family members, including grandparents. This would not only help countries in the global North like the UK to address the workforce demands but also enable the families of care workers to enjoy their rights to family life and maintain intergenerational care without disruption.

Moreover, our findings suggest that facilitating the grandparents' mobility enables the migrants to manage childcare within their family. It helps to reduce the families' reliance on welfare provision for childcare and helps them to avoid reducing their work hours, increasing the availability of the workforce in health and social care facilities. Hence, facilitating the family members' mobility will not increase the burden on the welfare state, but reduce it by making more support available within the family.

Note

1. Their care network was sometimes spread transnationally even between Nepal and the UK and USA or Australia or other countries in the cases when migrants' siblings were dispersed across the countries. However, we focus between Nepal and the UK in this study.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was partially supported by Open Society Institute.

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