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Care, Inequalities and Wellbeing among Transnational Families in Europe

Ruth Evans, Rosa Mas Giralt and CareWell project team members [1]

Report of the CareWell comparative, intergenerational study in Spain, France, Sweden and UK

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Resources

Download the report, summary, policy briefs and other resources

Films are available on the **CareWell YouTube channel**

Learning Resources for ESOL tutors produced by Migrant English Support Hub (MESH).

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Executive Summary

Introduction

This research project investigated the relationships between care, inequalities and wellbeing among different generations of transnational families in the UK, Spain, France and Sweden. 'Transnational families' can be defined as familial groups where one or more family members spend all or most of their time geographically separated from each other across borders, but nevertheless share a collective sense of connection as a 'family' (Evans, 2025; Baldassar et al., 2007).

European societies are undergoing significant demographic shifts due to population ageing and increased international migration, resulting in major changes in the provision of care, social protection and intergenerational responsibilities. These transformations may exacerbate existing inequalities facing migrant carers. Migrants' social rights in each national context are mediated by varying welfare models and specific migration regimes – immigration and naturalisation policies which regulate entry categories, conditions for settlement and acquisition of citizenship, and immigrant policies that determine the level of access to public services. Different policy scales (local, regional, national and transnational) affect the formal and informal arrangements through which migrants and their transnational families can organise care locally and transnationally. Furthermore, the COVID-19 crisis has brought into stark relief the care deficits many European countries are confronting as ageing societies.

Methodology

Using a multi-sited, family-focused ethnographic and participatory action research methodology, we worked with partner organisations to train and support migrant peer/ community researchers to undertake research with transnational families, building trust and capacity within communities.

We conducted interviews, participatory diagramming and other activities with 122 transnational families (UK: 25, Sweden: 40, Spain: 23, France: 29 families). This provided a total of 319 family participants in the large sample of different ethnicities and varying legal status to compare experiences at urban and rural scales, and between countries. In most families, we engaged with two or three different generations, including members living in countries of origin/other countries. We also selected 20 case study families across the four countries for in-depth research employing ethnographic approaches. We conducted semi-structured interviews with a total of 44 practitioners and policymakers working with migrant families in health and social care, education, integration, language learning, the voluntary and community sector to explore their perspectives.

Audio-recorded interviews/discussions were transcribed and translated where needed into English (UK and Sweden), Swedish, Spanish and French. A thematic (Limb and Dwyer, 2001) and narrative (De Fina and Georgakopoulou, 2012) analysis framework was developed. Preliminary findings and policy implications were discussed in a series of participatory feedback workshops with transnational families, peer/ community researchers, policymakers and practitioners. A number of accessible visual and other outputs were co-produced and disseminated with participants and stakeholders, including short films for policymakers and practitioners in the UK and Sweden[2], documentary films in France, PhotoVoice collages in Spain and learning resources for English for Speakers of Other Languages tutors[3].

2 See: **CareWell Transnational Families YouTube channel**

3 See learning resources on **Transnational Families: Family Challenges**, produced by Migrant English Support Hub (MESH).

Key findings

This research has shown that transnational families simultaneously manage multiple caring responsibilities, both proximately for co-resident family members, and by caring at a distance for kin living in other countries. Carers' and their family members' opportunities and access to social protection are shaped by intersecting inequalities based on legal status, nationality, race and ethnicity, disability/ chronic illness, socio-economic status, language-related inequalities, gender and generation. Indeed, the deficits of migration and care regimes, alongside the absence of kin who would usually be expected to provide informal care, create the need for children and youth to take on caring roles in transnational families. Children's and young people's care work is often devalued and invisible, but may be crucial in enabling parents and other family members to fill gaps in care provision in the absence of extended family kin and in facilitating access to formal care resources through language and digital brokering.

Our analysis of the policy context demonstrates that restrictions to accessing welfare and services emerge as an extension of migration control, particularly in the cases of France, Spain and the UK. Across all four countries, however, long-term settlement and 'integration' are undermined for both labour and humanitarian migrants due to the need to meet income or other requirements, and/or limitations of social rights. For families, particularly those with specific care needs, restrictive family reunion and family visit visa policies, particularly in France, Sweden and the UK, jeopardise intergenerational care and reciprocity, undermining the wellbeing of family members both locally and transnationally.

The research took place in the immediate aftermath of the COVID-19 pandemic and was able to capture how the physical and mental health, economic, social and emotional impacts of the pandemic were interlinked for migrants. Such impacts contributed to the further marginalisation of transnational families with caring responsibilities, particularly those with insecure legal status and low socio-economic status. Caring arrangements had to change due to enforced immobility, resulting in extended periods of separation when family members became 'stuck' in other countries due to the closure of borders and an inability to travel to see sick or dying relatives or attend funerals which families found distressing.

The accelerated shift towards digital technology becoming the primary gateway to access public services, seen particularly in Spain, the UK and Sweden since the pandemic, has resulted in an additional layer of inequalities. The digital divide particularly affects older generations and those with low levels of literacy or language proficiency in the dominant societal language and increases the reliance on children and younger generations. Children's roles in language brokering and mediating in institutional settings (schools, hospitals) is seen as particularly problematic since it raises ethical questions about consent and confidentiality, as well as concerns about the impact of such responsibilities on children.

The research has also highlighted several barriers to accessing affordable, appropriate and high-quality language education provision. These include: travel costs, pressure to progress through higher level language courses, inflexible timetables due to stretched resources and ineffective coordination of language education provision.

Negative impacts of caregiving were identified among participants in the key domains of education, employment and finances, family relationships, social participation, health and wellbeing. These negative impacts were mainly experienced by middle and younger generations across the four study countries who were predominantly responsible for caring for family members.

The research in Sweden and the UK found, as might be expected, that negative impacts were particularly experienced by migrants undertaking substantial care work for co-resident family members with a disability and/or chronic illness in destination countries. Negative impacts were also experienced, however, by younger and middle generation migrants in Spain and France juggling care at a distance for family members in other countries, alongside everyday caring roles for family members in close proximity.

There were particular pressures on women and primary carers in the middle generation, especially for those balancing remittances and proximate care, and, in the cases of Spain and France, doing so sometimes in very difficult working conditions.

While caring for a family member may foster resilience, such negative impacts of caregiving could have significant implications for transnational family carers' long term opportunities and life chances and individual and collective wellbeing. Our research supports the wider evidence that negative outcomes of caregiving may affect carers' economic, social and cultural rights, education and opportunities, leading to poverty, reduced employment and pension rights (EuroCarers, 2020; APPG on Young Carers and Young Adult Carers, 2023). These impacts of caregiving may be especially acute among transnational families with substantial caring responsibilities who are often already facing financial hardships and insecurity within destination countries. As we have shown, such difficult circumstances are due to limited entitlements to welfare and care resources, difficulties in securing long-term employment, restrictions on mobility through visa policies and family reunification rules, concerns about legal status and language and digital barriers to accessing support.

Policy and practice recommendations

1 Level out inequalities and differential treatment of refugees and other migrants

- **based on legal status, arrival and resettlement routes and/or nationality and ethnicity**
- **allow access to welfare and social protection in both origin and settlement countries, recognising transnational family ties**

Differential treatment of migrants according to legal status and nationality results in inequalities in social rights and unequal access to welfare and other forms of social protection within destination countries, as well as between countries in Europe.

Country-specific recommendations follow:

Spain:

- Ensure equal citizenship and dual nationality for all migrants; this would allow transnational citizens to exert their political rights in both countries to which they contribute and make it easier for transnational families to access and combine social protection resources from more than one country to meet their care needs.
- Restore universal health assistance to people in irregular legal situations, (abolished by the Government of Mariano Rajoy Popular Party in 2013 but formally overturned by a Royal Decree passed in 2018. In practice, those in irregular situations continue to be excluded).
- Extend the IMV (Minimum Living Income) to include migrants in irregular situations, who are currently excluded.

France:

- Ensure undocumented migrants have continued access to healthcare (AME State Medical Aid), which has often become the focus of political debate in the current context and at risk of such basic rights being withdrawn.
- Migrants' families should have access to welfare support in France if they have ties in other countries, such as the current exclusion from welfare benefits (for example, the minimum resource benefit) if the parent spends periods of time abroad where their child lives.
- Social security agreements should be extended to more countries representing migrant workers' countries of origin, such as ensuring access to the total pension amount, based on contributions made in both origin and receiving countries. This is important in protecting transnational families' financial security.
- Greater recognition of migrants' qualifications and diplomas across the origin and receiving contexts is needed, since these influence their social mobility and capacity to integrate in the labour market both 'here' and 'there'.

UK:

- Level out the differentiated system of refugees' social rights based on nationality in response to particular crises of displacement. This causes difficulties and confusion for local authority and third sector migrant and refugee organisation staff and volunteers who may have differing funding streams for different groups, which they need to target to meet funding requirements, while also seeking to address inequalities created by different eligibility criteria.
- Reduce the costs of visas and passports for family members.
- Streamline and reduce the processing time of asylum claims, humanitarian resettlement, family reunification and visa applications so that family members are not separated for so long and can fulfil caring obligations.
- Lift the restriction around right to work of asylum seekers.
- Improve official recognition of professional qualifications obtained overseas to enable job-seeking and avoid de-skilling.
- Provide adequate legal representation to asylum seekers and 'unaccompanied minors' (unaccompanied child refugees/ migrants).
- Provide long term funding to local authorities and strategic migration partnerships (SMPs) to provide integration support to migrants and resettled groups.
- Ensure fairness and consistency in age assessments of unaccompanied minors.
- Create a culture within government that is more supportive and compassionate towards migrants, not hostile.

Sweden:

Despite the universal model of welfare provision, the research in Sweden found that transnational family members with caring needs and responsibilities often faced inequalities in securing long-term employment, which impacted on their wellbeing and opportunities. Addressing this requires:

- Public employment agencies to be more closely involved in monitoring and evaluating internship programmes to ensure they do not reinforce inequalities in the labour market.
- Subsiding the costs of obtaining a Swedish driving license would make the labour market more accessible for migrants.

2 Expand the definition of 'family' in reunification policies

- **facilitate transnational family reunion and mobility across borders for extended family members**
- **fast-track where there are care needs**

Our research has demonstrated the need to expand the definition of 'family' in reunification policies and recognise a wider range of family members than just the immediate 'nuclear' family, so that migrants could 'sponsor' and be reunited with parents, adult siblings, cousins, nieces, nephews, aunts, uncles, grandparents, as well as children aged 18 or over.

We recommend expanding the eligibility criteria and definition of 'family' within all types of migration, including resettlement schemes and the asylum system, to include children aged 18 and over, parents, siblings and other extended family members, and fast-tracking applications where they are care needs. These changes would enable such transnational family members to provide culturally appropriate inter- and intra-generational care in response to their needs and is fundamental to their wellbeing.

3 Recognise children's care work in transnational families and address the whole family's support needs

- **recognise children's important roles in language and digital brokering as care work in itself**
- **recognise care work across borders**

This research has provided important evidence of the significant, sometimes substantial, unpaid care work that children and young people provide to support transnational family members who often have multiple care needs and the ways this may impact on their wellbeing, education, social participation and future life chances. More awareness about young caregiving in transnational families is needed among teachers, social workers, healthcare practitioners and other professionals.

Furthermore, children's important roles in language and digital brokering need to be recognised as care work in itself, since they may be drawn into these roles regardless of whether there are specific disability-related care needs within families. Interpreting in healthcare, social care, educational or legal settings was sometimes stressful for young people and they were concerned about making mistakes or not understanding fully. Children's language brokering roles also contravene statutory guidelines in the UK for safeguarding children (HM Government, 2023, p.15).

While young carers are recognised as a specific group that may require support in the UK, the majority of the children and young people interviewed with caring responsibilities in transnational families had not been recognised by professionals as young carers and were not accessing support. Our research points to the crucial need for policymakers and practitioners in France, Spain and Sweden to acknowledge the issue of young caregiving and develop strategies to recognise and address the support needs of children and young people caring for family members within transnational families.

The research has shown that a 'whole family' approach to supporting young carers needs to include extended family members, including those not living in the immediate household and recognise how adults and children may be simultaneously caring for other family members in other countries. A more inclusive, flexible approach to the provision of welfare and care resources is needed that recognises transnational family ties and caring obligations across borders and need to travel in the context of global mobility.

4 Make public services more accessible, welcoming and inclusive for migrant carers and their families

In all four study countries, family participants and practitioners highlighted significant barriers that transnational family members with care needs faced in accessing public services, including healthcare, social care, welfare entitlements, education, including adult language education, housing and other local authority services. Specific issues to address include:

- **improve the accessibility and efficiency of services**
- **address the digital divide**
- **expand interpreting and translation services (taking account of gender sensitivities and language varieties)**
- **provide intercultural training (transnational family ties, culturally appropriate care, forced and irregular migration)**
- **expand and improve the quality of language education**
- **increase long-term funding, collaboration with and support for third sector.**

Further information:

Report, films and other outputs are available on the website

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1 Introduction

This research project investigated the relationships between care, inequalities and wellbeing among different generations of transnational families in the UK, Spain, France and Sweden. European societies are undergoing significant demographic shifts due to population ageing and increased international migration, resulting in major changes in the provision of care, social protection and intergenerational responsibilities. These transformations may exacerbate existing inequalities facing migrant carers. Furthermore, the COVID-19 crisis has brought into stark relief the care deficits many European countries are confronting as ageing societies.

The notion of the 'transnational family' captures the growing recognition that members of families "retain their sense of collectivity and kinship in spite of being spread across multiple nations" (Baldassar et al., 2007 p.13). Such families are characterised by considerable mobility (and immobility), including circular, return and onward migration, which intensified following the 2008 global financial crisis (Mas Giralt, 2017). They often have differing legal status within the same family and shift between statuses due to restrictive immigration rules, changing mobility strategies and opportunities for productive work. The study countries (Sweden, France, Spain and the UK) provide an interesting, comparative sample with varying welfare models, migration and care regimes, with migrant women playing key roles as employees in the care sector (Williams and Gavanas, 2008).

While caring for a family member may foster resilience, it may also have negative, often gendered, impacts on carers' (often women's) wellbeing, economic, social and cultural rights and opportunities, leading to poverty, reduced employment and pension rights (Evans and Becker, 2009; EuroCarers, 2020). Young caregiving may also affect children's emotional wellbeing and diminish their access to crucial social resources and opportunities, perpetuating inequality and disadvantage across generations (Me-We, 2019; EU, 2017). Furthermore, the COVID-19 pandemic exacerbated many of the impacts and inequalities faced by informal carers in Europe (Eurocarers/IRCCS-INRCA, 2021). This project focuses not only on adult carers, but also explores children's active caring roles in transnational families, which have been rarely investigated to date.

Using a multi-sited, family-focused ethnographic and participatory action research methodology, we worked with partner organisations to train and support migrant peer researchers to undertake research with families, building trust and capacity within communities. We selected a sample of 122 transnational families across the four countries, comprising 319 participants of different ethnicities and varying legal status from two contrasting regions in each country to compare experiences at urban and rural scales, and between countries. In most families, we engaged with two or three different generations, including family members living in countries of origin/other countries. We also selected 20 case study families across the four countries for in-depth research employing ethnographic approaches.

The investigation in France, Spain, Sweden and the UK has been guided by our overarching research questions:

1. How are 'proximate' and 'distant' caring responsibilities negotiated between different generations of transnational families? What caring roles do children undertake? How does this affect power dynamics, childhood and parenting norms?
2. What are the health, economic, social and emotional impacts of the COVID-19 pandemic on transnational families? How are caring responsibilities changing and how are different generations responding to the crisis in terms of im/mobility?
3. How does unpaid family care affect the relational wellbeing, education and employment opportunities of different generations in transnational families? How do caring responsibilities and arrangements affect children's wellbeing, education and opportunities?
4. How do intersecting inequalities of gender, age and generation, ethnicity, race, socio-economic and legal status shape carers' and families' opportunities and access to social protection (healthcare, education, welfare, social care)?
5. What language barriers do different generations face? How is multilingualism used as a resource and how do they navigate systems for accessing support? How does language learning provide opportunities to overcome barriers?
6. In what ways can policy and practice support the care, wellbeing and equality of different generations?

This report gives an overview of the research context and methodology, before discussing in depth the key themes emerging from the dataset across the four countries in relation to the research questions above and concluding with policy and practice implications and recommendations.

2 Research context

This section gives an overview of the research context and key themes that inform our analyses. We discuss ageing populations and the intergenerational contract, care in transnational families, intersecting inequalities, the impact of COVID-19 on caring arrangements and how multilingualism relates to care and inequalities affecting transnational families.

Ageing populations, migration and COVID-19

European societies are undergoing significant demographic shifts due to population ageing and increased international migration, resulting in major changes in the provision of care, social protection and intergenerational responsibilities. These transformations may exacerbate existing inequalities facing migrants. With the second highest number (nearly 87 million) after Asia, international migrants comprise approximately 11% of the total population in Europe (IOM, 2020; 2024). Over half of these (44 million) were born in Europe, but were living elsewhere in the region, while the population of non-European migrants living in Europe was around 40 million in 2020 (IOM, 2024). Yet Europe has the slowest rate of proportional population change (1% increase) of all world regions due to population ageing and declining birth-rates, which would be much lower without international migration.

Most international migrants are of working age (20-64 years: IOM, 2020) and have significant caring responsibilities for younger and older generations based on an implicit 'intergenerational contract'. Migrants often provide not only 'proximate' care for children, disabled or older family members in settlement countries, but also care 'at a distance', providing emotional, social and financial support to kin 'back home' (Oso and Suarez-Grimalt, 2017a). Migrants are also increasingly ageing in Europe, with resulting care and social protection needs. Flows of resources are often reciprocal and diffuse across time, comprising not only conventional financial remittances sent from Europe to countries of origin, but also financial support, social remittances and care flowing from non-migrant family members to relatives in Europe (Palash and Baby Collin, 2018; Capstick, 2020).

The COVID-19 crisis has brought into stark relief the care deficits many European countries are confronting as ageing societies. The provision of care and wellbeing is shared among different actors – the State, the market, families and communities, including forms of transnational social protection for international migrants and their families (Levitt et al., 2017). This distribution results in major inequalities in access to care resources and services, in terms of gender, age and generation, ethnicity, socio-economic and legal status, both within each country and between countries.

While transnational social reproduction has been studied previously (Kilkey et al., 2018), the pandemic presented a different scenario that breaks away from the paradigm of increasing human mobility as a central feature of globalisation and contemporary transborder movements. Severe economic recession and job losses in Europe and globally may lead to diverse strategies of circular, return and onward migration, as seen in the intensification of transnational families' responses to the 2008 financial crisis (Oso and Suarez-Grimalt, 2017b; Mas Giralt, 2017). Illness and death led to increased caring roles for women and girls and high hospital and funeral costs in settlement countries and 'back home', adding to migrants' financial commitments and transnational grieving (Mas Giralt, 2019) and affecting relational wellbeing and opportunities. Our research investigates the impact of the pandemic and immobility regimes on migrant transnational families, who were already facing significant inequalities (Brandhorst et al., 2020; Merla et al., 2020; See also our Policy Briefs: Martínez-Buján, 2023; Limbu et al., 2024)

Transnational families and care

The notion of the 'transnational family' captures the growing recognition that members of families "retain their sense of collectivity and kinship in spite of being spread across multiple nations" (Baldassar et al., 2007, p.13). Such families are characterised by considerable mobility (and immobility), including circular, return and onward migration, which intensified following the 2008 global financial crisis (Mas Giralt, 2017). They often have differing legal status within the same family and shift between statuses due to restrictive immigration rules, changing mobility strategies and opportunities for productive work. Caring arrangements in transnational families were also severely affected by the immobility regimes that heavily curtailed travel during the COVID-19 pandemic (Brandhorst et al., 2020).

In transnational families, care has been conceptualised as reciprocal across the lifecourse, circulating among family members over time and distance (Baldassar and Merla, 2014). A lifecourse perspective may reveal changes in perceptions of caring obligations and intergenerational reciprocity over time. Older generations may migrate to provide care, while 'left-behind' grandparents (particularly grandmothers) often provide emotional and material support for migrant children and care for grandchildren/ other relatives. Expectations and ideas about ageing, care and family reciprocity along with caring roles and obligations, shift at different times in the lifecourse (Clark et al., 2009).

Our research is also informed by an ethic of care. This approach recognises that the boundaries between 'caregiving' (which may be viewed as social reproductive work) and 'taking care of' (may include paid work, financial support & remittances: productive work), are often blurred and can be conceptualised as different phases of a holistic caring process (Tronto, 1993). A combination of structural, relational and individual factors impact on carers' wellbeing, which we regard as socially and culturally constructed, rooted in a particular time and place, emerging through relationships with others (Atkinson et al., 2012; White, 2016).

Transnational parenting and the wellbeing of children 'left behind' emerged as a major focus for policy and academic concern (Kofman et al., 2011; Mazzucato and Schans, 2011). Children are often regarded as 'dependents', however, and their active social participation and caring roles within families are neglected. Young carers, especially girls, often provide practical and emotional support for parents, siblings and older relatives (Evans, 2011; Becker, 2007). The evidence of children's and young people's caring roles in migrant families in many European countries is limited. In the little available research, transnational dynamics of young caregiving have been overlooked, which this study seeks to address.

Intersecting inequalities

The study countries (Sweden, France, Spain and the UK) comprise varying welfare models, migration and care regimes, with migrant women playing key roles as employees in the care sector (Williams and Gavanas, 2008). Migrants' social rights in each country are mediated by these different welfare models and specific migration regimes - immigration and naturalisation policies which regulate entry categories, conditions for settlement and acquisition of citizenship, and immigrant policies that determine the level of access to public services. Different policy scales (local, regional, national and transnational) affect the formal and informal arrangements through which migrants and their transnational families can organise care locally and transnationally.

This project also analyses the relationship between multilingualism and care and how language issues may perpetuate inequalities. Younger generations often help older migrants to navigate bureaucratic legal and administrative systems and develop health, welfare and legal literacies to claim their rights (Capstick, 2016a; Simpson, 2019). Children may undertake 'language-brokering', interpreting for parents and older generations in confidential health, social care and legal settings. Such care may be crucial in helping families to integrate, but may also impact on children's wellbeing (García-Sánchez, 2018). It may lead to shifts in power dynamics within families and undermine parenting practices.

While multilingualism can be a tremendous resource in transnational family communication (Capstick, 2020), literacy acquisition may be challenging for adult migrants who did not attend school. Furthermore, knowledge is required to navigate not just a new language, but specialised discourses in health, welfare or legal settings (Simpson, 2020; Capstick, 2020). Language education is regarded as a key tool of 'integration' within European countries. Yet provision is often patchy and/or inadequate to meet the needs of learners and may be inaccessible for a range of reasons (Simpson and Hunger, 2023), which this study seeks to explore.

Our intersectional approach (Raghuram, 2019; Hankivsky, 2014) to analysing inequalities focuses primarily on gender, age and generation, language, legal and socio-economic status and how these inflect each other.

Concluding points

This section has given an overview of key themes relevant to the research context: ageing populations in European societies, international migration and the impact of COVID-19 pandemic. It has also highlighted the key concepts of transnational families, care, wellbeing, multilingualism and intersecting inequalities that guide our study. The next section outlines our methodological approach.

3 Methodology

This section gives an overview of the methodological approach used in this project and describes the research locations and characteristics of the sample in the four study countries. The approach to data analysis and dissemination are also outlined, alongside ethical considerations.

Methodological approach

This project adopted a multi-sited, family-focused ethnographic and participatory action research methodology (Kindon et al., 2007), which was most appropriate to explore the complexity of care, inequalities and wellbeing in transnational families. We recognise that definitions of family vary cross-culturally. Our approach, underpinned by an ethics of care perspective that recognises the interdependence of human relations (Tronto, 2003), was led by how participants 'do family', in terms of relationships of care and support, rather than using an essentialist definition. This approach was better able to accommodate a diversity of family forms (Adler and Lenz, 2023).

Community members from migrant backgrounds were invited to participate as peer research assistants/ community researchers to shape the design, data collection, analysis, co-production of outputs and dissemination. Working closely with partner organisations supporting migrants and refugees, peer researchers with appropriate language proficiencies were trained in research methods and ethical considerations. This can be an effective way to gain insights into migrants' lives and enabled trust to be built, which is particularly important when working with migrant communities who may have insecure legal status or limited proficiencies in the dominant language.

Peer/ community researchers and investigators used semi-structured interviews and participatory methods to engage children and adults with varying levels of education, 'expert' language proficiencies and literacy, including participatory diagramming and visual methods (circles of care, diaries, drawings, photographs, video). Activities mapped existing caring relationships and support networks.

We also engaged with a smaller sample of case study families through in-depth ethnographic approaches. Life history interviews, 'go-along' informal conversations, participant observation and participatory visual methods (documentary filming in France) were used flexibly with families, individually or in groups. This included family members residing in other countries, using online/telephone interviews or face-to face interviews/activities in those countries where possible. Life history interviews enabled family members to reflect on their trajectories over time, including past migration journeys, moments of change and transition, mobility strategies and imagined futures.

Research locations and characteristics of the sample

This project explores similarities and differences in migrant transnational families' experiences within four study countries with contrasting welfare models, migration regimes and post-colonial legacies. In each country, we focused on two contrasting cities/ towns and regions with diverse migrant populations and different landscapes of service provision (see Table 1).

Table 1: Research locations in each country

Town/ City and Region	France	Spain	Sweden	UK
1.	Marseille, major port city in South-East France	Madrid, capital city	Malmö, major port city in Southern Sweden	Reading, large town and surrounding area in Berkshire, South-East of England
2.	Small towns in South-East France, Region Sud (Rhône Valley, South Alps)	A Coruña and other towns in Galicia, northwest Spain	Small municipalities in rural Scania, Southern Sweden	Leeds and Manchester, major cities in North of England

Across the different research locations, we selected a sample of 122 transnational families (UK: 25, Sweden: 40, Spain: 23, France: 29 families). This gave a total of 319 family participants in the large sample of different ethnicities and varying legal status to compare experiences at urban and rural scales, and between countries.

In most families, we engaged with two or three different generations comprising both genders and including, when possible, at least one member residing in a country of origin or third country (using mainly online videocalls or calls) (see Table 2). Families were recruited with a range of care needs, including care of children and older relatives, as well as specific care needs related to chronic ill health and disability. Aside from countries of origin, many participant families had extended transnational family networks that included several other countries.

Table 2: Characteristics of large sample of transnational families across the four study countries

Study country	Breakdown of transnational families interviewed in large sample according to generation and gender	Type of migration	Countries of origin	Care needs within family
France	**29 families** Younger generation: Children (aged 6-17): 8 Male: 1 Female: 7 Young people (aged 18-24): 19 Male: 3 Female: 16 Middle generation (aged 25-59): 33 Male: 9 Female: 24 Older generation (aged 60-94): 17 Male: 4 Female: 13 Total interviewees in large family sample: 77	Economic migration, asylum seekers and refugees	• Afghanistan • Albania • Argentina • Armenia • Brazil • Cape Verde • Colombia • Cuba • Iraq • Russia • Syria • Turkey • Ukraine	Middle generation family member with specific care needs (related to disability/ chronic illness): 3 families Child with specific care needs: 1 family Older generation with care needs: 7 families Everyday care needs related to young or old age: 13 families
Spain	**28 families** Younger generation: Children (aged 6-17): 9 Male: 3 Female: 6 Young people (aged 18-24): 6 Male: 1 Female: 5 Middle generation (aged 25-59): 65 Male: 20 Female: 45 Older generation (aged 60-94): 14 Male: 2 Female: 12 Total interviewees in large family sample: 94	Economic migration	• Morocco • Senegal • Brazil • Bolivia • Colombia • Cuba • Honduras • Philippines • Peru • Venezuela	Middle generation family member with specific care needs (related to disability/ chronic illness): 11 families Child with specific care needs: 1 family Older generation with care needs: 22 families Everyday care needs related to young or old age: 25 families

Study country	Breakdown of transnational families interviewed in large sample according to generation and gender	Type of migration	Countries of origin	Care needs within family
Sweden	**40 families** Younger generation: Children (aged 6-17): 9 Male: 6 Female: 3 Young people (aged 18-24): 9 Male: 1 Female: 8 Middle generation (aged 25-59): 41 Male: 16 Female: 25 Older generation (aged 60 and over): 8 Male: 4 Female: 4 Total interviewees in large family sample: 67	Forced migration background (seeking/ received asylum; family reunification; resettlement)	• Syria • Iraq • Afghanistan • Iran • Sudan • Lebanon • Palestine • Tajikistan	Middle generation family member with specific care needs (related to disability/ chronic illness): 14 families Child with specific care needs: 8 families Older generation with care needs: 7 families Everyday care needs related to young or old age: 13 families
UK	**25 families** Younger generation: Children (aged 6-17): 17 Male: 4 Female: 13 Young people (aged 18-24): 4 Male: 3 Female: 1 Middle generation (aged 25-59): 47 Male: 14 Female: 33 Older generation (aged 60-94): 12 Male: 1 Female: 11 Total interviewees in large family sample: 81	Range of migration backgrounds (13 migrated as refugees; others: marriage and family reunification, economic migrants	• Sudan • Syria • Eritrea • Hong Kong • India • Nepal • Ecuador • Bolivia • China • Zimbabwe • Uganda • Tunisia • Algeria • Morocco	Middle generation family member with specific care needs (related to disability/ chronic illness): 11 families Child with specific care needs: 7 families Older generation with care needs: 2 families Everyday care needs related to young or old age: 5 families

We also selected 20 case study families across the four countries (5 in France, 6 in Spain, 4 in Sweden, 5 in the UK) for in-depth research employing ethnographic approaches. This included family members residing in other countries, using online/telephone interviews or face-to face interviews/activities in those countries where possible. Ethnographic research was undertaken by the France team in one origin context in Colombia (Medellín and Bogotá) where 12 participants from five families were interviewed. These families had a matched sample with two families in France and three families in Spain (interviewed by the Spanish team). Interviews were also conducted in Sweden with one family from the UK who moved back to the UK during the study due to their child's care needs and a follow-up interview was conducted by the UK team.

We conducted semi-structured interviews with a total of 44 practitioners and policymakers working with migrant families in health and social care, education, integration, language learning, the voluntary and community sector to explore their perspectives (see Table 3 below for breakdown).

Table 3: Number of policymakers and practitioners interviewed across the four study countries

	France	Spain	Sweden	UK
Number of interviewees according to sector	Public sector and authorities: 5 Third sector organisations supporting refugees and migrants: 5	Regional and local authorities: 2 Third sector organisations: 4 National policymakers: 2	Regional and local authorities: 3 Third sector organisations: 5	Public sector and local authorities: 7 Third sector organisations: 8 National policymakers: 2 Private sector hotel accommodation for asylum-seekers: 1
Total number of policy and practice interviews	10	8	8	18

Ethical considerations

The research conforms to the ethical protocols of the national funding organisations (UKRI-ESRC, ANR, AEI and Forte) and Association of Social Anthropologists of the UK and the Commonwealth. Ethical approval for the project was granted by the research ethics committee of the University of Reading, Aix Marseille University, the Swedish Ethical Review Authority and University of A Coruña before fieldwork commenced. Ethical considerations of rights to informed consent, anonymity, confidentiality, safety and security of the participants, peer and academic researchers, data protection, storage and dissemination, were of paramount importance throughout the research process. Pseudonyms and details of participants have been anonymised throughout this report to protect their identities.

Informed consent was secured through providing participants with accessible information leaflets in appropriate languages, including plans for data storage and archiving. Audio-recorded verbal consent was obtained from all participants at the start of each activity and written consent was obtained from professionals and parents/guardians of children aged under 16 who participated. Written consent was specifically sought for use of any video material that identifies participants. Safeguarding and ethical protocols were discussed with partner organisations and peer researchers during preparatory training workshops. When negotiating consent, the limits of confidentiality was made clear to participants if safeguarding concerns relating to children/vulnerable adults were raised. Peer and academic researchers were supported by research supervisors through discussion of distressing conversations or family situations, with counselling provision available for participants and/or researchers if required in some contexts.

Data analysis and dissemination

Audio-recorded interviews/discussions were transcribed and translated where needed into English (UK and Sweden), Swedish, Spanish and French. A thematic (Limb and Dwyer, 2001) and narrative (De Fina and Georgakopoulou, 2012) analysis framework was developed. In the UK, the large sample of family transcripts were analysed thematically using analytic relational templates and policy and practice interviews were coded using Nvivo qualitative analysis software. Similarly, in Sweden, the interview transcripts of the large sample were analysed using analytic relational templates. The transcripts of practitioners' interviews were analysed thematically. Data collected in France linked to family transcripts and policy and practice interviews were analysed thematically. In Spain, the large sample of family transcripts were analysed using a lifecycle perspective, and crossing migratory, labour and political trajectories "here and there". The interviews with policy makers and third sector organisation were transcribed and thematically analysed.

Although the coding framework, thematic and narrative analyses differed slightly in each country, they were linked to the research questions, topic guides and common themes discussed in interviews, enabling us to read across the data and identify overarching themes. A range of ethnographic data was gathered, including interviews and observations with multiple family members and members of personal support networks, a partially matched sample in France, Spain and Colombia, and in Sweden and the UK, and institutional ethnographies in the UK. The data were analysed thematically, guided by the overarching themes and research questions of the study.

Participatory approaches to data analysis and dissemination provide opportunities for marginalised groups to prioritise findings and engage in policy dialogue (Evans, 2017). A series of participatory workshops and/or community screenings were held with families, community researchers, policymakers and practitioners in the UK, Spain, Sweden and France. Workshops used a range of creative and innovative methods to discuss key themes, rank priorities and co-produce films, photovoice collages and training materials. Outputs will be launched in regional dissemination workshops and meetings with key stakeholders to inform policy and practice and achieve sustained societal impacts.

Concluding points

Having discussed the overall multi-sited, family focused qualitative methodology and data collected, the following sections analyse the policy context of the migration and welfare regimes in the study countries, before discussing the empirical findings.

4 Contrasting welfare and migration regimes

This section analyses the contrasting welfare and migration regimes in the four study countries to provide an overview of the policy context within which transnational family lives are situated at local, national and transnational levels.

Welfare and migration regimes in France, Spain, Sweden and UK

The four settlement countries in our research (France, Spain, Sweden and the UK) were selected due to contrasting welfare/care and migration regimes which incorporate the social rights of resident non-citizens and their families to a varying extent. Each combination of regimes results in different challenges and outcomes for transnational families in these contrasting national contexts, particularly if they have family members with specific care needs. Comparing the MIPEX[4] score of the four project countries starts to provide a general indication of their approach to immigration and to the promotion of social rights for migrants and their families. According to this index, in 2019, France (56/100) and the UK scored the lowest (56/100), followed closely by Spain (60/100), and Sweden scored highest (86/100)[5] (MIPEX, 2020).

In addition, the four project countries have contrasting migration histories, with France, Sweden and the UK regarded as 'old' countries of immigration, while Spain is considered a relatively 'new' destination country (Haas et al., 2020). Post-colonial legacies in the UK, France and Spain have permeated immigration and immigrant policies, with differential treatment for particular national groups from former colonies, both in terms of migration routes and naturalisation or humanitarian reception policies (cf. Heimbach-Steins, 2014; Kinnvall, 2016). Although for different time periods and to different extents, across the four countries, immigration and immigrant policies have tended to become increasingly selective and restrictive in terms of who is allowed to enter and under what conditions, i.e. undermining asylum and in France, Spain and the UK, limiting social rights (McAuliffe and Oucho, 2024).

Figure 1 maps the key policy areas that shape the social rights of migrants and their families and make up the intersection of welfare and migration regimes in any particular national context, while also acknowledging transnational social protection. In the case of the four study countries, in terms of welfare, France represents the Corporatist/Continental model, based mainly on social insurance; Spain, the Familistic/Mediterranean model, with limited social security and family or community orientated; the UK, the Liberal/Anglo-Saxon model with lower levels of state intervention and reliance on market forces; and Sweden, the Social Democratic/Scandinavian model, characterised by universal benefits at more generous levels (Martinelli et al., 2017)[6]. These systems are linked to the migration regimes in each country through the varying entitlements to accessing social benefits and services attached to different migrant visas or entry categories (Sainsbury, 2006; 2012). In the case of families, family reunification rules, as part of immigration policies, differ across the four countries.

4 The Migrant Integration Policy Index (MIPEX) is a tool which evaluates and compares what governments in 56 countries around the world are doing to promote the integration of migrants. It measures a set of indicators related to policies involved in the social inclusion of migrants such as family reunion, health, education, labour market mobility, anti-discrimination, political participation, permanent residence and access to nationality (Solano and Huddleston, 2020).

5 Of all the Nordic countries, Sweden (86/100) and Finland (85/100) are the only ones among the top ten highest scoring countries – with Sweden being the highest among all the countries included in 2019, thus with a more comprehensive approach to migrant integration, which tries to guarantee equal rights, opportunities and security for immigrants and citizens (Solano and Huddleston, 2020).

6 These models have received a great deal of criticism from social policy specialists, and have changed significantly over recent decades, but they remain useful in providing an overall indication of the systems' original configurations and approaches (Martinelli et al., 2017).

Spain has a more 'generous' overall approach which provides the opportunity to reunify with the older generation (over 65 years of age) aside from partners/spouses and children under 18, which is the case for the other countries[7] (UK Government, 2024; Office Français de l'Immigration et de l'Intégration, 2024; Ministerio de Asuntos Exteriores, Union Europea y Cooperacion, 2024; Migrationsverket, 2024).

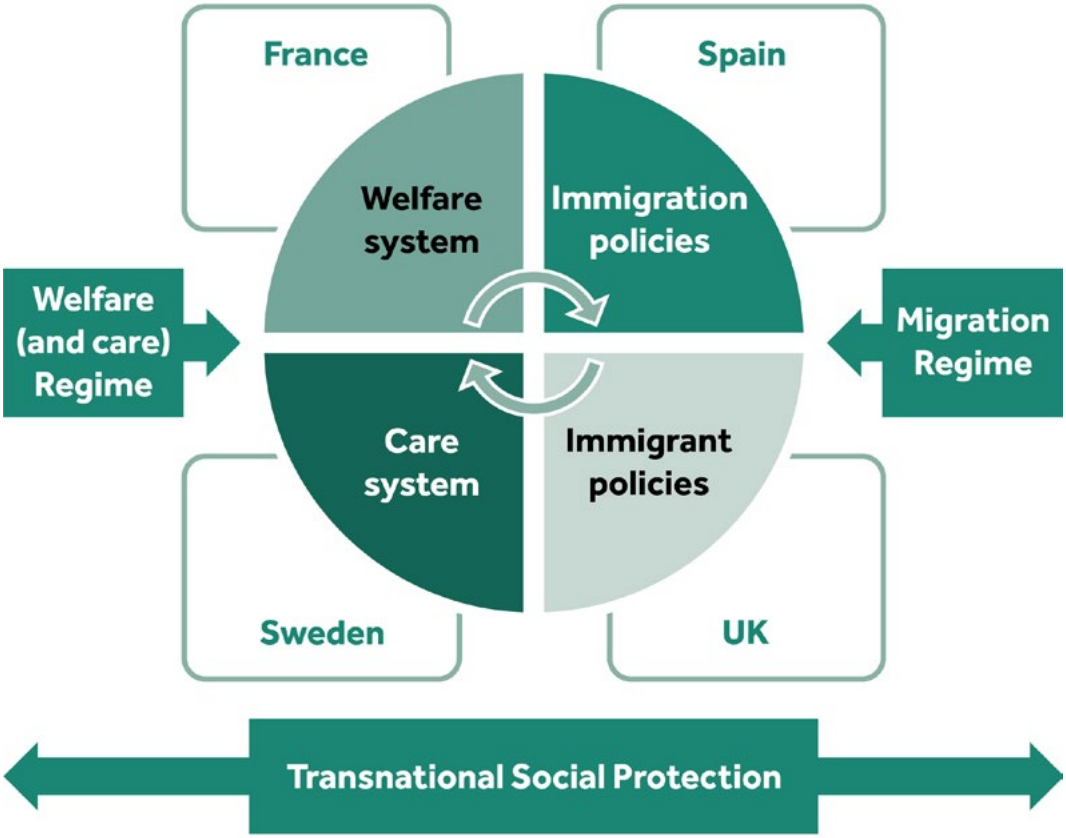

Figure 1: Contrasting welfare and migration regimes in France, Spain, Sweden and the UK (Sainsbury, 2006, 2012; Levitt et al., 2017; Martinelli et al., 2017)

The four study countries also have contrasting care regimes, with migrant women playing key roles in the care sectors – in France, Sweden, the UK, predominantly as employees of long-term residential care and health, while in Spain, immigration policies have favoured the entry of migrant women to meet the growing demand of care both in formal and informal settings (Bettio and Plantenga, 2004; Bettio et al., 2006). These different care regimes also mediate the opportunities that transnational families with care needs have to access state support/services in each country due to different levels of service provision, 'ethnic-sensitive' social services such as language interpretation, and entitlements (e.g. Mas Giralt and Sarlo, 2017).

In addition to the four national policy contexts discussed in more detail below, research has increasingly highlighted the importance of acknowledging the transnational nature of migrants' and their families' social protection strategies and provision. This may include, for instance, how different nation-states might provide for a population on the move, for example, through policies that may cater to migrant citizens residing in other countries or through multi-lateral policy agreements (e.g. Levitt et al., 2023). More attention has been paid, however, to how migrants and their families may piece together a package of social protection from more than one nation-state and from different actors – the State, the market, families and communities (Levitt et al., 2017, 2023; Ryndyk et al., 2021). In our project, these types of transnational strategies, emerged as particularly relevant among transnational families in France and Spain.

7 There are also exceptional circumstances that apply to dependent children over 18 years of age who have a disability, and, for example in the UK, it is possible to apply on exceptional circumstances for older parents with care needs, but this is difficult and few cases are granted.

France

The corporatist/continental French welfare system is "both extensive and fragmented", with origins on a social security system (*sécurité sociale)* created in 1945 aiming for universal coverage, gradual generalisation of health care and old age pensions, but mainly based on contributory schemes (Isidro and Math, 2020, 165). Over time, it has transitioned towards more means-tested schemes and some 'universalisation', for example in health care, replacing the previously contribution-based schemes which tend to be more exclusionary for those with an irregular employment history or new residents (Sainsbury, 2012). Since the 2010s, austerity-oriented reforms have aimed to downsize the social welfare system, with several laws generating strong social resistance among the population (Rainhorn and Del Giudice, 2023).

After continuous residence in France for three months, anyone regardless of legal status, has a right to AME (aide médicale d'Etat), which allows free access to public health services (Service-Public, 2024; Rouland et al., 2022). This includes undocumented migrants with few financial resources. Asylum seekers have access to temporary housing while their application is being processed, and a per diem welfare support (La Cimade, 2024).

Most welfare benefits and public services, however, are only accessible to documented migrants. Social protection schemes generally apply only to the person residing in France in a sustained manner (e.g. proof of six months of residence per year), and benefits may be exported only in case of existing bilateral international agreements with other countries or EU/EEA context (Isidro and Math, 2020). For instance, migrants need to prove a five-year period of residence to access a guaranteed minimum income (RSA) or 10 years for older age pensions (ASPA). However, this does not apply to national or EU/EEA citizens, refugees and people from Algeria (due to a pre-existing agreement for equal treatment with Algeria). Non-EU children born abroad must enter France through the family reunification route to qualify for family, housing and guaranteed minimum income benefits.

The condition of regular residence mediates access to most benefits and services in France. However, the definition of regularity and the evidence or permits accepted as proof of this have varied over time and across benefits, leading to the exclusion of an increasing number of migrants and their family members (Isidro and Math, 2020). Not having the 'right' document or awaiting a new residence permit can lead to exclusion from or suspension of social benefits for many. Key issues affecting transnational families in our research were difficulties in accessing regular residence permits and frequent obstacles to renewing permits (increased by the digitalisation of procedures which tends to exclude those with limited language skills or ICT-proficiency/access). Differential entitlements between regular migrants (and among them between refugees and others as well as between EU/EEA/Ukrainian and non-EU/EEA citizens) and irregular migrants, lead to a great deal of variability in accessing most benefits, resulting in increased inequalities.

Spain

In Spain, as in other southern European countries, the welfare regime has been defined as 'familiarised' due to the family's central role as the principal provider of assistance and care (Saraceno, 2016). This regime is articulated through a migration model that favours the influx of migrant women, who are employed by the private market to meet the growing demand for care resulting from inadequate public social provisions (Bettio et al., 2006). However, the most vulnerable sectors of the population, unable to pay market rates for care, require the solidarity of kinship and personal networks to secure social protection. This informal transfer of welfare is particularly relevant for the immigrant population, given the difficulties migrants encounter when accessing public services and benefits, which, in the case of Spain, is subject to employment stability and residence status (Van Ginneken, 2013).

Nevertheless, the family and community "reserve" that migrant families can fall back on is smaller than that of the local population, forcing them to resort to alternative strategies of a transnational nature. Research has shown how in systematic periods of crisis, spatial mobility is one of the principal means used by the immigrant population to solve their needs for social protection (Cabezón-Fernández and Oso, 2022). Regrouping, new migrations or return have proved essential in tackling situations of social exclusion and the need for care. This strategy has proved to be especially relevant among Latin American immigrants as Spanish migration policies were developed in a context of post-colonial relations with less restrictive visa regulations and citizenship requirements for this population (who are entitled to Spanish citizenship after two years of legal residence in the country, in contrast to 10 years for people from other regions).

The Spanish welfare system covers national citizens and regularised migrants. Migrants can access social protection schemes through two different types of entitlements, either by participating in the formal labour market or through residence in the Spanish territory (based on being registered with municipalities and other eligibility criteria) (Moreno-Fuentes, 2020). However, as we found in our project, many migrants, even if in a regularised status, are employed in the informal economy, which effectively excludes them from accessing contributory schemes. Overall, undocumented migrants are generally excluded from state social protection[8]. In 2013, the then Conservative government of Mariano Rajoy banned irregular migrants from accessing (universal) public healthcare services (except for emergency treatment or infectious disease, and pregnancy). This ban was, in principle, overturned by a Royal Decree passed in 2018 by the incoming social-democratic government (Moreno-Fuentes, 2020); however, in practice, migrants in irregular situations have continued to be barred from accessing healthcare, even in cases of chronic and serious chronic conditions, and required to pay for any medical services they receive. Undocumented migrant children and adolescents under the age of 18, however, are an exception, as they have the same social rights as citizens and regular migrants. They can be enrolled in school (education is compulsory until the age of 16) and access public healthcare. Asylum seekers are guaranteed access to social protection while their application is being considered; they are provided with legal assistance, healthcare and a structured reception programme[9] (European Council on Refugees and Exiles, 2024). However, there have been serious concerns about the shortcomings and delays which affect the functioning of this reception system (Defensor del Pueblo, 2023, p. 53).

Sweden

Sweden, like other Nordic countries, is characterised by *universal* welfare systems (social democratic model) which seeks to ensure that all citizens and regularised residents have access "to the same (high) quality public services, independently of origin, gender, income or place" (Martinelli, 2017, 33). In this model, the state is the main provider of welfare, health and social services, including a public model of childcare for preschool children (Rummery et al., 2021), coupled with comprehensive parental leave provision to enable both parents to share care responsibilities and paid work (Arnalds and Duvander, 2023). In principle, all labour or humanitarian migrants with a residence permit in Sweden (temporary or permanent) have a right to work, social welfare and healthcare as well as childcare and schooling of children.

8 The decentralised character of the Spanish welfare system, where autonomous regional governments and municipal authorities are responsible for running a range of social services and social protection schemes, results in territorial differentiation on approaches to irregular migrants' access to social protection across the country (Moreno-Fuentes, 2020).

9 To be able to access these rights fully, applicants need to be included in the official asylum reception places; if they find independent accommodation, they have no guaranteed access to financial support, or the assistance provided in reception centres (European Council on Refugees and Exiles, 2024).

Undocumented children under the age of 18 are entitled to the same rights as children with documented residence status, such as the right to schooling and healthcare. Adult undocumented migrants have the right to basic care, that is, health and dental care "that cannot be postponed" (e.g. emergency treatment, maternity care, abortion, contraceptive counselling) (Region Skåne, 2024).

For a long time, Sweden has prided itself on its liberal *asylum policies* (Valenta and Bunar, 2010). However, after 2015/16, when the country registered some of the largest numbers of asylum seekers (per capita) in Europe (Kleres, 2018), its approach shifted. Like many other European countries, Sweden joined 'the race to the bottom' by restricting its asylum policies (Hagelund, 2020). Having formerly granted permanent residence permits to most of those recognised as refugees, in 2016, Sweden began issuing temporary residency to all those granted different forms of humanitarian protection (Migration Agency, 2020). Those granted refugee status are now allowed to live and work in Sweden for three years, while those with subsidiary protection status receive a 13-month residence and work permit (Migrationsverket, 2023). To obtain permanent residence, refugees and others with subsidiary protection need to meet three criteria: a regular income, full-time employment or fixed-term employment of at least 18 months, and an income threshold which covers the individual's accommodation costs and the so-called 'normal amount for a single adult', which is a standard calculation of ordinary living expenses (Jansson, 2024, p.3094).

The fusion of immigration policy and integration requirements is increasingly evident in other areas of the Swedish immigration policy too. Stricter self-sufficiency and maintenance requirements have also been introduced for those applying for family reunification (Hagelund, 2020). People who have been granted refugee protection and resettled refugees are allowed to bring their family members to Sweden if they apply for family reunification within three months of arrival. All other protection categories need to fulfil the criteria regarding employment and accommodation. A similar emphasis on 'integration outcomes' can also be noted in the Swedish resettlement programme. This programme has for a long time been characterised by a relatively high resettlement quota, a general focus on vulnerable refugee groups, and the absence of additional requirements. However, in 2022, Sweden introduced significant policy changes in this area including, among others, a criterium for 'integration prospects'. Accordingly, the Swedish Migration Agency now is able to assess education, work experience and enterprise skills of individuals applying for resettlement, along with information about their values which considered relevant for 'integration' into Swedish society. This means that, while resettlement had initially been conceived as an exclusively humanitarian endeavour, the vulnerability criteria for selection now have to be weighed against the integration requirements. This is likely to make it difficult for individuals in protracted refugee situations to qualify for selection (Suter and Ekstedt, 2023).

Individuals with residence permits based on international protection (including resettled and other refugees and recognised humanitarian migrants) are entitled to participate in a two-year 'Establishment Programme' (*etableringsprogrammet*) which is the core refugee *integration system* in Sweden. The responsibility for the implementation of this programme falls on the Swedish public employment services (PES) (*Arbetsförmedlingen*). The programme encompasses civic orientation and language courses, as well as specific measures targeting refugees' labour market participation. The labour market integration measures consist primarily of employment guidance by PES case officers who, based on the refugees' occupational backgrounds and aspirations, create an individual establishment plan, and assist them in validating their qualifications and finding internships and jobs. Since women are strongly encouraged to participate in the Swedish labour market (Martinelli, 2017, p.22), the establishment programme also seeks to address this particular group of refugees and support them in their access to paid employment.

UK

The welfare system in the UK (Liberal or Anglo-Saxon model) is characterised by a weaker role of the state, reliance on the market, and a lesser contributory approach than other European countries. Thus, it is more based on means-testing and flat-rate subsistence benefits (e.g. Deeming, 2020). As entitlement to most benefits and healthcare is determined only by residence and need, migrants have for long been perceived as a strain on the welfare or health systems despite a lack of evidence to support this (Avdagic and Savage, 2021). Over time, a series of policy changes have been introduced to control and manage immigration, and welfare has been central to these changes. Alongside this, residence periods to qualify for settlement status and naturalisation have gradually been extended, currently normally requiring five years' legal residence (Home Office, 2024).

Overall, access and entitlement to the welfare state for British citizens and settled residents differ in varying degrees from the entitlements of nationals from the European Economic Area (EEA/EU), and non-EEA migrants, refugees, asylum seekers, irregular migrants[10], or those on work or student visas, among others. Asylum seekers are excluded from mainstream welfare and generally not allowed to work (Gower, 2024). Instead, if destitute, they can apply for accommodation (but have no choice on where to be housed) and minimal financial assistance, known as 'asylum support'; in principle, they can also access healthcare and compulsory education for children (aged up to 18). For other migrants, many visas are conditioned with a No Recourse to Public Funds (NRPF) restricting access to welfare benefits and essentially creating "a mosaic of differentiated rights for newcomers in the UK" (Mas Giralt and Sarlo, 2017, p. 326). Such a web of differentiated and intertwining policy mechanisms and welfare entitlements makes the welfare and policy scenario a complex one, not only from the level of policy but also for frontline staff as well as for those accessing the welfare system. Furthermore, the restrictive immigration legislations and welfare measures adopted over time have effectively created a "hostile environment" for migrants and asylum seekers. Hostile conditions are designed with the principle of welfare deterrence in which stigmatization, destitution, and control of movement remain core to the design (Mills and Klein, 2021).

Historically, these changes have mainly been responses to (perceived) increments in the number of arrivals of migrants and/or asylum seekers. Since 2010, policy changes aimed at reducing net migration have also been applied to British citizens and settled residents seeking to bring a partner and/or children to the UK. Language and minimum income requirements were introduced in 2012 and the income threshold increased significantly by the Conservative Government in 2023. In July 2024, the new elected Labour Government announced that the minimum income threshold would be kept at £29,000 while a review of this requirement was undertaken (Jorgensen, 2024). Policies on family migration such as the introduction of a minimum income threshold to sponsor spouses' migration are aimed at not only restricting the number of family migrants but also to reduce the likelihood of the new entrants' reliance on welfare benefits (Vargas-Silva et al., 2016).

10 Those in irregular situations are commonly excluded from all mainstream welfare and can only access basic compulsory education and emergency healthcare.

The UK humanitarian reception system has become increasingly fragmented and undermined. Since 2004, there has been a focus on resettling small numbers of vulnerable refugee children or families, or particular national groups at risk, either through United Nations High Commission for Refugees (UNHCR)[11] or through specific schemes such as, from 2022, the Afghan Citizens Resettlement Scheme[12], or Ukrainian schemes (Refugee Council, 2024). A specific visa pathway was also introduced for Hong Kong British Nationals (Overseas) citizens (BNOs) and their close family members to come to the UK (Walsh, 2021). Resettled refugees (as well as BNOs) have access to specific tailored support in arrival to the UK, including access to the job market, education, healthcare and mainstream services (Refugee Council, 2024). However, as we have found in the present project, resettlement experiences can vary for those who have specific care needs and depending on the geographical area where they are settled.

In contrast to resettlement schemes, those trying to reach the UK to claim asylum are faced with a lack of safe entry routes, a situation which has led to increasing numbers of perilous 'Channel crossings' in small boats and border related deaths (Refugee Council, 2023). Despite evidence that most of those who have arrived through 'channel crossings' are granted asylum (for example, in 2022, two-thirds of arrivals), and as many as half may be trying to join family members in the UK (Morris and Qureshi, 2022), the UK government has so far failed to provide safe routes and address issues and backlogs in family reunion.

Concluding points

This section has analysed the contrasting welfare and migration regimes across the four study countries to provide an overview of the policy contexts that mediated the experiences of the transnational families that participated in the research. Through this analysis, restrictions to accessing welfare and services emerge as an extension of migration control, particularly in the cases of France, Spain and the UK. Across the four countries, long-term settlement and 'integration' are undermined for both labour and humanitarian migrants due to the need to meet income or other requirements, and/or limitations of social rights. Concluding points – change:

For families, especially those with specific care needs, restrictive family reunion and family visit visa policies, particularly in France, Sweden and the UK, jeopardise intergenerational care and reciprocity, undermining the wellbeing of family members both locally and transnationally.

11 Numbers of resettled refugees via UNHCR are currently 75% lower and refugee family reunion visas are 36% down from pre-COVID-19 levels in 2019 (Refugee Council, 2023).

12 Rights to family reunion were not originally included in the Afghan Citizens Resettlement Scheme (ACRS) (2022-2024) that evacuated Afghans to the UK in August 2021 in response to the crisis in Afghanistan. However, the newly elected Labour government announced in July 2024 that ACRS would be expanded to enable family reunion for some Afghans who were resettled under Pathway 1 (Separated Families Pathway) of the scheme (Refugee Council, 2024).

5 Intersecting inequalities

This section analyses how intersecting inequalities influence the opportunities and access to social protection of different generations of carers and relatives in transnational families in France, Spain, Sweden and the UK. We focus on the most prominent inequalities evident among interviewees, that is, legal and socio-economic status, gender and generational position.

Legal status

Legal status importantly influences families' access to social protection and opportunities. It shapes caring arrangements both locally and transnationally, especially in families with significant caring needs and obligations, such as those affected by disability and chronic illness.

Undocumented migrants are excluded from access to welfare entitlements and face the greatest vulnerabilities and inequalities with respect to other migrants. Findings from Sweden show that even when undocumented migrants have access to emergency healthcare services, such protection does not extend to regular healthcare, with severe repercussions for families, especially those with high care needs. This is also the case in the UK, where undocumented migrants but also migrants with visas conditional to No Recourse to Public Funds (NRPF) are not able to claim most benefits, tax credits or housing assistance. Findings from Spain show that individuals' legal status may differ within families due to acquiring legal status at different time points (for example, through the reunification of extended family members with caring responsibilities). This can create dependent relationships and power inequalities within families.

As noted in Section 4, in the UK, asylum seekers are placed outside of the general welfare system and are generally not allowed to work. Their social rights are limited to free healthcare and education for children, a very limited cash allowance and accommodation provided through the National Asylum Support Service, which may disperse families to other towns or cities at short notice. Alongside other migrants in the UK, asylum-seekers face hardships in relation to family caregiving, linked to difficulties in seeking family reunification and obtaining family visas for visits and an inability to remit financial resources to family members. This results in women and children having to take on a higher level of caring responsibilities, especially if there are young children or disabled siblings in the family.

Differential treatment of migrants according to their nationality are observable across all the study countries. In Spain, naturalisation processes are different depending on the country of origin, reflecting a colonial migratory regime. While Latin Americans have to wait two years until they can obtain permanent residence to naturalise and can have dual citizenship, Moroccan and Senegalese migrants face significant inequalities; naturalisation requires 10 years of permanent residence and having to renounce citizenship to their origin country, which implies losing political rights. Post-colonial ties with a previous destination country may also influence the situation of onward migrants in France, as shown by the case of Latin Americans and Cape Verdeans, with respectively Spanish and Portuguese citizenship, who have full access to social rights in France. This generates inequalities within families, when some family members migrated directly to France.

Even when migrants have citizenship rights and therefore mobility rights to travel, findings from the UK show that transnational family members may experience restrictive immigration policies that result in immobility, with migrants unable to secure family reunion or even temporary visas for family members to provide care. For example, Nayasha (aged 49), a mother from Uganda, had been living in the UK for 19 years and had British citizenship. She cared for her sister who had a chronic illness and lived nearby in the UK. The family tried to apply for a family visa for a niece or aunt to come to care for her in the UK, but this was refused. This led to the sister's two school-age daughters becoming young carers for their mother.

Differential treatment of migrants is also linked to employment and socio-economic status, affecting, for example, migrants working in informal employment and women with caring responsibilities. For those on income support and universal credit (unemployment benefits), the allowed periods of absence from the UK for holidays are too short to allow those with caring responsibilities either in the UK or elsewhere to travel to countries of origin and lead to penalties if exceeded. For example, Semhar (56 years of age, who had a chronic illness) from Eritrea went to visit her daughter and new-born grandchild in the Netherlands, after not seeing her for six years. Having exceeded 14 days leave, she was sanctioned, and excluded for several months from receiving disability-related benefits.

The increased stratification of rights related to specific conflict/forced migration situations is observable across all the study countries in recent years, leading to unequal access to entitlements to regularisation and welfare. This can be seen in the UK in relation to particular resettlement schemes for Syrians and Afghans and the Hong Kong British National (Overseas) visa scheme. A particularly prominent example in France is that of Ukrainians fleeing the war in their country since 2022, resulting in institutionally-driven inequalities with respect even to their co-nationals, who migrated during other time-periods (such as the previous conflict-driven migration from 2014 onwards). In Spain, other migrants, especially those who are still undocumented after several years in Europe, including forced migrants from Albania and Turkey, felt a sense of discrimination and resentment for such unequal treatment and difficult conditions, sometimes perceiving it as a form of institutional racism. In the UK, such a stratified humanitarian regime, Brexit and the wider 'hostile environment' fostered by immigration and immigrant policies and political and media discourses led to an increase in negative public perceptions and hate crimes against 'migrants' and/or 'asylum seekers/ refugees' (Williams et al., 2023). Furthermore, the research from Spain suggests that racial inequalities in accessing welfare and other public services, the labour market and at school, constrain migrants' legal trajectories to regularise their situation. This especially concerns Moroccan migrants interviewed who experienced islamophobia.

Socio-economic status

Across France, Spain and the UK, access to formal support is more challenging for migrants in financially difficult situations, especially if they have been forcibly displaced and have extended family networks dispersed across several countries. This was particularly significant during the period of the COVID-19 pandemic as well as more recently with the increased cost of living both in origin and receiving countries. In Europe, as discussed in Section 4, this especially affected undocumented migrants and those working in informal sectors, who are excluded from state support. A precarious situation in economic and legal terms affects caring arrangements and related inequalities (e.g. ensuring family income, being able to travel to the origin country). As for Lena from Armenia (aged 50) who had lived in Marseille with her husband for over four years and was still undocumented, commented: "*In France, if we would have the residence permit... We are hard-working people, [...] we could work peacefully and independently to achieve everything".*

Undocumented migrants are particularly exposed to social risks, with a negative impact on the wellbeing of their families, their opportunities and social mobility. In France, undocumented participants originated mostly from Albania, Armenia and Turkey and sometimes from other countries (such as Ukraine and Colombia) and remained in an undocumented and invisible situation for several years. Participants faced vulnerabilities and were confined to informal work, which also had a negative impact on their future pensions and support available during old age. As Lena (aged 50) from Armenia explained: "*My husband, for example...no, he doesn't get anything* [working contributions and state support] *here yet [...] If you work officially, of course, upon reaching a certain age, you can receive a pension or be entitled to an allowance".*

Families' socio-economic status is also shaped by transnational family members' socio-economic conditions in origin contexts in the global South, which are often characterised by fragile social protection systems that produce inequalities. As Idalina (aged 51) from Cape Verde living in Marseille argued: *"[...] hospitals there are horrible, there is no care, when you go there you have to pay, you have to bring everything back, even the food, even the doctors are not qualified enough."* Such healthcare and welfare contexts influence families' living conditions, needs and capacities to engage in caring arrangements in countries of origin and destination. In fact, this may produce a reliance on migrants' support from Europe to ensure transnational family members' diverse social protection needs are met, including income, healthcare, education, housing and care of family members.

Furthermore, migrants often face economic hardships in European countries and their caring obligations may hinders their social mobility and inequalities they face in destination contexts. As the findings from Sweden show, migrants' low socio-economic status was partly a result of their caring needs and obligations (which affected their language learning, finding a job etc.) (discussed further in Section 10). Low socio-economic status also constrains migrants' legal status in terms of being able to secure permanent residence or to the possibility of family reunification which could help to alleviate their proximate caring responsibilities. As observed in France among the few families who were more privileged in their origin country, migrants could focus mainly on the needs of their nuclear families in Europe and on their career, which improved their socio-economic situation over the lifecourse.

Alongside the socio-economic impacts of caring and legal status, transnational families are also affected by other types of disparities affecting migrants more generally, such as limited recognition of qualifications and deskilling in European contexts, inequalities in the labour market and restrictions on international mobility, as well as geographical disparities in access to services. For example, despite the provision of childcare and healthcare in rural areas of Southern Sweden, some interviewees expressed difficulties in accessing these facilities due to long distances and poor public transport connections.

Gender

Caring relationships often reproduce gender-related inequalities and hierarchies. The findings from France, Spain and the UK show how women often had more significant caring responsibilities both locally and transnationally. The findings from Sweden suggest that both men and women engage in caring, though undertake different tasks. This was also reflected in some families in the UK, particularly where there were high care needs. We adopted a gendered lens throughout the analysis of the findings and discuss gendered caring dynamics further in Section 6.

Generation

Caring relationships reproduce generational and age-related disparities, often intersecting with gender and other markers of social difference. This project adopts a generational lens and analyses the experiences and inequalities faced by the 'younger generation', comprising children and young people (aged up to 18) and young adults (aged 18-24); the 'middle generation', that is adults aged 25-60; and the 'older generation' (aged 60 and over).

As discussed in Section 6, across the study countries, middle generation adult migrants (often women) are significantly involved in multi-dimensional caring responsibilities with their nuclear and extended family locally or transnationally, with resulting impacts on their wellbeing and opportunities. The research from all the study countries also shows that children and young people undertake a continuum of caring responsibilities from low to high levels of support, especially where there are limited extended family networks in settlement countries (discussed in Section 7). Young caregiving may affect young people's education, wellbeing and long-term outcomes (discussed in Section 10).

Older migrants (aged 60 years and over), often face inequalities linked to language issues in the receiving contexts, which affects their social participation and opportunities and leads to greater reliance on younger and middle generation family members as language and digital brokers. Discrimination and culturally inappropriate social care and healthcare may create further inequalities for older migrants. A practitioner working in a UK Local Authority integration service commented on how older migrants' social participation may be affected by language issues: *"It's very common that the families that we work with have caring responsibilities [...] for older relatives who might not speak any English at all and might not feel comfortable being in the UK and going out and accessing things".*

Concluding points

This section has highlighted key markers of social difference (legal status, socio-economic status, gender and generation) relevant to our analysis in this research project. We have shown how they intersect to produce specific inequalities facing transnational families in particular migration and welfare contexts. Furthermore, the cumulative effects of intersecting inequalities are related to different care needs within families, but also the geographical dispersal and transnational constellation of the family network and the wider migration, care and welfare regimes discussed in Section 4. The next section analyses the particular dynamics of intergenerational care within the transnational families participating in the research.

6 Intergenerational care in transnational families

This section addresses the research question: how are 'proximate' and 'distant' caring responsibilities negotiated between different generations of transnational families in the four study countries? It discusses the gendering of care work and analyses the caring arrangements of older family members and of those with a specific disability or chronic illness both proximately and at a distance. Finally, we explore the intersection of transnational family care and im/mobilities.

Gendering of care work

As noted in the previous section, strongly gendered constructions of care were evident in many families in all four countries, associating practical, proximate caregiving and domestic work with 'women's work'. Such constructions of care were particularly evident among women interviewed in the UK in families from Sudan, Eritrea, Uganda, Syria and Morocco. The research in Sweden and the UK indicates, however, that men are involved in proximate care work, although the caring tasks they are responsible for may differ from those of women. In the UK and Sweden, some men became primary carers for their wife with a disability or chronic illness or helped share caring responsibilities or provide other support for their wives who were caring for disabled children, and boys and young men in Sweden and the UK also had caring roles within the family (discussed in Section 7).

In addition to undertaking proximate caring roles, the research in Spain among Colombian and Brazilian families and in France with families from Colombia, Cuba and Ukraine and in a few cases in the UK, suggests that women are sometimes also the main income earner supporting families, which challenges conventional constructions of masculine 'breadwinning' roles. Such breadwinning roles are often undertaken by women both locally and transnationally, in addition to providing practical proximate care and domestic work.

In some cases, patriarchal values are reproduced across borders; older generation men were still the 'decision-makers' and arbiters of family roles, responsibilities and disputes, as the findings in the UK reveal. Furthermore, in some cases, migrant women have to provide care in the origin country, sometimes against their will.

Findings from Spain show that even when middle generation women work outside the home, they do not necessarily have control of the household finances, which are mainly managed by men. Women's need to work is driven by transnational care and social protection needs. However, gender and age also intersect with families' cultural background and migration. For example, in the women-led transnational families from Brazil, Colombia and the Caribbean living in Spain, women, who assumed the role of breadwinners, appeared to have more decision-making power. They could use their income to renegotiate and delegate some of their care responsibilities and obligations to other members of the family *here* and *there*.

When migrants need help to care for their children, such as single mothers without a family network in the receiving country, or sometimes when they need care themselves when they are sick, their own (older) mothers sometimes move for a period to France or Spain to provide care. Nevertheless, their situations were marked by inequalities linked to their socio-economic status and legal status/nationality.

The research in France also highlights families' difficulties affording childcare and a cultural preference for kin to care for young children, which could mean sending a child to be cared for by a grandmother or other female relative in their country of origin. Isidora (aged 17) from a Colombian family living in France commented:

> *"When I was younger, [in] my family, [it] is very frowned upon leaving children with babysitters [...] when I was 6-7 months old, my mother said: 'Let's see, she's a baby, I can't leave her with a stranger, I prefer her to be with my mother', so she sent me to Colombia with my grandmother".*

Older family members

In the UK, Sweden and France, older parents and other relatives were mainly cared for by the middle generation, and sometimes younger generation, of migrant families through proximate care when they were co-resident or they lived close by locally (usually in the same city), as well as at a distance for older parents and relatives in the country of origin or other settlement countries. In Spain, care of older parents and other relatives was predominantly provided by migrants at a distance, since older family members usually remained in countries of origin. Care at a distance for older family members involved emotional support, making arrangements for proximate care to be provided in countries of origin/ other settlement countries and sending regular financial remittances to pay for care needs.

State provision of formal care services for older people in the global South is severely limited in most of the countries of origin or some resettlement countries of families participating in our research. In Ecuador, Colombia, Bolivia, Peru, Morocco and Senegal, families who had migrated to Spain organised care for older family members through kinship networks and through private medical care due to the lack of state health and social care provision. Female family members, usually of the middle generation, who often had close blood ties to the person with care needs, were usually chosen as the main carers for older people in origin countries. Migrant family members of the middle generation usually provided financial support to sustain this caring relationship. So, sisters, sisters-in-law and sometimes nieces were involved in providing proximate care, and migrants paid for private healthcare costs, education and housing of those with care needs and of those providing proximate care. Given the lack of state welfare systems, the remittances migrants provide assemble a transnational social protection system of sorts, although this was rather fragile and subject to shocks such as the COVID-19 pandemic, changes in employment, the cost of living crisis and other economic pressures.

An example of a four generation family (see Figure 2 below) provides insight into how working class transnational families from Latin America organise caring arrangements 'here' in Spain and 'there' across borders. Fernanda and her daughter Martina are the centre of the household care system. They both care for Miguel (Fernanda´s husband), who has a severe disability, for Miguel's aunt, and for Lucy, Martina's 2-year-old daughter in Spain. Fernanda's son and Fernanda´s son-in-law, also support the provision of care, but it is Fernanda and Martina who are the main providers of proximate care in Spain. At the same time, the family send remittances to pay for the care needs of Fernanda's elderly grandmother, who lives in Colombia and has a visual impairment. Fernanda pays an informal salary to one of her sisters so that she can stay at home and care for their grandmother. Her sister is assisted by another sister and niece who are also co-resident with the grandmother.

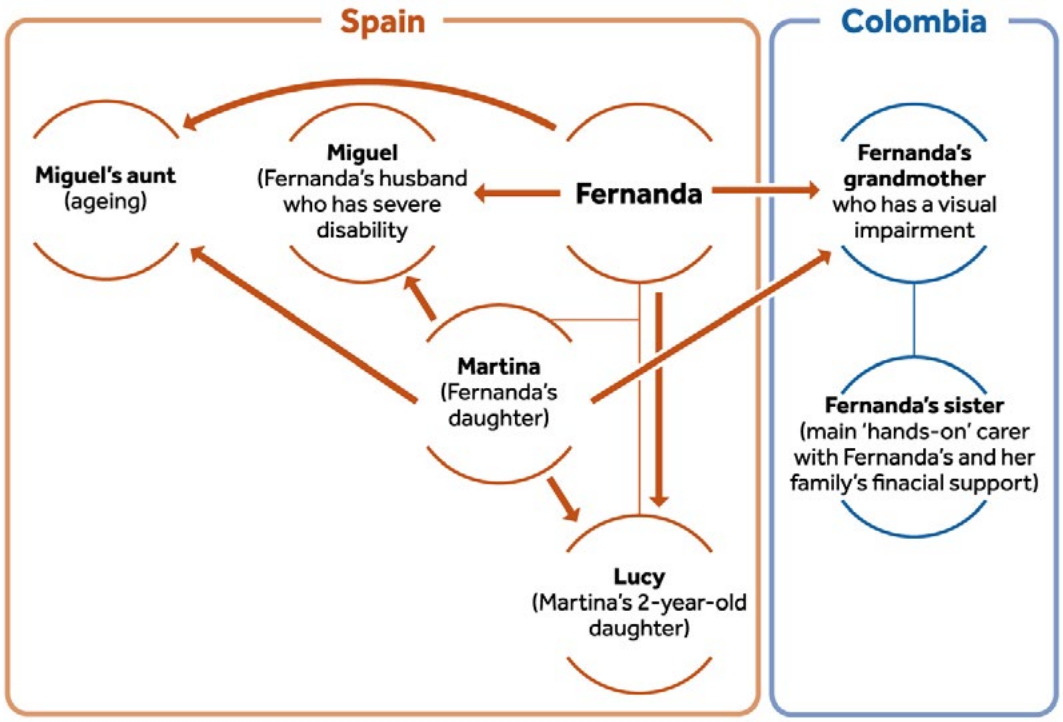

Figure 2: Diagram of Fernanda's family's transnational caring relations and mobilities across borders

Middle generation family members in the UK, France and Sweden often also provided care 'by proxy' at a distance through financial and emotional support for their siblings and other relatives to enable them to provide proximate care for their ageing parents in countries of origin or other settlement countries. Family members in the UK also provided proximate care during occasional family visits.

In a few cases in the UK, the older generation lived with or close to their adult children or had been reunited with adult children in the UK who provided care support. In one example, an Eritrean family (older parents and two adult children and their children) had been resettled in the UK from Sudan by the UN High Commission for Refugees. The grandmother had a chronic illness and was regularly cared for by her husband, daughter and grandchildren. In two other examples, adult children had been able to bring their parents to the UK to care for them. The possibility of such transnational mobility is dependent on legal status and the family's legal and administrative literacy and financial means to apply for family visas and reunification.

In a small number of families interviewed in the UK, France and Spain, the older generation provided childcare for their grandchildren while their adult children worked. They sometimes also helped with the application process for reunification to enable their extended family in their country of origin to re-join them. A four generation family living in the UK demonstrates the active role of the older generation in providing childcare, involving the circulation of care across borders. The husband and wife arranged for their parents in China to take turns to come to the UK to provide childcare for their young children to enable them to set up and manage their small business, usually staying for six month periods. The grandmother interviewed travelled to the UK with her ageing mother (great-grandmother of the children) so that she could also care for her during her stay.

Care of family members with a disability and/or chronic illness

In the UK and Sweden, the majority of families interviewed were caring for one or more family members with a disability and/or chronic illness, while this was also the case for half of the families interviewed in Spain (22 families) and 8 of the families interviewed in France. Over three quarters (19 of the 25 families) in the UK sample had proximate and/or distant caring responsibilities related to disability or chronic illness. Many of the middle generation had a disability or chronic illness requiring care, while also having caring responsibilities for children and older relatives. Over a quarter (7) of the 25 families in the UK included children and young people with a disability or chronic health condition that required sometimes intensive care from their parents and siblings, alongside also providing remittances, emotional support and/or practical care for older parents with chronic illness.

In Sweden, nearly three quarters of the sample (29 of the 40 families) had caring responsibilities due to disability or chronic illness of a family member. Over one third of the families (14) had a member of a middle generation requiring care due to disability or chronic illness. One fifth (8 and 7 families respectively) of the families had either a child or an older family member with chronic illness or disability needing care. Moreover, about a third of families provided everyday care for young and older family members.

The research in Sweden with forced migrants, and in the UK where just over half of families (13 out of 25) were from a forced migration background, suggests migration may precipitate a disruption of caring practices and responsibilities within the families. In pre-migration contexts, extensive family networks allowed more individuals to provide informal care. After migration, however, the number of family members who were responsible for proximate care was often reduced, leaving this responsibility mostly to the immediate, nuclear family living in Sweden and the UK, that is, usually parents and sometimes also children. Family members emphasised how much they missed the wider network of extended kin who would usually be expected to provide care within the family.

Among the families interviewed in Spain and France, care needs were related primarily to everyday caring needs of children or ageing relatives, both 'here' and 'there'. Among more recently arrived migrants in France, the middle generation sometimes needed to meet the linguistic care needs of their children, older parents and peers through language brokering roles, such as translating, accompanying them to appointments, making phone calls and so on, in addition to financial care for proximate and distant family members. Migrants often lacked extended family networks they could rely on to provide proximate care, for example for their children in times of acute illness or emergencies, leading to vulnerabilities.

Around half of the families in Spain (22 families) were caring for one or more family members with a chronic illness, usually related to the ageing of relatives, which sometimes developed into a disability. As highlighted earlier, older relatives, particularly those with chronic illness, were usually located in countries of origin among families who migrated to Spain. The precarity migrants face in the labour market (long working hours, instability, low wages) means that their ability to bring older family members who are not able to engage in paid work to Spain is constrained; many already struggled to provide financially for their children, without also having to support other economic dependents in the context of high living costs.

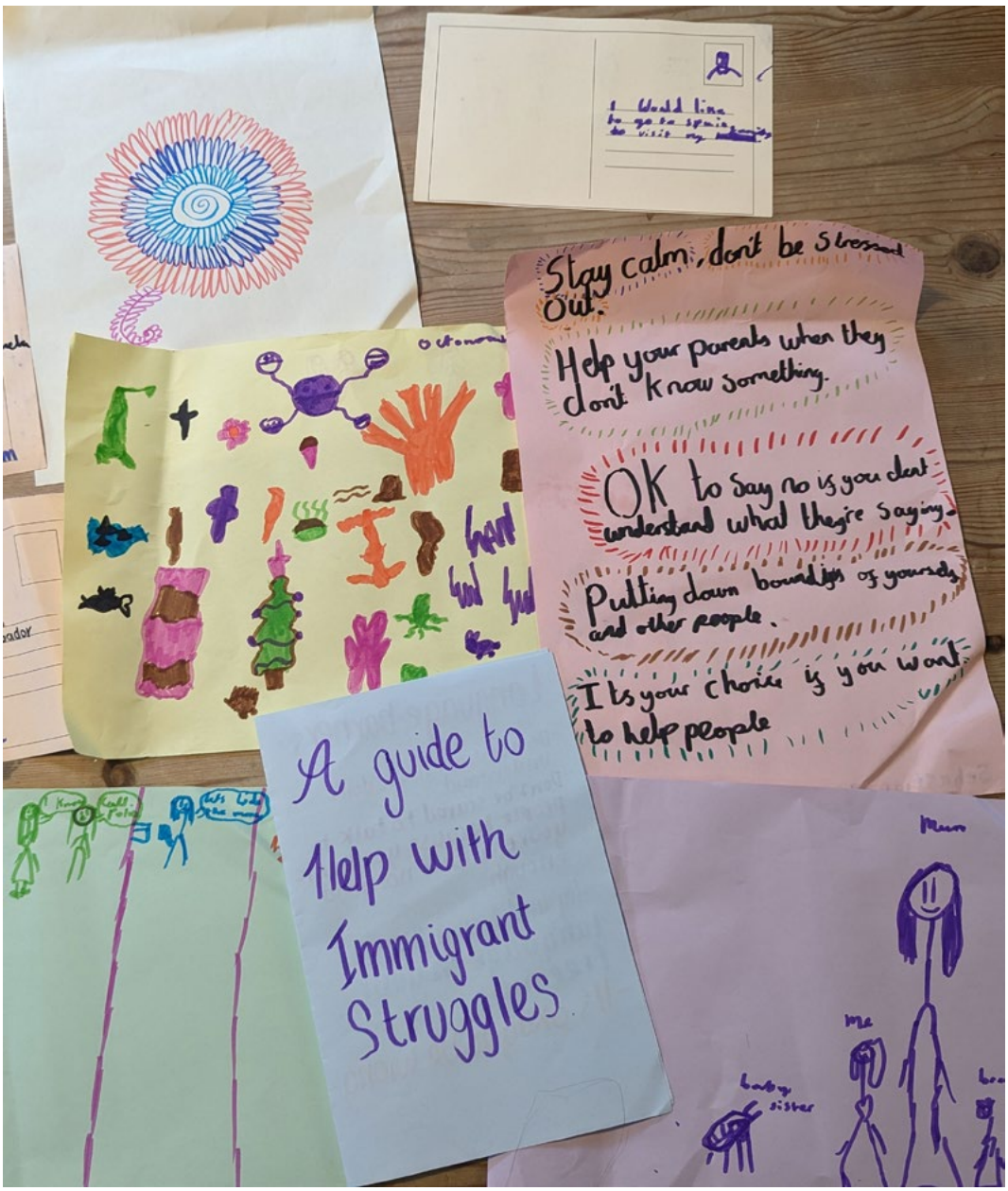

Figure 3: Photograph of participatory artwork produced by children participating in the research about their caring roles (feedback workshop, Migrant Support, Manchester, UK, 2024).

Transnational family care and im/mobilities

Across all the four study countries, reciprocal caring relations at a distance were evident in transnational families, with family members both giving and receiving care across borders. Care here includes emotional support (in terms of encouragement, advice, listening, moral and spiritual support), financial support (regular remittances, money to buy medicine, pay for emergency costs etc) and practical care (making arrangements and negotiating with other kin for proximate care).

Middle generation migrants often experienced tensions related to providing for their children as well as their extended family both 'here' and 'there'. When migrants were not physically present to provide proximate care, they were regarded as responsible for providing the financial resources to enable proximate care to take place. However, in some cases in Spain, Sweden and France, the research found that family members received money transfers, sometimes referred to as, 'reverse remittances', from

transnational family members living in other countries when facing financial pressures. This is somewhat surprising, especially in Sweden, given the universal welfare regime and higher level of support available to forced migrants compared to the other study countries.

Cultural expectations of the intergenerational contract were evident among most families interviewed. Young people and young adults in Sweden expressed their strong concern to 'pay back' their parents and other family members for the help and support they had received. Naila (aged 26), a Palestinian Syrian, lived in another European country while her parents and two siblings lived in Sweden and another sibling lived in Cuba. Her parents experienced chronic illness and were struggling financially, leading to Naila's strong desire to work and earn an income to support them:

> *"I feel happy when I help my family, I feel that I am paying back to them. Sometimes, I feel that I am not helping them as I should. They have helped me a lot and I want to be there for them. I took an intensive [language] course to be able to finish the language quickly and start working as soon as I can to support them more".*

Geographical distance created through migration limits the involvement of transnational family members in proximate caregiving and restricts the timeliness and extent to which they can respond to acute health emergencies, such as a sudden worsening of a health condition or a serious case of COVID-19. When families have a high level of care needs, such health emergencies may be particularly detrimental for the health and wellbeing of family members. Among forced migrants in Sweden and the UK, restrictions on international travel during the asylum process, financial and other barriers severely curtail the possibilities for distant family members to provide proximate care in acute moments of care need.

Furthermore, the research in Sweden suggests that distant family members may not always be informed fully or in a timely manner about such acute situations and their ability to provide care and support is limited which, in turn, leads to frustration.

Research in the UK revealed how transnational families who were able to travel (both legally and in terms of financial resources) provided proximate care to meet acute and longer term care needs of transnational family members on a temporary basis during family visits. In one case, UK family members assisted relatives with hospital visits and access to medical treatment for a young nephew with epilepsy in Morocco.

Contrasting examples of transnational families below show how the migration regime, migrants' legal and socio-economic status, nationality, migration trajectory and level of care needs intersect to influence their level of im/mobility.

Nawal, aged 46 was the primary carer for her disabled son (aged 15) and three other children. Her husband first came to UK as refugee; Nawal followed with her children from Sudan and had secured British citizenship and had been living in the UK for 10 years at the time of interview. Her husband travelled to Sudan much of the year, leaving Nawal with little care support. Her older sons (aged 18 and 20), helped with household chores and caring tasks, but they were away studying at university. Her daughter (aged 12) helped to care for her disabled brother. Nawal's experiences show how being separated from extended family kin compounded the negative impacts of her care work:

> *"This experience is the first of its kind and extremely difficult, especially because we are away from our relatives. For example, there are times when I'm exhausted and can't do much but I must push myself (.) I am happy, I mean I am not angry at God for giving me a disabled child, but sometimes I feel... [...] I feel like I have no other choice, it's compulsory."*

She expressed her sadness at not being able to travel to see her mother and siblings (whom she had not seen for four years) and was unable to attend her father's funeral. The prospect of visiting and communicating with family members had become even harder since the recent conflict in Sudan. Her family members in Sudan were unable to

obtain a visa to visit or reunite with her in the UK due to restrictive immigration policies that have reduced mobility rights for citizens of fragile, low income states in Africa in recent decades (Mau et al., 2015).

The research in France with undocumented migrants also highlighted the restrictions on mobility they faced due to their legal status, which prevented them from visiting family members who were sick or dying. For example, Inna from Ukraine (aged 52) who had lived in France for 8 years and who was still undocumented, unlike more recently arrived Ukrainians, was not able to travel to Ukraine when her father was dying of cancer: *"when my father was sick, I couldn't go. [...] I can't leave, because I have a son [aged under 18] here. And if they don't let me come back later... ".* Some migrants lacking mobility rights sent packages for family members through acquaintances travelling to their origin country who had secure legal status in France, as Seda from Armenia (woman aged 18) commented: "*There are some people who have papers and everything, who travel, well if there is something [...] important or urgent, well they bring it, we ask, they put it in their suitcases and they bring it".*

In contrast, an example of a Colombian family interviewed in France who had family members living in Spain and the US shows how transnational family members of different generations with greater mobility rights were able to draw on extended family networks to meet proximate care needs at particular times of crisis, while other family members provided care at a distance. When Isidora (aged 17), living in France, was ill and hospitalised, family members from several countries provided different forms of support:

> *"When I was hospitalised, my aunt had to stop her work for a week to come help my mother, [...] so that she would help me and be with me.[...] So in the end they sent for my grandmother and she came [from Colombia] with my cousin, the little one, and they arrived to boost my spirits and morale...."*

In order to help her mother to be able to continue to work, her aunt came to take care of her from Spain, her grandmother came for a period from Colombia to also take care of her younger sister at home. Their flights were partly financed by the partner of her aunt living in the US. Other members of her extended family in Colombia sent natural remedies for the health issues Isidora faced. The recent migration of Colombians and other Latin Americans to France from Spain linked to economic reasons was facilitated by their process of naturalisation in Spain and possession of Spanish (EU) citizenship, which permits greater international mobility (see also Bermúdez Torres, 2021).

Concluding points

This section has illustrated how transnational families organise the care of family members within their proximate households and at a distance with family members in countries of origin or other countries. It has shown how the migration and welfare regimes, such as restrictive family reunification, visa policies and irregular legal status that limit mobility, and limited entitlements to social protection in destination and origin countries, accompanied by a lack of extended family networks in the destination country, have negative impacts on migrant carers. Such financial and emotional pressures may be particularly acute in transnational families with higher care needs relating to disability and chronic illness.

7 Children's and young people's caring roles

While 'young carers'[13] are recognised in the UK in care policies as having specific rights as children and as carers, in Sweden, Spain, France and most other European countries, they are not recognised by the state or third sector organisations as a specific group that may require formal support (Leu and Becker, 2011). This section addresses the research question, 'What caring roles do children undertake? How does this affect power dynamics within transnational families?

Children's and young people's care work in transnational families

Leu and Becker's (2017, p.752) classification of the level of awareness of young carers and their policy response characterized the UK as Level 2 "Advanced", with "widespread awareness and recognition of young carers amongst public, policy makers and professionals" and "specific legal rights". Sweden, alongside Australia and Norway, were classed as Level 3 "Intermediate" (with some awareness, partial rights in some regions, and some dedicated services and interventions). France was classified as Level 6 "Awakening" ("embryonic awareness of young carers as a distinct social group among the 'vulnerable children' population"), while Spain would fall into Level 7 "No response", with "no apparent awareness or policy response to young carers as a distinct social group" (p.752).

Our research suggests that children and young people in transnational families in the UK, Sweden, Spain and France are engaged in a wide range of caring tasks for both proximate and distant family members. Figure 3 shows the six main types of caring tasks that children and young people (aged up to 25) undertook in our research.

Figure 4: Caring tasks of children and young people (aged up to 25 years) in transnational families

13 'Young carers' are defined as "children and young people aged under 18 who provide or intend to provide care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility that would usually be associated with an adult" (Becker, 2000: 378). 'Young adult carers' are defined with similar responsibilities in the age group 18-24 years.

Differences in young people's care work across the four study countries appear to be significantly influenced by the characteristics of the sample and their migration trajectories. In the UK and Sweden samples, the majority of families were caring for family members with high care needs related to disability and chronic illness and had often arrived as refugees through the asylum or resettlement routes, resulting in the absence of a parent or extended family members who could help to provide proximate care. In contrast in Spain and France, care work was predominantly focused on the middle generation providing financial support for family members in origin countries, in addition to meeting everyday proximate caring responsibilities for children and occasionally older parents/ relatives.

Across the four study countries, language brokering and providing practical assistance to navigate care, welfare and immigration systems in settlement countries were significant roles that young people engaged in. Language skills and digital literacy are necessary for interacting with welfare institutions, which the middle and older generations often struggled with more than young people. Many older young people were an integral part of families' communication with institutions and public service providers. This role depended on families' ethnicity and linguistic backgrounds, length of time in settlement countries and post-colonial linguistic legacies in origin and settlement countries. Young people often became proficient in the dominant societal language and digital literacy quicker than their parents or older relatives and so were drawn into such roles due to the migration context, inadequate or insufficient translation and interpreting services when accessing services and the language and digital barriers families faced. Such roles often distinguish the care work of migrant children from that of non-migrant children providing care within the family.

Furthermore, many children and young people provided emotional support transnationally, as well as for proximate family members. Young people in Sweden explained that parents suffer emotionally because of loneliness; they miss family members living abroad whom they have often not seen in years. Many young people provided emotional support at a distance via phone and video calls to extended family members in other countries. Such emotional support and transnational connections appeared particularly important for family members living in precarious circumstances in situations of conflict or transit settlement camps. Maissa (aged 9, living in the UK) explained how she supported her grandfather in Syria who had chronic health conditions: *"I talked to my grandfather when my mom phones him I talk to him. I try to make him laugh and I make him wants to see me every day because I make him laugh and he loves me. I mean I love making him laugh".*

Young people also provided assistance to support family members directly with healthcare and when responding to acute medical issues and emergencies. In families with high care needs related to disability and/or chronic illness in Sweden and the UK, some young people had significant roles in providing personal and healthcare support for family members. Personal and health care support was mostly provided by young people aged 12 and over who were deemed to have more competencies than younger children to provide this care for middle generation or older family members, or intra-generationally for siblings. Substantial care work could have negative outcomes on their wellbeing, opportunities and long term outcomes[14].

Many young people in transnational families in all four countries also undertook culturally expected roles of sibling childcare and household chores. Within many cultural contexts, young people, especially girls, are expected to help care for younger siblings and cousins. The transnational family constellation and spatial separation from family members is significant in creating the need for young people to provide childcare for younger siblings; partners/ spouses may be absent and parents are often separated from extended kin who would usually be culturally expected to provide care. Young people's

14 See Suter et al., (forthcoming) Young people's caring practices in transnational families in Sweden and the UK: Care ethics and wellbeing, for more information.

childcare roles are also influenced by the wider resource environment and care regime that may make private sector childcare unaffordable for most of the families interviewed in the UK, France and Spain, while universal childcare was available to migrant families interviewed in Sweden.

In Spain, many girls take on sibling caregiving roles while their mothers are working, which they sometimes found stressful. Aga (aged 12), from Senegal, who had lived in Spain with her mother for the last six years, explained:

> *"Well I would sleep, when my mother went to work, I would wake up and go to my sister's room because she was alone and then we would wake up and I would make them breakfast, shower them and dress them. Then I heated their food in the microwave because my mother told me not to heat in the oven or in the gas, so I only heated in the microwave. (...) I felt like a mother (...) Sometimes it was a bit boring because I had to shout because sometimes my siblings misbehaved, and I didn't know how to make them shut up".*

The research in Spain also found that older daughters and sons contributed economically to the organisation of transnational care. Those who had lived in the country of origin for several years maintained strong ties with family members 'there', especially with grandparents and aunts and commonly collaborated with their parents in sending remittances from an early age. While some older young people contributed to household costs in the UK, financial support and contributions to remittances did not emerge as a significant care role of young people among those interviewed in the UK, Sweden and France.

The level of young people's caring responsibilities varied considerably depending on care needs within family, household structure and the availability of adults to provide care, age, gender and so on, in addition to the transnational constellation of family members and the migration context, including the migration regime and access to formal care resources. In our research, high levels of young caregiving were often linked to a high level of care needs, inadequate formal care resources and the absence of a parent or other extended family members who would usually be expected to provide informal care.

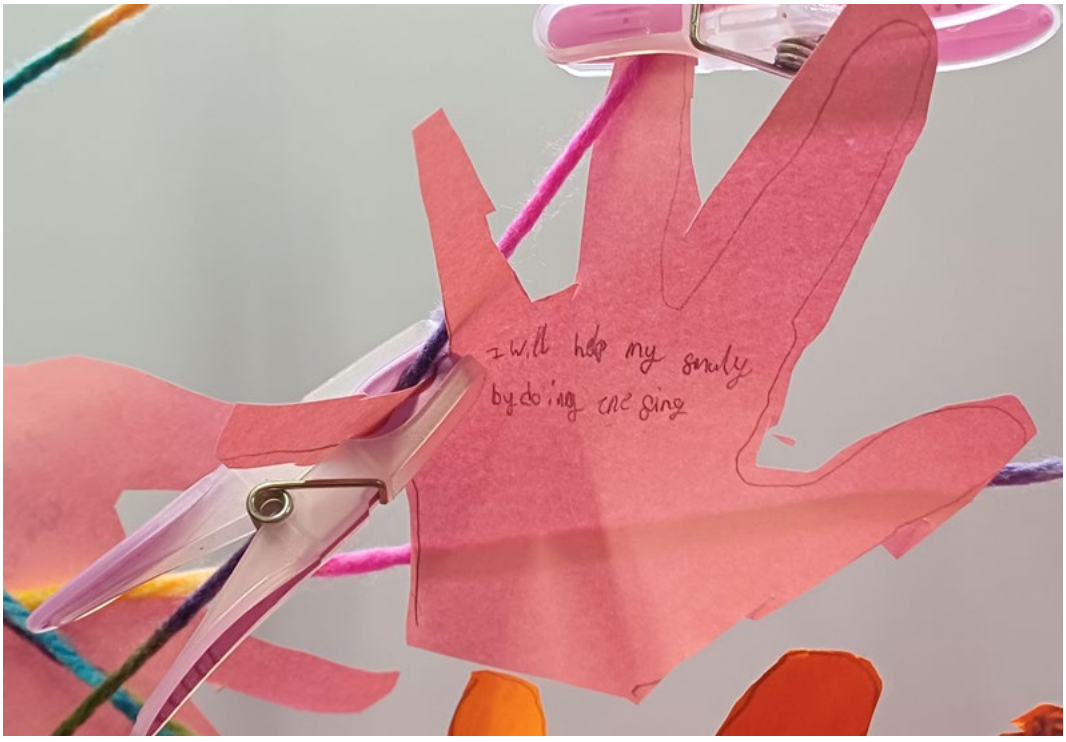

Figure 5: Photograph of participatory artwork, where a child participating in a feedback workshop (St. Vincent's, Leeds, UK, 2023) wrote: "*I will help my family by doing eny gin* **[sic: 'anything']".**

Young caregiving and power dynamics within transnational families

Conflicts may arise when parents heavily rely on their children, and young people cannot provide for all their practical and emotional needs. When young people had a low level of caring responsibilities, parents perceived this as culturally appropriate. When caring roles were more substantial, parents regretted having to rely on their children for support. In these families, formal care resources were not accessible or available, or failed to fulfil their particular needs, leading to young people having to take on caring responsibilities.

Some tensions were also evident among siblings, due to some siblings having more responsibilities than others, which may reproduce gendered and age inequalities. The research from Spain, UK and France often point to specifically gendered expectations for girls and young women to care for younger siblings and to engage in household chores, based on notions of women's 'naturalised' nurturing caring roles as mothers and home-makers, although this was not evident in the Sweden sample.

The research from all four study countries suggests however that the age and competencies of young people, as well as sibling birth order, are particularly significant in determining which child in the family takes on more caring responsibilities. In addition, geographical separation from transnational family members who would usually be culturally expected to provide such care is particularly important in creating care needs among transnational families. Across all four countries, as young people grew older, their caring responsibilities increased, linked to perceived age-related competences. The research in Spain suggests this could accord them more authority and respect within the family. Older sisters were highly respected by the younger siblings they cared for.

Furthermore, strong emotional ties may develop through caring relationships. While young people with caring responsibilities may become closer to their parent(s), they may also resent their caring roles or feel disadvantaged compared to their siblings who are not required to do care work due to their age, gender, disability or individual attributes. Meanwhile, younger siblings may be envious of older siblings with caring responsibilities due to their close relationships with parents and the respect and position of authority they hold within the household.

Concluding points

This section has highlighted the important caring roles that children and young people engage in to support transnational family members. Such care work is often devalued and invisible, but may be crucial in enabling parents and other family members to filling gaps in care provision in the absence of extended family kin and in facilitating access to formal care resources through language and digital brokering. While such roles may be valued within families, such care work may have negative impacts on young people's wellbeing, education and opportunities (discussed in Section 10), however, and sometimes result in familial tensions and conflicts.

8 Health, economic, social and emotional impacts of the COVID-19 pandemic

This section analyses the health, economic, social and emotional impacts of the Covid-19 pandemic on transnational families with care needs in the four study countries. While recognising that health, economic, social and emotional impacts are interrelated and often overlap, this section highlights the main issues that affected transnational families and coping mechanisms from the perspectives of families, policymakers and practitioners. It also addresses the research question of how caring responsibilities changed during this global health crisis and how different generations responded.

Physical and mental health impacts

In all of the four study countries, migrants and minority ethnic groups experienced higher mortality and hospitalisation rates, and difficulties in accessing healthcare (Brun and Gosselin, 2021; Rodríguez García de Cortázar et al., 2022; Platt, 2021). Pre-existing inequalities in occupational distribution, social rights due to nationality or legal status, migration trajectories, and cultural factors such as language barriers or family configurations, resulted in migrant groups being disproportionally disadvantaged during the COVID-19 pandemic.

Many middle generation participants were predominantly employed in manual or unskilled jobs (e.g. domestic and care work, cleaning services, transport, fishing and agriculture) which could not be undertaken remotely. This meant that they were more likely to be exposed to COVID-19 than other workers. In Sweden, many participants reported having contracted the virus at least once, and they or a family member having experienced severe and/or long-term health issues due to the infection. Practitioners in the UK also highlighted the lack of an appropriate and timely response by health authorities to the emerging evidence that the illness had more serious consequences for those from minority ethnic backgrounds.

Although in all four countries measures were taken to extend healthcare to all, many irregular migrants were unaware of this, and others were afraid to ask for it. Migrants were blamed by far right parties and the right-wing press for higher infection rates, which increased their psychological suffering. Some members of transnational families from Chinese backgrounds reported being subject to physical attacks.

The need to continue working to provide financially for local and transnational family members also increased the risk of contracting COVID-19. Middle generation participants with financial responsibilities who had to take time off work due to COVID-19 infection, came back to work before they had recovered because they could not afford to be off work and to stop sending remittances. Patricia, a Colombian migrant woman, 30 years old, who arrived in Spain in 2018, commented: *"I worked being ill but it's that I couldn't afford to be out of work. My mother in Colombia lost her job during the pandemic, so they got by on what I sent them".*

The extremely vulnerable situation that emerged in countries of origin of participants (the majority of whom were from low and middle-income countries in the global South), alongside the economic precariousness participants faced in destination countries, forced family members to continue to work and risk infection in order to guarantee the survival of their relatives elsewhere. Lockdowns meant the economic ruin of many households in origin countries characterised by very limited public welfare and healthcare systems and a predominance of informal work.

One participant in the UK with mental illness reported increased alcohol misuse due to the physical and mental strain of the pandemic. There were also reported increases in gender-based violence and child abuse in countries that resorted to extreme lockdowns such as Spain (Rodríguez Fernández, 2022; Lorente Acosta, 2020). Practitioners in Spain reported that deportation proceedings were opened by the authorities against irregular migrant women who reported cases of gender violence during the pandemic.

In all four countries, participants reported difficulties in accessing health services due to language and digital barriers when having to use the telephone or make appointments online. In Sweden, less restrictive containment measures alleviated participants' stress and anxiety.

In all four countries, many participants reported that their mental health was negatively affected, due to long delays in securing their legal status or in receiving the outcome of their asylum claim. Mental health support was not provided or was insufficient.

Economic impacts

During the pandemic, recent migrants and those in more precarious legal situations such recently arrived asylum seekers (who are not allowed to work in the UK) or those who were undocumented, faced greater financial difficulties.

In all four countries, the measures implemented by the government to alleviate the economic impacts of the COVID-19 pandemic were designed for the regularised population in formal employment. This meant that workers in informal jobs and the most vulnerable workers who worked formally but with very precarious contracts of a few hours were left without any income protection. As Veronica (aged 46) from Albania living in Marseille commented: *"My husband did not work for two months because of the COVID-19 and as he works black* [*sic*, informally], *he received no help from the state".*

In the UK, many transnational families benefited from protection schemes such as extension to free school meals to support families with No Recourse to Public Funds (NRPF), furlough and income protection interventions and homelessness assistance for those with NRPF. However, eligibility criteria were not clear, while some migrant families were unable to access them due to informality or low working hours (that is informal employment, zero hour contracts or variable hours/income), but also because schemes depended on employers.

In Spain, the discriminatory law against domestic workers, who were not recognised as workers at the time[15], left many migrant women, often heads of single-parent households, excluded from state protection measures. This meant they needed to resort to the solidarity of relatives, friends and neighbours locally and transnationally, which in turn increased the difficulties of people who were already in a precarious economic situation.

Third sector organisations, particularly in the UK and Spain, played a prominent role in protecting undocumented migrants and asylum seekers during the pandemic. Practitioners reported that NGOs, charities and other grassroots organisations were forced to assume a substituting position for the lack of state provision.

Thus with little to no state protection, particularly in Spain and the UK, the situation facing many transnational families, especially migrant workers in the informal sector, was that of survival. The dynamics of France's and Sweden's labour markets appear to offer more protection for migrant families during a crisis, due to greater government control.

15 Care workers' situation was finally recognised and the law changed by the left-wing coalition in government in 2022.

In all four countries, migrants' financial and material transfers were deeply affected and interviewees who had caring responsibilities, local and/or transnational, faced additional pressures. Middle generation participants shared accounts of having to continue supporting their families in other countries while facing economic hardship themselves. As Valdo (aged 57), from Cape Verde and living in Marseille commented:

> *"The quality of life has changed for me, because we earn less so we help our family less and wellbeing has also dropped because everyone had less money. In Cape Verde before the pandemic I had sent a container with food and a bit of everything, so my family in Cape Verde did well for the first few months. But otherwise, the COVID-19 made life difficult for us, but not changed the way we take care of it."*

Participants in Spain, France and Sweden expressed frustration about the price inflation that emerged after COVID-19, in destination countries and especially in countries of origin. Inflation added extra pressures on transnational family members sending remittances. They had to work more hours to afford payments for care needs in countries of origin, such as those providing care for older and disabled family members, medical treatment etc. As Dam (aged 46) from Senegal, who had lived in Spain for 18 years, commented:

> *"When the pandemic started even my wife wasn't working at the time and we didn't get any help. That's why I was working overtime, I would go to work in the morning at 7:00 until 15:00 when I would come back for lunch and then go back to work at 16:00 until 20:00, almost 12 hours a day. Because we have a sick person in Senegal and if you miss work it can be dangerous because you will not be able to help her. In addition to this, with COVID-19 all the prices raised there. If before COVID-19 you used to send 100 euros, with COVID-19 this amount raised to 150 euros per month. And I have also my three children here".*

In Spain, domestic workers who had the "chance" to move in with their employees did so. Living in the same house blurred the boundaries between private life and working time, and mistreatment was reported. This increased levels of anxiety and stress among women; many reported that they started using medication to ease anxiety and depression. Patricia (aged 30) from Colombia, living in Spain, commented:

> *"It was hard [...] I had no space, no privacy. The girls, as I was there, wanted to be all the time with me, they don't understand I wasn't at work anymore [...] They didn't allow me to go out, and if I go, she [the employer] made me take a test. [...] Yes, when everything finished I felt disappointed, I expected they would pay me a bit more, but they paid me the same".*

Another strategy migrants in Spain adopted to overcome unemployment was changing employment sector. While agriculture often became a refuge sector during the pandemic, the living conditions of transnational families worsened significantly. Changing job often meant moving to another town or region, which deepened feelings of isolation, as family members were forced to live apart.

Job losses during the economic crisis that followed the pandemic had a major impact on migrant families, due to their concentration in industries most affected by COVID-19, such as domestic work, taxi drivers, security, hospitality. This led to economic hardship. There was a wave of layoffs in the unregistered informal economy. Many transnational families with no savings that were dependent on daily wages, lost their income. In all four countries it appears that levels of social exclusion and poverty increased after the pandemic among transnational families, and this seems to have long-term effects.

Social impacts

During COVID-19 pandemic, education was disrupted for both children and adults in transnational families in the four study countries. This was due, to a certain extent, to the increase in informal care needs within the family, but mostly to digital and resource barriers, particularly in language learning. The impossibility of attending language

classes in person, and sometimes also attending digital courses for those migrants who had no access to internet or IT equipment, had a negative impact on language acquisition as it slowed down language learning processes. Some participants in Sweden reported that digital courses were of poorer quality than the in-person classes. This in turn, negatively impacted language learning, with repercussions for employment prospects. In the UK, in contrast, practitioners highlighted that online language courses were sometimes more accessible to mothers of young children, and that they were a source of comfort against isolation and loneliness. In Sweden, due to the "difficulty" of learning Swedish, the shift to online learning frustrated people's efforts in language acquisition. This had negative impacts on children and young people of school age, leading to significant frustration because of the slowing down of their language learning, which in turn increased the likelihood of negative educational outcomes.

In all the study countries, we noted a general slowdown of all administrative procedures, especially in the renewal of residence and work permits. Permit extensions were insufficient, and numerous cases were recorded of people returning to situations of irregularity due to the slow functioning of public administrations. Many members of transnational families in Spain were in an irregular legal situation during the pandemic, while others had secure legal status but this became irregular, as they lost their jobs or even because of the slowdown in administrative regularisation processes. In Sweden, participants reported that refugee resettlement processes had slowed down due to the pandemic. In the UK, the backlog of asylum claims waiting to be processed increased significantly; the number of cases waiting more than six months for an initial decision has more than doubled since 2020 (Tyler-Todd et al., 2023).

Digitalisation of procedures and remote services increased inequalities in access to rights and support due to the digital divide. In all four countries, many temporary work contracts were not extended, making it difficult for individuals to provide financially for their families. This had an impact on the legal status of transnational family members, as most residence permits depend on having a formal full-time employment contract and on migrants' ability to sustain their household economically. The lack of stable, long-term employment due to COVID-19 pandemic undermined individuals' options to regularise their legal situation in the receiving countries. In turn, this directly impacted on family reunification processes.

For example, Javad (aged over 50) lived with his wife and four children in a middle-sized town in the south of Sweden. They fled to Sweden in 2017 and now have a three-year temporary residence permit. The temporary residence permit can be extended if he has permanent employment that covers the family expenses. At the time of interview, he worked in the agricultural sector with a 50% employment contract (for the other 50% he received state benefits). He used to work full-time, yet, due to the long-term health effects of Covid, he had to reduce hours to his current half-time contract. He struggled to provide financially for his family and it affected his opportunity to secure an extension to their residence permit.

In all four countries social distancing measures disrupted 'local' intergenerational caring relationships, as they could not visit each other. This led to a re-organization of caring roles within the family and often led to increased reliance on young people. For example, those who had parents who did not speak the majority language had to inform them about COVID-19 safety recommendations. The rapid increase in digitalisation of public services in all four countries during the pandemic also increased the caring responsibilities of young people and young adults, as they became key digital brokers in helping parents and older relatives access public services. The complexity of digital processes has made young people indispensable 'assistants' for older generations, from arranging an appointment with the social worker or the doctor, to applying for a particular benefit or financial support.

When COVID-19 restrictions on international travel were lifted, those who were able to immediately travelled to visit family members and deliver 'hands-on' proximate care. For example, a father and daughter (aged 16) living in the UK travelled to India when restrictions were lifted during the COVID-19 pandemic to provide care for the father's older parents who were ill with COVID-19. The daughter felt that this care really helped them to recover: '*I think they got a lot better after we were there because we...like someone was actually looking after them'.*

The different protection measures adopted in the countries of origin and destination and other countries where relatives lived, caused a lot of confusion and sometimes government mistrust. Given the lack of support on the ground, transnational families interviewed relied on personal and community networks at local and transnational level. These networks, as well as third sector organizations, guaranteed the survival of individuals and families and were especially important for undocumented migrants. At the transnational level, some families reported a reversal of money transfers from family members in origin or third countries (e.g. Palash and Baby-Collin, 2018) to Spain and France if family members were in a better socio-economic situation, due to highly skilled employment or because they were able to access a larger local support network. Maryam (aged 42 years), a Moroccan migrant woman who had lived in Spain for 20 years explained:

> *"I lost the job [...] my brother helped me, the one who is in France, and my brother in Morocco he also sent me clothes for the children and so on. And here with my friends we care for each other, Moroccan women are very united, we cooked together, if we knew someone was in necessity we would raise bit of money".*

Similarly, Serigne, a Senegalese migrant, politician and activist, who had lived in Spain for 18 years, commented on the 'culture of care' and 'solidarity' among many transnational families from the global South:

> *"Coming from the culture of care, from the culture of solidarity 'I have little, I share it with the other', in the face of government abandonment, immigrants in Spain resorted to informal networks of solidarity woven within the extended family, but also organized among neighbours, friends, members of the community and complete strangers".*

Likewise, two middle aged Latin American women who migrated to France (Carolina, aged 39 from Brazil and Angela, aged 41 from Colombia) relied on the financial and emotional support from family members in their country of origin when they separated from their French partners and found themselves alone.

Money transfers from transnational relatives to family members based in Sweden were also observed among participants, although this was found to be related to the low income and economic hardships they experienced, rather than related to the pandemic.

Emotional impacts of immobility

In the four study countries, the restrictions to mobility and distancing measures implemented during the COVID-19 pandemic emerged as sources of significant emotional harm for transnational families. Isolation experienced by the general population was felt particularly acutely by transnational families due to the closure of borders, alongside often a lack of social networks in destination countries.

Family members in destination countries worried about the situation relatives faced in countries of origin and other countries, due to the very limited public healthcare or welfare provision in many low and middle-income countries.

As Olinda (aged 19) from Cape Verde, living in Marseille commented:

> *"...we were all worried because we said to ourselves at all times above all that the healthcare there in Cape Verde is not the same as in France, it's to say that all the same we were afraid, because it was not necessarily the same rules in addition, over there, the lockdown rules were not necessarily respected. So [...] we always had this fear about family and especially for the older ones".*

The situation was particularly difficult for participants who were asylum seekers and refugees with relatives living in refugee camps interviewed in the UK . Forced transnational families with members displaced to different countries and living in refugee camps with already poor living conditions before the pandemic, had to deal with the death of family members without any information or any possibility to travel or provide support.

The forced immobility migrants faced due to border closures and restrictions on migration, caused a huge amount of stress and suffering among families interviewed. Having to be apart from family members in other countries during such a distressing situation as the COVID-19 pandemic had major emotional impacts on participants. Due to long waiting periods and delays in the processing of asylum applications, and the impossibility of proceeding with family reunification plans, many transnational family members had to resign themselves to living with the illness, emotional pain and death of family members thousands of kilometres away. It exacerbated grief and had major impacts on their emotional wellbeing.

The fear of not being able to see older or sick relatives again was a common feeling expressed by transnational family members in all four countries. Not being able to travel when relatives fell seriously ill, to accompany them, to take care of them, or even to travel to provide or receive comfort when relatives died, was deeply distressing. Many interviewees experienced mourning alone during the pandemic, causing deep emotional and psychological wounds. Juana, (aged 27), a Colombian migrant woman who had lived in Spain for 5 years commented:

> *"Last year (2021) was a bit difficult for me because my uncle died, he was like a father to me, so it was very hard for me. And then to come back and see that he was no longer there... And my grandmother also died when I was here (in Spain). So to see how my family is getting older and not being able to be there. Because here you also have a different kind of mourning than over there because here I thought about it a lot and cried a lot but over there [in Colombia] you are accompanied and you say goodbye to them in the wake protocol and all that [...] I couldn't go because my papers took about 8 months, normally it takes about 3 or 5 and it took me 8 because of Covid, and I had planned to go in July and I couldn't".*

Caring arrangements had to change due to COVID-19 enforced immobility, resulting in extended periods of separation when family members became 'stuck' in other countries due to the closure of borders.

Across middle and older generations, words and silence became resistance tools within transnational families. In all four countries transnational families resorted to video calls and WhatsApp and other communicating means to keep in touch with their loved ones. Emotional care was provided regularly, if not every day, by all generations through these means. Nevertheless, we noted that family members tried to hide as long as possible health issues and other financial problems in order not to worry family members abroad. It is a recurrent story in the interviews that people who became ill with COVID-19 did not tell their relatives until they had recovered.

The research in the four countries also demonstrated different responses among the younger generation during the pandemic. Disabled children (and disabled adults) experienced high levels of stress when they did not understand changes in their routines. This was particularly the case in those countries where lockdown measures were more extreme, such as in Spain, where people were not allowed to go out under any circumstances. Tensions often emerged among families living in very often overcrowded houses. Children also showed great capacity for resilience and adaptability to the new situation, however; they provided a great deal of emotional support to adult family members 'here' and 'there', who were under great pressure due to financial responsibilities and health worries.

Concluding points

The research has demonstrated that the physical and mental health, economic, social and emotional impacts of the COVID-19 pandemic were interlinked. These impacts contributed to the further marginalisation of transnational family members who were often already experiencing considerable economic hardships and insecurity.

The forced immobility migrants faced due to border closures and restrictions on migration, caused a huge amount of stress and emotional suffering for transnational families. Caring arrangements had to change, resulting in extended periods of separation when family members became 'stuck' in other countries due to the closure of borders and an inability to travel to see sick or dying relatives or attend funerals.

Long-term economic impacts (and associated health impacts) were particularly evidenced among participants in Spain who were often in irregular, informal work that fell outside of government protection measures for formal workers. Social impacts were focused on the digital divide and delays in administrative procedures including related to family members' legal status. In Sweden and the UK, impacts were evident in terms of the slowing down of language learning processes and the knock on effects on employment prospects due to the challenges of accessing language education when in-person courses were not available. The next section explores digital barriers in more depth through addressing language-related inequalities and multilingualism in a wider context.

9 Language issues and multilingualism

Valuing and including people's first languages provides protection, not only by strengthening families' capacity to engage with others about their care, but also in helping migrants and their families communicate, for example, in complex health situations. This section discusses the key research findings on language-related inequalities, barriers to language learning and how families use multilingualism in their caring practices. We seek to address the research questions: which language-related inequalities do different generations face, and how is multilingualism used as a resource?

Language-related inequalities, interpreting and translation

Research in all four countries shows that a lack of proficiency in the dominant societal language, alongside a monolingual bias in institutional settings and inadequate translation and interpreting services, creates inequalities among transnational families. The UK research shows that language barriers especially disadvantage women carers. For families with temporary legal status in Sweden, language proficiency affects employment and is also a requirement for permanent residency. This also affects families seeking family reunification, who, in addition, struggle to meet the requirements for financial provision and accommodation for additional family members.

The research found that many transnational families feel one of the main barriers relating to language is the negative perceptions towards languages other than the dominant language, e.g. English in the UK, being used in institutional settings. This monolingual bias in institutions is accompanied by inadequate interpreting and translation services. For example, practitioners in the UK reported a lack of awareness among statutory professionals of the need for interpreters and translators that encompass a range of language varieties when accessing public services. As one practitioner commented:

> *"[The local authority] were very quick to spend thousands of pounds interpreting information into different languages with no cognizance of the fact that maybe this person speaks a different dialect, so what you're saying may [not] be completely understood, even if they were able to read it. So, yes, language remains a huge barrier".*

Other practitioners pointed to a lack of knowledge among migrants of their rights to a professional interpreter, for example, during a doctor's appointment (Healthwatch, 2024).

Participants reported experiencing difficulties in obtaining appropriate interpreters in healthcare settings. In Sweden, interpreters are available when interacting with state institutions such as healthcare, but participants reported this usually takes time to organise and uses up the time available in medical consultations. Translation and interpreting services for specific and lesser-used minority languages, such as Dari, are hard to access, especially in rural areas. A concern noted in Sweden is that changes in government policy may also include the introduction of fees for using interpreters in the future.

The research found that a lack of accessible interpreting and translation services in turn increased the sometimes problematic reliance on family members, including children, for interpreting. In all four countries, younger children were observed to learn the dominant language at a quicker rate than their parents, older siblings and relatives of older generations. As discussed in Section 7, many children and young people find themselves engaging in language and digital brokering, acting as a bridge between their family and institutions when dealing with doctors or teachers. When language brokers or mediators are called on to overcome a language barrier, family members and the service provider may feel concerned about confidentiality, especially if they are not familiar with such informal interpreting. Other research in multilingual settings (Ra and Napier, 2013) has shown that inadequate interpreting may impact service quality in a negative way, and may raise serious ethical concerns about consent. When parents have low

literacy in their first language, it is not always the case that they turn to their children for mediation or translation, as some parents feel that this burdens their children (see also Section 7). Mediation by children generally was not always seen positively by parents. Some parents interviewed in Sweden were very clear that they do not ask their children to act as mediators, interpreters or translators, explaining that they want their children to focus on their studies rather than spend time helping the family like this.

Adult family members may not wish to rely on translation and interpretation services, which in Sweden and the UK are seen as difficult to arrange and potentially expensive. They also mentioned not wanting to rely on machine translation, although UK-based participants noted the practical utility of tools such as Google Translate. Access to language learning opportunities is also important for adult family members to enable them to support their children's education, for example, in home-school communication between parents and teachers and education authorities. The findings from Sweden show that parents also wish to help their children with their schoolwork and their reading in the dominant language of their new country.

'Home' language use and maintenance

Participants in Spain and the UK made the point that language issues do not only relate to learning the new language: in multilingual societies and in multilingual families' maintenance of 'home' or first languages is seen as crucial, not least for ensuring communication within families across generations.

In all four countries, however, family members reported a monolingual bias in their encounters with institutions. Families in the UK and Sweden noted that having opportunities to speak and write in a first or home language when interacting with public services (for example, with the help of an interpreter or with a staff member that speaks their language), is beneficial to their health and wellbeing, but such opportunities are not always in place. Similarly, families from Latin America living in Spain, who share Spanish as a first language, experienced resistance to their use of their own varieties of that language. Among families from Senegal and the Maghreb living in Spain, the first language was spoken at home while Spanish was spoken outside the home, with people communicating across languages depending on the context. Opportunities to learn and use the language of family interaction were reported to have a positive impact on the self-confidence of children of migrant backgrounds, particularly in classroom settings.

Some parents, particularly those from Arabic-speaking backgrounds in the UK, France and Spain were worried that children would lose their first language, thereby breaking familial ties with their country of origin. This concern was not found in the Swedish data, which may be related to the fact that children have the right to study their first or home language in school (Swedish National Agency for Education, 2024). Losing the parents' first language may be regarded as a loss of identity and as detrimental to the family bonds that need to be forged and maintained with older generations as part of intergenerational caring relationships. In Spain in particular, parents felt that the next generation would not be able to look after older generations in the future because they did not speak their language.

Multilingualism was often seen as a resource within the community for transnational families. Participants in France noted that knowing another language in addition to the first or home language and French can be a benefit for migrants in terms of sociability and social capital, enabling communication with migrants from other groups (e.g. Arabic and Russian speakers). This allowed participants to extend their social networks and often to find work and assist new arrivals. Similarly, it was observed among children speaking Russian or Arabic that young migrant children cared more for their linguistic peers and developed friendships and emotional care with them at school more easily than with children speaking other languages.

Language-related discrimination

Participants reported their negative experiences of members of settled communities using language as a proxy for racist and discriminatory practices when they focused on a foreign language as a marker of difference. People who are users of non-local varieties might experience this too. For example, although Portuguese and Galician are mutually intelligible, some individuals in Galicia will 'pretend' that they do not understand a Portuguese speaker from Brazil, as a means of signalling the newcomer's non-belonging.

In order to overcome these discriminatory practices, young people from Latin America altered their accent depending on the situation, switching across different varieties by using different pronunciation and vocabulary according to context. When they were with Latin American family members, they spoke with the accent of the region that the family is originally from, but when they were outside the family domain, for example at school or with friends, they adopted the local way of talking. Strategies around changing one's accent enables children and young adults to gain faster integration into mainstream schooling; young people in Spain felt that they were able to 'fit in' quicker when they adopted features from Castilian. These practices of accommodation also helped Arabic-speaking Moroccans in Spain avoid Islamophobia. Similarly, migrants in Sweden and the UK spoke of not using home languages in public spaces in order to avoid discrimination.

Digital literacy

Digital literacy was found to be important when transnational families were dealing with public institutions at every level and in each of the four countries. Mention of digital technology was especially prominent in the UK and Spain, and its use is involved in most aspects of dealing with institutions, especially since the COVID-19 pandemic. Bureaucratic procedures shifted to online spaces during the pandemic, requiring digital literacy skills. Interactions with state institutions such as employment agencies, social insurance, benefits and services, and schools, are increasingly carried out through digital services and platforms. For example, Marzieh (aged 24), daughter of an Afghan woman with chronic illness who had been living in Sweden since 2015, reported that she and her siblings had to assist their mother in bureaucratic interactions requiring the use of official apps, "*because she has no idea how it works.*"

On the whole, members of younger generations were better able to engage with different digital literacies such as using smart phones, tablets and laptops, used to access a range of apps and social media platforms. Older participants explained that they were less confident with these digital practices and found it difficult to use platforms such as WhatsApp to communicate with family members in other countries. This meant that the loss of a proximate family network through migration or forced displacement was even more acutely felt. Some older interviewees who described their expertise with literacy online explained that they acted as mediators for family members without such skills.

While digital technology may present opportunities for accessing health and financial support and communicating with transnational family members in other countries, a digital divide risks exacerbating social and economic inequalities. Our findings show that linguistic challenges faced by migrant families navigating institutional care systems in an unfamiliar environment require access to specific, and frequently inaccessible, knowledge that is only available online. This can prevent those who are outside the institution from accessing "powerful" languages, registers, genres, discourses and literacies (Capstick, 2016b). Moreover, access to knowledge of rights and specific institutional practices related to care is needed in such interactions; knowledge that migrants, particularly young migrants, often do not have (Rechel et al., 2013).

Language education for adult migrants

The language issues for children noted in the research mainly relate to their role as language brokers for other family members, in contexts of care. For adult migrants, language education presents a specific challenge. Across the four countries in the study, and in common with other country contexts worldwide, policy and media discourse emphasises the importance of learning and using the dominant societal language (usually one national language) to support the social integration of migrants, stressing the benefits of language learning for social cohesion (Cooke and Peutrell, 2019, Simpson and Whiteside, 2015).

Patterns of provision and coordination of adult migrant language education vary wildly, though, between and within the four countries. In Sweden a language course (Swedish for Immigrants, SFI) is provided by each municipality at no cost for all those whose first language is not Swedish. People on establishment allowance (i.e. within 24 months of receiving a residence permit) and on social allowance (i.e. who have been in Sweden longer than two years, or who have extensive care responsibilities) usually access this. They are then usually obliged to take language classes, but some participants were not able attend due to the amount of care work they were engaged in.

In the UK, while the governments of Scotland and Wales have developed explicit, funded policies to support and coordinate English language education provision for adult migrants, no such strategy currently exists for England. Language provision for adults has declined in France since the pandemic, while in Spain participants report concerns over the quality of the teaching for adult migrants by teachers of Spanish who do not always have appropriate training or qualifications for teaching a second language.

In Spain, as in the UK, there is often a reliance on volunteers to teach language, particularly when the providers are working in the third sector, e.g. with a charity or NGO, or a religious organisation. In the UK, for example, volunteers provide much-needed English language speaking and listening practice and are especially supportive in informal conversation classes. Such informal classes often provide a more flexible approach to learning and attendance than formal language classes, which some refugees and asylum seekers appreciate. When volunteers are unqualified and untrained, though, they cannot be expected to provide a comprehensive language education.

Practitioners in the UK, as well as family participants in the UK and Sweden with caring responsibilities, highlighted gender-related difficulties around travel and timetabling in access to classes of English and Swedish respectively. This in turn hinders carers' ability to learn the dominant societal language. A significant barrier to accessing opportunities for language learning is the cost of travel, particularly for asylum seekers, as well as for older women, who find travel to a class and negotiating caring responsibilities to be difficult. Such barriers can lead to irregular attendance and participants dropping out of language education. Practitioners also explained that there are also particularly high levels of drop-out due to migrants (and particularly asylum seekers) experiencing mental health challenges or simply not being able to prioritise their learning and the homework required to participate fully in formal classes.

Other barriers to access include finding classes at the appropriate level (particularly at the very low and the high ends of proficiency) and the pressure for learners to take mandatory language exams that demonstrate their progression. In Sweden, some interviewees were placed in refugee accommodation in remote places. Hence they often found it impossible to attend language classes on a regular basis because of a lack of public transport (coupled with their caring responsibilities). Finally, practitioners in the UK noted that providing space for learning, increasing sizes of classes when teaching online and drawing on teachers in training as volunteers are potentially ways that universities could support the sector.

Concluding points

The research has highlighted participants' concerns about the legal requirements for proficiency in the dominant societal or official language of the nation states in which the research took place. These requirements, often framed as obligations on the part of migrants to 'learn our language,' can be juxtaposed with the multilingualism that is transnational families experience on the ground. Participants drew on a wide range of linguistic resources, which they deployed as a multilingual repertoire, according to the context of use (setting, and purpose of interaction, etc.), as well as to their individual competence in a particular language.

Where competence in the dominant language is not high, members of younger generations often play an important role in language brokering. Children's roles in mediating in institutional settings (schools, hospitals) is seen as particularly problematic, however. It raises ethical questions about consent and confidentiality, as well as concerns about the impact of such responsibilities on children. The increasing role of digital technology in accessing public services is also a prominent issue, implying a need for digital literacy. Not everyone has the skills and ability to engage in digitally-mediated interaction with institutions, and the relevant platforms and apps can be inaccessible, particularly to older generations, who are at risk of exclusion through their inability to use digital technology effectively.

This points to the importance of adult migrant language education. Our research has highlighted several barriers to accessing affordable, appropriate and high-quality language education provision in the study countries. These include: travel costs, pressure to progress through higher level language courses, inflexible timetables due to stretched resources and ineffective coordination of language education provision.

10 Impacts of caring on wellbeing, education and opportunities

Building on the previous sections about intersecting inequalities, dynamics of caring relationships, effects of the COVID-19 pandemic and language-related issues among transnational families, this section addresses the research question, how does unpaid family care affect the relational wellbeing, education and employment opportunities of different generations in transnational families? It adopts an intergenerational perspective and analyses the specific impacts of caring responsibilities on children and young people, middle generation adults and older generation within families.

Key impacts of care work

The research identified five key domains of participants' lives that were most affected by their care work: employment and financial situation, education, family relationships, social participation and wellbeing and mental health (see Figure 4). Impacts were often experienced in more than one domain. Wellbeing and mental health overlaps with all the other domains, however, since they all had knock-on impacts on participants' wellbeing and mental health.

Overall, it is difficult to generalise about whether and to what extent care work had a negative or positive impact on carers with regard to the five dimensions identified. Often respondents expressed ambivalent feelings towards their caring situations. However, when care work was extensive, when family members required substantial care, particularly in the case of single parents or a primary carer who lacked other support, caring responsibilities were perceived as negative and as having detrimental outcomes for their economic and social participation, wellbeing and opportunities.

Figure 6: Key impacts of care work among transnational family members interviewed in France, Spain, Sweden and the UK

Employment and financial situation

Across all four countries, many middle generation adults that had employment had to reduce hours of work due to their care work, leading to reduced income and reduced retirement contributions. Some working parents said that they were often late for work or had to leave early due to caring responsibilities and many felt stressed at having to combine caring with employment, especially if their employer was not flexible. Some on temporary contracts experienced the risk that their contracts would not be extended due to this. Some middle generation interviewees in the UK had to sell the house they owned because they could not afford to pay the mortgage anymore or were not able to buy a house because of reduced income and working hours due to the caring responsibilities.

In all four countries, some middle generation primary carers (of disabled children/ children with chronic illness) were not able to work due to their caring role. Among the Swedish interviewees (most had lived in Sweden for under eight years at the time of interview), many could not access the labour market because their caring obligations hindered them from learning the language and undertaking training in order to qualify for potential jobs. Due to their caring responsibilities, carers often had no opportunity to enrol in education, do an internship, get a job, learn the language, or create social networks.

Many interviewed in Sweden relied on state financial assistance and commented that they did not receive enough money to cover their living costs and were unable to travel to visit family, even within Sweden and could not afford to obtain a driver's licence, leading to difficulties in obtaining or retaining employment. One family also said they could not afford medicine for their child. In some cases, however, a lack of proficiency in the dominant societal language (Swedish) prevented them from receiving state financial benefits; they were not able to fill in the forms needed to apply for welfare benefits, precluding them from accessing what they were entitled to. Furthermore, due to their difficult financial situation, participants could not apply for family reunification (which requires a regular income). Some struggled to send remittances to family members, despite the meagre income they had, commenting that their family members abroad, "*have even less*".

In the UK, France and Spain, there was a notable gender difference among parents with a child with high care needs, as it was often mothers who were not able to work due to childcare or who worked reduced hours (and thereby earned less income and had less pension contributions). However, this also depended on the type of family (nuclear, extended, single parent), on the time-point in their migration trajectory and on the cultural background. In Spain, it was mostly Moroccan mothers that were not in employment due to childcare, whereas Latin American and Senegalese women sought to reduce their working hours to meet childcare needs.

The research from Spain suggests that because of significant caring obligations, women often remain in precarious informal work, such as domestic work and care work, complicating their regularisation and naturalisation prospects. Furthermore, this situation affects their access to social protection resources linked to formal employment, leading to precariousness and difficulties in supporting the family financially. Such financial pressures affect power dynamics in relationships and may disrupt plans for the reunification of older parents who need care.

Many mothers in Spain, for example, accessed informal, flexible jobs in the privacy of an individual's home (such as domestic service and care work) that allowed them to provide childcare while working. Indeed, women working in domestic service sometimes felt forced to bring their youngest children to work, as a result of the lack of day care facilities in Spain, the high cost of the private day care facilities and the often irregular status of the migrants which prevented them from accessing the few available places. This impacts on their labour trajectory, anchoring them in precarious jobs. Meanwhile they also worried about children left at home, and felt guilty, feeling they were neglecting them.

When women are overloaded with caring responsibilities at proximity and distance, this impacts their opportunities and social mobility. In France, some qualified migrants who were single mothers and who lacked an extended family network found that their caring obligations negatively affected their professional development; they were not able to advance in their career and develop their skills as they would have liked.

Interestingly, caring obligations could also represent a route into the labour market, as evidenced in Sweden when carers started working as personal assistants, and were paid by the municipality for their care work. However, not all family members who wanted to become a personal assistant for their high-need family member were approved by the municipalities. In contrast, in the UK, a person in need of care may receive a care allowance to pay for formal care provisions, but it cannot be used to employ a family member. The sum is low and related to legal status. In Spain, there is a similar system to that of Sweden, however in practice, it functions poorly (long waiting time to gain approval as a formal carer).

In France, older migrant women's income was sometimes impacted by their care work for their grandchildren while their adult children worked, due to reduced paid working hours. In Spain, some of the older generation who had reunited with family were still of working age. Many had been (irregularly) regrouped to meet the care needs of the family and as a result, were not able to participate in the formal labour market and did not have social insurance or the right to a pension. This placed them in a particularly precarious economic situation and made them economically dependent on younger family members. Marina (aged 59) from Colombia, for example, was reunited in Madrid by her daughter after some time living apart. Now she looks after her grandchildren while her daughter and her son-in-law work: "*I would like to work a few hours but in any case I have to be at home looking after the children, because if I go to work, the child doesn't have classes and I'm working, how do I do it? that's the little dilemma".*

In both Spain and France, adolescent caregivers struggled to access part time jobs due to their care responsibilities. The lack of income prevented them from being able to afford educational necessities, such as private English language courses, that would enhance their job prospects. Many also risked losing the jobs that they had obtained due to their caring responsibilities.

Education

In all four countries, many young people with considerable caring responsibilities said that their schooling (including homework) was affected. They pointed to a lack of time to do homework due to the fact that caring for their sibling, undertaking housework or helping with administrative issues and language took priority. Research from Spain suggests that caring responsibilities reduced young people's opportunities to build friendships with classmates outside school. This meant they missed out on building important relationships in class and in turn, could have a negative impact on their educational outcomes. Some children of Chinese heritage in Spain, however, were doing well at school despite significant caring responsibilities and work obligations in the family business.

Some young people's caring responsibilities influenced their aspirations for future education and employment. It motivated some to learn the language faster so they could help out and assist their family members in need.

In all four countries, middle generation carers found it often difficult (and sometimes impossible) to attend language classes and other kinds of training which was often needed to access the labour market. Many also stated that they sometimes arrived late or needed to leave early due to their caring obligations (see also Section 9). In Sweden, some family members could only attend language classes because they had been granted a personal assistant to care for their disabled relative when they were in class. Some people without a personal assistant or support network found it impossible to sustain their attendance at language classes on a regular basis. Some interviewees

were also deeply psychologically affected by their (emotional) care for family members in need and found it difficult to engage in learning. Some adults, mostly single mothers, in France and the UK also postponed their university studies due to family caring responsibilities and the need to engage in paid work.

Wellbeing and mental health

In all four study countries, middle generation adult carers with significant to substantial caring responsibilities reported that their care work caused tiredness, fatigue and/or insomnia. Many also experienced worries, distress and chronic stress due to fighting for a diagnosis of a family member's condition and trying to access adequate healthcare. Many carers experienced social isolation, which was worsened when primary adult carers and young adult carers lacked family support. Adults had to juggle multiple obligations (work, caring for family members etc.) and felt that they did not have any time for themselves. They emphasised how much family members depended on them ("*What if something happens to me...?*").

This sense of responsibility to care for and provide for family members was particularly accentuated in families without legal status. For example, Ali, a 23-year old man of Afghan background in Sweden was the primary carer for his disabled brother and ill mother commented:

> *"[...] because you are a refugee, and you do not have a social security number[16] and you have to find a way by yourself, to find a black job, or any illegal work, and you have to manage with that limited payment that you get through that. It is really difficult. But whatever is in my hands, (...) I will provide it to them with happiness. Because then I feel better. (...) It is really a feeling of responsibility that gives me energy, but frankly it is really hard".*

Many interviewees also reported constant worries about their distant family members' wellbeing (e.g. living in conflict zones or refugee camps or in countries of first asylum) or the uncertainty of whether family reunification was possible. Being unable to provide proximate care for a family member in need caused immense distress and severely impacted on transnational family members' mental health. The absence of a supportive family network also caused distress and increased the pressures on unpaid carers. Separation from extended family networks due to forced migration placed considerable pressure on parents caring for children, especially those with a disability or chronic illness. A Local Authority practitioner in the UK highlighted the additional care needs and difficulties facing recently resettled families:

> *"We do have lots of health needs of children which means that perhaps they're not able to be at school; parents are caring for them. So yeah, lots of additional support needs and just lots of very large families, families with a large number of children who are used to living in a community where they would probably [be] in an extended family unit with lots of support from family members and being in the UK they will be, you know, quite isolated as a nuclear family in one property and yeah, that can be really, really challenging".*

Further, the inability to visit family members abroad (due to lack of finances, lack of respite care provision, family member's health situation or legal status) had a major impact on the wellbeing of some interviewees.

Many adult carers reported that their extensive care work prevented them from having any time for themselves or possibilities for self-care, leading to both psychological and physical health issues. Many reported experiencing depression, which in Spain, appeared to be more prevalent among women, and other mental health issues. Some used legal drugs to alleviate their suffering.

16 In Sweden, having a social security number facilitates access to healthcare and other social welfare provisions.

In all four countries, children (until 18 years) and young people (19-25 years) expressed mixed feelings about their caring responsibilities, reporting that it could lead to tiredness and stress. This has effects on their ability to focus on their education and engage in friendships outside school. Impacts on their social life also led to anxiety and sadness. Some young people experienced constant worries related to their caring obligations, for example of making a mistake when caring for siblings or interpreting for family members at healthcare appointments. Many said that they had no one to talk about their situation and kept it to themselves, which may have a socially isolating effect. In the Spain and UK research, gendered expectations of girls undertaking more care work than boys sometimes led to conflicts within the families when girls protested and challenged parents and older relatives about the unequal distribution of care tasks. In the UK, some young people also expressed worries about the wellbeing of family members in other countries who need healthcare.

In all the study countries, young people also expressed positive feelings about their caring obligations, expressing a sense of pride and self-worth in helping their family, and resulting in a feeling of being respected.

Family relationships

Reciprocal caring relationships were evident among most of the families interviewed in all four study countries, often based on an implicit intergenerational contract (see also Section 6). Strong links of solidarity often developed between the older and younger generation based on reciprocal caring relationships. The figure of the "grandmother" was particularly important among Latin American families in Spain, regardless of whether the grandmother lived in Spain or elsewhere. Acute caring situations were sometimes regarded as bringing families closer together. Indeed, some middle generation interviewees in Sweden and in the UK reflected that such experiences can foster resilience, pride and closeness within the family.

Furthermore, many young people in all four study countries felt that their caring responsibilities led to closer family relationships and expressed a strong sense of belonging to the family. Siblings in Spain that supported each other grew up with a sense of being united and created strong support networks.

Despite developing reciprocal caring relationships among proximate and distant transnational family members, however, conflicts and tensions were also evident in all the study countries. Such conflicts sometimes led to separation and divorce between spouses, and frustrations with extended family members over unmet or unrealistic expectations.

Among interviewees in Spain, many girls and young women were involved in household chores and childcare for siblings due to their families' precarious economic situation and migration status. They expressed feelings of resentment that they were losing out on their youth and a sense of being 'exploited' by their parents when they compared themselves to their classmates without such caring responsibilities. This led to conflicts with their parents; older family members, children and those with care needs were usually protected from such family conflicts.

Migrants in Spain and France, who were predominantly providing distant care for family members in countries of origin, including those with age-related chronic illness, worked hard to send remittances and call daily for emotional support. However, they sometimes felt overloaded or exploited. Migrants in France with family members of low socio-economic status in the origin countries felt under considerable pressure, which was exacerbated during the COVID-19 pandemic and in recent years due to rising living costs. Many interviewees in Spain and France felt that the sacrifice they had made for the extended family and the care they provided (often through financial remittances) was not reciprocated, which led to stress and frustration.

Middle generation and young people with substantial caring responsibilities for a family member with a disability or chronic illness reported that their care work meant they were not able to spend time with other proximate family members, as they would have liked. Some middle generation carers in the UK were distressed that extended family were not able to join them in the UK to help alleviate their care work and they were unable to travel to visit extended kin in their country of origin due to their care work. This situation sometimes resulted in unconventional caring practices, for example, the husband or children provided care which was not culturally expected. In some cases, this led to family conflicts when conventional gender and/or family roles were challenged and negotiated.

Furthermore, middle generation family members in Sweden and the UK providing substantial proximate care for family members with a disability and chronic illness sometimes expressed a sense of isolation and separation from transnational family members. This was usually related to the geographical distance, barriers to travel due to restrictive immigration policies and costs and an inability for the everyday care work to be shared by extended family members living in other countries. For many in Sweden and the UK, forced separation from older parents, siblings, and in some cases also (some of) their children over many years was very difficult to deal with. Many felt that family members abroad did not understand their situation, particularly mental illness or the complex impairments that their child or relative experienced. Meanwhile several transnational family members providing emotional support at a distance to family members in the UK expressed a sense of powerlessness in not being able to help primary carers with the proximate care of family members.

Social participation

Middle generation carers in all four countries reported that extensive caring responsibilities left little or no time to meet friends or develop new friendships, or engage in leisure activities, which were also hindered by low income and financial pressures. In the UK, some adult carers reported that they were unable to participate in volunteering activities or cultural events, which they would have liked to do. Some said that community members from their ethnic group did not understand that their high level of care work prevented them from attending such events, resulting in a sense of social isolation.

Across the four study countries, young people and young adults reported that their caring responsibilities had a negative impact on their social lives and leisure activities. Socializing with friends was difficult because of time constraints, lack of understanding from friends, or not being able to bring friends to their home. In Spain and the UK, low income and financial pressures on families also affected children's and young people's ability to socialize with their peers and engage in extra-curricular activities. A feeling of 'being different' or a lack of understanding by peers also can lead to a sense of not belonging to the destination country, and an increased reliance on developing friendships with peers from the same country of origin.

Concluding points

This section has shown that care work in transnational families impacted on five key domains of participants' lives: employment and financial situation, education, family relationships, social participation and wellbeing and mental health, with impacts usually experienced in more than one domain. Negative impacts were mainly experienced by the middle and younger generations across the four study countries who were predominantly responsible for caring for young, middle or older family members either proximately and/or at a distance.

11 Conclusion and recommendations for policy and practice

The previous sections have addressed the key research questions 1-4 of the project, outlined in the Introduction. In this section, we summarise the key findings and address the final research question, 'In what ways can policy and practice support the care, wellbeing and equality of different generations of transnational families?' by identifying the policy implications and recommendations.

Key findings

This research has shown that transnational families simultaneously manage multiple caring responsibilities, both proximately for co-resident family members, and by caring at a distance for kin living in countries of origin or other settlement countries. Carers' and their family members' opportunities and access to social protection are shaped by intersecting inequalities based on legal status, nationality, race and ethnicity, disability/chronic illness, socio-economic status, language-related inequalities, gender and generation. Indeed, the deficits of migration and care regimes, alongside the absence of kin who would usually be expected to provide informal care, create the need for children and youth to take on caring roles in transnational families. Children's and young people's care work is often devalued and invisible, but may be crucial in enabling parents and other family members to fill gaps in care provision in the absence of extended family kin and in facilitating access to formal care resources through language and digital brokering.

The contrasting welfare and migration regimes across the four study countries mediate the experiences of the transnational families that participated in this research. Restrictions in accessing welfare and services emerge as an extension of migration control, particularly in the cases of France, Spain and the UK. Across the four countries, long-term settlement and 'integration' are undermined for both labour and humanitarian migrants due to the need to meet income or other requirements, and/or limitations of social rights. For families, particularly those with specific care needs, restrictive family reunion and family visit visa policies, particularly in France, Sweden and the UK, jeopardise intergenerational care and reciprocity, undermining the wellbeing of family members both locally and transnationally.

The research took place in the immediate aftermath of the COVID-19 pandemic and was able to capture how the physical and mental health, economic, social and emotional impacts of the pandemic were interlinked. Such impacts contributed to the further marginalisation of transnational families with caring responsibilities, particularly those with insecure legal status and low socio-economic status. Caring arrangements had to change due to enforced immobility, resulting in extended periods of separation when family members became 'stuck' in other countries due to the closure of borders and an inability to travel to see sick or dying relatives or attend funerals which families found distressing.

The accelerated shift towards digital technology becoming the primary gateway to access public services, seen particularly in Spain, the UK and Sweden since the pandemic, has resulted in an additional layer of inequalities. The digital divide particularly affects older generations and those with low levels of literacy or language proficiency in the dominant societal language and increases the reliance on children and younger generations. Children's roles in language brokering and mediating in institutional settings (schools, hospitals) is seen as particularly problematic since it raises ethical questions about consent and confidentiality, as well as concerns about the impact of such responsibilities on children.

The research has also highlighted several barriers to accessing affordable, appropriate and high-quality language education provision. These include: travel costs, pressure to

progress through higher level language courses, inflexible timetables due to stretched resources and ineffective coordination of language education provision.

Negative impacts of caregiving were identified among participants in the key domains of education, employment and finances, family relationships, social participation, health and wellbeing. These negative impacts were mainly experienced by middle and younger generations across the four study countries who were predominantly responsible for caring for family members.

The research in Sweden and the UK found, as might be expected, that negative impacts were particularly experienced by migrants undertaking substantial care work for co-resident family members with a disability and/or chronic illness in destination countries. Negative impacts were also experienced, however, by younger and middle generation migrants in Spain and France juggling care at a distance for family members in other countries, alongside everyday caring roles for family members in close proximity. There were particular pressures on women and primary carers in the middle generation, especially for those balancing remittances and proximate care, and, in the cases of Spain and France, doing so sometimes in very difficult working conditions.

While caring for a family member may foster resilience, such negative impacts of caregiving could have significant implications for transnational family carers' long term opportunities and life chances and individual and collective wellbeing. Our research supports the wider evidence that negative outcomes of caregiving may affect carers' economic, social and cultural rights, education and opportunities, leading to poverty, reduced employment and pension rights (EuroCarers, 2020; APPG on Young Carers and Young Adult Carers, 2023). These impacts of caregiving may be especially acute among transnational families with substantial caring responsibilities who are often already facing financial hardships and insecurity within destination countries. As we have shown, such difficult circumstances are due to limited entitlements to welfare and care resources, difficulties in securing long-term employment, restrictions on mobility through visa policies and family reunification rules, concerns about legal status and language and digital barriers to accessing support.

Policy implications and recommendations

1 Level out inequalities and differential treatment of refugees and other migrants

- **based on legal status, arrival and resettlement routes and/or nationality and ethnicity**
- **allow access to welfare and social protection in both origin and settlement countries, recognising transnational family ties**

As noted in the discussion of intersecting inequalities (Section 4), differential treatment of migrants according to legal status and nationality results in inequalities in social rights and unequal access to welfare and other forms of social protection within destination countries, as well as between countries in Europe. Processes of naturalization and the right to hold dual citizenship also differ according to national contexts. The proliferation of different visa and resettlement schemes and asylum processes witnessed in many European countries in recent years, and in our research, in France, Spain and the UK, differentiate between migrants based on their legal status, arrival and resettlement routes and/or nationality and ethnicity. Such differential treatment results in some groups being privileged, with rights to residence/ leave to remain, work permits and access to social protection, while others are excluded and subject to processes of racialisation and hostility. Developing agreed norms and approaches to refugee resettlement and asylum claims across the European Union (also including the UK) would help to level out inequalities created by different national policies and resettlement schemes.

Such differential entitlements within and between countries may also foster resentment, processes of racialisation and inequalities related to particular nationalities or legal statuses, both among refugee and other migrant communities, and among majority populations. The case of recently arrived Ukrainians fleeing the war in Ukraine from 2021 onwards in France, Spain and the UK is particularly pertinent, since they have received preferential treatment compared to other refugees and migrant groups and even compared to their compatriots, who arrived previously. Many Ukrainians who migrated to France and Spain prior to 2021 have remained undocumented for many years and excluded from welfare and other social rights. Family participants in France felt that their wellbeing would be improved, "*by giving all refugees the same rights and not differentiating them.*" (Sokol, 20, male, Albania).

Specific recommendations for each country in relation to levelling out inequalities and differential treatment of migrants are discussed below.

Spain

In Spain, nationality-based inequalities are particularly evident, based on a colonial logic that offers a fast-track means of gaining citizenship for migrants from Latin American countries (two years) compared to African migrants who have to wait ten years before they can apply. Migrants from African countries are also unable to hold dual nationality, excluding them from political rights in their country of origin, which differs from Latin Americans who are permitted to hold dual nationality. There is a need to ensure equal citizenship and dual nationality for all migrants as this would allow transnational citizens to exert their political rights in both countries to which they contribute and make it easier for transnational families to access and combine social protection resources from more than one country to meet their care needs.

Access to social protection in Spain is linked to an individual's position in the labour market. In a country where labour is marked by precariousness and informality, and where simultaneously, obtaining a permit is conditional on having a labour contract, migrants are left unprotected, which was especially challenging during the COVID-19 pandemic. For example, the IMV (Minimum Living Income) is, a benefit given to people at risk of social exclusion, but it excludes migrants in irregular situations.

Specific recommendations to reduce these inequalities facing undocumented migrants in Spain are to:

- Restore universal health assistance to people in irregular legal situations, (abolished by the Government of Mariano Rajoy Popular Party in 2013 but formally overturned by a Royal Decree passed in 2018. In practice, those in irregular situations continue to be excluded).
- Extend the IMV (Minimum Living Income) to include migrants in irregular situations, who are currently excluded.

France

The research in France also highlighted the barriers undocumented family members faced in accessing healthcare due to administrative issues. Such administrative delays exposed transnational families to healthcare risks during the COVID-19 pandemic. As in Spain, recommendations to improve access to social protection, particularly healthcare, for undocumented migrants were emphasised by family participants in France. The research also highlights the need to avoid the differential treatment of migrants linked to the presence of family members in the destination context and/or their educational background and skill profile, which currently privileges those who are highly skilled.

The research in France further highlights the need to recognise transnational family ties and allow access to welfare, social protection and labour markets in both origin and settlement countries. Transnational families represent an increasing social reality in a globalised era and hence they should not face obstacles to manage family care needs across borders. For example, a young person with a disability and chronic illness who was entitled to welfare benefits in Armenia has lost this entitlement after he migrated to France.

Specific recommendations include:

- Ensure undocumented migrants have continued access to healthcare (AME State Medical Aid), which has often become the focus of political debate in the current context and is at risk of being withdrawn.
- Migrants' families should have access to welfare support in France if they have ties in other countries, such as the current exclusion from welfare benefits (for example, the minimum resource benefit) if the parent spends periods of time abroad where their child lives.
- Social security agreements should be extended to more countries representing migrant workers' countries of origin, such as ensuring access to the total pension amount, based on contributions made in both origin and receiving countries. This is important in protecting transnational families' financial security.
- Greater recognition of migrants' qualifications and diplomas across the origin and receiving contexts is needed, since these influence their social mobility and capacity to integrate in the labour market both 'here' and 'there'.

The research in France also shows the importance of strengthening healthcare and welfare systems in countries of origin. This would help to ensure that transnational family members' needs for care are more adequately met by the state in origin or other countries, rather than having to rely on remittances from the middle generation to fund private healthcare and other social protection.

UK

In the UK, different visa and resettlement schemes, established in response to, for example, the Syrian, Afghan and Ukrainian conflicts and the political situation in Hong Kong, operate by various criteria and grant newcomers different levels of support and entitlements that create a differentiated system of refugees' social rights[17]. This causes difficulties and confusion for local authority and third sector migrant and refugee organisation staff and volunteers who may have differing funding streams for different groups, which they need to target to meet funding requirements, while also seeking to address inequalities created by different eligibility criteria (see also **Turcatti et al., 2024**).

Specific recommendations to reduce inequalities facing migrants in the immigration and asylum-seeking system and in the labour market in the UK, based on the views of practitioners and family members include:

- Reduce costs of visas and passports for family members
- Streamline and reduce the processing time of asylum claims, humanitarian resettlement, family reunification and visa applications so that family members are not separated for so long and can fulfil caring obligations
- Lift the restriction around right to work of asylum seekers
- Improve official recognition of professional qualifications obtained overseas to enable job-seeking and avoid de-skilling
- Provide adequate legal representation to asylum seekers and 'unaccompanied minors' (unaccompanied child refugees/ migrants)
- Provide long term funding to local authorities and strategic migration partnerships (SMPs) to provide integration support to migrants and resettled groups
- Ensure fairness and consistency in age assessments of unaccompanied minors
- Create a culture within government that is more supportive and compassionate towards migrants, not hostile.

17 While resettlement schemes in the UK appear to offer privileged entitlements to social protection for particular nationalities compared to the majority of people applying for asylum, they are not unproblematic, as shown by the lack of refugee family reunion rights provided for in the Afghan Citizens Resettlement Scheme 2022-2024, although policy has recently changed (Refugee Council, 2024). Similarly, Ukrainians in the UK under the Homes for Ukraine scheme, Ukraine Family Scheme or Ukraine Extension scheme are excluded from refugee family reunion and have no options to sponsor any family members to join them in the UK (Refugee Council and Safe Passage, 2023).

Sweden

Despite the universal model of welfare provision and high Migrant Integration Policy Index (MIPEX) score (see Section 4), the research in Sweden found that transnational family members with caring needs and responsibilities often faced inequalities in securing long-term employment, which impacted on their wellbeing and opportunities. Such challenges were not only related to barriers to language learning and participants' care work for family members, but were also to related to not being able to afford to obtain a Swedish driving license which was a requirement for employment. Furthermore, participants undertaking internships found themselves in a constant loop of temporary positions which never resulted in longer-term employment and led to mistrust of public services. Specific recommendations include:

- Public employment agencies need to be more closely involved in monitoring and evaluating such internship programmes to ensure they do not reinforce inequalities in the labour market;
- Subsiding the costs of obtaining a Swedish driving license would make the labour market more accessible for migrants.

2 Expand the definition of 'family' in reunification policies

- **facilitate transnational family reunion and mobility across borders for extended family members**
- **fast-track where there are care needs**

Family reunification policies are inconsistent between different European countries and based on assumptions about family structures informed by Western nuclear family models that do not acknowledge the diversity of family forms and intergenerational care common among transnational families from origin contexts in the global South (Kofman et al., 2011). Of the four study countries, Spain has a more 'generous' overall approach which provides the opportunity to reunify with the older generation (over 65 years of age), aside from partners/spouses and children under 18, which is the case for France, Sweden and the UK[18] (UK Government, 2024; Office Français de l'Immigration et de l'Intégration, 2024; Ministerio de Asuntos Exteriores, Union Europea y Cooperacion, 2024; Migrationsverket, 2024).

Our research has demonstrated the need to expand the definition of 'family' in reunification policies and recognise a wider range of family members than just the immediate 'nuclear' family, so that migrants could 'sponsor' and be reunited with parents, adult siblings, cousins, nieces, nephews, aunts, uncles, grandparents, as well as children aged 18 or over. Barriers to parents reunifying with children aged 18 or over can result in disruption to young people's education and transitions to adulthood. Long delays or refusal to permit family reunification, alongside prohibitive costs and conditions of applying, affects wellbeing, potentially increases children's caring roles and infringes migrants' right to family life.

Families' experiences highlight the importance of immigration authorities in France, Spain, Sweden and the UK providing adequate consideration of family care needs when assessing visa and reunification applications. Family members would then be able to fulfil inter- and intra-generational caring obligations and meet proximate care needs. The research highlights the need to fast-track applications for visas and family reunification where there are specific care needs and consider such situations as 'exceptional circumstances' to facilitate transnational family members' mobility to provide care for family members.

While rights to refugee family reunion are enshrined in the United Nations 1951 Refugee Convention, each signatory to the Convention might have different rules in place.

18 There are also exceptional circumstances that apply to dependent children over 18 years of age who have a disability, and, for example in the UK, it is possible to apply on exceptional circumstances for older parents with care needs, but this is difficult and few cases are granted.

Research from the UK shows the difficulties family members who had been resettled in the UK by the UN Refugee Agency face in visiting and reuniting with family members in third countries, including other European countries (see also our film, *Refugee Families Caring and Seeking Reunification*, co-produced with family participants and Mas Giralt and Evans, forthcoming).

Furthermore, refugee children are not currently allowed to reunite with their parents or relatives in the UK, making the UK approach very harsh and out of step with other countries in Europe (Refugee Council, 2024). It also contravenes the principle of the best interests of the child under the UN Convention of the Rights of the Child and national laws.

Such policy failures have damaging consequences for the wellbeing and education of refugee children, in turn affecting their life chances (Refugee Council and Safe Passage, 2023). Family members and practitioners interviewed in the UK ranked the need to expand definitions of 'family' and facilitate the mobility of transnational family members as a key priority for change. We also support the Refugee Council and Safe Passage's (2023, p.3) specific calls for change regarding refugee children:

- amend the Immigration Rules to allow refugee children in the UK to sponsor parents and siblings;
- amend the Immigration Rules to remove barriers to children joining refugee non-parent adult relatives in the UK.

We recommend expanding the eligibility criteria and definition of 'family' within resettlement schemes and the asylum system to include children aged 18 and over, parents, siblings and other extended family members, and fast-tracking applications where they are care needs. These changes would enable such transnational family members to provide culturally appropriate inter- and intra-generational care in response to their needs and is fundamental to their wellbeing.

3 Recognise children's care work in transnational families and address the whole family's support needs

- **recognise children's important roles in language and digital brokering as care work in itself**
- **recognise care work across borders**

This research has provided important evidence of the significant, sometimes substantial, unpaid care work that children and young people provide to support transnational family members who often have multiple care needs. Children's care work comprised language and digital brokering, emotional support (both proximately and at a distance), childcare, household chores, personal care and healthcare support and among young people in Spain and France, financial support. While children's caring roles may be valued within families, such care work may have negative impacts on young people's wellbeing, education and life opportunities, as a recent UK All Party Parliamentary Party on Young Carers and Young Adult Carers Inquiry (2023) has shown.

While young carers have been recognised in legislation and policy in the UK as a particular group requiring support, the majority of the children and young people interviewed providing care had not been identified as young carers by teachers, social workers or other professionals and were not accessing support. In Sweden, Spain, France and most other European countries, children and young people with caring roles are not recognised by the state or third sector organisations as a specific group that may require formal support (Leu and Becker, 2011). Our research points to the crucial need for policymakers and practitioners in France, Spain and Sweden to acknowledge the issue of young caregiving and develop strategies to recognise and address the support needs of children and young people caring for family members within transnational families.

Across the four study countries, language and digital brokering and providing practical assistance to navigate care, welfare and immigration systems in settlement countries were significant roles that young people engaged in. Such support often enabled

facilitated parents' and other family members' access to formal care resources, yet it is often invisible. Young people interviewed found interpreting in healthcare, social care, educational or legal settings sometimes stressful and were concerned about making mistakes or not understanding fully. Children's language brokering roles also contravene statutory guidelines in the UK for safeguarding children (HM Government, 2023, p.15) which state that "Professional interpreters should be provided where needed. Practitioners should not need to rely on family members or partners for interpretation services".

UK family participants and practitioners saw the need to increase the recognition of children's and young people's care work in transnational families as a key priority. More awareness is needed among teachers, social workers, healthcare practitioners and other professionals. Children's important roles in language and digital brokering need to be recognised as care work in itself, since they may be drawn into these roles regardless of whether there are specific disability-related care needs within families.

Participants in the UK also emphasised the need to assess and meet the care needs of the whole family, not just those of an individual with a health or social care need. While the principle of the 'whole family' approach applies in the UK across all age groups and across all categories of care under the Children and Families Act 2014 and Care Act 2014, some participants felt that the needs of children and adult siblings, for example, providing proximate care had not been adequately met. The research has shown that the 'whole family' approach needs to include extended family members, including those not living in the immediate household and recognise how adults and children may be simultaneously caring for other family members in other countries.

Furthermore, the research reveals how 'sedentary' models of welfare discriminate against transnational family members who have caring responsibilities across borders, resulting in negative impacts on the financial security and wellbeing of family members with care needs. For example, in the UK, a harsh financial penalty cutting welfare benefits for several months was imposed when a grandmother with chronic illness visited her daughter and grandchild in another European country for longer than the permitted 14 day holiday period. Other participants highlighted the need for respite care for disabled family members to be provided for periods longer than 2-3 weeks occasionally, to enable primary carers to have a break and visit family members in other countries.

A more inclusive, flexible approach to the provision of welfare and care resources is needed that recognises transnational family ties and caring obligations across borders and need to travel in the context of global mobility.

4 Make public services more accessible, welcoming and inclusive for migrant carers and their families

- **improve the accessibility and efficiency of services**

In all four study countries, family participants and practitioners highlighted significant barriers that transnational family members with care needs faced in accessing public services, including healthcare, social care, welfare entitlements, education, including adult language education, housing and other local authority services. Barriers were related to:

- bureaucratic administrative systems that used specialist, jargonistic language;
- a lack of knowledge of migrants' rights and entitlements to support and how the 'system' works;
- a reliance on online application processes that required digital literacy skills;
- discriminatory attitudes from public sector workers.

Delays in accessing entitlements to social protection increased the socio-economic precarity of families, which was especially challenging in the context of the COVID-19 pandemic and cost of living crisis.

Despite the European Union's principles of protecting the most vulnerable, migrants in Spain reported a lack of access to entitlements by local authorities at the municipal and regional levels, especially when they were governed by extreme right and right-wing parties (VOX and Popular Party). They also reported experiencing racist attitudes from public sector workers in the Municipalities. Such attitudes resulted in a refusal to provide information on how to access basic public services, such as how to enrol children in school or how to obtain basic health assistance, and in refusing to process some mandatory procedures such as housing registration (*empadronamiento*), which is the first step in the long road to naturalisation for migrants but also necessary to demonstrate residence and be able to access universalistic public services or social protection schemes. There is a need for workplace inspections to specifically combat such discriminatory practices in public institutions.

In Sweden, despite universal access to healthcare, many participants expressed a strong sense of dissatisfaction with the healthcare services they received. They often felt that their treatment did not correspond to the (possible) severity of a health issue present in their family, and experienced difficulties and long waiting times in obtaining appointments with doctors. This often led to mistrust in the healthcare system and uncertainty about whether they received equal treatment compared to non-migrants. Providing accessible information about how the Swedish healthcare system works could help to foster better understanding and reduce mistrust.

- **address the digital divide**

In all four study countries, many bureaucratic procedures have shifted to online spaces and require digital literacy skills, particularly in the post-pandemic environment. Practitioners in the UK highlighted how access to welfare entitlements and public services was increasingly restricted to online applications processes which could exclude migrant families from their entitlements to support. Participants highlighted the importance of addressing the digital divide and ensuring services were accessible to older migrants and those with limited digital literacy skills, as well as those seeking asylum and other migrants on low incomes who lacked internet access and digital devices, due to financial constraints. Unaccompanied asylum seeking and refugee children in the UK were identified as a particular group who were often affected by the digital divide.

- **expand interpreting and translation services (taking account of gender sensitivities and language varieties)**

The research across the four project countries identified the need to expand interpreting and translation services in order to improve the accessibility of public services and reduce the reliance on young people and other family members to provide language brokering, for example, in healthcare, social care, educational, welfare and legal settings. Participants reported experiencing difficulties in obtaining appropriate interpreters particularly in healthcare settings.

More appropriate interpreting and translation services are required that pay attention to gender sensitivities (such as gender matching when discussing confidential health or legal issues) and language varieties, such as Syrian or Sudanese Arabic etc. rather than a non-specific Arabic interpreter who may use a different dialect[19].

The research in the UK and Sweden specifically identified the need for more qualified and culturally aware interpreters, particularly in healthcare settings. In the UK, practitioners also identified the need for more funding for interpreters in legal settings and in social care, particularly when supporting unaccompanied refugee children.

The policy proposal in Sweden (Liberalerna, 2022) to limit the availability of free-of-charge interpreters is of great concern, as this would result in migrants having to pay for an interpreter when interacting with local authorities and would have likely increase the language brokering roles of children and young people.

- **provide intercultural training (transnational family ties, culturally appropriate care, forced and irregular migration, value of multilingualism)**

Alongside providing adequate interpreting and translation services, the research identified the need for intercultural training for professionals in public sector institutions to increase their awareness of the lived realities of transnational family ties and caring responsibilities across borders.

The research with families with high care needs highlighted the importance of professionals having greater awareness of cultural expectations of appropriate care. Training for social workers and healthcare professionals needs to include consideration of what culturally appropriate care might look like for the different migrants they support, based on a person-centred approach.

Intercultural training for professionals in public sector institutions, including welfare, education, health and social care and employment support should also raise awareness of how experiences of forced and irregular migration may affect their client group.

Alongside intercultural training for professionals, particularly teachers and local authority staff, the research in Spain identified the need to include more cultural diversity and awareness of multilingualism, particularly about the value and importance of migrants' first languages, within the educational curriculum. This would help to welcome students from migrant backgrounds and highlight the value of diversity within schools. More training and awareness of the value of multilingualism among professionals in public services, including education, was also identified as important in the other study countries (France, Sweden and UK).

- **expand and improve the quality of language education**

The research has demonstrated the crucial importance of language proficiency in the dominant societal language in order to facilitate interactions with state institutions and public services, including employment, education, health and social care and welfare and improve families' socio-economic status and 'integration' prospects in the longer term. The provision, coordination and quality of adult migrant language education however needs to be improved across the four study countries.

Barriers to language classes experienced by transnational family members with care needs need to be addressed, such as refunding transport costs, providing a range of class times and days of the week to take account of childcare and other caring responsibilities and access to public transport, and improving information about accredited/ non-accredited courses and how to access these.

19 See also the film, ***Language and Interpretation Needs in Accessing Healthcare***.

The research in Sweden highlights age-related inequalities in access to language education. The eligibility criteria for the state 'establishment programme' excluded refugees aged 66 years or older from accessing this important opportunity for language learning, regarded as a key means of 'integration' and 'successful settlement' in the destination country (Ager and Strang, 2008). While there were no age limits on enrolment in the public 'Swedish for Immigrants' language courses, migrants enrolled on these courses are not entitled to the same financial allowance as those participating in the establishment programme. While older generations may experience more difficulties in language learning than younger generations, especially in cases of low levels of literacy in their first language, inclusive opportunities for language education need to be provided for all and could help to reduce the reliance of older family members on younger and middle generations to provide language and cultural brokering.

In the UK, practitioners identified the need for more funding for English for Speakers of Other Language (ESOL) provision and to level out the funding landscape across resettlement schemes and make it easier for providers to access funding to improve ESOL provision. Provision could be increased by providing tuition in hotels and other residential settings accommodating asylum seekers in all local authorities. Practitioners thought that accredited language education courses should be provided over longer periods to take account of barriers learners faced. More recognition is needed of the challenges migrant women with caring responsibilities may experience, particularly among those whose language learning and education may not have been prioritised previously.

- **increase long-term funding, collaboration with and support for the third sector**

The research in the UK, Spain and France has demonstrated the crucial role that the third sector plays in supporting refugees and other migrants and facilitating their access to public services, often filling the gaps in statutory provision. However, third sector organisations in the UK, Spain and France faced considerable challenges, including limited funding, competition for different funding streams, understaffing and insufficient resources to train volunteers and staff in the challenging context of austerity, the COVID-19 pandemic and its aftermath, the cost of living crisis and increasingly restrictive migration regimes and political discourses[20]. In Sweden, the third sector has a much more limited role due to the universal (social democratic) welfare model (Martinelli, 2017). However, third sector organisations increasingly fill in the gaps of the formal welfare system (Osanami Törngren et al., 2018).

Research with practitioners in the UK identified the need for more long-term funding from central Government for the third sector, as well as for Strategic Migration Partnerships and local authorities to provide integration support for refugees and resettled migrants, rather than piecemeal funding of one to two years.

Research in France demonstrated the need for local and regional authorities and the administration (public services) to support and foster greater co-operation with third sector actors to facilitate the welcome of new arrivals and provide integration support. Place-based differences were evident in terms of access to support for minority ethnic groups such as Yezidi migrants; the dynamics of local authority and third sector interactions and support of local and regional authorities in different locations impacted on families' wellbeing and access to social rights.

20 See also the Policy Brief: ***Refugee and Migrant Organisations in the UK as Spaces of Care*** (Turcatti et al., 2024).

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Care, Inequalities and Wellbeing among Transnational Families in Europe

Report of the CareWell comparative, intergenerational study in Spain, France, Sweden and UK

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