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Enforced Transnationalism From an Ethics of Care Perspective: Barriers to Living 'Care-Filled Lives' and Resistance Tactics Among 'Forced' Transnational Families in the UK

Rosa Mas Giralt[1] | Ruth Evans[2]

[1]United Kingdom, Lifelong Learning Centre and School of Geography, University of Leeds, Leeds, UK | [2]United Kingdom, Department of Geography and Environmental Science, University of Reading, Reading, UK

Correspondence: Rosa Mas Giralt (r.masgiralt@leeds.ac.uk)

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ABSTRACT

Heavily restricted humanitarian protection schemes, protracted waiting periods, and immobility regimes are increasingly disrupting familyhood and intra-/intergenerational caregiving practices for many forced migrants and their extended families. This paper draws from the experiences of 16 displaced families of diverse ethnicities living in the UK with higher care needs related to disability, chronic illness and/or mental health, which have hitherto been overlooked. Integrating feminist ethics of care with the notion of 'enforced transnationalism', the analysis shows how displaced families are subjected to a *continuum* of migration, welfare, and social care policies over time which result in processes of family 'nuclearization' and immobility. Barriers to family visits and reunification compound limitations on welfare and social care support when families seek to fulfil transnational caring obligations. This increases the pressures on the middle and younger generations providing informal care and negatively affects families' relational wellbeing. Despite this, transnational families deploy resistance tactics through maintaining and re-building intra- and intergenerational caring relationships and values of family solidarity to live 'care-filled lives' in the places where they have sought sanctuary. The paper significantly deepens the theoretical and empirical scope of the concept of 'enforced transnationalism', bringing relational selves and care front and centre in studies of forced migration and transnational familyhood.

1 | Introduction

In the current context of 'crisis'-driven displacement and the aftermath of the Covid-19 pandemic, migration regimes in the UK and Europe have continued to tighten restrictions, increasingly infringing migrants' rights to family life. Even if granted refugee status or humanitarian protection, in the UK and other European countries, refugee family reunion is only accessible to adults who have been granted protection status and limited to their spouse or partner, any children under 18,

and in exceptional circumstances dependent children over 18, who formed part of their family unit before they fled their country (Refugee Council 2023). Furthermore, in the UK, unaccompanied minors, who have been granted refugee status are generally not permitted to sponsor any family member for reunification. Such restrictive definitions of 'family members' and who is 'entitled to initiate reunion' fail to acknowledge the diversity of family forms and intergenerational care common in many countries of the Global South (Kofman et al. 2011).

In addition, visitor or sponsorship visas that family members may apply for once an individual or nuclear family is settled in the UK, are difficult to secure due to significant financial and other requirements[1] (Justice and Home Affairs Committee 2023). Existing research has shown that 'mobility' is key for caregiving in transnational families, particularly when physical presence and proximate care are necessary due to family illness or death (Baldassar et al. 2007). Immobility regimes such as the heavily restricted humanitarian protection schemes and limits of family reunion policies in the UK are increasingly disrupting familyhood and intergenerational caregiving practices for many forced migrants and their families (Brandhorst et al. 2020; Merla et al. 2020; Tiilikainen et al. 2023).

Al-Ali et al.'s (2001, p. 595) notion of 'enforced transnationalism' is helpful in conceptualising how "state policy, the context of flight, historical antecedents, or the dominance of particular ideological, moral or cultural positions can combine to constrain or push transnational activities in certain ways". This paper further develops this notion by integrating it with Tronto (2013) feminist ethic of care. The interaction of these two conceptual framings provides a powerful lens to examine how 'enforced transnationalism' is perpetuated through a continuum of structural barriers and exclusionary strategies over time, while recognising the emotional geographies of prolonged family separation and the centrality of care to relational wellbeing. This continuum of enforcement strategies, as Christ and Etzold (2024) have observed, starts with family reunification rules. We extend this analysis by showing that, for forced migrant families (with higher care needs), 'enforced transnationalism' then continues through family visa, social care, and welfare regimes over prolonged timescales.

The article thus contributes significantly to the emerging scholarship tracing the impacts of 'enforced transnationalism' on the lives and caring relationships of those with refugee or precarious/no legal status and their family members (e.g. Brandhorst et al. 2020; Tiilikainen et al. 2023). It focuses on the experiences of 16 displaced families of diverse ethnicities living in the UK and dispersed across different European and other countries. We pay particular attention to the pressures faced by displaced families with higher care needs related to disability, chronic illness and/or mental health, which have hitherto been overlooked. The few available studies exploring disability and forced migration in the UK (Roberts and Harris 2002; Yeo 2015) focus on institutional barriers to formal care support faced by disabled refugees, rather than exploring informal caring relations within forced migrant families. The experiences of transnational families with higher care needs considered in this paper significantly enrich understandings of 'enforced transnationalism' by bringing informal family caring relationships, relationality, and intersecting inequalities of forced migration, care, and disability sharply into focus.

We start by considering the existing literature on familyhood and 'enforced transnationalism' and by outlining the conceptual framework and research methodology. We then examine the disruptions to inter- and intra-generational caring relationships posed by 'enforced transnationalism'. Next, we explore how 'enforced transnationalism' is perpetuated through exclusionary and sedentary forms of welfare and social care policies. We then show how some participants resisted the 'family nuclearization' and 'individualization' dynamics imposed by immobility regimes. We close by reflecting on the article's empirical and theoretical contributions and policy implications.

2 | Familyhood and 'Enforced Transnationalism'

Existing literature on transnational families has illuminated many facets of how migrants and their family members maintain familyhood and continue to care for each other across borders (Baldassar et al. 2007; Kofman et al. 2011). However, most of this research, especially in Europe, is based on labour migrants' experiences (Tiilikainen et al. 2023). A growing scholarship explores the experiences of 'forced' transnational families focusing mainly on asylum-seeking and undocumented migrant parents, whose ability to fulfil familial roles is undermined by administrative barriers and restrictive policies, leading to strained or broken-down relationships, tensions, and health problems (Näre 2020; Akhigbe and Effevottu 2023). Madziva (2016) highlights asylum-seeking Zimbabwean parents' difficulties in continuing to provide emotionally and/or materially for their children and spouses 'left behind' under conditions of protracted separation and prohibitions to engage in paid employment in the UK. The inability to provide financial support or deliver 'hands-on' care can lead to the breakdown of marriages or deterioration of family relationships, and in extreme cases, death and harm.

A range of terms are used to capture the *involuntary* and *imposed* nature of transnational family configurations that forced migrants are compelled to adopt due to the 'enforced immobility' (Stock 2016) or 'forced separation' (Brandhorst et al. 2020; Tiilikainen et al. 2023) inflicted by contemporary 'immobilizing regimes of migration' (Merla et al. 2020). Different policy mechanisms and practices either preclude forced migrants from reuniting with family members and kin, or slow down and perpetuate separation.

Building on Al-Ali et al.'s (2001) notion of 'enforced transnationalism', Christ and Etzold (2024, p. 282) argue that refugees, but we would add forced migrants more generally, have to adopt transnational family configurations because of "barriers to family reunification that are arbitrarily or even strategically upheld by European nation states". The authors identify three potential transnational family constellations which emerge within conditions of 'enforced transnationalism': "reunited nuclear family figuration", "involuntary separated (nuclear) family figuration", and "extended family figuration" (where nuclear family members are coresident and extended family members are involuntarily separated but maintain ties across

two or several states) (Christ and Etzold 2024, pp. 286–290). They clarify that the latter, which was often the situation facing family participants in our research, emerges from the lack of "legal options for safe pathways of family members other than the nuclear family" (Christ and Etzold 2024, p. 290), and even this is limited for parents of adults.

As Coddington and Williams (2022, p.591) have highlighted, migration regimes are gradually deploying border enforcement strategies that "target not only individual migrants themselves, but also the wider familial and social networks of which they are part" (i.e. forms of "relational enforcement"). Through the 'slow death' of protracted waiting periods (Coddington and Williams 2022) and limited reunification/visiting rights, asylum processes in the UK often enforce 'individualizing' isolation or 'nuclearization' of families through excluding any other family members who are not children aged under 18 or partners. Asylum seeking, and other humanitarian protection schemes, such as the United Nations High Commission for Refugees (UNHCR) resettlement process, also tend to prioritise 'individualization' rather than relational subjectivity (Ehrkamp et al. 2019; Maghbouleh and Omar 2025). These processes greatly impact on families' wellbeing.

Moreover, as our research shows, even when forced migrants have secured residence rights and/or citizenship, they may still be subject to visa restrictions that result in the immobility of family members. As Neumayer (2006, p. 81) argues, "for passport holders from poor, authoritarian countries with a history of violent political conflict, travel is and remains severely restricted", resulting in an "increased global mobility divide" between citizens of the global North and South (Mau et al. 2015, p. 1206).

3 | Conceptual Approach

While forced separation of families due to restrictive migration regimes has been explored previously, this paper makes an innovative contribution by integrating Tronto (2013) feminist ethic of care with the notion of 'enforced transnationalism' (Al-Ali et al. 2001). Following Tronto (2013) and others, we adopt a holistic understanding of care, that recognises the vulnerability and interdependence of human beings throughout the lifecourse, across time and space. Tronto (2013) calls for societies to put responsibilities for care at the centre of their democratic political agendas, to counter dominant preoccupations with economic production. She argues a re-imagining of democratic life is needed, since "our social, economic and political institutions no longer fit with our modes of caring" (Tronto 2013, p. 13). The starting point for this re-imagining is an understanding that living well means people can care with their fellow citizens:

> *The key to living well, for all people, is live a care-filled life, a life in which one is well cared for by others when one needs it, cares well for oneself, and has room to provide for the caring – for other people, animals, institutions and ideals – that gives one's life its particular meaning.*
>
> (Tronto 2013, p. 170)

By integrating this ethic of care perspective with the notion of 'enforced transnationalism', we can capture how displaced families become separated through forced displacement and resettlement processes and are 'forced' to live and reconfigure caring arrangements transnationally due to restrictive migration and welfare regimes. It enables a family-focused understanding of forced migrants' caring relationships over time, as they navigate enforcement strategies. Deepening the theoretical scope of the concept of 'enforced transnationalism' in this way brings into sharp focus the emotional geographies of prolonged family separation and the often crucial importance of extended family relationships to caring and living well. It enables us to analyse the implications of the complex spatial configurations of 'forced' transnational families dispersed across several countries on intergenerational caregiving throughout the lifecourse and thereby understand more fully how 'enforced transnationalism' affects familyhood, care, and relational wellbeing.

We follow Sampaio and Carvalho's (2022, p. 2) understanding of wellbeing as processual and involving material, subjective, and relational dimensions, which "[l]ike care, (...) is subjectively and collectively constituted and understood differently across places, life stages, and one's life experiences". We pay particular attention to relational and collective aspects of wellbeing as we examine how values of family solidarity, the ability to live a 'care-filled life' and intergenerational reciprocity are disrupted by 'enforced transnationalism'. Recognising relational selves as part of "the large web of caring relationships within which our lives gain meaning" (Tronto 2013, p.182) challenges dominant approaches evident in policy which frame wellbeing as individual and often neglect situated, intersecting power inequalities.

Further, we draw on De Certeau's understanding of everyday resistance as tactics, or 'making do' within 'enemy territory' (1984), to examine how forced migrants exert agency and resist enforcement strategies by maintaining family solidarity across time and space. Following Sereke and Drzewiecka (2024), we understand tactics and strategies as a continuum, rather than a binary opposition as is sometimes implied by De Certeau, to understand how forced migrants deploy different forms of power, including strategic power, to navigate restrictive migration, care, and welfare regimes.

4 | Methodology

This paper is based on analysis of the UK qualitative data set collected as part of a larger research project, *Care, Inequality and Wellbeing in Transnational Families in Europe: a comparative, intergenerational study in Spain, France, Sweden and UK* (2021–2024). The project used a multi-sited family-focused ethnographic and participatory methodology in the UK, Spain, France, and Sweden. In the UK, research was undertaken with 30 families living in the South East and North of England. We worked with four partner community organisations to train and support migrant peer researchers to undertake qualitative interviews and participatory diagramming with two or three generations of 25 transnational families. Ethnographic approaches were undertaken with an additional five families.

The paper focuses on the experiences of 16 transnational families where one or more family members had been granted refugee status or had sought asylum in the UK or another European country and/or had been granted humanitarian protection through a resettlement scheme. Their countries of origin included: Eritrea, Guatemala, Hong Kong, Sudan, Syria, Uganda[2], Ukraine, and Zimbabwe. Semi-structured interviews, diary activities, and/or participatory diagrams were conducted with 15 children and youth (aged 6–24), 30 younger and middle generation adults (aged 25–59) and 6 older generations (aged 60–70) between 2022 and 2023. In 11 families, some participants lived in other countries and participated through an online video/phone call or were in the UK temporarily and took part in person. The majority (13/16) of families had specific care needs related to disability, chronic illness and/or mental health. In others, there were care needs for young children and/or older relatives. The analysis is also informed by interviews with 18 policymakers and practitioners working in local authorities, private sector and third sector organisations supporting migrants and refugees. All quotations have been anonymised to protect the identity of participants.

Audio-recorded interviews were transcribed and translated where needed into English. A thematic analysis framework was developed and family transcripts were analysed using relational templates, enabling us to read across the data and identify overarching themes. Thematic analysis was undertaken of the ethnographic data. Policy and practice interviews were coded using Nvivo qualitative analysis software. Following preliminary analysis, four participatory feedback workshops were held with family members, community researchers, and practitioners in the research locations. Workshops discussed key themes, ranked priorities, and co-produced participatory theatre of families' key messages for policy and practice, resulting in film outputs, including *Refugee Families Caring and Seeking Reunification* that address issues raised in this paper.[3] Two feedback workshops were also held with policymakers and practitioners.

5 | Forced Family Separation and the Disruption to Inter- and Intra-Generational Caregiving

This section analyses how inter- and intra-generational relationships were disrupted by 'enforced transnationalism' over time, sometimes with significant consequences for the reciprocity underpinning caring practices. As mentioned earlier, in the UK, refugee family reunion is normally only accessible to 'immediate' (nuclear) family members (Refugee Council 2023) and often perpetuates 'enforced transnationalism' with other relatives. Ehrkamp et al. (2019) show how UNHCR resettlement, which resettles less than 1 percent of those formally recognised by UNHCR as refugees, is based on eligibility criteria informed by individualised, medical models of trauma. Further, the United States' criteria for (in)admissibility, based on medical grounds that include among others, a physical or mental disorder with associated harmful behaviour, "often shaped other countries' criteria" (p.118). Such medicalised trauma practices exclude family members whose health is deemed not to meet the eligibility criteria, resulting in processes of individualisation (Ehrkamp et al. 2019).

Many of the families interviewed, who had been resettled to the UK by UNHCR as a 'nuclear family' shared the difficulties they faced in reuniting with extended family members not normally included in the current rules, such as older parents (see also Maghbouleh and Omar 2025). This jeopardised their ability to maintain intergenerational relationships and provide reciprocal care, as demonstrated by Alissa's (aged 31) experiences, who fled from Syria to Lebanon in 2010. In 2017, Alissa, her husband, their two eldest daughters, and Alissa's younger brother were resettled to the UK by UNHCR. While seeking safety, her extended family had been dispersed across several countries, including Syria, Lebanon, Germany, and Turkey; Alissa had not seen them since leaving Syria. She emphasised how this enforced prolonged separation had affected her wellbeing and *"aged"* her.

The situation was particularly poignant due to the care needs of Alissa's parents, who had been living in a refugee camp in Turkey for over 10 years. Alissa's father had a serious heart condition and had surgery in Syria, and other medical interventions while in the refugee camp, but the family struggled to access the required treatment in Turkey. Alissa referred to conditions at the camp as "*mujn (...) the place where they raise chickens and animals*", and the discrimination that Syrians experienced in Turkey. Alissa could not travel to visit her parents due to the financial cost and difficulties securing visas and documentation. Her profound desire was to bring her father to the UK, so he had access to appropriate healthcare, and to be reunified with her parents, so that she could care for them both. However, this had not been possible:

> *"We're unable to travel. I wish I could go and take care of them but it's difficult. I don't have the money [for] the tickets. [...] Why can't the process be easier in this country? ...my mother and father need me. They are elderly and have special needs and illnesses. [...] Why they have to be underage [referring to children aged under 18] to be able to bring them through family reunification?".*

Alissa also emphasised that the absence of her parents or other kin in the UK meant that they had limited social support. Although Alissa and her husband were the main carers for their children, their oldest daughter, Shayna (12 years of age), also undertook childcare for her siblings and supported, translated, and interpreted for her parents. She provided transnational emotional care for her grandparents, emphasising the importance of calling her grandfather often: *"The most important is I talk to him over the phone I tell him that 1 day you will come and live with us and we'll be happy together"*. Sadly, the family's strong desire to reunite was not possible, as Alissa's father died in the refugee camp in Turkey shortly after the family were interviewed.

For families with higher care needs, the restrictive rules for eligibility to reunite, particularly with ageing parents, can have significant impacts on the middle generation who have multiple caring responsibilities. Merla et al. (2020) highlighted the negative implications of immobilising regimes of migration on transnational migrants' ability to provide *proximate* care. Similarly, our research found that the disruption to inter- and/or

intra-generational caregiving roles could lead to emotional distress and mental ill health for family members unable to fulfil such roles and to loneliness, distress, or serious health implications for those in need of care.

In some cases, conflicting care needs arise between different branches of the dispersed transnational family, which can have detrimental impacts on the wellbeing of the middle generation, who may also be coping with their own health conditions. This was the case in Marah's (aged 39) and Ahmed's (aged 44) family who fled Syria and sought refuge in Jordan in 2012. At the time, Marah was pregnant and the conditions they faced in the refugee camp in Jordan led to her giving birth to her twin daughters early. One of the twins was born with a rare genetic condition which required extensive medical attention. Trying to access treatment, the family moved out of the refugee camp. Although UNHCR paid for some of the hospital costs, the family became indebted trying to cover the remainder and were refused treatment in some hospitals in Jordan based on their Syrian nationality.

In 2017, Marah and Ahmed and their three children were resettled to the UK due to their daughter's serious health condition. Ahmed had to prioritise his daughter's life, as without treatment she would not survive. This meant he had to leave his own parents behind in Jordan; he was not allowed to bring them to the UK, even though they were both ageing and needed care (his father had had a stroke that left him blind). They were still living in Jordan with one of Ahmed's sisters in very difficult circumstances. Ahmed's parents applied for resettlement in 2013 but, at the time of writing, the family had not been able to reunite. Marah's mother died in Syria but her father, who was ageing and had heart problems and diabetes, was still living there. Marah and Ahmed also had siblings who were missing or facing health or other problems in Syria or other countries.

Both Marah and Ahmed lived in a state of constant worry and stress about their respective parents and siblings from whom they were separated, with significant impacts on their mental health. Their daughter had multiple surgical interventions since arriving in the UK and needed 24-h care. They struggled to provide the necessary proximate care for her and her siblings, and Ahmed also experienced health problems. They expressed a sense of 'being torn' and unable to fulfil intergenerational care obligations. As Ahmed explained:

> *"...even if I wanted to travel and leave my daughter here for example and travel with a travel document, I won't be able to come back if I leave. When you have a citizenship you can return but at the same time the idea of going to meet your family and having these health conditions for your daughter is difficult. The solution is for my family to come to me, for example, because they also sought asylum, they entered Jordan in 2013 but until now they haven't been contacted about travel and other matters. [...] ...to go to visit them there, how can I leave my child in such a situation? I'm afraid of losing her. You can't split yourself and responsibilities in half. (...) This is the fire that I am stuck in between two: my father, my mother and at the same time my daughter. I am hanging in a balance between two things. I just hope to help them but there is no way to do that."*

The same wish to be reunited was echoed by Ahmed's mother, Ramia (70 s), in Jordan:

> *"I don't have anyone to take care of me apart from my son in Britain who call us and I feel delighted he asks about us, I wish he can gather us together and we can travel to him so that he can take care of his father, he can take care of me and we can improve our state. We are mentally exhausted. I wish we can reunite and become one family together in Britain."*

Ahmed's and Marah's daughter, Maissa (9 years of age) also expressed this strong desire for family reunification: *"for our family we will give anything just for them to come and live with us even if it's only for a few days. The important thing is that they come and live with us. And it's also difficult for one to live without their relatives and loved ones."*

This complex and profoundly moving case highlights how the UNHCR resettlement process and lack of mobility rights have severe impacts on the emotional and psychological wellbeing of relational selves seeking to care for their kin, despite being displaced across borders. Indeed, many families interviewed who had been resettled in the UK had experienced enforced 'nuclearization', first by fleeing from war or conflict, and then by having to 'leave behind' older parents, adult siblings, nieces, or nephews in refugee camps. In line with Maghbouleh and Omar's (2025, p. 2452) research with Syrian refugees resettled in Canada, our findings contribute to evidence of the 'nuclearizing effects' of resettlement policies, which are "deeply entangled with migration control policies". For many of the resettled families considered in this paper, the process of resettlement represented a further traumatising experience which stripped them from 'the large web of caring relationships' that gave meaning to their lives, undermining family solidarity and their ability to live a 'care-filled life' (Tronto 2013, p. 182).

6 | Restrictive Immigration Policies, Lack of Care Ethics and an Exclusionary Sedentary Model of Welfare and Social Care

When transnational family members have secured refugee status or citizenship and thus, in principle, have regained mobility rights, participants found their mobility constrained by financial barriers and the sedentary model of welfare and social care in operation in the UK. For unpaid carers of family members with high care needs, the immobilising nature of a disability and/or health conditions meant that disabled children or adults were not able to accompany them on family visits abroad and a higher level of respite care or other social care support was needed in unpaid family carers' absence. Inadequate social care provision to enable carers to have a break to maintain family ties in their country of origin or other countries, alongside legal status and financial barriers, resulted in forced geographical

separation from transnational family members over sometimes several years, causing significant emotional distress and mental health impacts on carers.

Meanwhile transnational family members in our research, particularly those living in Sudan, Eritrea and Uganda, found they were excluded from visiting kin in the UK to help provide proximate care for family members due to discriminatory visa policies. As Neumayer (2006) and Mau et al. (2015) observe, citizens from affluent societies in Europe and the Americas have privileged mobility rights, while travel is heavily restricted for citizens from the Global South, particularly conflict-affected, poor African countries. Such visa restrictions, alongside financial constraints and the sedentary welfare and care regime in the UK, subjected many families to renewed immobility dynamics.

Some participants' experiences, reveal the inadequacies of short 'respite' breaks or 'holiday' rights for those in receipt of respite care or welfare support, jeopardising family members' ability to visit relatives in countries of origin or elsewhere. The time required for such family visits and sometimes, the need to put alternative care arrangements in place during unpaid carers' absence, was not appropriately recognised by the social care or welfare benefits system. These experiences echo some of the difficulties and exclusions that disabled asylum seekers and refugees and their families in the UK face in accessing support and respite care (Roberts and Harris 2002).

For example, Samira (aged 46), from Sudan, was the full-time primary carer for her daughter (aged 15) who had complex needs (autism, learning difficulties, and ADHD) and was assisted by her son (aged 13), who had been recognised as a young carer. Samira had been reunited with her husband in the UK following his asylum claim and her two children were born in the UK; she had lived in the UK for 16 years at the time of interview. Samira explained that her husband had been largely absent for the last 7 years, travelling to Sudan and other countries. She was therefore a de-facto single parent, lacking the practical support of her sisters and other female relatives abroad who wished they could help alleviate her care work. Respite care was provided by the local authority for 3 days twice a month, which both Samira and her son said was insufficient: *"I go shopping, take my son somewhere and anything I want to do, work has to be done in those 3 days. It is not enough even for simple housework at home"*.

Samira requested respite support for a period of 2 to 3 weeks to enable her to travel to see her family in Sudan and Egypt, but was told by social care professionals that it was not possible, causing significant emotional distress:

> *"... I rarely ever travel, I can't see my family, and I can't be part of their joys or sorrows because I can't be with them. This is also what disturbs my family the most, that they can't see me or come to us, so they can't be with us [and] help us".*

When family members were able to travel to visit family members in other countries, the inadequacies of the sedentary welfare system and a lack of recognition of transnational kinship ties and caring obligations across generations was revealed. For example, Semhar, a grandmother (aged 56) from Eritrea who had been resettled from Sudan to the UK by UNHCR with her husband and two adult children, had a chronic abdominal condition which required several surgeries. She received welfare benefits as she had not been able to secure work due to language and health barriers. She also had a daughter (Haben, aged 28) living in the Netherlands who had reunited with her husband from Sudan. Haben was on maternity leave at the time of the interview and commented on how lonely she was, missing the support of her parents and extended family during her pregnancy and as a new mother:

> *"My family were not with me when I was pregnant, I stopped my study and after I had my baby, I was by myself at home 24 h, and didn't feel very well and easily depressed. My husband was at work most of the time even though we live together. As our culture of Eritreans, we raise a child with the help of your family, relatives and as whole community, unlike here just all responsibility, is for one person, so if my parents were here I wouldn't stop my activities and likewise I would help my parents anything they need like interpreting when they go to hospital and help to solve when they face any problems."*

Following family reunion with her husband, Haben did not have Indefinite Leave to Remain in the Netherlands at the time of interview and so lacked mobility rights to travel to the UK to visit her family. Haben commented on how these restrictions impacted on intergenerational expectations of care: "*Generally, this time our parents need us more than any time, we should care them, as they raise us and support us to get education and everything, now it would be their turn to be treated, which I couldn't get chance for that because of our separation*".

Semhar and her husband finally managed to visit Haben in the Netherlands for the baby's Christening, with financial support provided by Haben's husband. This was the first time they had seen each other for 6 years. However, Semhar found that the welfare system did not recognise transnational caring obligations and imposed a devastating financial penalty for staying outside the UK for longer than allowed:

> *"Last time I went to see my daughter, as I am in benefit, I not allowed to spend more than 14 days for holiday, when I came back, they took off my benefit worth 7 months and on the top of my language barrier and my age, it was very hard time for me. Therefore, it would be good, reconsider to make longer holidays, so families can visit to each other more often".*

Her daughter, Haben, emphasised her priority for the future was to reunite with her parents and siblings in the UK so that she could be supported in bringing up her child, while also helping to care for her parents: "*I wish or hope, I would join my parents, like my sister and her children live with our parents, so that I would help and support to them and I would get help from them, it would be good for our wellbeing"*.

This example highlights the importance of intergenerational solidarity and care across the lifecourse that is needed to enable family members to live a 'care-filled life' that is crucial for their collective wellbeing. It also demonstrates the impacts of dispersal of extended family members across several countries in situations of displacement. This family's, and other refugee families', options for documented onward migration to the UK have been subject to increased restrictions on mobility since the UK's departure from the European Union (Lindley and Van Hear 2007).

These and other examples show how intergenerational caring obligations and care needs that required welfare or social care support, combined with the restrictive, racialised immigration regime, to create exclusionary processes of 'enforced transnationalism' for many families. This was despite some or all family members having acquired settled refugee status and/or citizenship rights. As Turner (2020) suggests, immigration policy, and we would add, welfare, healthcare, and social care policies, are underpinned by ideological notions of 'the family' and target the family as a site of intervention based on "racialized, imperial, heteronormative and violent forms of bordering" (Coddington and Williams 2022, p. 592).

Participants' experiences also highlighted impediments to transnational family members being able to live a 'care-filled life' (Tronto 2013) in which they were able to provide what they considered 'culturally appropriate care' for family members in need. Alongside a lack of cultural sensitivity in providing healthcare, social care, and welfare support, heavily curtailed possibilities to secure family reunion or obtain family visas may increase the 'care load' of young people. Further, it may undermine cultural expectations of the caring responsibilities of adult siblings and extended family members and result in the 'nuclearization' of familial responsibilities for proximate care work.

For example, Nayasha (aged 49, from Uganda, a British citizen) cared for her sister who had a chronic health condition and her two children. She migrated to the UK on a student visa, for which she had to keep reapplying to avoid becoming undocumented. She was reunified with her son after 7 years and obtained Indefinite Leave to Remain after ten years when her daughter was born. She explained that social care professionals assessed her house as 'risky' and not appropriate for her sister, given her medical condition, and so her sister was moved to her own social housing with her two teenage daughters, which in turn increased their care work. Nayasha emphasised the need for healthcare professionals to recognise individual needs and be more culturally sensitive, giving the example of her sister not being able to have a shower while in hospital, which was detrimental to her wellbeing: "*I know it is... can be difficult trying to please everybody, but I think there should be some basic guidelines on how to meet individual, cultural needs, basic cultural needs, trying to listen to that*".

Nayasha expressed how 'strenuous' and 'draining' her care work was, supporting her sister and her nieces, with personal care, domestic chores, and emotionally, while also working as a paid care worker to send remittances to family members in Uganda, and provide for herself and her children. Although family members in Uganda wanted to help meet their sister's care needs and alleviate the pressures on Nayasha and her sister's daughters, the family found themselves unable to travel due to restrictive family reunification and visa rules in the UK:

> *"Again, yeah, we tried that, because we have lots of extended family members, nieces and... yeah, nieces and aunties. We tried to apply, but the government was very clear that they are already offering what that person would be doing [by providing a paid care worker for limited time-periods each day], so they refused and they... they instructed us not to even appeal. The application, we were trying to get somebody from within our family who could be with this patient every day, meet her needs, both cultural, social, emotional, somebody to be available all the time, but the government said no, because they were apparently providing all the needs of this patient, which wasn't true."*

This case illustrates how restrictive visa policies may result in children becoming young carers and taking on significant caring roles for family members with a disability or chronic illness that may have a detrimental impact on their wellbeing and outcomes (see also Suter et al. 2025). When following up 2 years later, we learned that the family were finally granted a visa for an adult niece to travel to the UK to provide proximate care when the family's situation reached crisis point following the mother's admission to residential care.

As discussed in Suter et al. (2025), the lack of extended family networks in migration contexts and immobilising welfare, care, and visa regimes increase the pressures on migrant family members, including children, to provide proximate care, resulting in the 'nuclearization' of caring responsibilities and need for young caregiving to fill the gaps in formal care provision.

7 | Resistance to 'Family Nuclearization' and 'Individualization'

Following our discussion of how the resettlement process, restrictive visa and family reunification policies, and exclusionary, sedentary models of welfare and social care operate as barriers to inter- and intra-generational family care, this section focuses on the agency and everyday resistance of transnational families to such immobility dynamics. De Certeau's notion of 'tactics' ("the art of the weak", 1984, p. 37) is helpful in conceptualising the ways that agency is exercised, even under highly restrictive immigration and care regimes. Practices of care at a distance were reconfigured through participants' efforts to "take advantage of 'opportunities'" (De Certeau 1984, p. 37) and continue to fulfil values of family solidarity and reciprocity across space and time, thereby resisting the 'nuclearization' pressures exerted by immobility regimes at the international and national scales.

Some multi-generational families, affected by conflict and displacement and facing an inability to flee together, tried

navigating humanitarian and migration regimes to secure the safety of different family members in stages, and with the hope that they could be reunited in the future. As De Certeau (1984, p. 39) observes, tactics of resistance are based on a "clever *utilisation of time*" and of the opportunities it presents. For example, Nadir (aged 58) and Mariam (aged 50), from Syria, helped their three sons (the youngest was aged 14 at the time) to escape from Syria and apply for asylum in Sweden in 2014. Nadir and Mariam remained in Syria with their daughter and son-in-law, and an adopted granddaughter. Once their youngest son, Karam (aged 23 by then), was granted Swedish citizenship, he applied for family reunification with his parents in Sweden. However, his application was rejected, so he left his job and paused his studies in Sweden to migrate to the UK where he secured settled status as an EU citizen. He then obtained a family visa for Nadir and Mariam to come to the UK. It is important to note that Karam moved to the UK before 'Brexit'; this type of mobility strategy would no longer be possible between Sweden (or other European Union or European Economic Area countries) and the UK.

Once in the UK, Nadir and Mariam were advised by an immigration lawyer not to apply for asylum but for residence, based on their son's settled status as EU citizen. This can be seen as an example of mobilising 'strategic power by proxy' (Sereke and Drzewiecka 2024), as the family drew on their son's legal right (EU settled status) in the UK and the advice of a lawyer with 'insider' knowledge of the migration regime based on their institutional position, to apply for what was regarded as a more likely successful route to settlement. However, at the time of interview, they had been waiting for nearly a year and still had not received a decision on their residence application. Nadir had several health problems, including a herniated disk, diabetes, and memory problems, and was cared for by Mariam, who also had health conditions, and Karam. Nadir and Mariam received benefits but would have struggled without the financial help that Karam provided.

Nadir and Mariam had not seen their two other sons, daughters-in-law, and grandchildren living in Sweden for ten years, while the situation for their family members in Syria remained extremely difficult. The protracted waiting for a resolution to their application for residence, and resulting immobility, and a lack of resources was taking a serious toll on the mental health and wellbeing of the family. The tactics and strategies by proxy deployed here by different members of the family seeking sanctuary under varying migration regimes can be considered a 'last resort' (De Certeau 1984), that were subject to the spatialising control of nation states. Karam commented on how he had put his life on hold and was "*trapped*" by the situation:

> *"No, my mother and father [are not] refuge seekers, [they are] what they call residency applicants and they're still waiting for a decision which worries me a lot because I'm trapped, I can't finish my studies because I have to take care of them, but I can't live the same social life as before because the decision was delayed. (...) I don't know if they are staying or if they are going back and this affects me mentally."*

Despite such pressures, Karam emphasised the values of intergenerational reciprocity that underpinned his sense of obligation towards his parents: "*I believe in treating others as they were treating me. My parents took care of me my whole life so now I'm doing the same."* This strong sense of solidarity and mutual care, which underpinned the family's tactics and strategic deployments of power, stretched across their extended family, despite geographical distance, and was crucial to their relational wellbeing: "*I take care of them and they take care of me. We are one. If anything happens to anyone of us, everyone gets affected because we are all in one circle*.[4]"

Such a collective, tactical response to care needs was also evident among other participants, who had seen their extended family networks dispersed and/or decimated due to conflict, death, displacement, and the 'nuclearizing' effects of humanitarian protection schemes. Participants tried to creatively rebuild a 'community of care' in the places where they had been resettled, as Mesgena and Baraka (2023) also found among African refugees living in Israel trying to cope with the prolonged forced separation from their kin.

In our project, Ismail (aged 54) from Sudan had lived in Egypt for 13 years as a refugee before being resettled in the UK by IOM ten years previously with his wife and older daughter. They sought to rebuild a *care-filled* life by developing mutual relationships of care with others in similar situations in their new locality and deploying strategic power by forming new institutions that were recognised by the state. Ismail experienced several health conditions which prevented him from working and spoke Fur and Arabic but little English. His remaining extended family and kin were displaced in Chad and central Africa, mainly in refugee camps. He explained that he had started a community charity in his locality in the UK "*to provide care for families*" which now counted "*over 800 individuals including children"*.

He emphasised the value of family bonds and the need to extend this beyond blood ties: "*Family relationships are very beautiful, this bonding between people should expand to include friends and even other tribes"*. He expressed gratitude for the assistance he had received from support groups, evoking how third sector or community organisations in the UK may represent 'spaces of care' for migrant families (Turcatti et al. 2024). His wish for the future was to be able to continue supporting this community group, emphasising that such reciprocal, mutual care and support was necessary.

This and other examples demonstrate the tactics of resistance and strategic deployments of power that forced migrants adopted within family and community spaces, despite highly restrictive immigration and care regimes, based on the values of family solidarity. Such places and opportunities to develop mutual, reciprocal care for others, which may be asynchronous and vary across people's trajectories of displacement, the life-course, and differing institutional contexts in settlement countries, appeared to give meaning to life. This provides further support for Tronto (2013) recognition of the human importance of living a 'care-filled life'.

Some participants' experiences suggest, however, that family solidarity and the obligation to provide care at a distance may

sometimes come at the cost of their own economic wellbeing and cause family tensions, as Akhigbe and Effevottu (2023) also found. Some participants who faced significant financial and personal difficulties in the UK due to the health or chronic conditions of a proximate family member, still felt compelled to continue sending financial resources to other family members in their countries of origin or other countries.

Family solidarity and intergenerational reciprocity thus underpinned the relational wellbeing of forced transnational families, even if this meant prioritising some family members over others at different times, or worked to the detriment of the economic wellbeing and social mobility of coresident family members in settlement countries who were trying to navigate the conditions imposed by 'enforced transnationalism'.

8 | Conclusion

This article has demonstrated how forced migrants and their families are subject to forms of 'enforced transnationalism' (Al-Ali et al. 2001) over time through a continuum of enforcement strategies which jeopardise their ability to live 'care-filled lives' (Tronto 2013). Participants' experiences show the emotional distress caused by prolonged separations and difficulties to visit or receive visits from transnational family members. Displacement often leads to different branches of the extended family becoming dispersed across multiple borders globally; some may continue to live in unsafe conditions (such as in refugee camps), while others may have sought sanctuary or been resettled elsewhere in Europe subject to differing immigration rules. Such 'enforced transnationalism' undermines opportunities to maintain or rebuild inter- and intra-generational caring relationships, which can have serious impacts on the mental health and wellbeing of displaced families.

Individualised, medicalised practices of resettlement by the UN Refugee Agency, alongside narrow definitions of 'family' in national immigration rules, resulted in the 'nuclearization' of displaced extended families. This prevented family members from visiting and reuniting with their kin in settlement and third countries, including other European countries. Onward migration to the UK and residence applications for family members dispersed in Europe have become more restricted since the UK's departure from the European Union. In addition, it usually takes months for family visas to be issued (Justice and Home Affairs Committee 2023) (see also our films[3]). Moreover, the research has shown how sedentary models of welfare, health, and social care discriminate against transnational family members who have caring responsibilities across borders and have negative impacts on the financial security and wellbeing of family members.

The research thus contributes to the growing literature (Kofman et al. 2011; Christ and Etzold 2024; Maghbouleh and Omar 2025) calling for the narrow, Eurocentric definition of 'family' used in UK and other European reunification policies to be expanded to recognise a wider range of family members beyond the immediate 'nuclear' family. Further, our research calls for adequate consideration of transnational family care needs and chronic illness/disability by immigration authorities, welfare, health, and social care providers to facilitate the mobility of carers and those with care needs and support them in fulfilling their caring roles. This would help to alleviate the pressures on 'nuclear' family members who provide proximate care in settlement countries, including young caregivers, and foster families' relational wellbeing.

This paper has considerably deepened the theoretical and empirical scope of the concept of 'enforced transnationalism' by integrating an ethic of care perspective and by analysing the experiences of displaced families with higher care needs, whose experiences have been rather neglected to date. This expanded concept helps to illuminate the emotional geographies and multiple layers of enforcement strategies in operation across a continuum of migration, welfare, and social care policies, which result in the enforced 'nuclearization' and immobility of transnational families over time and space. Despite this, transnational families exert their agency by maintaining and rebuilding intra- and intergenerational caring relationships and values of family solidarity in family and community spaces, which are so vital to their relational wellbeing. Such ethics of care underpin their tactics of resistance and strategic deployment of power in situations of displacement and help to give meaning to their lives in the places where they have sought sanctuary, enabling them to live 'care-filled lives'. This powerful lens helps to bring care, which is often invisible and devalued, and relationality, to the front and centre within studies of forced migration and transnational familyhood.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Endnotes

[1] In 2012, changes to family migration rules affected not only migrants but also British citizens or long-term residents (5 years +) wishing to reunite with non-British child/ren partners or other relatives in the UK. These included minimum income requirements and, in the case of the Adult Dependent Relative Visa (the only route for an older parent/grandparent or other 'adult dependant'), also stringent conditions related to the high degree of personal care required by the relative, which have made it nearly impossible for families to apply successfully (Justice and Home Affairs Committee 2023). The length of residence, income and/or other requirements for this visa make it

inaccessible to those with limited financial means which was the case for all the families considered in this paper.

[2]This family did not apply for asylum but experienced a protracted migration trajectory. Due to the significant time that they were subject to migration control and affected by im/mobilities, they are included in the sample.

[3]Our films, *Refugee Families Caring and Seeking Reunification, Young Caregiving in Transnational Families, Applying for a family visa to meet care needs* and others are available here: https://www.youtube.com/@CAREWELLTransnationalFamilies.

[4]The circle referred to here relates to the 'circles of care' participatory activity used with participants to map caring relationships in proximity and at a distance.

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