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CARE SYSTEMS FOR COMMUNITY-DWELLING ELDERLY ANGLO-INDIANS: EVIDENCE FROM TWO WAVES OF THE COVID-19 PANDEMIC IN CALCUTTA[1]

Brian Gomes and Jillet Sarah Sam

ABSTRACT

This article traces how diverse networked systems of care were employed to address the needs of community-dwelling Anglo-Indian elderly (i.e. those not residing in institutional care homes) during the Covid-19 crisis in Calcutta. The article draws on ethnographic interviews and observations from March 2020 to May 2021. The article reports three significant findings. First, care convoys and collectives, involving both kin and non-kin, were instrumental in elder care. Second, these networked arrangements, in which the elderly themselves are active participants, are strongly shaped by patterns of kinship and residence among Anglo-Indians in the city. However, these patterns were also modified to navigate the pandemic. Third, voluntary organizations at the church, neighbourhood and community level also contributed to elder care during the Covid-19 pandemic.

I. INTRODUCTION

Since March 2020, India has experienced two major waves of the Covid-19 pandemic, the first in 2020 and the second in 2021. The Government of India (GoI) soon identified the elderly (defined as people over 60 years of age) as being especially vulnerable to the virus. This meant that apart from the many restrictions on mobility and interaction experienced by the general population, the elderly experienced stricter restrictions.

[1] Following our respondents, we refer to the city as Calcutta rather than its official name (Kolkata).

For instance, on 13th April 2020, the GoI issued special guidelines for the elderly, encouraging them to isolate at home and not venture out unless for medical emergencies or essential activities. Taking a cue from these guidelines, other agencies such as government offices, supermarkets, public transport and churches restricted the entry of the elderly until late 2020, well after the restrictions on the general population were relaxed. These restrictions were reimposed during the traumatic second wave in April 2021.

These restrictions created particular challenges for elderly Anglo-Indians in Calcutta. Although institutional care arrangements for elderly Anglo-Indians do exist in Calcutta, the majority grow old in their own homes and neighbourhoods. Anglo-Indians also have distinctive patterns of elder care which are not based on the predominant multigenerational coresident family format prevalent elsewhere in India. Instead, among Anglo-Indians, elder care has been organized through diffused, often transnational, networks. Emigration rates among Anglo-Indians have been relatively high since Indian independence, especially among the younger generations. This means that care for elderly Anglo-Indians is often distributed across people spread out around the world. Further, practices of familial and kin residence also encourage the networked provision of care for elderly Anglo-Indians in Calcutta. Although the young are expected to participate in elder care, parents do not always expect to live with children once they are married. Historically too, since childcare was networked (relatives other than parents could be primary caregivers), elder care was also networked (youngsters cared for their aging former caregivers who were distant relatives and family friends) (Bear, 2012; Caplan, 2001).

Considering these factors, in this article we study the experience of community-dwelling elderly Anglo-Indian residents of Calcutta during this pandemic. We document the fear and hardship experienced by them, and the resources they drew on to address the “new normal” of the pandemic. The article has four remaining sections: Section II contains a discussion on the literature on elder care. Although few studies explicitly focus on elder care among the Anglo-Indians, we review the broader literature to understand how care work is organized in this community. Research methods are discussed in Section III, while Section IV contains the findings of the study. We end with concluding observations in Section V.

II. REVIEW OF LITERATURE

Elder Care

In India, a relatively small segment of elder care occurs in an institutional context. Until very recently, institutional elder care was heavily stigmatized (Cohen, 1998; Lamb, 2000). Instead, elder care in India was conventionally undertaken by younger family members (Raju, 2014), often in the context of a multigenerational patriarchal joint family (Samanta et al., 2014). The heightened migration of younger family members seeking economic opportunities, both within India and abroad, is also noted to have affected intergenerational family ties (Jamuna, 1998) and posed new challenges for the care of the elderly who remain in India (Nandal et al., 1987; Raju, 2014; Subrahmanya, 2000). Some of the stigma attached to institutionalised elder care has started to decline since the 2000s (Kalavar & Jamuna, 2011; Lamb, 2011). Despite these changes, for a large part of the Indian population elder care still continues to occur in the community-dwelling context, where they live in their own homes and neighbourhoods, irrespective of whether their kin reside with them.

Caregiving for the elderly involves a variety of activities including routine assistance (Katz et al., 1963; Lawton & Brody, 1969) and social interactions (Barker, 2002; Kruijswijk et al., 2014; Matthews & Rosner, 1988). Caregivers may be either kin or non-kin. Kin ties refer to links through blood relations and marriage. The literature notes that a variety of kin participate in elder care: spouses (Lambotte et al., 2019; Langer & Ribarich, 2007; Samanta et al., 2014; Tennstedt et al., 1989), children (Matthews & Rosner, 1988), grandchildren (Mills et al., 2005; Samanta et al., 2014), daughters-in-law (Gupta & Pillai, 2002; Kruijswijk et al., 2014; Samanta et al., 2014), sons-in-law (Kruijswijk et al., 2014), siblings (Langer & Ribarich, 2007; Pashos & McBurney, 2008; Tennstedt et al., 1989), and nephews and nieces (Dellmann-Jenkins et al., 2001; Pashos & McBurney, 2008; Tennstedt et al., 1989). Care by non-kin includes institutions (old age homes, hospitals, *ashrams*) and professional caregivers (Kalavar & Jamuna, 2011; Lambotte et al., 2019). Other sources of care by non-kin, particularly in the context of community-dwelling elderly, include neighbours (Barker, 2002; Broese van Groenou & De Boer, 2016; Lambotte et al., 2019), friends (Barker, 2002; Broese van Groenou & De Boer, 2016; Lambotte et al., 2019), local merchants, such asbakers, pharmacists, and hairdressers (Lambotte et al., 2019, p. 4) and

volunteers (Broese van Groenou & De Boer, 2016). For community-dwelling elderly, the role of non-kin becomes even more significant when family members live far away (Broese van Groenou and De Boer, 2016).

There has been a conscious effort to move away from dyadic relations of elder care towards conceptualizing it in terms of more extensive networks of caregivers. Keating et al. (2003) introduced the idea of a care network where both kin and non-kin provide complex, interconnected, and sometimes complementary mechanisms of care. However, Kemp et al. (2013) and Lambotte et al. (2019) argue that most theoretical models of care networks have failed to analyse their dynamic characteristics. Although in theory care networks are supposed to look beyond dyadic relationships, in practise the unit of analysis in most care network models has devolved into a focus on dyads *within* the network (Kemp et al., 2013).

To overcome this gap, Kemp et al. (2013) developed an alternative model of care networks known as the "care convoy" model. A care convoy refers to "the evolving collection of individuals who may or may not have close personal connections to the recipient or to one another, but who provide care, including help with activities of daily living (ADLs), socio-emotional care, skilled health care, monitoring and advocacy" (p. 18). In this model, the unit of analysis is the networked (non-dyadic) interaction and collaboration among caregivers (both formal and informal) (Kemp et al., 2013; Lambotte et al., 2019). The care convoy model has been adopted widely in social gerontology.[2] Over time, Lambotte et al. (2019) further refined this care convoy model to incorporate the active role played by the elderly themselves in the caregiving process. In a recent study, Kemp (2021) employed the care convoy model to understand interaction between formal caregivers, friends, and family members in American elder care during the pandemic. However, Kemp's analysis does not consider a very wide range of non-kin actors such as neighbours, shopkeepers and shop owners and other service-related people (such as driver, security guard, bank employees). In contrast, this article adopts the care convoy model to understand the complex, networked and agentic care arrangements emerging through the interaction

[2] See for instance, studies by Ball et al., (2014); Kelly et al., (2018); Reckrey et al., (2021); Stokes Patterson (2020); Moen & DePasquale, (2017).

between a variety of kin, non-kin, non-professional actors, and elderly Anglo-Indians during the first two waves of the Covid-19 pandemic in Calcutta.

The care convoy model has been revised through a focus on technology. Winance (2010) developed the concept of a "care collective" where care emerges through the interactions between non-humans (technical objects) and humans (including the elderly, their family members and professionals). Here, care is both provided and received by all people in the care collective. Winance (2010) argued that the technical object makes possible such sharing of care among humans in the care collective and can modify "distance or proximity" and "relationships of dependency" between them (p. 107). Ahlin (2017, 2020) refined Winance's concept in two important ways - by incorporating the transnational nature of care and by focusing specifically on information and communication technology (ICT). Through her concept of the "transnational care collective", Ahlin (2017) refers to care generated through interactions between the elderly, their transnationally located family (by which she means their children), care professionals (such as nurses), and ICTs. Ahlin (2020) argues that transnationally located children perform "good care" by combining ICTs with service by professional caregivers to interact daily with parents and check on their varied requirements (such as diet, medical routines, social interactions with others, and finances). Unlike Winance (2010) and Ahlin (2017, 2020), who did not go beyond the family and professional caregivers, in this article we will illustrate the role of non-kin such as neighbours, friends and non-professional carers within care collectives (transnational or local). Ahlin also focuses solely on communication technology within ICTs, such as the use of mobile phones, or social media channels (such as Skype, Facebook Messenger). In contrast, while employing the concept of care collectives, this article will also examine non-communication technology such as digital platforms. Considering digital platforms helps us document the active role that the elderly themselves undertook in their own and the care of others during the pandemic.

Elder Care Among Anglo-Indians

Few studies explicitly focus on elder care among Anglo-Indians. Existing studies have focused on the care of elderly Anglo-Indians in institutional settings. Andrews (2012) analyses the importance of "ethnic-specific socio-cultural" (p. 22) institutions which primarily cater to elderly Anglo-Indians such as the Lawrence De Souza, Tollygunge

and Mary Cooper homes in Calcutta, noting that residents feel comfortable there because other residents have similar ethnic and cultural backgrounds. Andrews (2012) identifies two significant factors which recently prompted elderly Anglo-Indians to move into old age homes in Calcutta. First, they were left on their own in the city after family members migrated to foreign countries. Second, some felt unsafe while living in central Calcutta, due to the hostility they encountered from new neighbours from different communities. These factors make it important to understand care arrangements of elderly Anglo-Indians who are community-dwelling in Calcutta, rather than those residing in old age homes. There are no studies that focus on community-dwelling elderly Anglo Indians. Instead, references to their care arrangements are scattered across the broader literature on the community. For example, Sen (2017) has documented the support provided to community-dwelling elderly Anglo-Indians by voluntary organizations such as the Calcutta Anglo-Indian Service Society (CAISS hereafter) and churches in Calcutta.[3]

To understand elder care among community-dwelling Anglo-Indians, we need to understand kinship structures and patterns of residence in this community in contemporary India. Caplan (2001) notes that among Anglo-Indians in Chennai, there is considerable diversity in the types of families and which family members cohabit with each other. Despite the expectation that Anglo-Indian families are nuclear in nature, he found that a form of joint family, quite different from the joint Hindu family, was peculiar to the Anglo-Indians. Placing the conjugal couple at the centre, Caplan (2001) defines a joint family as consisting of two or more cohabiting couples. This joint family could include the parents of both the husband and the wife, or married siblings residing together with their respective children. Caplan (2001) also notes other forms such as single person households, nuclear households (one couple cohabits with/without children), supplemented nuclear households (relative of the couple other than their children cohabit with them) and other households (for instance, two unmarried siblings who cohabit).

While the form varied greatly, Caplan (2001) notes that Anglo-Indians cherished the idea of a close family. This frequently resulted in “supplemented” (p. 161) families,

[3] For a more detailed discussion of the history of CAISS, see Sen (2017).

where even distant relatives would cohabit. There was an expectation that those who are better off must extend help to family and kin who are either down on hard times or trying to improve their lot in the world (Bear, 2007; Bear 2012; Caplan, 2001). One translation of this maxim is that it is not uncommon for poorer relations, particularly elderly relatives, to supplement the Anglo-Indian family. In her study on the railway Anglo-Indian families of Calcutta and Kharagpur, Bear (2007) finds that in these families, “expansive bilateral reckoning based on affective household ties gives particular weight to fraternal and sororal connections. These provide networks that cross-cut families of marriage and link them to families of birth” (p. 430). She also found that extended families may live in different households but are bound by sharing Sunday meals after attending church together.

In the context of the ideal of close families, Caplan (2001) notes that there is a strong expectation that the young care for elderly relatives. Given the varied patterns of families and residence discussed above, parents do not always expect to reside with an adult married child (Bear, 2012). However, it is expected that an individual must take care of the elderly, especially at a point when the elderly person is no longer able to do so for themselves. Caplan (2001) notes that local disapproval along with a strong sense of filial duty act as incentives for the care of such elderly family members. This elderly figure might be a parent, a female relative (say a grandmother or aunt) who provided primary care to the individual as a child, or some other elderly relative. In striking contrast to the conventions of broader Indian society, there is no clear rule about whether the son or the daughter should care for the elderly parent. In the next section, we will explain how we drew on this literature review to structure our research design.

III. DATA AND METHODS

This article draws on an ongoing ethnographic study of community-dwelling elderly Anglo-Indians in Calcutta which was started by the first author in 2018. This ethnography covered Ripon Street, Elliot Road, Entally, Park Circus, Bow Barracks, Salt Lake, Picnic Garden, and Garia. As part of this broader ethnography, the first author observed Anglo-Indian elderly in nearly 100 households. Both authors jointly conducted thematic analysis of these observations.

As with Caplan's survey in Chennai (2001), in Calcutta the form of the households also varied considerably. Before the pandemic, this included single person households, nuclear households, supplemented nuclear households, joint families, supplemented joint families and other families. In our sample, it was unusual for the mobile and autonomous elderly to reside with adult married children. During fieldwork, multiple respondents remarked that among contemporary Anglo-Indians in Calcutta, children usually leave the parents' house, provided they can afford to do so, to start their married life under a separate roof. Most elderly cohabiting with adult married children did so only when they were no longer mobile, particularly inside the house. Many physically autonomous elderly persons either lived by themselves, with dependent adult sons, or with unmarried adult daughters. Some also resided with relatives through blood (cohabiting siblings) and marriage (for example, a deceased cousin's wife).

For the purposes of this article, where the focus was to understand the experiences of the elderly in the pandemic, the two authors jointly conducted detailed interviews with 45 Anglo-Indian households within the larger ethnographic sample.[4] The households were spread out across the different neighbourhoods Ripon Street/Elliot Road (9), Picnic Garden (24), Park Circus (5), Entally (3), Garia (3) and Salt Lake (1). The interviews were conducted in multiple rounds from March 2020 to May 2021, with each elderly person having been interviewed at least twice. All interviews were conducted either telephonically or through digital media calls. In addition, text messaging and social media exchanges were also drawn upon. Interviews were conducted to understand the experience of the elderly in both the first and the second wave (except for one household).[5]

[4] Names of all respondents have been changed to preserve their privacy.
[5] In this case, our respondent withdrew from public life (including participation in our study) due to depression caused by the sudden death of their elderly spouse from Covid-19 in mid-2020.

IV. FINDINGS: NEGOTIATING THE PANDEMIC AS AN ELDERLY COMMUNITY-DWELLER

We found that in the first wave, where mobility was more strictly restricted, community-dwelling elderly Anglo-Indians drew on initiatives conducted by churches, neighbourhood organizations and voluntary organizations. Their ability to draw on such formal organizations was shaped by their socio-economic status and physical location in the city. During the pandemic, they often drew on care convoys and care collectives, combining people in local and transnational locations, not only for their own care but also care for other elderly people. During the pandemic, their engagement with technology was heightened - they explored new technology (such as digital platforms) and also used familiar technology (such as social networking sites) more frequently as part of care arrangements. We also found that elderly community-dwelling Anglo-Indians creatively reshaped residential arrangements to address uncertainties generated by the pandemic, particularly the lockdowns. However, we also found that some elderly Anglo-Indians felt left out and struggled to deal with the pandemic on their own.

Voluntary Organizations and Churches

Voluntary organizations and churches actively organized care for the elderly, particularly during the first lockdown which was national in scale. Community organizations (such as CAISS), neighbourhood organizations (Bow United Organization, BUO hereafter) and churches organized Covid-19 relief initiatives directed particularly towards poor and elderly Anglo-Indians.

Before the pandemic, CAISS had been distributing monthly free rations to poor elderly Anglo-Indians. From May to July 2020, CAISS increased the frequency of ration distribution because the places they worked and the small shops frequented by them had closed due to the lockdown. CAISS distributed weekly rations through a network of young Anglo-Indian volunteers to ensure that it could be delivered to the elderly persons (so they need not travel to collect it as they had before the pandemic).

The BUO was established in 2008 by Anglo-Indian residents of the Bow Barracks area of Calcutta, to address the needs of residents and help its many elderly residents (a large proportion of whom were Anglo-Indians). During the first wave (from April to

September 2020), the BUO organized specific initiatives to alleviate the expected social isolation of elderly residents of Bow Barracks. The elderly could call on a network of younger volunteers from Bow Barracks over the phone and ask them to buy and deliver essential items (such as food and medicine) to their homes. They could also call the volunteers for any emergency help. The BUO also continued its pre-pandemic practice of distributing monthly free rations to the poor and the elderly. From April to May 2020, BUO volunteers delivered these rations at the doorstep of elderly residents of Bow Barracks. However, due to travel restrictions during the first lockdown, some elderly Anglo-Indian residents of Ripon Street and Picnic Garden, who also used to come to Bow Barracks to collect these rations earlier, were excluded from this initiative.

Churches in Picnic Garden and Entally distributed free rations as Covid-19 relief. The Church of Our Lady of Vailankanni, which has a substantial Anglo-Indian membership, distributed monthly free rations from May to September 2020 to poor church members living in Picnic Garden. A 500 grams energy drink packet was added to regular rations to enhance nutrition among the elderly during the pandemic. Similarly, Fatima Church collaborated with the neighbouring St Teresa's Church to distribute monthly free rations to poor church members living in Entally from May to August 2020. Many of our elderly respondents not only donated money themselves, but they also reached out to relatives and friends abroad to contribute to these initiatives.

These organizations reverted to their original ration distribution efforts a few months after the first lockdown ended and ceased any significant Covid-19 relief activity. Further, during the second wave of Covid-19, they did not organize any Covid-19 relief since, unlike the first lockdown, the second lockdown was more local, and the shops were not completely closed.

Care Convoys

We consider two illustrative cases, both of which involve a strong component of self-care. Roslyn's care convoy involves both kin and non-kin. Due to her strained financial circumstances and estrangement from her son and daughter-in-law, Roslyn (77 years) has been renting a storeroom by herself in Picnic Garden since 2016. Although her son lives in the same neighbourhood, he meets her only every alternate month to hand

over some money. Roslyn has no other kin because she was the youngest of her siblings, who are all deceased. Rather than her son, the most significant node in her care convoy is Pinky Mondol (28 years), Roslyn's next-door-neighbour since 2017.

When we spoke to her in May 2021 Roslyn's son had visited her only twice since the pandemic started, mainly to give her some prepared food, groceries, and money. She keenly recollects that he did not inquire about how she was coping with the pandemic. Whenever Roslyn needed anything during the pandemic, she would first turn to Pinky. The two women continued to meet each other daily in the common area while washing utensils and for tea. During this period, Pinky also taught her how to attend online church services. In June and September 2020, Roslyn suffered from fever, chest pain and stomach upset. Pinky accompanied Roslyn to a nearby clinic and purchased cooked food, groceries, and medicines for her. Roslyn also became Pinky's primary source of information about the neighbourhood (such as the condition of the market or shop opening times).

From May to September 2020, Roslyn received monthly food rations as pandemic relief from the Church of Our Lady of Vailankanni. Each month, church volunteers would deliver rations to Roslyn on the ground floor of her building. During this period, Roslyn also asked Pinky to go out and buy medicines for her. After the church rations stopped in October 2020, Roslyn started to visit the neighbourhood markets herself to buy groceries and medicines until March 2021. Pinky was also instrumental in getting Roslyn vaccinated. She informed Roslyn in January 2021 that vaccination centres were now open for her age group and gave her the phone number of a vaccination center where her brother-in-law worked. Roslyn then called and booked a slot for herself. When Roslyn went to the vaccination center, Pinky's brother-in-law met her at the entrance and helped her navigate the entire vaccination process. In the month of May 2021, Pinky told Roslyn not to go out as cases of Covid-19 were on the rise again. Instead, Pinky went out to buy groceries, food and medicines for Roslyn.

As observed in the literature, the idea of a close family is enacted in specific ways among Anglo-Indians. Although most elderly Anglo-Indians in this sample did not reside in the same household as their adult married children living in Calcutta, Bear's description of an extended family joined together by the Sunday lunch could be

observed (Bear, 2007). During the pandemic this network became a central part of a larger care convoy which assisted in both routine and instrumental activities of the elderly person, even though family members resided in separate households. It was common for parents and their married children living nearby in separate flats (with separate kitchens) to be linked through ties of daily care.

Our second case reflects an extended joint family, where the households are linked, through both sororal kin ties and filial ties, in a care convoy. Linda (81 years) has been living in a Picnic Garden flat by herself since the death of her husband and daughter. Her nephew, Peter (66 years), moved into a flat in the same neighbourhood with his wife and adult, differently abled son in the 2000s. Soon, his sisters, Pearl (66 years) and Catherine (70 years) moved into a different flat in the same neighbourhood. Before the pandemic, the siblings would spend Saturday evenings at Linda's flat and eat Sunday dinner at Peter's residence. During the pandemic, these siblings have been a significant source of care for each other. Since Catherine is the eldest, Peter told her not to leave the house at all. He also told Pearl to be careful while going to the neighbourhood market to buy groceries. Since they could not meet physically due to the high number of Covid-19 cases from April 2020 until September 2020, they would call each other three times in a week. From October 2020 to April 2021, the siblings started to meet each other again in-person. During this period, Peter would go over to the sisters' flat four times a week just for a 15-minute chat (but not a meal). After cases started to increase again in April 2021, Peter reduced his visits to twice a week. They also checked on each other daily via phone and video calls.

The siblings also became a crucial source of care for Linda, who was diagnosed with Alzheimer's disease in December 2019. During the first wave, in April 2020, Peter prevailed on Linda to stop having her domestic helper come to her home. While the siblings usually called Linda twice a week earlier, since the pandemic they call her daily. Peter spoke to Linda on WhatsApp video call each morning to update her about the neighbourhood and check on her needs. Pearl also called her every night because she worried that Linda would be prone to accidents while cooking in the absence of the domestic helper. Pearl's calls also acted as a cross-check: if Linda forgot to mention some need to Peter it would be caught during Pearl's call. Although Pearl offered to send over cooked meals, Linda insisted on cooking for herself. So, from

mid-April until October 2020, Peter's son ordered groceries from a popular grocery delivery platform for Linda whenever he placed an order for his household. Since the siblings were worried about accidents and Linda refused to place the burden of cooking food on their shoulders, Peter advised her to resume the services of the domestic helper from November 2020 onwards. This domestic helper visited Linda's flat to cook, clean and shop for her. Since the second wave was announced at the end of April 2021, the siblings have convinced Linda to discontinue the services of her domestic helper. This time around, the siblings are not letting Linda cook and Pearl and Catherine prepare meals for her in their own kitchen. Pearl then drops off these cooked meals at Linda's flat thrice a week.

Care Collectives

We start with a case that demonstrates the significance of socio-technical care collectives in the lives of community-dwelling elderly Anglo-Indians during the pandemic. Melvyn (78 years) lives with his wife Gladys (77 years), in his childhood neighbourhood of Ripon Street. Their two daughters, who live in Australia, used to speak to them three to four times a week via WhatsApp and video calls. The couple could not discontinue their domestic help's services even after the pandemic struck, due to their significant mobility issues. So, Melvyn's elder daughter, Helen, instructed the domestic help on Covid-19 appropriate behaviour and sanitization.

During the early part of the first lockdown (April 2020), Melvyn had a heart attack. He asked Gladys to telephone Jamie (a 74-year-old Anglo-Indian friend and neighbour). Since Gladys has significant mobility issues herself and the ongoing lockdown made mobility difficult, Jamie coordinated everything locally in this health emergency. Jamie booked an ambulance, accompanied Melvyn to the hospital and informed Helen in Australia by calling her through WhatsApp from the ambulance. Jamie visited Melvyn every morning for the entire week he was hospitalized, to check with the doctor and observe Melvyn. He also arranged for medicines and other medical equipment, and secured Melvyn's discharge from the hospital. When Jamie informed Helen that Melvyn would be hospitalised, she, in turn, informed her younger sister and three of Melvyn's cousins in Australia through a conference call. After Melvyn's operation, Jamie would update Helen daily through a WhatsApp call on his way back from the hospital. After this daily update, Helen would in turn update her younger sister and

Melvyn's cousins through a conference call. When they had specific questions, Melvyn's younger daughter and cousins would call Helen individually, since Melvyn was too weak to interact with people on the phone. Helen also called Gladys to reassure her and to check on her daily.

After Melvyn was discharged, the domestic help moved in with them full-time to help take care of him for two months. Jamie also arranged for a man to buy groceries and pay the internet, electricity, and phone bills. Jamie would visit the neighbourhood shop to buy Melvyn's medicines because he could read the expiry dates himself. Jamie also updated others in the neighbourhood and the church about Melvyn's progress, since Melvyn had not regained his strength after the surgery. Since Melvyn's cardiac operation, Helen checks on Melvyn's diet with Gladys and Jamie, a daily practise she adopted at the start of the pandemic. From the month of June, when Melvyn became stronger, both daughters called him daily through WhatsApp. During June 2020, Melvyn's cousins called him twice a week on a WhatsApp conference call, which reduced over time to once a week and then twice a month. They continued to check on the couple during May 2021 when the BBC reported that the Covid-19 situation during India's second wave was grim.

In the case outlined above, the care collective for the elderly person is linked to the immediate neighbourhood (spouse, other relatives, friend, community people, domestic helpers) and even to nodes in Australia (daughters and cousins), all connected through communication-based digital technologies. However, as we can observe in the case of Linda (above), since the pandemic, care collectives for the community-dwelling Anglo-Indian elderly in Calcutta have expanded to include digital platforms, which are non-communication based digital technologies. For instance, we can observe in Linda's case that her nephew, Peter, alarmed at the combined effects of Alzheimer's and absence of her domestic help, turned to a grocery delivery platform to address Linda's routine needs at the height of the first wave. Since the pandemic started, we found that the use of digital platforms was on the rise. Before the pandemic, the elderly would prefer not to use digital platforms since they preferred to visit the markets themselves. However, since the pandemic started, more elderly Anglo Indians have become conducive to the inclusion of digital platforms within their

care collectives because their mobility was particularly constrained during lockdowns and periods of heightened infections.

Adjustment Strategies: Lockdowns and Two Covid-19 Waves

Elderly Anglo-Indians negotiated the pandemic through creative and drastic adjustments. Some elderly Anglo-Indians who resided alone changed their pattern of residence significantly to navigate the pandemic, particularly during the lockdowns and the peaks of the two Covid-19 waves. Some respondents in single person households moved in with married children (two cases), siblings (two cases) and other single Anglo-Indian friends (two cases) during the pandemic.

Here we consider an illustrative case of two Anglo-Indian sisters who moved in with each other to navigate the two lockdowns and transformed a support network of another friend into a care convoy. Wendy (68 years) has been living in Picnic Garden in a flat by herself since 2004 because her husband passed away and her only child was institutionalized. In 2009, 75-year-old Winnie, Wendy's divorced sister, moved into a flat nearby. The sisters found this flat through the help of Wendy's church friend, Beryl (78 years), who alerted them to an empty flat downstairs in her own building. Beryl, who migrated to Calcutta from a small railway colony in the early 2000s, has lived alone since an estrangement from her only daughter and her husband's death in 2012. Before the pandemic, the three women would meet each other every Sunday at church and have celebrated Christmas together at Winnie's flat since 2009.

The lockdowns announced by the government of West Bengal[6] during the first and second waves prompted Wendy to move into Winnie's flat until December 2020. During this time, Wendy would buy essentials (such as groceries and medicines) for herself and Winnie by visiting the neighbourhood market, and from the few mobile vendors who came to the neighbourhood. Wendy also did the cooking, with some help from Winnie. While the sisters had other people checking up on them during the

[6] The West Bengal government initially announced a state-wide lockdown from 23rd to 27th March 2020. Then the GoI imposed a nation-wide lockdown on 24th March 2020. All public transport was shut down and only essential shops were open during limited periods. People were permitted to go out only for essential services. The GoI extended the national lockdown multiple times until June 2020, with each phase permitting greater mobility. No national lockdowns were imposed in the second wave. Instead, the West Bengal government announced a state-wide lockdown from on 30th April to 28th June, 2021. Here, mobility was permitted only between 7 am to 10 am and 3 pm to 5 pm.

pandemic, Beryl lacked such a care convoy. During the first lockdown, an erstwhile support group transformed into a care convoy. Since churches were closed from April to December 2020, Wendy, Winnie, and Beryl form a small prayer group with a Bengali Christian neighbour. The prayer group met physically twice a week and after prayer the four women drank tea, ate snacks, and discussed daily life. Beryl struggled with supplies during the first wave because she became fearful of stepping out of the house. She was unable to access certain supplies, such as milk, eggs, and bread, which were available only in the neighbourhood market. So, at the end of each prayer meeting, Wendy and Winnie checked if Beryl needed medicines or groceries. When Beryl informed them, Wendy would buy supplies for her on her next supply run at the neighbourhood market and drop them off at Beryl's flat. Beryl started to go to the market again to do her own shopping in December 2020.

Wendy moved back to her own flat in January 2021, only to move back into Winnie's flat again when the West Bengal government imposed a lockdown during May 2021. Although Wendy felt she personally could handle the second lockdown after her experience of the first one, she was concerned about Winnie's ability to manage on her own. When Covid-19 cases started rising in April 2021, the prayer group started meeting again through Whatsapp video twice a week. Since Beryl did not use a smartphone, Winnie (and, after she moved back in, Wendy) would walk up to her flat to share a smartphone with her. Beryl stopped visiting the market again in April 2021. Beryl has been able to manage groceries by herself in the second wave because this time mobile vendors for all products (including milk, eggs, and bread) came and sold their wares in front of each building. However, she still asks either Winnie or Wendy when she needs medicines, and they walk over to the pharmacy nearby to pick anything up for her. The sisters also became concerned with Beryl's low protein intake (she preferred only eggs), and so during the second wave they started to cook fish and meat for her on the weekends. The sisters cook at their flat and then walk up and give Beryl the food. In turn, Beryl gives them any special egg dishes that she cooks at her flat.

Next, we consider a case where the pandemic also resulted in reconciliation within families in a way that facilitated elder care. Here an incidence of Covid-19 or a resultant death compelled previously dissociated family members to re-evaluate and

overcome these differences. The devastation caused by the disease and the lack of public resources prompted many to draw previously dissociated family and kin into their care convoy. A Covid-19 death changed the dynamics within a supplemented joint Anglo-Indian family. The Sinclair siblings, Luke (75 years), Bertha (70 years), and Rupert (65 years), lived in their childhood home in Park Circus. By the time the pandemic hit, there were two other members living in the household: Rupert's youngest daughter, Lara (28 years), and Bertha's husband's cousin, John (62 years). Bertha, a widow, has two daughters who live in England. Due to past conflict between Rupert and Bertha, who had stopped talking to each other, the household was split into two separate kitchens. Rupert and Lara maintained one kitchen while Bertha and John maintained another. Luke interacted with both his sparring siblings and would eat in both kitchens.

When the first lockdown was imposed, Rupert and Bertha started to surreptitiously check on each other's health. Since they were still not on talking terms, they used Lara as a go-between. Bertha contracted Covid-19 in February 2021. In this period, Lara and Rupert became the primary care-giving members in Bertha's care convoy. After Bertha developed a fever, Lara booked a Covid-19 test for her and bought medicines for her from the neighbourhood pharmacy. The next day, when Bertha started to struggle to breathe, Rupert secured a hospital bed for her by calling up some doctors he knew through their shared volunteer work with CAISS. From then on, Rupert and Lara were preoccupied with Bertha's health and arrangements related to it. Lara would call the hospital daily to check on Bertha and then update Rupert, Luke, John, and Bertha's daughters in England. During this period, the two kitchens were merged into one, with John procuring groceries and cooking for himself, Luke, Rupert, and Lara.

Bertha passed away a week later. Rupert conducted most of the procedures after her death. He settled the hospital bill, got her body discharged from the hospital and organised Bertha's funeral. After Bertha's death, the members of this household, where John is a deceased sister's husband's cousin, decided to continue with the merged kitchen as a first step to bring peace in this supplemented joint family. Now the cooking is done collaboratively by Lara and John, while Rupert procures groceries from the neighbourhood market.

Left Out During Lockdowns

Not all elderly Anglo-Indians in Calcutta were able to successfully negotiate the pandemic through care convoys and collectives. The lockdown experiences of some respondents made this starkly clear. One reserved elderly couple, estranged from their children and neighbours, had experienced a collapse of their support and care network because their community and church friends were either deceased or had migrated away from Calcutta. They struggled to find medicines during the lockdowns.

In two separate cases, we observed that despite the existence of a care convoy, elderly men struggled to buy medicine (and in one case, food) during the lockdowns. In both cases, the elderly men were in daily touch with their children who lived abroad. Neither man informed their children, possibly because they categorized this lack of food and medicines as a routine problem to be handled on their own rather than a larger problem requiring intervention from the children. Further, due to the class stigma associated with the ration drives, both men did not reach out to the Covid-19 relief measures undertaken by CAISS and the Calcutta churches.

V. CONCLUSION

This article demonstrates that community-dwelling elderly Anglo-Indians in Calcutta actively shaped their own arrangements of care, in the form of networks such as care convoys and collectives, during the pandemic. These networked care arrangements were strongly influenced by patterns of family and kinship peculiar to the community (such as extended joint families, supplemented families) as well as diverse patterns of residence among the community-dwelling elderly in Calcutta (interactions with neighbours, friends, and domestic help). We also demonstrate that kinship and residence patterns were modified to negotiate the pandemic, sometimes through active intervention on the part of the elderly person (moving in with married children, siblings, and friends) and involuntarily in other cases (contracting the illness or death). Voluntary formal organizations at the church, neighbourhood and community levels also contributed to elder care during the first wave of the pandemic.

Care convoys and collectives, involving both kin and non-kin, were instrumental in addressing material, medical and social needs during the pandemic. The nodes in the

care convoy could, and did, extend to other cities in India and abroad. Yet, by its restrictive and fear-inducing influence on elder mobility, the pandemic also necessitated a locus of care concentrated at the neighbourhood level. We also demonstrate that the pandemic prompted a shift in the support network of some elderly Anglo-Indians into functioning as a care convoy. The care collectives of community-dwelling elderly Anglo-Indians expanded during the pandemic to include care through digital platforms in addition to heightened use of digital communications technologies. Such platforms enabled the elderly to take on a more agential role in self-care and the care of other elderly persons. While we have discussed the varying dimensions of care convoys and collectives, in the case of some community-dwelling elderly Anglo-Indians residing by themselves, these care mechanisms either collapsed or were inadequate in negotiating the pandemic, particularly the lockdowns.

Brian Gomes *is a graduate student in the Department of Humanities and Social Sciences at the Indian Institute of Technology Kanpur. His research interests include social gerontology, sociology of Anglo-Indians and urban sociology. He can be reached at bgomes@iitk.ac.in*

Jillet Sarah Sam *is an Assistant Professor in the Department of Humanities and Social Sciences at Indian Institute of Technology Kanpur. Her research includes the economic sociology, urban sociology, and digitization. She can be reached at jssam@iitk.ac.in*

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