Bianca Brijnath

Indians Abroad: Kinship, Capital, and Technology in Transnational Care

Abstract Migration and an ageing population will create and demand new modalities of care. These processes are shaped by structural forces like citizenship, flows of capital, and access to healthcare, as well as individual notions of family, love, and compassion. This chapter explores how care is conceived and delivered in transnational Indian families, and what families gain and lose as a consequence of geo-physical distance. There is emphasis on how the notion of "family" is sustained and yet also altered across borders, the role of remittances in funding transnational health-seeking, and what happens when distant "real" kin are replaced with immediate paid care attendants. Three key concepts—kinship, capital, and technology—are used to structure the analysis and ethnographic data from urban India and auto-ethnographic data as a member of a transnational family to provide evidence for the argument.

Keywords capital, care, kinship, older people, technology, transnationalism

Published in: Brosius, Christiane and Roberta Mandoki, eds. 2020. *Caring for Old Age. Perspectives from South Asia.* Heidelberg Studies on Transculturality 8. Heidelberg: Heidelberg University Publishing. DOI: https://doi.org/10.17885/heiup.597

Introduction

More than twenty years ago, Arjun Appadurai (1996, 55) counselled, "where lives are being imagined partly in and partly through realisms that must be in one way or another official or large-scale in their inspiration, then the ethnographer needs to find new ways to represent the links between imagination and the social life." Today, the scale of human life has considerably expanded, and transnationality is now a daily reality in many people's lives. In 2015, there were 244 million international migrants, of whom Indian migrants constituted the largest majority (United Nations 2015). Though migrants tend to be mainly of working age, migration alone cannot overcome the challenge of old-age dependency ratios as a result of global ageing (United Nations 2015); by 2050 there will be more people over the age of sixty than children under fourteen years of age (United Nations 2006).

The challenges for researchers are to develop frameworks capable of encompassing all of these complexities. But simultaneously, the task is not to lose sight of the minutiae of people's lives. Migration and an ageing population will create and demand new modalities of care. These processes are shaped by structural forces like citizenship, flows of capital, and access to healthcare, as well as individual notions of family, love, and compassion. In this chapter, I explore how care is conceived and delivered in transnational Indian families, and what families gain and lose as a consequence of geo-physical distance. Specifically, I explicate how the notion of "family" is sustained and yet also altered across borders, the role of remittances in funding transnational health-seeking, and what happens when distant "real" kin are replaced with immediate paid care attendants. Three key concepts—kinship, capital, and technology—are used to structure my analysis. I draw on ethnographic data from urban India and my own experience as a member of a transnational family to provide the evidence for my argument (Brijnath 2009, 2014). In marrying these concepts and narratives, what emerges are old landscapes shaped by the inequities of power, citizenship, and access to care through which families must negotiate new forms of agency, of being together, and of coming to terms with (im)possible ways of caring.

India's diaspora

An increasing number of families are now part of the Indian Diaspora, the world's largest diaspora (United Nations 2015). Currently there are an estimated twenty-five million non-resident Indians and people of Indian origin located across the globe (Ministry of External Affairs 2016a). These diasporic communities are far from homogenous and there are tremendous variations in migration pathways and family formations as mediated through prisms of gender, generation, class, education, locality, and so

on. Whether migrating to become nurses in Oman, construction labourers in Dubai, university students in Australia, biotech engineers in the United States (US), or small-business owners in the United Kingdom (UK), Indian migrants have diverse journeys and ways of becoming and being part of the bricolage that is the Indian diaspora (Mishra 2006). So while I deploy the term "diaspora" here to function as a connector between a nation-state and its emigrants, I recognize that the concept is far more polysemous and suggests also a process, a condition, a state, a space, an effect, a model, and a performance among other definitions (Fernandez 2009). Moreover, the continued conflation between the definition and functions of diaspora underscores the fluidity of the term, the interplay between dramatic and economic modes of being in its ontological roots, and the need to pay close attention to distinctive ways of constituting multiple, competing discursive formations and subjectivities of diaspora (Mishra 2006; Fernandez 2009).

In the Indian case (like so many others), economic imperatives are the major driver of migration. Migration, most often for the purposes of work or study, has typically involved young middle-class Indians settling overseas while older family members remain in India. This demographic trend has reaped significant rewards for the Indian economy in terms of remittances and investment; for example, in 2015 alone US$ 72.2 billion were remitted to India (World Bank 2016). Globally, India has consistently been the leading recipient of remittances, principally from the United Arab Emirates, the US, Saudi Arabia, and the UK (World Bank 2016).

Flows of such vast sums of money have seen ongoing efforts by the Indian government to consolidate and cement its relationship with its diaspora. In 2004, the Ministry of Overseas Indian Affairs was established (now amalgamated with the Ministry for External Affairs), and since 2006, the Overseas Citizen of India initiative has been in operation (Ministry of External Affairs 2016b). This initiative affords people of Indian origin and their spouses (irrespective of the spouse's ethnic and national heritage) the same rights as non-resident Indians, excepting voting rights and ownership of agricultural properties (Ministry of External Affairs 2016b). Alongside these "hard" political programmes, there are several "soft" bilateral and multilateral programmes driven by the Indian government, business, and non-profit organizations around social, cultural, scientific, and economic exchange. Arguably the most influential of these "soft" efforts are Bollywood films, which have served to bind the diaspora into an "imagined community" with a globally shared "public culture" (Brosius and Yazgi 2007). Often portrayed as the "consumable hero of globalized India" in contemporary Bollywood films (Deshpande 2005), non-resident Indians have come a long way from their historic depictions in Hindi films as narcissistic outsiders representing the worst excesses of Western culture (Brosius and Yazgi 2007).

But running alongside this open political and economic courtship of Indian diaspora is also a sense of unease in the national imagination about

the fate of older Indians who are viewed as "forgotten" and "left behind." Migration, urbanization, the changing role of Indian women, growth in consumerism, and the adoption of supposedly more "Western lifestyles" have led to a perception that older people are not as securely positioned in their family hierarchy nor are they as revered as previous generations were (Dharmalingam 1994; Jamuna 2003; Kumar 1996; Mahajan 2006). Politicians, policy-makers, gerontologists, and those in the media have been quick to dramatize this "wicked spectre" of modernity as the cause for the maltreatment, loneliness, and poor state of health of older Indians (Cohen 1998; Lamb 2005, 2009). Several other chapters in the present volume have already explored the inverse relation between modernity and ageing in greater depth, critically examining the evidence behind the rhetoric. Earlier works by Lawrence Cohen (1995, 1998) and Sarah Lamb (2005, 2000) have also found a link in popular discourse and in Indians' perceptions of a "bad" old age and modernity. Lamb in her work on old age homes in Kolkata documents the public outrage against such institutions, concluding that "Indians take such emerging and novel modes of serving the ageing to represent a profound transformation—a transformation involving not only ageing per se, but also principles underlying the very identity of India as a nation and culture" (Lamb 2009, 89).

However, as Lamb (2009) also points out, while such dramatic emotional reactions prevail in India's gerontological and media landscape, in actual practice older people and their carers enunciate far more ambiguous and complex understandings of ageing and care. With only a few exceptions, little has been documented from the perspective of Indian families themselves. Failure to address this lacuna leaves unexamined the practices and processes that create and sustain the relationships and identities that constitute transnational lives, including the economic and political dimensions (Baldassar et al. 2007). But a close-up, textured analysis of how families stay connected across boundaries of distance, citizenship, and illness illuminates how families are made together apart, what forces facilitate this construction, and how such forms of family formation may contest the boundaries of nation states, access, citizenship and belonging. Accordingly, the remainder of this chapter focuses on detailing such an analysis in order to explore how care is conceived and delivered in transnational Indian families and what families gain and lose as a consequence of distance.

Kinship across borders

Kinship, love, duty, and family are profound sources of meaning in people's lives. How they are used automatically attunes us to the cultures from whence they came. Using familial terms of address—*bhaiya* (brother), *didi* (older sister), *mataji* (mother)—between family members and strangers is a form of brokering relationships and invoking bonds of reciprocity. In structuring relations between spouses, parents, children, and siblings,

capital is also apportioned, prioritized, and spent on blood kin, extended family, and fictive kin. Take the Mukherjee brothers who have grappled for many years with their father Gautam's dementia. The three brothers, originally from India but now based in the US and Europe, have tried many different options for Gautam: home care in the US, aged care facilities in Florida, and finally home care in India. When they decided that Gautam and his wife Shilpi should return to Delhi, it turned out to be Gautam's last journey since he died in 2008. Assisting Shilpi with caring were two poor Christian middle-aged women. Although of different circumstance to their wealthier Hindu employers, these women called Gautam 'papa' as they cared for him. In turn Shilpi reciprocated with gifts and home-baked cakes on birthdays and special occasions. In the absence of "real" children, the walls of class and employer–employee relations dissolved to create such fictive kin. Sandra, who was paid to care for Gautam, recalled her previous employment:

> In Kalkaji that old lady died about two years ago. I could not go because I was working but I would always call *bhabhi* and keep asking, "How is ma's state? How is she?" ... Even though she gave me so much trouble I remember that family very fondly (June 6, 2008).

For paid carers looking after an older person with dementia, the use of terms such as 'papa' or 'ma' or '*bhabhi*' (sister-in-law) was a multi-pronged strategy that displayed respect for their employers and elders, avoided an indifferent employer–employee relationship (Vatuk 1969), and reinforced the meaningfulness of their work. It was also a way to try and gain the "attendant affection, rights and obligations" of other family members by providing care "like family and doing what family does" (Karner 1998, 70). Saroj, another paid carer, said:

> I like doing this work. It is *sevā* (care) for the old and elderly, and in your own heart also you get a relief knowing that this person—who is like my mother—[that] her body is also working (April 17, 2008).

Extending family networks to include fictive kin appears to be supported by real family members in India and abroad. A number of Indian non-governmental organizations now offer support services to emigrant children for their older parents in India (Lamb 2009). For a fee, tasks such as accompanying older people to doctor's appointments, spending time with them, and running errands can be completed with the promise that such services will be delivered in the same manner as children would provide to their ageing parents.

These new commercial "children" help to articulate new collectives of care and illustrate the complex ties of migration, distance, and income. The Mukherjee sons paid for their fictive kin's salaries and their own parents' household expenses. The eldest son, a doctor, also arranged for medication

to be sent from the US to India, while the younger sons shipped diapers. All three brothers staggered their visits to India as much as possible so that their parents were never alone for more than a few months. The irony of course is that as the Mukherjee's offered each other economic and material forms of care, they also experienced the losses associated with loneliness and the emotional insecurities of being physically absent from each other. Their geo-physical distance exemplifies Ghassan Hage's (2005) argument that human mobility is not axiomatic in transnational families as family members do not actually spend much time moving around. Rather, it is transnational cultures and its accoutrements that circulate—global relations, goods, emotions, and money—and thus notions of transnational family and care should be approached not as emplaced within multiple sites, but rather as located within a single geographically discontinuous site (Hage 2005, 2012).

Extending this concept of circulation, Baldassar and Merla's (2014, 25) framework of care circulation emphasizes "the reciprocal, multidirectional and asymmetrical exchange of care that fluctuates over the life course within transnational family networks subject to the political, economic, cultural and social contexts of both sending and receiving societies." Disputing the notion that transnational families are dysfunctional, through a series of carefully edited ethnographies, they show how practices of transnational care are inherent to the construction of kinship and moral economies of care and individual social identity. Thus children who migrate for economic reasons might live further away from their parents, but by virtue of their higher incomes, they are able to remit more monies home and facilitate greater choices for their parents in seeking care. But access to resources and negotiated commitments among family members are not the main motivators of care; feelings of obligation are important and are linked to cultural constructions of duty and responsibility (Baldassar 2007). For transnational families, care often includes both financial and communicative labours (Hage 2012).

In Indian families the circulation of financial and social remittances between adult children and ageing parents are shaped by moral precepts of care, service, and reciprocity (Brijnath 2014; Singh and Cabraal 2014). Family members respond to each other based on perceptions of behaving like a "good" or "proper" family, sharing in the care of older parents who once cared for them. As recalled by Sunil Bhatnagar, a neurologist in Delhi:

> I have a patient right now whose children have quit their business or stopped their business in the UK to come and take care of them, to come and be with their father. I said, "Nonsense! Back you go and start your business again. How can you stop your business and come?" (May 28, 2008).

While Dr Bhatnagar strongly recommends "that the family must go on with their life … [that] their lives must not come on hold," transnational families experience complex and conflicting emotional demands. On the one

hand, they enjoy the economic privileges of living abroad and of not being required to undertake day-to-day care (which is emotionally and physically exhausting work). On the other hand, they grapple with the vulnerabilities of being far away and of feeling guilty because they are unable to help on a day-to-day basis. Guilt is an inherent part of the equation, a finding specific not only to Indian transnational families but also found in other transnational families of different ethnicities (Abel and Nelson 1990; Joseph and Hallman 1998; Lin and Rogerson 1995; Schoonover et al. 1988).

Moreover, such feelings do not exist only as cultural, moral, and ethical dilemmas, shielded from wider politico–legal manipulations. Governments of migrant-sending countries, which have capitalized on remittances, have been quick to emphasize the importance of kinship, care, and citizenship; examples include migrant Filipino workers being lauded as "national heroes" (Rodriguez 2002), and the construction of migrant Haitians as the saviours of "those left behind" (Schiller and Fouron 1999, 341). In other instances, the underlying expectations of the state are more punitively framed. For example, in 2007, the Government of India passed the Senior Citizen's Act to legally enshrine the obligation of adult children or relatives to care for older people (Ministry of Social Justice and Empowerment 2008). Currently, adult Indian children, whether in India or abroad, face penalties for breaching this law, including up to three months' imprisonment (Ministry of Social Justice and Empowerment 2008). Arguably, the law has been ill-conceived and poorly implemented, limiting its reach and efficacy (Brijnath 2008). Nevertheless, its very existence draws attention to the domestic socio-political contexts and machinations of migrant-sending countries, which inform contemporary practices of transnational caregiving.

Capital and transnational flows

It must not escape attention that as states export shared understandings of culture, identity, and nationality to bind their diaspora closer, these attempts are practiced largely by poorer countries. The entire business of transnational care—migrating for improved economic opportunity, remitting money, organizing care—point to systems in migrant-sending countries that are often unable to cope with existing needs, and migrant-receiving countries that do not want to bear the costs associated with meeting these needs.

Wealthy nations like the US, UK, and Australia have long sought to exclude those people whom they consider will burden their health systems. Exclusions on the basis of health status, age and/or duration of residence, tactics of "othering" those who are different, the increased privatization of healthcare, and attempts to minimize insurance payouts are ways in which older Indians may be denied making claims to resources in wealthier countries where their children reside and may even hold citizenship. In the Mukherjee's case, even though two of their sons held US citizenship,

Shilpi and Gautam could not avail of any state-based concessions. Financial and visa constraints prompted their eventual return to Delhi. As Shilpi explained:

> It was very costly .... Our visa was expiring in six months, we had to go anyway. Whatever we had to do we needed cooperation from everyone. Here he has his medical insurance and everything so we thought we might as well come home. Whatever happens we have friends here, doctors here, attendants. The diagnosis had been done—what else remained? The medicines were being sent from there. To avoid all these complications, we thought it is better to come back although till now the children want us there (March 10, 2008).

The lack of claim to US state-based support limited the scope of care available to Gautam. But depending on the scale of remittances and flows of capital, older people in India have the opportunity to seek healthcare not only in India, but to access new medical technologies elsewhere. However, these sources of capital are inherently private and there are no state--sanctioned subsidies available in India. Rather, families must draw solely on their own private capital, here defined as forms of social, economic, cultural, knowledge, and human capacities (Bourdieu 1990).

Similar to private care-seeking in India (where eighty-seven per cent of healthcare is privately funded (Radwan 2005)), when Indian families seek care transnationally, they must negotiate a potentially unregulated market. There are now transnational grey markets, i.e. quasi-legal spaces, where pharmacopeia and other medical materials are being sold by ersatz and legitimate health practitioners. In these privatized, market-driven spaces where hope mingles with desperation, buyers' and sellers' successes depend on the capitals they are able to draw on. When Nina decided to take her husband to Cologne, Germany from Delhi for stem cell treatment for his dementia, she asked her elder son to accompany her for support and her younger son in Singapore to pay for the treatment. Her elder son, who accompanied her to Cologne, said:

> Mom handles most of it, of course she gets fed up many times and she calls me and so I help out sometimes. Sometimes I won't help out for two weeks but I'll come here every day, say hello to them, spend even if it is 15 minutes because I live very close by—my house is just 300 metres away—so I do make it a point to spend time with them. Occasionally I'll take dad for golf and stuff like that. There is really nothing one can do, we took him for his stem cell treatment in the hope that there was nothing better to try, so let's see (July 17, 2008).

The pursuit of such treatments, with limited efficacy, cost Nina and her family significant amounts of money, time, and other resources. Though an

extreme case, Nina's family's story is not unique and forms part of a wider spectrum of transnational medicine procurement. Other examples include the Mukherjee's son sending drugs from the US for his father's dementia, the Panikker's son sending medication from Germany, Mrigakshi's son sending medicine from Poland, and Bhageshwari's sister who couriered medicine from the US.

In all these cases, the children drew on their economic, knowledge, and social capital as well as shared memories and feelings of reciprocity, duty, guilt, and love in procuring drugs and sending them to India. These are new kinds of doctors without borders and highlight a growing informal channel of drug distribution that works in various ways (Brijnath et al. 2015). In the drawing rooms of diaspora there are stories to be heard of drugs flowing from India to Singapore, the US, Europe, and elsewhere. Tales of sleeping pills, antibiotics, analgesics, alongside Āyurvedic powders and sacred amulets, carried in one's own suitcases, by friends, and sent in the post. Lower costs, easier availability, and different understandings of health drive such practices (Horton and Cole 2011; Brijnath et al. 2015; Lee et al. 2010; Tiilikainen and Koehn 2011; Wallace et al. 2009).

The circulation of these drugs is also a circulation of different understandings of health in biomedicine, traditional, and transcendental medicine. Although biomedicine may occupy a dominant position, multiple health models are in dialogue with each other and at various stages of appropriation and indigenization all over the world. Nina's quest to get stem cell treatment for her husband is a story of travel both of human beings and medical information. Just as German tourists journey to India for mantras, massages, artificial hips, and new hearts, so too do Indian tourists travel to Cologne for the fabled stem cell treatments. Ironically, those Indians going abroad might be treated by other Indians abroad; migrant-receiving nations have also poached the health capital of poorer countries. India, for example, has the highest physician emigrant labour force in the world. Approximately 60,000 doctors reside in the North Americas and Australia while a national shortfall of 600,000 doctors is deeply felt in rural India (Mullan 2006).

Technologies near and far

Finally, in sustaining bonds of kinship over long distances, we need to understand how capital and information communication technologies function as virtual bridges to distance. Keeping "in touch" through traditional (emails, phone calls) and new media *(Skype®, WhatsApp®, Facebook®)* is critical to maintain emotional connections within transnational families. This polymedia environment provides multiple opportunities for co-presence—i.e. synchronous, continuous, multi-sensory forms of communication that enable the sharing of the minutiae of everyday life (Baldassar 2017). These new communication technologies allow families

to connect across geographically disconnected sites "as if they were there" (wherever "there" might be), as well as to give and receive care through verbal and non-verbal means. Alongside talking, video-calls, emoticons, message alerts, and text messages are some ways in which families may create intimacy, communicate love and affection, and create co-presence in each other's daily lives (Madianou and Miller 2012).

Moreover, as Tanja Ahlin has demonstrated (2017), information communication technologies are not mere communication platforms and instead operate as non-human actors that can transform important aspects of human care. During times of medical crisis, for example falls, fractures, and palliation, which can significantly affect the dementia illness trajectory, communication technologies become vital links to mobilizing various forms of capital and support (Brown 2016; Miller 2011; Horst and Miller 2006). Even in more routine scenarios, such technologies are critical to helping families get respite by planning holidays when overseas relatives visit so that the latter can look after a person with dementia. In still other cases, communication technologies may put a more humane face on what is often perceived as a harsh organization. When I visited the Senior Citizen's Cell at the Delhi Police Headquarters, I was astounded to learn that the Cell sends birthday cards on behalf of the Delhi Police to every person who is over sixty years and registered with the Cell. Moreover, depending on the workload of the day, telephone calls might also be made to these older citizens to wish them on their birthday. The inspector in-charge recounted to me:

> Like today I made a call to one of the people registered; he was ex-army, at least above Brigadier level. When he came on the phone I just wished him "Happy Birthday," I didn't tell him who it was. Later I explained who I was and he was very happy. He was eighty years old today and wasn't doing anything so he was happy to get this phone call. Even on World Elder's Day we send all our people registered cards to wish them (July 25, 2008).

The effect of communication technologies in forging different ways of organizing care has not only been felt within families and in institutions. It has also increased the knowledge and cultural capital of older people, previously unexposed to such technologies, and now exposed to platforms such as emails, videoconferencing, and instant messaging. When my paternal grandparents upgraded their 56K modem to cable, they suddenly found themselves on the internet highway perusing *National Geographic*® and the *New York Times*®, opening pictures and videos from family and friends. They are no longer as disconnected from their children's lives as they used to be.

On the other hand, my maternal grandmother had late-stage dementia and lived with my family in India, the US, Dubai, and finally Singapore. As her illness progressed she was increasingly dislocated from us. Though

she was physically present, dementia had virtually taken her away many years before she died. Yet she continues to feature in multiple geographies as conversations about her take place among her children all over the world through such technologies.

The links between economic capital, infrastructure, and kinship are salient here; without motivation (for example, the need to remain connected to kin located elsewhere), infrastructure (the physical existence of cables, computers, and satellites), and capital (capacity to pay for internet services and phone bills), new ways of articulating care and accruing capital would not be possible. More likely the tyrannies of distance and time would take their toll. Building and sustaining co-presence thus involves continuous work, nurturing of emotional reciprocities, and building on shared histories as well as access to resources, money, infrastructure, time, security, and latent ability (physical and mental) (Baldassar 2007; Baldassar and Merla 2014). New technologies also demand their own kinds of care (e.g. charging phones, paying bills, and protecting equipment from damage) (Ahlin 2017).

But careful attention needs to be paid to new communication technologies and context. Zooming down the virtual highway detracts neither the inequalities nor orthodoxies which structure individuals' lives. My paternal grandparents still live in a small city in a poor country where my eighty-two-year-old grandmother needs to get up at 5:30 am every morning to ensure the water is pumped. My maternal grandmother was undone by illness and an Indian passport in foreign lands that restricted her access to affordable care. New communication technologies cannot be a panacea for failing state infrastructure, and novel methods to maintain intimacy across distance should not distract our gaze from why families have to live apart to begin with. Far from creating homogeneity or reducing barriers, transnational care seems to underscore how existing inequities, especially regarding access, have been thrown into starker relief. It is important that these points permeate the current discourse in Indian media and policy on ageing, families, and transnationality; and there is a shift away from the more simplistic but ultimately unhelpful narrative of "bad" families and "wicked" modernities.

Conclusion

To develop a more sophisticated understanding of eldercare in transnational Indian families, I have offered three conceptual tools in this chapter—kinship, capital, and technology. To trace how these concepts intersect and flow, we must first grasp that *we are already living in transnational realities*. With an Indian Diaspora of about twenty-five million strong and growing, the stories cited here are neither novel nor unique. Similar examples can be found in the literature on other communities, and many more tales circulate in everyday conversation. These stories show that while the

ambiguities of ageing, identity, and the politics of life are greater than ever before, the old inequities like class, citizenship, and poverty have not disappeared. Rather, they have been shifted onto a transnational platform. The depletion of human resources from a poor nation to meet the health needs of wealthier countries, the increased trend towards privatized care, the multiplicity of health systems sought for treatment, and the movement of drugs highlight a landscape where capital, culture, and technology flow through legitimate, illicit, and grey zones.

Critical focus needs to be directed onto the micro, to how people interpret and negotiate health and illness in this transnational world. Distilled to its essence, these three conceptual tools define families' capacity to care. All three are interrelated, and I have drawn on my research on dementia care in urban India and lived experience as a member of a transnational family to explain these connections. In fully appreciating Appadurai's (1996) insights and the intricate links between imagination and social life, we need to build our "ethnographic suitcase." A sturdy object, lined with solid, well-worn ideas around gender, class, citizenship, and race. Then stitch the strong yet elastic straps of health and illness to hold everything together. In this "suitcase" we begin by putting in kinship, capital, and technology; these are our anthropological visas, as it were, which give us the ability to circulate back and forth between home, abroad, and somewhere in-between. There is still space in the suitcase to add many more tools, but for now the basic tools are there. All that is left to say is, *pher milna* (when we meet again), as we begin to find new ways to represent this transnational life.

References

World Bank. 2016. Migration and Abel, Emily K., and Margaret K. Nelson. 1990. "Circles of Care: An Introductory Essay." In *Circles of Care: Work and Identity in Women's Lives*, edited by Emily K. Abel and Margaret K. Nelson, 1–31. Albany: State University of New York Press.

Ahlin, Tanja. 2017. "Only Near is Dear? Doing Elderly Care with Everyday ICTs in Indian Transnational Families." *Medical Anthropology Quarterly* 32, no. 1 (March): 85–102.

Appadurai, Arjun. 1996. *Modernity at Large: Cultural Dimensions of Globalization*, *Public Worlds*. Minneapolis: University of Minnesota Press.

Baldassar, Loretta. 2007. "Transnational Families and Aged Care: The Mobility of Care and the Migrancy of Ageing." *Journal of Ethnic and Migration Studies* 33 (2): 275–297.

———. 2017. "Transformations in Transnational Aged Care: A Century of Caring among Italians in Australia." In *Transnational Aging and Kin-Work*, edited by P. Dossa and C. Coe, 120–138. New Brunswick: Rutgers University Press.

Baldassar, Loretta, Cora V. Baldock, and Raelene Wilding. 2007. *Families Caring across Borders: Migration, Ageing, and Transnational Caregiving*. New York: Palgrave Macmillan.

Baldassar, Loretta, and Laura Merla. 2014. *Transnational Families, Migration and the Circulation of Care: Understanding Mobility and Absence in Family Life*, *Routledge Research in Transnationalism*. New York: Routledge.

Bourdieu, Pierre. 1990. *The Logic of Practice*. Translated by Richard Nice. Stanford: Stanford University Press.

Brijnath, Bianca. 2008. "The Legislative and Political Contexts Surrounding Dementia Care in India." *Ageing and Society* 28 (7): 913–934. doi: 10.1017/S0144686X08007368.

———. 2009. "Familial Bonds and Boarding Passes: Understanding Caregiving in a Transnational Context." *Identities-Global Studies in Culture and Power* 16 (1): 83–101. doi: 10.1080/10702890802605836.

———. 2014. *Unforgotten : love and the culture of dementia care in India*, *Life course, culture and aging: global transformations*. New York: Berghahn Books.

Brijnath, Bianca, Josefine Antoniades, and Jon Adams. 2015. "Investigating Patient Perspectives on Medical Returns and Buying Medicines Online in Two Communities in Melbourne, Australia: Results from a Qualitative Study." *Patient* 8 (2): 229–238. doi: 10.1007/s40271-014-0082-z.

Brosius, Christiane, and Nicolas Yazgi. 2007. "'Is There no Place like Home?': Contesting Cinematographic Constructions of Indian Diasporic Experiences." *Contributions to Indian Sociology* 41 (3): 355–386. doi: 10.1177/006996670704100303.

Brown, Rachel H. 2016. "Multiple Modes of Care: Internet and Migrant Caregiver Networks in Israel." *Global Networks* 16 (2): 237–256. doi: 10.1111/glob.12112.

Cohen, Lawrence. 1995. "Toward an Anthropology of Senility: Anger, Weakness, and Alzheimer's in Banaras, India." *Medical Anthropology Quarterly* 9 (3): 314–334.

Cohen, Lawrence. 1998. *No Aging in India: Alzheimer's, the Bad Family, and Other Modern Things*. Berkeley: University of California Press.

Deshpande, Sudhanva. 2005. "The Consumable Hero of Globalised India." In *Bollyworld: Popular Indian Cinema through a Transnational Lens*, edited by Raminder Kaur and Ajay J. Sinha, 186–203. New Delhi: Sage Publications.

Dharmalingam, A. 1994. "Old Age Support: Expectations and Experiences in a South Indian Village." *Population Studies* 48 (1): 5–19.

Fernandez, Jane. 2009. "Introduction." In *Diasporas: Critical and Inter-Disciplinary Perspectives*, edited by Jane Fernandez, 3–38. Oxford: Inter-disciplinary Press.

Hage, Ghassan. 2005. "A Not So Multi-sited Ethnography of a Not So Imagined Community." *Anthropological Theory* 5 (4): 463–475. doi: 10.1177/1463499605059232.

———. 2012. "Responsibility in the Lebanese Transnational Family." In *Responsibility*, edited by Ghassan Hage and Robyn Eckersley. Carlton: Melbourne University Publishing.

Horst, Heather A., and Daniel Miller. 2006. *The Cell Phone: An Anthropology of Communication*. Oxford: Berg.

Horton, Sarah, and Stephanie Cole. 2011. "Medical Returns: Seeking Health Care in Mexico." *Social Science & Medicine* 72 (11): 1846–1852. doi: 10.1016/j.socscimed.2011.03.035.

Jamuna, D. 2003. “Issues of Elder Care and Elder Abuse in the Indian Context.” *Journal of Aging & Social Policy* 15 (2/3): 125–142.

Joseph, Alun E., and Bonnie C. Hallman. 1998. “Over the Hill and Far Away: Distance as a Barrier to the Provision of Assistance to Elderly Relatives.” *Social Science & Medicine* 46 (6): 631–639.

Karner, Tracy X. 1998. “Professional Caring: Homecare Workers as Fictive Kin.” *Journal of Aging Studies* 12 (1): 69–82.

Kumar, Stanley Jaya 1996. “The Aged and Aged Disabled: The Indian Scene.” *International Review of Modern Sociology* 26 (1): 81–90.

Lamb, Sarah. 2000. *White Saris and Sweet Mangoes: Aging, Gender, and Body in North India*. Berkeley: University of California Press.

———.2005. “Cultural and Moral Values Surrounding Care and (In)dependence in Late Life: Reflections from India in an Era of Global Modernity.” *Care Management Journals* 6 (2): 80–89.

———. 2009. *Aging and the Indian Diaspora: Cosmopolitan Families in India and Abroad*. Bloomington: Indiana University Press.

Lee, Jane Yeonjae, Robin A. Kearns, and Wardlow Friesen. 2010. “Seeking Affective Health Care: Korean Immigrants’ Use of Homeland Medical Services.” *Health & Place* 16 (1): 108–115. doi: 10.1016/j.healthplace.2009.09.003.

Lin, Ge, and Peter A. Rogerson. 1995. “Elderly Parents and the Geographic Availability of their Adult Children.” *Research on Aging* 17 (3): 303–331.

Madianou, Mirca, and Daniel Miller. 2012. *Migration and New Media: Transnational Families and Polymedia*. Abingdon: Routledge.

Mahajan, Sanjeev. 2006. “Problems of Urban Senior Citizens in India.” *Indian Journal of Social Research* 47 (1): 63–73.

Miller, Daniel. 2011. *Tales from Facebook*. Cambridge: Polity Press.

Ministry of External Affairs. 2016a. *Annual Report 2015–2016.* New Delhi: Government of India.

———. 2016b. “Overseas Indian Affairs.” Government of India. http://www.mea.gov.in/overseas-citizenship-of-india-scheme.htm.

Ministry of Social Justice and Empowerment. 2008. “An Integrated Programme for Older Persons.” Government of India, Last Modified April 1, 2008. Accessed August 24, 2010. http://india.gov.in/outerwin.php?id=http://socialjustice.nic.in/.

Mishra, Sudesh. 2006. *Diaspora Criticism*. Edinburgh: Edinburgh University Press.

Mullan, Fitzhugh. 2006. “Doctors for the World: Indian Physician Emigration.” *Health Affairs* 25 (2): 380–393.

Radwan, Ismail. 2005. “India: Private Health Services for the Poor. Health, Nutrition and Population (HNP),” discussion paper, Washington, DC: The World Bank.

Rodriguez, Robyn M. 2002. “Migrant Heroes: Nationalism, Citizenship and the Politics of Filipino Migrant Labour.” *Citizenship Studies* 6 (3): 341–356.

Schiller, Nina Glick, and Georges E. Fouron. 1999. “Terrains of Blood and Nation: Haitian Transnational Social Fields.” *Ethnic and Racial Studies* 22 (2): 340–366.

Schoonover, Claire B., Elaine M. Brody, Christine Hoffman, and Morton H. Kleban. 1988. “Parent Care and Geographically Distant Children.” *Research on Aging* 10 (4): 472–492.

Singh, Supriya, and Anuja Cabraal. 2014. "'Boomerang Remittances' and the Circulation of Care: A Study of Indian Transnational Families in Australia." In *Transnational Families, Migration and the Circulation of Care: Understanding Mobility and Absence in Family Life*, edited by Loretta Baldassar and Laura Merla, 220–234. New York: Routledge.

Tiilikainen, Marja, and Peter H. Koehn. 2011. "Transforming the Boundaries of Health Care: Insights from Somali Migrants." *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 30 (5): 518–544.

United Nations. 2006. "Population Ageing 2006." United Nations Department of Economic and Social Affairs, accessed August, 30 2010. http://www.un.org/esa/population/publications/ageing/ageing2006.htm.

———. 2015. "Population Facts." New York: UN Department of Economic and Social Affairs: Population Division.

Vatuk, Sylvia. 1969. "Reference, Address, and Fictive Kinship in Urban North India." *Ethnology* 8 (3): 255–272.

Wallace, Steven P., Carolyn Mendez-Luck, and Xochitl Castaneda. 2009. "Heading South: Why Mexican Immigrants in California Seek Health Services in Mexico." *Med Care* 47 (6): 662–669. doi: 10.1097/MLR.0b013e318190cc95.

Remittances Factbook 2016. Washington, DC.