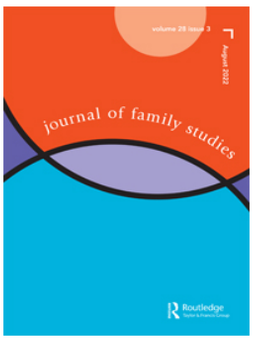

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RESEARCH ARTICLE

'She's Like Family': transnational Filipino families, voluntary kin and the circulation of care

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ABSTRACT

Increased mobility has affected transnational families' organization and provision of care. Focusing on the experiences of Filipino nurses in Norway, this article emphasizes how support structures in the Philippines and Norway affect the provision of care within transnational families. By applying the care circulation framework, this article sheds light on the complexity of transnational caregiving and draws attention to how the provision of care is a multidirectional process that relies on a range of actors. It looks at migrants not only as providers of care but simultaneously as receivers of care. The literature on transnational families has helped broaden the definition of the family to include inter- and intra-generational relationships beyond the nuclear family, including a growing recognition of the role of kin-like relationships. This article supports this broader definition of family and highlights the importance of kin-like relationships. Considering the increased impact of 'migration regimes' on the experiences of migrants, attention is paid to the challenges created by distance and by national policies and to their effects on the way care is provided within transnational families.

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Care circulation; welfare regimes; transnational families; voluntary kin; Philippines; Norway

Introduction: care in transnational families

Increased mobility has affected how care is organized and provided to families around the globe. When adult children migrate, they may leave behind not only children but also aging parents (Miyawaki & Hooyman, 2021). Transnational families who find themselves separated by geographical distance and national borders may continue to see themselves as a unity with a strong obligation to the collective welfare of the family and therefore exchange care and support across national borders through 'transnational caregiving' (Baldassar et al., 2007). While the provision of care in transnational families in many ways resembles that found in families living in geographical proximity, structural factors, such as migratory policies and formal care arrangements, and the temporality of the migrants' lives, which is evident through the migration cycle and family life

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cycle, influence the care needs and capacity. While much research has focused on care provision within families, the care provided to migrants and their families often involves non-related caregivers such as neighbours, paid helpers and voluntary kin (Vivas-Romero, 2020).

This article draws on a multi-sited qualitative study of Filipino migrant nurses in Norway and their family members in the Philippines. It sets out to illuminate the complexity of transnational caregiving and draw attention to how care provision and well-being within transnational families rely on a range of actors with varied access to resources. Through her research on Peruvian-Colombian migrant domestic workers, Vivas-Romero (2020) has drawn attention to the relationship migrant workers construct with individuals to whom they are not formally related, so-called voluntary kin, and how these relationships play an important role in providing emotional and practical care. In her research on Filipino migrants in Finland, Saksela-Bergholm (2020) demonstrates the important role played by minority churches in supporting their members spiritually, emotionally, financially and practically. Even though Roman Catholicism remains hegemonic in the Philippines, the number of evangelical churches has increased during the last century (Liebelt, 2011), and most of the nurses in this study who referred to support from religious communities were members of evangelical churches, which primarily consisted of fellow Filipinos. With a particular focus on the role of voluntary kin in the country of destination, I aim to contribute to current debates on care within transnational families and how care may be mutually secured and exchanged by answering the following research questions: How do regimes of welfare and migration in the countries of origin and destination affect the circulation of care within transnational families? What role do kin-like relationships play in the provision of care in transnational families?

Studies of Filipino nurses in Norway and the Nordic countries, a growing though still a relatively limited field of research, have largely focused on the professional identities of immigrant nurses and the authorization processes they face (Dahl et al., 2017; Korzeniewska & Erdal, 2021; Näre, 2013; Nortvedt et al., 2020; Seeberg & Sollund, 2010). Less attention has been devoted to their transnational lives, and more specifically transnational care provision; however, Bikova (2015, 2017), through extensive research on Filipino au pairs in Norway drawing primarily on the care chain literature, has drawn attention to the transnational provision of care within Filipino families.

The analysis of transnational care has mainly followed either the global care chain literature or the transnational care literature in which the concept of care circulation is central (Degavre & Merla, 2016). The care chain is described as a globally established chain of personal links, usually made up of women, based on the paid and unpaid work of caring. These chains start in poor countries and end up in richer ones, leading to a deficit of care for migrants and their families left behind (Hochschild, 2000; Parreñas, 2001; Zickgraf, 2017). The flow of care is unidirectional, with remittances as the only means through which migrants can care for their relatives (Degavre & Merla, 2016). This draws attention to the negative effects of migration in terms of 'care drain' and 'care replacement' and emphasizes the social costs of migration for migrants and their non-migrating family members 'left behind', especially children and elderly relatives (Lutz & Palenga-Möllenbeck, 2012).

While the care chain approach has advanced the understanding of care transnationalization and drawn attention to uneven development and geographical inequalities in power and wealth (Yeates, 2012), it has been criticized for building on an ethnocentric idealization of the nuclear family (McKay, 2007), with the household as the unit of analysis (Yeates, 2004, 2005). Based on a growing recognition among migration scholars of the multitude of family forms and connections, it has been argued that care chain research should extend beyond the nuclear family to include intergenerational analyses and the wider cultural contexts of diversity in family forms (Yeates, 2004, 2005).

In the following, I outline the conceptual framework of care circulation before introducing the relationship between regimes of migration and welfare and the need and capacity to care. This is followed by a description of the study methods. I then present and discuss the empirical findings, starting with how the differences in welfare regimes affect the care needs and capacity. Subsequently, I investigate how care for children and the elderly is organized transnationally before looking at the role of religious communities and voluntary kin. In the concluding section, I discuss how migration and welfare regimes structure care in a transnational setting with a specific focus on how religious communities and voluntary kin fill some of the gaps that are created by distance and lack of proximate care in the country of migration.

Care circulation and regimes of mobility and welfare

In line with previous studies on Filipino migration emphasizing the crucial role of remittances (Basa et al., 2011; Semyonov & Gorodzeisky, 2008), economic concerns and remittances were common among the nurses and their families in my study. Care-related concerns of a non-economic character were also important in all the stories collected. To fully grasp the complexity of the transnational family relationship and the impact of migration on families, I needed a framework that goes beyond the role of remittances and care drain. I found this in the concept of care circulation introduced by Baldassar and Merla (2014). The care circulation framework captures the complexity of care within families and communities by looking at 'multigenerational, multidirectional, multidimensional and reciprocal relationships' (Miyawaki & Hooyman, 2021, p. 16). Analysing care through the prism of care circulation enables a move away from a focus on migrants as providers of care to acknowledge that they can simultaneously be receivers of care.

Care circulation is understood as '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 context of both sending and receiving societies' (Baldassar & Merla, 2014, p. 22). The conceptual framework of care circulation includes a wide range of care relationships and views care as circulating between family members over time as well as across geographical distances (Baldassar et al., 2007). This approach shifts the focus from migrants as providers of care to acknowledge the ways in which all family members participate in a variety of caregiving activities. The distinction between caregivers and care receivers is often blurred, and the roles of givers and receivers of care are dynamic and vary throughout life, family and migration cycles (Kilkey & Merla, 2014). With its multidimensional definition of care, the care circulation approach calls for a broadening of the definition of care. Five elements of care are identified, namely financial and material (remittances or goods), physical or hands-on

(feeding, bathing), practical (advice, assistance), emotional and moral support, and accommodation (providing shelter) (Baldassar et al., 2007; Degavre & Merla, 2016; Merla et al., 2020). What all the different forms have in common is that they require diverse resources to which migrants and their family members have different degrees of access depending on factors such as age, stage in migration and family cycle, country of origin and country of residence (Degavre & Merla, 2016). Consequently, the pattern of who receives and who gives care fluctuates across the life cycle (Merla & Baldassar, 2016), and an analysis of care circulation within transnational families need to be sensitive to the (family) life cycle and migration cycle.

The framework challenges the normative idea of families as nuclear (Lamas-Abraira, 2019) and includes both nuclear and extended family members who are 'actively engaged in family survival and maintenance, ranging from those whose involvement is extensive and constant to those whose roles are more marginal' (Baldassar et al., 2014, p. 159). Previous research has highlighted the continued support of transnational families in caregiving and Baldassar and colleagues (2017) also describe processes of 'kinning' that include elderly care receivers and migrant carers; however, less attention has been paid to the care work provided by migrant peer networks in the country of destination (Oliver, 2017).

In this article, an extended definition of family is applied, which includes the extended family formation and voluntary kin, shifting the focus away from the ideal of the Western nuclear family (Francisco-Menchavez, 2018). I would argue that this is more in line with how family is understood and practised in a Filipino context. The kinship structure is the primary unit of socialization in the Philippine society and paramount in terms of providing security and protection. Owing to the bilateral tracing of descent, Filipino families are relatively large, and family relations are characterized by a myriad of reciprocal obligations and privileges. It is also noteworthy that Filipinos tend to recreate 'family like' relationships outside of the unit of family and relatives, relationships that may be formalized through ritual kinship such as godparenting or by using kin terms for non-relatives (Miralao, 1997; Torres, 1985). Although modernization and the increased mobility of family members have transformed and reconstituted kin practices in the Philippines (Aguilar, 2014), the importance of being, or desire to be, 'family' has not diminished (Asis et al., 2004).

The care circulation framework acknowledges that the practice of care is 'shaped and constrained by the broader (macro) socio-structural context in transnational settings' (Baldassar & Merla, 2014, p. 22). Migration policies with visa regulations and family reunion schemes condition the movement of family members (Merla, 2014; Merla et al., 2020) and structure the interactions and chances of reunification in transnational families (Ariza, 2014; Fresnoza-Flot, 2018; Parreñas, 2005; Wall & Bolzman, 2014). The migration regime thus structures the ability of migrants and their families to provide care (Merla, 2014). For the nurses and their families included in this study, the Norwegian immigration regulations regulated their access to visas and residence permits. Family reunification with husbands or wives and with children under the age of 18 was a relatively uncomplicated process for the Filipino nurses once they themselves had secured a permanent residence permit. In contrast, family reunification with their parents was almost impossible due to strictly nuclear family-based immigration regulations. Parents of persons over the age of 18 are entitled to a nine-month visa to visit their children. For these parents to be granted a residence permit in Norway, they need to be over the age of 60 and able to prove that they have no family members left in the Philippines

(including a spouse, children, grandchildren or great-grandchildren) (Immigration Act, 2008, § 46). Consequently, none of the nurses in my sample were living together with their parents in Norway; all of them were providing and receiving care 'from a distance'.

While there has been an increased focus on how 'migration regimes' and immigration policies in receiving states impact on care provision in transnational families (Kilkey & Merla, 2014; Merla et al., 2020), less attention has been paid to how different welfare regimes affect people's need and ability to receive and provide care. Migrants find themselves at the intersection between the welfare regimes of the country of destination and the country of origin. Degavre and Merla (2016) argue that migrants' capacity to provide care is shaped by the welfare regime in the receiving country, whereas their non-migrant relatives' need for care is shaped by the welfare regime of the sending country. The considerable differences between the welfare regimes of Norway and the Philippines influence family members' care needs and capacity. Norway has been described as a 'service welfare state', and the delivery of social care (for children and the elderly) and health care is predominantly provided by the public sector (Greve, 2007). The contributions of migrants, including Filipino health workers, who constitute the largest immigrant group employed in the municipal health care sector in Norway, play an increasingly important role in the health care sector (Claus, 2018). Unlike Norway, the Philippines has a limited range of social protection programmes, and its social policy institutions protect only a small number of people against a very limited range of social risks (Cook & Kwon, 2007). Reciprocal care arrangements in transnational families thus offer vital informal social protection to family members living in the Philippines (Saksela-Bergholm, 2019).

Transnational caregiving is based on a dialectic relationship between the capacity and the obligation to provide care. The *capacity to care* is affected by macro-structural (policies), meso (community) and micro (personal) factors (Baldassar et al., 2007). Being able to be mobile and to communicate across geographical distances are key conditions for transnational care circulation. While academic work on transnational families and care circulation has contributed to a 'de-demonizing' of distance by highlighting how the use of new technologies enables the exchange of care across borders (Baldassar, 2016), the role of proximate care, which requires a physical co-presence, has received less attention in the transnational family care circulation literature (Merla et al., 2020). *The obligation to care* is both culturally informed and the result of kin relationships and negotiated family commitments within family networks (Baldassar et al., 2007). While parents may be the main providers of care for their children as they grow up, the relationship changes as the parents grow older and their need for care increases. A central concept in Filipino culture is the debt of gratitude, *utang na loob* (Alampay, 2014), described as a form of showing appreciation towards another person's good deed by responding appropriately to such kindness (Rungduin et al., 2016). Children are expected to have a sense of *utang na loob* towards their parents for having raised them (Alampay, 2014). Who should provide what care, and at what stage, is not a given, and is further complicated in a migration setting.

While the care circulation framework has introduced new ways to assess the mobility of care, the framework is not without limitations. As noted by Lutz (2018), it relies on the assumption that new technology is universally available and able to facilitate co-presence across distance. Although it has eased communication and opened up new possibilities for caring across distance and borders, these technologies have their limits and cannot replace 'hands-on care'. While highlighting the important role technology plays in the

exchange of care across distance, some of the work has nonetheless inadvertently underemphasized the importance of physical proximity and the related mobility regimes (Merla et al., 2021).

Data and methods

This article is based on multi-sited qualitative fieldwork, which focused on the lived experiences of nurses migrating from the Philippines to Norway with the prospect of finding work in the Norwegian labour market. I draw specifically on in-depth interviews with nurses in Norway and their families in the Philippines. The fieldwork was carried out in and around Oslo, Norway and in five different regions in different parts of the Philippines between April 2017 and April 2019. A multi-sited approach allows for an examination of the lives of family members in the various places they reside and is thus suitable for mapping the caregiving activities in transnational families (Baldassar & Merla 2014).

Twenty-two Filipino nurses residing in Norway were recruited for in-depth interviews through various entry points, including religious communities, nursing homes and personal contacts. Eighteen women and four men, one of whom is transgender, were interviewed. The nurses, who all had a bachelor's degree in nursing from the Philippines, ranged in age from 27 to 48 years old and had arrived in Norway between 2000 and 2013. The majority had entered on student visas (5), au-pair visas (5) or jobseeker visas (8). In addition, three nurses had been recruited directly by a Norwegian employer in the early 2000s and one nurse had entered on a family reunification visa. A checklist that included topics related to their migration decision and experiences, their work experiences in Norway and living a transnational life was developed to guide the interviews. The interviews were conducted in a location chosen by the nurses and informed consent was obtained from all participants. The interviews were conducted in Norwegian, English or a mix of the two languages, depending on the nurses' preferences. Working in Norway, the nurses were accustomed to expressing themselves in Norwegian. They also had advanced skills in English, as English is the language of instruction in nursing schools in the Philippines. The interviews were later transcribed and organized for subsequent thematic analysis. A 'contextualist' thematic method was employed to acknowledge the way in which the nurses made meaning of their experiences and how the broader context impacted on those meanings (Braun & Clarke, 2006).

After the interviews, I asked the nurses if they could ask their families residing in the Philippines if they would be willing to meet with me during my upcoming trips to the Philippines. After consulting their families, several of the nurses put me in contact with their parents or siblings. While some of the families had to be ruled out due to travel restrictions in the southern part of the country, I was able to visit four families in different parts of the country. During these visits, I was generously invited into their homes and offered food and they shared their feelings and experiences related to having a family member working overseas. Even though the families had been introduced to the research project through their children or siblings whom I had met in Norway and thus had some knowledge of the purpose of my visit, I also introduced myself and the research project in each of these visits to give them the chance to give their informed consent or refuse to participate. All the families I visited accepted the invitation to

participate in the project. However, the relatively small number of families visited, four in total, could indicate that the decision on whether to participate or not had been taken based on information from their family members in Norway prior to my arrival in the Philippines. The interviews were mainly conducted in English, although my basic knowledge of Tagalog turned out to be useful during these visits. The parents had a reasonable to good command of English and were also usually accompanied by other family members with more advanced English skills. In addition to listening to their verbal accounts, I also observed in various ways how migration was affecting their lives, and how they stayed in touch with their loved ones overseas. To protect the identity of the participants in this study, pseudonyms are used in all the narratives and quotes presented in this article.

In the following sections, I present the main themes that emerged from the thematic analysis. First, I address the differences in welfare services between Norway and the Philippines and their effect on care needs and capacity, before discussing the organization of care for aging parents. I then move on to examine aspects related to being a parent in a foreign country before concluding the analysis by looking into the role of fellow Filipinos in Norway and voluntary kin.

'If You Rely on Public Services You Will Die': remittances and social welfare

Previous studies on Filipina migration, including research on Filipino au pairs in Norway (Bikova, 2015), have highlighted migration as 'a means to fulfilling a family project' (Asis et al., 2004), a view which was echoed by many of the narratives in this study as well. The decision to leave the Philippines to find work overseas was often seen as a response to a difficult economic situation in the Philippines. While the parents had often provided for the nurses' upbringing and a costly nursing education, the act of migrating gave the nurses an opportunity to return the support and care. Migrants' commitments to sending remittances can be strongly guided by moral obligations (Saksela-Bergholm, 2019). The desire to provide financially for parents underlines the reciprocity that is said to be an inherent aspect of the Filipino family and an expression of the *utang na loob* that Filipinos have towards their parents. Rose, who was single and still in her twenties when she left the Philippines had married a Filipino man and given birth to a child in Norway. When she narrated her decision to migrate, she rationalized it by focusing on the money she was able to remit and how it served as a way of 'paying for all their [her parents'] sacrifices. Maybe I'm paying for the years they took care of me, maybe it's just like that'. By migrating, she was making use of the possibilities at hand and doing what was (culturally) expected of her.

The decision to leave the Philippines was also a response to the dearth of nursing positions, meagre salaries and limited public social welfare. After living close to a decade in Norway, Raquel, who at the time of the interview had a Norwegian partner and a permanent position in the Norwegian health care sector, explained her migration decision as a response to the lack of social security in the Philippines. By migrating, she could provide care for her parents, which the public services failed to do.

> If you get sick, there is no free health care [in the Philippines]. If you rely on the public services, you will die. The quality is very poor. So I can afford to buy medicine for my parents. If they fall ill, I have the money.

The differences in the welfare regimes between Norway and the Philippines were also seen to affect the care needs and capacity. Based on her research on immigrant nurses in Norway, Seeberg (2012) argues that gains such as a higher salary and social status may to some extent compensate for the losses experienced by the nurses and their families. Will, who was still single and worked as a registered nurse in Norway, explained how the Norwegian welfare state, albeit requiring high taxes, provided for his medical needs. He contrasted this system with the precarious situation of his parents in the Philippines.

> So even if Norway, even if you pay taxes, a lot of taxes in Norway, but you can see, you can experience your taxes as well. Free health system. In the Philippines, if you don't have money, you will die.

The narratives of the nurses also show how changes in their own family situation or in the lives of their siblings and parents can change the level and direction of remittances and the way remittances are spent. As noted by Faist and colleagues (2015), remittances and care provided for children and elderly relatives may be more predominant in specific periods in life. For the migrants, their capacity to provide financial care for their families was linked to changes in their own family situation, such as becoming parents or buying property in Norway. Daisy, who had married a Norwegian man and given birth to a child in Norway, explained that she used to remit a large part of her income but had to reduce the amount she remitted after she became a mother.

> I used to send 7 000 Norwegian kroner every month, especially when my brother was still in college. […] I supported my family, his education and myself. But at that time, I was still single. I don't have any luxury in my life. Even though I'm married, I still send money to my family. But it is less now. I had to cut half of it since I've got children now.

While nurses' ability to remit money changed as their family and life situation in Norway changed, the need to provide remittances varied according to the situation of their family members residing in the Philippines, especially in the event of sickness in the family. Even though Rose had her own family in Norway to provide for, her sister's illness meant that Rose also had to support her.

> Right now, I'm helping my sister because she was diagnosed with a chronic disease. And she stopped working, so it means she has no money. She has insurance, but it's not enough. She has been hospitalized how many times? Because [the disease] is a very complicated disease, and she is divorced, so I'm helping her a little.

The way Rose was providing for her sister's medical needs clearly shows that the support from migrants covers not only their parents' needs but also extends to other family members, such as adult siblings (Bikova, 2015). These examples also show how disparities between the welfare regimes of the country of origin and destination affect the need for, as well as the capacity to provide, care within the transnational families. While the limited social protection programmes in the Philippines increased the need for care, the migrant nurses' access to extensive welfare services in Norway increased their ability to care.

The act of migration was often justified as a means of providing for family in the Philippines. Yet the economic support migrants receive from parents and relatives for education, air tickets and recruitment fees, as well as support during the initial period in a new country, demonstrates that financial care in migrant families is a multidirectional process. Migrants depend on care and support to be able to fulfil their migration project. The nurses were generally reluctant to ask their parents for financial help and to share the challenges and problems they encountered having arrived in Norway. The choice to not communicate negative emotions such as sadness or worry is in itself a form of emotional and moral care for those left behind (Baldassar et al., 2007; Sampaio, 2020). This is how Will justified not sharing his problems with his parents.

> As much as possible, I don't want to tell my parents and the family about my problems because they will get worried. Because my parents are old. And I know them, that if they know that something is wrong about me, they cannot sleep and all. So I don't want to bother them.

In times of difficulty and when facing challenges, the nurses preferred to reach out to family members or friends living in Norway. Angel, who had a Filipino husband, two children and a sister in Norway, stated that she only called her parents when things were going well. If she was tired or stressed, she called her sister who 'knows how life is here'. Family members, including the ones who have already migrated and the ones who remain at home, are likely to form the core social network for migrants (Bryceson, 2019). For the nurses in this study, this core social network also extended to close friends and voluntary kin, and many of the nurses had come to Norway on the initiative of relatives or friends. Having relatives and friends in Norway served as motivation for choosing to migrate to Norway (Zabko et al., 2019). Will, who was invited to Norway by his best friend, described how his friend helped him financially as well as practically and helped him get established in Norway. Having a friend already resident in Norway who knew the ropes eased his entrance into the labour market. While Will was still in the Philippines, his friend in Norway had applied for authorization as a health care worker on his behalf, and his application was approved prior to his arrival. Since he arrived in Norway, he had also been sharing an apartment with his friend, whom in many ways performed the function of a sister, and Will explained that she was 'like family'. In addition to providing practical and financial care, she was also important in terms of emotional care.

> She knows everything about me. We went to college [together]. So that's the reason why we know everything [about each other]. We went to college, we were in the same boarding house. And then she went here first and then I came after her. And after that, we lived together. I think we've known each other for about fifteen years. She's like family. So in Norway, she will always be the one to know about me if there's problems and all.

While Will described positive experiences with receiving help from his network, other nurses had experienced that the help they had been promised beforehand did not materialize once they arrived. Jesse, who had arrived on her own in Norway almost a decade ago had also been invited by her best friend and promised that she could rely on her for accommodation and clothing, told me that this had changed once she arrived in Norway. This example also illustrates how personal relationship ties are defined internally, subjectively and might be temporary (Nicińska et al., 2022).

'There Are No Nursing Homes in the Philippines': division of care responsibilities

While the migrants were often responsible for financial and material care, they relied on their siblings in the Philippines to provide physical or hands-on care for their parents. Will, who provides for his family economically, explained how he and his siblings share the responsibility of caring for their parents.

> They are living with my sister now, because my brother already has a family. My sister already has a family too, but she has children. My parents are very fond of their grandchildren, so they are taking care of them.

Adult children responsible for present and future proximate care provision for their parents may eventually benefit from it (Kordasiewicz et al., 2018). While the siblings who stay behind take on the main responsibility for the proximate care, they also receive physical care from their parents in return, such as childcare, which their migrating siblings have less access to.

Although a lot of care work in transnational families takes place at a distance, certain types of care require proximity and can only be exchanged during visits. The migrant nurses thus arranged for visits to look after their parents. Not only were trips back to the Philippines important for the migrants in terms of providing care for their parents, but they also enabled the parents to provide hands-on care for their migrating children. Will, who migrated to provide a better life for his family, would travel back to the Philippines every year to spend time with his family. While Will was the one who initiated the visits, his father told me that his son's return visits gave him the chance to provide physical care for his son who was working hard in Norway to provide for their needs. When his son visited, the whole family would gather and spend time together, and his father would 'cook anything that he wanted'.

While care for older parents residing in the home country has largely been seen as result of reciprocity in care in transnational families, it is also to a large extent a result of either the way welfare services are organized or, in the case of the Philippines, of the lack of such services. The lack of public support structures for elderly people in the Philippines created a need for support from the extended network of kin. In addition to the care provided by their children, many parents had 'helpers' who assisted them. Some had hired helpers that they were not related to, but often the helpers were relatives who lived with them and provided care. The helpers and their families would receive benefits in return.

Even though the nurses had grown up in a highly familiarized society where the responsibility of caring for the elderly lies with the family, for many of them, living and working in Norway, where care for elderly is highly institutionalized, had altered their perceptions of institutional care. Gloria had moved to Norway together with her Filipino husband almost two decades ago and had continuously sent money home to the Philippines to provide care for her aging parent. Having lived and worked in Norway for almost two decades, she explained how her perceptions had changed and that she was planning to make use of nursing home facilities in Norway when she herself would grow old.

> I'm not scared. My husband and I are looking forward to it, as long as we're in the same institution, we don't need to be in the same room. Why not? I don't understand Norwegians or others who don't want to be in a nursing home. I think that the ones living here [in this nursing home] have a good life. […] I have my kids, and at least they can visit me whenever they want and when it fits their schedule. And I'll probably get grandchildren as well, and they can also visit me. But if I go there [the Philippines], I don't have anyone. I will get very lonely. I might have to pay someone to look after me, who might not even do a good job. Here there are professional staff working in the nursing homes who will look after me. They can observe when I have a wound, if I'm dehydrated, when I have fever. So why not?

In Norway, public opinion, as well as welfare policies, largely regards elderly care as a public responsibility. While filial responsibility is present in the Norwegian society, and family networks provide extensive care for the older generation, public services are expected to take the main responsibility for the elderly as their care needs grow (Veenstra & Daatland, 2012). The way Gloria described the benefits of being in a nursing home as a way of easing the care burden of her children seems to correspond to the general perception among Norwegians. As a nurse, she also highlighted the advantages of being in a professional setting with staff who were educated and trained to cater to her needs. Similar changes in attitudes to eldercare are also noted by Goździak et al. (2020) in their studies of Polish nurses in Norway.

'In Norway the Kids Are Supposed to Be in Kindergarten': parenting across cultures

Several of the nurses had left young children in the care of husbands and parents in the Philippines. For the nurses who had left their children in the Philippines, finding stable work was not only important in terms of being able to remit money but also to be able to be reunited with their children. Unlike their fellow Filipinos who worked as au pairs, and who were not entitled to family reunification (Bikova, 2015), the nurses in this study knew that the sooner they were able to find a permanent position, the sooner they could be with their children. However, being reunited in Norway also caused some stress for the migrant nurses and their families. Grace, who had been living alone in Norway for eight years and providing care at a distance, told me that in many ways, life was much more stressful now that her family was living together. While living in the Philippines, her family had been used to having a helper who would take care of cooking and cleaning. Now that her husband and two children lived with her, her workload had increased.

Being a parent in Norway without any extended family available to provide practical care for their children was described by many of the nurses as one of the disadvantages of living far away from parents and kin. Rose, who had a young child, reflected on how her life as a mother differed from what it would have looked like had she stayed in the Philippines where her family and relatives would have provided physical care.

> It would be a big difference in the Philippines, because in the Philippines, you could hire a nanny or a babysitter, and babysitter is very cheap. And I have my parents there, I have my cousins, my aunts. So if I want to go to work or I want to go to the mall for a coffee, then I can leave my baby there with them, and no need to pay.

While the proximate care the nurses and their children in Norway received from the (grand)parents was limited, the Norwegian welfare state did compensate to some extent, not just through higher salary and status, as Seeberg (2012) suggests, but through universal public childcare coverage, cash-for-care, parental leave quotas for fathers, additional rights to sick leave for parents and a tax deduction for childcare expenses. The social benefits for parents in Norway were described as an advantage of being a parent in Norway as compared to the Philippines. Sending children to kindergarten was, however, a foreign experience for the migrants. Growing up in the Philippines, they had either been looked after by their mothers or close relatives or by a helper who lived in their home. Like several of the nurses, Daisy was reluctant to send her child to kindergarten at an early age. Unlike some of the other nurses who had invited their parents to Norway to delay the entry into public childcare, she did not have that option. While she saw that kindergarten could benefit both the child and the parents, leaving her child in the care of people she did not know was not easy.

> And children are supposed to be in kindergarten, that's not common for us. We used to have a helper. […] On his first day in kindergarten, I cried when I got home. I thought that I cannot do this, but I did not have any choice. But now I'm only working nightshifts to be able to spend more time with my child. […] I tried to arrange so that my child stays at home with me two days a week. It's not that I'm against kindergarten, I can see that it has a great impact on his development, he is more independent now.

To reduce the care loads of their daughters and delay the use of kindergartens, many parents of migrant nurses in Norway applied for a visitor's visa for nine months to provide care for their daughters and baby grandchildren. During these months, the grandmothers and grandfathers would provide the care that they would have given in the Philippines if the daughter had stayed.

Because the immigration regulations in Norway limit (grand) parents' visas to a nine-month period, the migrant mothers had to find alternative childcare arrangements for the grandparent-less periods. The system of free education and subsidized kindergartens in Norway enabled the nurses to work despite the lack of support from their family network. However, school and kindergarten opening hours are tailored towards regular office working hours in Norway and do not cover all the needs of occupational groups such as nurses for whom shift work is frequent. Rosemary, who had three young children and was married to a Norwegian citizen, explained how she arranged the childcare needed for her to work as a nurse.

> Usually, I get support from the Filipino community. They are very good at asking me if I need a babysitter. […] When I work night shifts, I call them and ask if they are available. And then I meet them at the metro station after work. That's what our life is like here.

Although Norway offers comprehensive support of the dual earner/dual carer model through the parental leave scheme and the right to formal childcare (Bjørnholt & Stefansen, 2019), this example highlights the need for family support even within such a welfare regime. With no family members nearby, many of the nurses turned to other Filipinos in Norway, with whom they created kin-like relations and on whom they relied on for physical and practical support.

'I Get to Experience the Family That I'm Looking for': fellow Filipinos and voluntary kin

Being separated from their families, many of the nurses expressed that having a network of fellow Filipinos was important in terms of providing various forms of care that stretched beyond childcare. According to Will, the Filipinos he met in Norway served as his extended Filipino family.

> Personally, the Filipino community for me plays a very vital role. Especially emotionally and psychologically for me. Because I'm very close with my family, so the only family I can also consider here are also Filipinos, especially Filipino friends. So I get to experience the family that I'm looking for from them.

Due to the geographical distance, the parents left in the Philippines would at times reach out to the Filipino diaspora to provide assistance and care to their adult children in Norway. When Jesse left the Philippines, she had made arrangements for her accommodation, but for various reasons that arrangement did not work out, and she was in desperate need of a place to stay. Through her family's network, Jesse was able to find short-term accommodation while she continued her search for a place to live on a more permanent basis. In this next phase, the Filipino community continued to play an essential role. Through a Chinese girl she met in Norway, she was introduced to a Filipino church.

> And when I got to the church I almost fainted because I was, I don't know the feeling, it was mixed feelings that I finally felt like I'm at home because I've seen a lot of Filipinos. […] I told them that I need a place to stay. […] So they brought me to her [a Filipina in the church] and they told me that she usually helps people […] And she told me it's ok, you can transfer to my house before the weekend. […] So I transferred there at her house, at the Filipino woman's house who adopted me for a while. So I stayed there and she helped me. […] The woman that adopted me, I told her that I just want to go home. I cannot live here anymore. […] And she was comforting me, and she was encouraging me. And she said 'come here, I'm looking for an extra job as well, so we can try together'. […] And if I cannot buy my monthly card [for public transport], she and her friends [from the church] would help me. They would collect money so that I would have monthly card every month. So I got free food, and I got monthly card.

Several of the nurses emphasized that Filipino churches had provided arenas of help, support and fellowship during difficult periods of their lives. Another advantage of the Filipino network in Norway was that many of them had been living in Norway for an extensive period and had thus acquired a better understanding of how things work in Norway. For the newly arrived nurses, their fellow Filipinos were an important source of information that they relied on in navigating an unfamiliar society. Carmen, who had arrived in Norway together with two of her friends shortly after graduating from nursing college in the Philippines, shared that the advice she received was important in terms of navigating an unfamiliar setting. 'Because they [have lived] longer in Norway, they know the system already. They told us "this is not legal, why do you do like this?" and so on'.

The nurses would often refer to members of their core Filipino network in Norway in familial terms such as 'ate' (older sister) and 'tita' (aunt). Daisy, who had given birth after arriving in Norway had 'formalized' her relationship to some of her Filipino friends by

making them the godparents of her child, thereby creating lasting bonds that would support her and her child.

> Most of the people I know here have lived here for a long time. My child's godmother and godfather have lived here for twenty or thirty years. They are mature and they know a lot of stuff. I ask them for a lot of support in terms of babysitting and stuff.

These examples, which are in line with previous research on Filipino labour migrants (Francisco-Menchavez, 2018), shed light on how migrants create new social relations to provide care for one another as they find themselves without the family networks they had previously relied on. Existing and newly established social ties are also important resources for migrants as they navigate unfamiliar Norwegian (welfare) institutions (Zabko et al., 2019).

Conclusion: voluntary kin and the circulation of care

In this article, I have sought to illuminate the complexity of transnational caregiving and to highlight how regimes of mobility and welfare impact on care needs and capacity. The care circulation framework, which offers a multidimensional and multidirectional definition of care, has been a useful approach as it calls attention to how care takes on numerous forms that are provided by a variety of actors in transnational families. While care provided within transnational families takes on many of the same forms found in families that are living within the boundaries of a nation state, the role of migration and welfare policies is evident in the narratives of the nurses and their families in this study.

The Norwegian migration regime affects access to care through its visa regulations. Filipino families rarely take a nuclear form (Francisco-Menchavez, 2018), and the Norwegian family reunification scheme is built on the ideal of the nuclear family, thus making it almost impossible for the nurses to be reunited with their aging parents. Consequently, migrants' ability to provide proximate care for their parents is greatly restricted. At the same time, it also limits elderly parents' ability to provide proximate care for their children and grandchildren.

As shown, the roles of giver and receiver of care are also dynamic and vary over life, family and migration cycles. While changes such as growing families and aging parents alter the amount, form and direction of care provided, the relationship between care needs and capacity cannot be fully grasped without looking at the differences in the welfare regimes of the respective countries. Whereas the Norwegian welfare state provided social security for its citizens and other residents, including migrant nurses and their immediate families residing in Norway, families left in the Philippines were not covered by the same comprehensive welfare regime. As a result, their care needs and ability to provide care varied correspondingly.

As noted at the outset of this article, some previous studies on care circulation in transnational families have inadvertently underemphasized the importance of physical proximity. This article has demonstrated that despite strong family connections and extensive care provision within transnational families, geographical separation may create a care deficit for migrant nurses. Even though some of their care needs were met and compensated by welfare policies in Norway, the nurses experienced a gap

between their need for care and the care provided by family members and Norwegian public institutions. To fill this gap, the nurses turned to fellow Filipinos in Norway. Without being formally related, these individuals created a family away from home and served as voluntary kin. Filipino churches were an important arena in which such relationships were created.

While the bulk of research on transnational families and care circulation has highlighted the continued support of family members across borders and distance, it has only, to a limited extent, included the role of migrant peers and voluntary kin. Looking at care as a multidirectional process has encouraged an enlargement of the definition of family to also include voluntary kin, both at home and abroad, thereby decentring the nuclear heteronormative family as the operational family form.

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