

“Goodness and kindness”: Long distance caregiving through volunteers during the COVID-19 lockdown in India

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S. Roy planned the study, extracted data, performed data analysis, wrote, and revised the paper.

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Abstract

Background and objectives: The first Covid-19 lockdown in India was announced on March 24, 2020, with less than four hours' notice, leaving older adults without access to domestic help and paid caregivers. As traditional caregiving models ceased to function in the new setup, relatives of older adults turned to strangers and volunteers in an effort to provide urgent care to their older family members.

Research Design and methods: A pan-India group of volunteers was formed during the lockdown on a popular social media website to connect people of all ages in need of help with those able to offer assistance. A sample of 242 messages pertaining to older adults was extracted for quantitative content analysis.

Results: All but two requests were placed by adult relatives of older adults. Requests covered a number of needs, some of which were directly tied to the pandemic and lockdown, while others were general in nature but were greatly exacerbated by recent events.

Discussion and Implications: The use of social media to encourage acts of kindness at a time of crisis was an innovative attempt to meet the immediate needs of older adults. The lockdown, however, exposed the lack of dedicated supports and services for older adults in India.

Keywords

Intergenerational support, assisted living, independent living

Introduction

Caregiving models vary across countries and cultures, with each model representing a unique caregiver-older adult relationship. Traditional caregiving is broadly divided into two components: paid, formal care performed by trained professionals, and unpaid, informal care undertaken by family members. Less commonly, in some care arrangements, family caregivers may be compensated for their services (AARP, 2020); in other instances, professional caregivers may perform “double duty” by using their professional skills to perform unpaid caregiving for older family members at home (DePasquale et al., 2016). Although both formal and informal caregiving have been linked to stress and burnout, family caregiving is associated with higher physical and psychological burden, in addition to financial strain, increase in household chores, neglect of caregivers’ own needs, and social isolation of caregivers (Chan, 2010; Vaitheswaran et al.). Conversely, caregivers also report feelings of personal growth, increased meaning and purpose in life, and greater life satisfaction associated with caring for older relatives (American Psychological Association, 2011). Most caregivers experience both emotional distress and psychological benefits in relation to their caregiving responsibilities (Roth et al., 2015).

In western countries, informal family caregiving is generally supplemented with institutional care options. In developing countries, caregiving duties are almost entirely performed by the family unit owing to lack of care facilities, limited personal resources, dearth of state support, and dominant cultural mores (Chan, 2020). Although the subject of family caregiving has attracted due attention by scholars and policy makers in the West, the nature and impact of family caregiving in developing countries, such as India, remain largely unexplored. Therefore, care relationships, expectations, and performance of elder care in developing

countries warrant close examination, especially from the perspective of population aging within rapidly evolving sociocultural contexts.

Elder care in India

Living arrangements

Like most predominantly traditional cultures, elder care in India is rooted within the home and family. This care arrangement is facilitated by the “joint family” system in which multiple generations of immediate and extended family reside within the same household. The availability of several people belonging to diverse age groups allows for (gendered) division of labor and delegation of duties. Consequently, the multifaceted responsibilities of caregiving (physical, psychological, financial, social) are shouldered collectively by the family rather than by one or two individuals. Generally, the physical care of older adults is undertaken by the women in the family, especially an older spouse and/or daughter(s)-in-law, while other aspects, such as financial decisions, may be the domain of the male members. Irrespective of how responsibilities are shared, older adults are generally assured physical and emotional care in such living arrangements, although instances of elder abuse are also on the rise. (Rajan & Kumar, 2003; Prasad & Rani, 2007; Rajan & Balagopal, 2017; Ugargol & Bailey, 2018).

In recent decades, the gradual disintegration of the joint family system, especially in urban India, is straining traditional caregiving norms. Modernization, urbanization, globalization, and the consequent migration of younger family members for educational and professional opportunities is creating a large population of “left behind” older adults, while simultaneously giving rise to the nuclear family set-up typical of modern society (Rajan & Kumar, 2003; Ugargol & Bailey, 2018). This change is further exacerbated by the demographic transition that India is currently undergoing. Increasing life expectancy and falling fertility rates continue to

impact the number of available children to care for older parents, especially if the former choose to migrate. Per 2011 census, India's older population stands at over 100 million individuals. The country, however, is grossly underprepared to cater to the needs of this population. Recognition of this lack of preparedness has propelled the government to legally obligate children/heirs/relatives to care for older adults, instead of expanding state-funded safety nets and infrastructure to care for this population (Rajan & Balagopal, 2017).

Although multigenerational living arrangements continue to remain overwhelmingly common in India, with an estimated 90% of older adults residing with children in 2001 (Bloom et al., 2010), recent statistics state that about 14% of widowed older adults, 16% of separated/deserted/divorced/partnered-but-not-married/never married older adults, and 1 out of 10 older women in India now live alone (UNFPA, 2012). It has also been suggested that in urban India, financially independent older adults are increasingly opting to live alone instead of with children or in old age homes, preferring to contract domestic help for assistance with daily needs (Gangopadhyay, 2020). A recent study of 9,852 older adults in India found that joint-family living arrangements did not enhance subjective well-being of the participants when compared with living alone. Moreover, people experienced greater emotional well-being when living with their spouses only, compared to living with children only or both spouse and children (Samanta, 2014). The desire to live alone may be linked to longer life expectancies, interest in active aging, and opportunities to expand social capital (community participation, civic engagements, group memberships) in later life (Samanta, 2014). In other words, older adults are increasingly looking outside the multigenerational family unit for support and sustenance as they grow older.

Caregiving roles

Changing demographics and sociocultural norms have significantly altered the nature of care relationships. Although most families continue to provide care for older family members, the execution and motivation of care may assume different forms. A study of 24 caregiver-older adult dyads undertaken in Kerala, India, a state with high rates of emigration, found that caregiving was primarily motivated by spousal and filial duty and reciprocity, compounded by gendered expectations of both men and women. Notably, in a departure from tradition, older spouses understood that they essentially had only each other to depend upon in times of crises, which led some to harbor negative feelings regarding non-reciprocity of care from their emigrant children (Ugargol & Bailey, 2020). On the other hand, caregivers – female spouse and/or “left behind” daughters-in-law – often felt greatly burdened by their various responsibilities towards the household, children, jobs, and older adults. The absence of an emigrant son changed family dynamics with the daughter-in-law assuming the mantle of “head of household” and, in some cases, giving up her job in order to juggle familial duties. An older spouse, on the other hand, found herself fully engaged in caring for her husband post-retirement, thereby transitioning from full-time employment to full-time caregiving (Ugargol & Bailey, 2018). Responsibilities such as these have the potential to create acute dissatisfaction among caregivers. Young daughters-in-law may develop resentment at having to give up their jobs and endure long-term separation from their husbands in order to care for their in-laws. Older parents may feel neglected by their children when they have only each other to depend upon in old age. Conversely, reciprocal love, respect, and acceptance between older adults, children, and children-in-law were found to make caregiving experiences mutually rewarding for all concerned (Ugargol & Bailey, 2020).

In addition to direct physical and emotional care, another form of caregiving -- that of sending remittances -- is performed by children who live away from home but wish to provide for their aging parents (Ahlin, 2020). International, inter-state, and within-state migration for education, employment, business, and marriage is a common phenomenon in India. Per 2011 census, the migration-related data of which was released only recently, 450 million internal migrants were recorded within India (De, 2019); in 2017, over 17 million Indians were living in other countries (Sanghera & IndiaSpend, 2018). In current times of high geographic mobility, intranational and transnational caregiving is fast gaining foothold in the caregiving landscape. This “caregiving from a distance” model is supported by two primary pillars – the use of technology, and arrangements for alternative care options with the help of neighbors, relatives, and paid help. Therefore, facilities such as affordable audio and video calls, ease of transferring remittances, health monitoring through virtual tracking, and the ability to perform online activities on behalf of older adults from anywhere around the world, have greatly facilitated long-distance caregiving opportunities (Akundi, 2019; Ahlin, 2020). In India, traditional caregiving arrangements have expanded to accommodate communication technology and additional stakeholders, such as full- or part-time domestic help and/or healthcare agencies, to provide immediate physical care, while adult children provide emotional and financial care from a distance. Other dimensions of long-distance caregiving include: regular - often expensive - trips back home to visit and provide care to an ailing parent; decision-making about parents’ daily care, healthcare needs, house maintenance/repairs, car servicing, and financial matters; monitoring parents’ care; taking parents on vacations; and, sometimes, putting one’s life in another city/country on hold to temporarily move back to the parents’ residence for caregiving purposes (Baldock, 2005; Horowitz & Boerner, 2017).

Overall, the family remains the primary source of care for older adults in India. The mode of caregiving, however, has evolved with time, and innovative solutions will continue to be required as long as the family, rather than the state, remains at the center of elder care in the country.

Caregiving during the COVID-19 lockdown

The sudden onset and devastating consequences of the coronavirus pandemic has adversely impacted older adults and caregivers alike. Older adults are at greater risk for Covid-related mortality due to weaker immune systems and higher likelihood of pre-existing comorbidities (Wu, 2020). Around the world, older adults have been advised to practice extreme caution and adopt social distancing measures. Although some research suggests that older adults are coping better with Covid-19 stressors than younger age groups (Klaiber et al., 2020), general consensus states that the older population is vulnerable to social isolation (arising from mandatory social distancing), loneliness, and the ill-effects of these on their mental and physical health (Armitage & Nellums, 2020).

The effort to keep the older population safe, however, has brought about unprecedented changes in the nature and scope of caregiving services. In western countries, nursing homes and care homes are bearing the brunt of the pandemic; formal caregivers, considered “essential workers”, are being forced to risk their own lives to work with a high-risk demographic in aggregated settings, and a deadly disease, without adequate personal protective equipment (Reilly, 2020). Predictably, stress, burnout, and the psychological burden of risking the welfare of their own families is taking a toll on formal caregivers (Neumann, 2020). In developing countries, with precarious healthcare infrastructure and dearth of residential care homes, the

responsibility of caregiving has been transferred entirely into the hands of family members (Thomas, 2020; Vaitheswaran et al., 2020).

On March 24, 2020, when the government of India announced the world's strictest countrywide lockdown for 21 days with barely four hours' notice to a population of 1.3 billion (Gettleman & Schultz, 2020), people were caught unawares and underprepared for what eventually turned into a 68-day "complete lockdown" until May 31, followed by partial lockdowns from June onward. Older adults, especially those who live alone or with an older spouse, were left in a lurch as they lost their immediate and essential support system of domestic staff who catered to their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) to enable independent living and facilitate "aging in place" (Levine et al. 2003; Wiles et al., 2011). The sudden interruption in paid, in-home supports and services for older adults during the lockdown was particularly concerning for their adult relatives, many of whom have migrated to other countries or cities within India and were unable to provide direct care to their older relatives. This resulted in the adult relatives scrambling for alternatives from a distance. In desperation, and as a last resort, many turned to complete strangers for help.

The present study

The present study has two goals: first, to identify the urgent needs of older adults, as shared by their adult relatives, especially those providing long-distance care during the lockdown period, and second, to explore the role of volunteerism to facilitate long-distance caregiving in the absence of traditional options. This information is important as it will highlight the challenges facing a modernizing country with a massive older (age 60+) population and a severe lack of facilities and services to address the specific needs of older adults.

Design and Methods

This study was conducted on a popular social media website on which a group was formed in mid-March - the beginning of India's lockdown - to connect those in need of assistance with those able to offer required assistance. As of 30th June, the last date for which data were collected, the group had over 47,000 members. The goal was to create a pool of volunteers to perform acts of kindness for strangers during the lockdown period.

Data collection:

On average, the group webpage recorded 40 new messages per day, totaling approximately 3,960 messages from March 24 – June 30, 2020. For this study, a sample of about 2,680 messages was scanned to extract 242 messages that referred to older adults. Messages were scanned backwards starting from June 30 until April 25. Persistent technical limitations prevented access to messages from April 24 - March 25. The 242 relevant messages were extracted based on one of three inclusion criteria: 1) the messages mentioned the age (60+) of the recipient of assistance; 2) the messages included terms such as “elderly”, “aged”, “old”, “aging”, or “senior”; and 3) the messages indicated the care recipients as having Parkinson's or dementia. A further 181 messages were identified for similarity in content but were excluded from data analysis as they did not specify the age or older status of the care recipients.

Data Analysis:

A quantitative content analysis approach was used to analyze and categorize the data (Riffe et al, 2019). Frequencies were calculated to identify the needs of older adults that were unfulfilled due to the pandemic and the consequent absence of their support system, and were therefore being addressed by strangers.

Results

The diverse nature of requests is presented as 7 categories and 8 sub-categories in table 1. With the exception of two messages posted by older adults themselves, all requests were made by adult children, extended family members, or family friends of older adults. Help was requested for parents (113; 46.69%), grandparents (9; 3.71%), in-laws (17; 7.02%), uncles, aunts, relatives (26; 10.74%), friends' older relatives (17; 7.02%), and other associations such as neighbors, teachers, senior couples and older adults in general (58; 23.96%). A hundred and forty-one (58.26%) care recipients were indicated to be living alone. Of these, the children/relatives of 9 (6.38%) care recipients lived in another country, 10 (7.09%) lived in another city, and the rest did not specify location. In all instances, "living alone" implied the absence of the younger generation within the same household. In the data, older individuals and couples were said to be living alone.

Of the 242 messages, 81 (33.47%) requests were made for females, 47 (19.42%) for males, 75 (30.99%) for couples, and 39 (16.11%) for unspecified care recipients. The overall age range of care recipients was 60-99 years, with an average of approximately 75.49 years (only 111 messages provided a specific age). Some terms used to describe care recipients included:

“elderly, lone relative”, “old and ailing female relative”, “elderly, grieving mother”, “aged parents”, and “senior citizen”.

The highest number of requests (28.92%) was recorded for the category “home delivery of essentials” that included the purchase and delivery of groceries, medicines, oxygen cylinders, adult diapers, and clothes to a patient in the hospital. Freshly-cooked meals with regional preferences and/or dietary specifications, such as “diabetic-friendly meals”, were also requested.

“Health needs” recorded the second-highest number of requests (27.27%). This category included requests for doctor recommendations for non-Covid illnesses; hospitals for non-Covid patients; online consultations; emergency helplines; transport to hospitals for dialysis, chemotherapy, and falls; home-based non-Covid blood tests, echocardiograms, and plastering of broken bones; and urgent blood donations before surgeries. Some people requested a search for specific medicines that were not available in their cities while others requested information regarding mailing medicines to another country from which a visiting older adult was unable to return to India due to travel restrictions.

The third-highest number of requests (12.39%) was recorded for the “miscellaneous” category and comprised requests that could not be accommodated in the other categories. These included: procurement of masks and gowns, car/refrigerator/AC mechanics, smartphone purchase for video calls with children abroad, a wheelchair with commode, furnished accommodation for an older patient released from hospital, a home visit by a barber for a shave and haircut, payment of electricity bill, plastic chairs for a woman who had donated all her furniture to a blind school but needed a replacement for her own broken chair, and several requests to check on older relatives who were unreachable for various reasons. Two people

shared “missing persons” information; one later provided the update that his father’s body had been found and that his request to the group had been closed.

“Home-based services” (9.91%) were requested for older patients recovering from surgery and to relieve their older spouses of caregiving duties. Specific requests were made for recommendations for “night maid”, 8/12/24-hour domestic help, personal care workers, and a companion to keep an eye on one’s mother. Help was also requested for daily chores, cooking, and general upkeep of the house. Sometimes, two roles were combined, such as a “24-hour attendant and home caretaker”.

The category “travel” (9.05%) included requests for information regarding e-passes, travel permission, health certificates, and mandates surrounding post-travel quarantine for older adults. The lockdown imposed severe restrictions on both within and interstate travel. Public transport was unavailable throughout the country, and private vehicles were allowed to ply only after obtaining e-passes from the government for urgent and genuine reasons. Most states also mandated post-travel home/institutional quarantine, with different states imposing different rules based on journey origin. Frequently changing regulations further compounded the confusion surrounding travel, and resulted in people seeking clarity from group members who had undertaken recent trips.

The category “cyclone” (9.09%) included requests that followed a super cyclonic storm, Amphan, which devastated eastern India on May 16, 2020, and left millions without electricity, water, and communication for days. This prompted a barrage of requests for delivery of drinking water, battery-operated lights, diesel generator sets, power banks, transportation services, and general information about restoration of services in localities where people were unable to reach their older relatives over the phone or Internet.

“Elder services” (2.89%) such as community volunteers for seniors, recommendations for old age homes, assisted living facilities, and dementia care homes were also requested.

Discussion and Implications

This study was undertaken to identify the needs of older adults during the Covid-19 lockdown in India, as communicated on a social media group. The findings highlight the predominant culture of intergenerational care in the country, even if the care is performed and facilitated from a distance. The “caregiving from a distance” model in India, however, functions optimally when family members are substituted by paid help to address the immediate physical needs of older adults. The caregiving situation during the lockdown period, therefore, was severely impacted by restrictions on human movement and, consequently, the abrupt interruption of paid help for daily needs. Although caregiving has long been associated with physical proximity (Baldock, 2005), the lockdown brought into focus the benefits, potential, and wide reach of long-distance caregiving. Further, the unprecedented nature of the pandemic and lockdown highlighted the role of technology in the provision of informal care from unlikely sources, such as strangers and volunteers, to the increasing numbers of older adults living alone or with an older spouse in India.

The findings pointed to two sets of requests: one set was posted on behalf of older adults, while another was posted by caregivers. For example, requesting help to pick up and home deliver the batteries of an older adult's hearing aid may be considered a request placed on behalf of an older adult. But requesting quarantine-related information to travel to another city to pick one's mother up and return home together may be considered a request placed by a caregiver herself. Both sets of requests were aimed at alleviating the hardships facing older adults, but the perspectives are different.

The first type of requests – those placed on behalf of older adults – may be linked to digital literacy. As mentioned before, only two of the 242 requests were placed by older adults themselves. One requested travel-related information while the other thanked everybody for their “kind and compassionate gesture in creating this group” and requested volunteers in his city to reach out to him as he “could do” with their help. Additionally, one post mentioned that they were looking for cooked meals for senior citizens who were able to order online if a restaurant would be willing to deliver. Aside from such instances, there was no other mention of older adults using digital technology. Instead, one person requested help with money withdrawal from the bank as their uncle does not use ATM cards, another requested help with cash payment of an electricity bill that could easily be paid online, and a third person requested home delivery of groceries as their relative was unable to use mobile applications. Of the two people who requested help with purchase of smartphones, one also asked for help with WhatsApp so that their grandmother could see them during video calls. The lockdown forced people to adapt to digital transactions, online shopping, banking, doctors' consultations, telemedicine, and communication. However, it is not clear how many older adults actually used these platforms

owing to a “digital gap” or lack of familiarity/discomfort while using complicated applications (Conger & Griffith, 2020).

The two sets of requests revealed two types of needs of older adults – those created by the pandemic and those that were general in nature, but were compounded by the pandemic. For example, urgent requests for recommendations for non-Covid hospitals for non-Covid ailments were generated by the pandemic as many hospitals refused patient intake without Covid test results, leading to the negligence of non-Covid illnesses. Sometimes, such unlawful actions led to the loss of life, as with the case of a 76-year-old man diagnosed with Parkinsonism who died after being denied hospitalization on suspicion of Covid even though he displayed no symptoms (Mirror Now Digital, 2020). The second type of needs was not created by the pandemic, but was greatly impacted by it and the resulting lockdown. For example, older adults who are unable to cook typically employ domestic help who visit each day to prepare fresh meals. During the lockdown, the restrictions on people’s movement prevented daily visits by domestic help and forced people to either cook for themselves or rely on neighbors and friends for meals.

In India, domestic workers play a significant role in enabling independent living among older adults. Male and female servants sweep and mop houses, cook, wash utensils and clothes; drivers and gardeners help with travel and home maintenance; live-in workers perform additional duties such as folding clothes, making beds, and shopping for essentials. Unless an individual requires nursing care, domestic workers may also help with caregiving duties (Qayum & Ray, 2010; Mukherjee et al. 2020; Gangopadhyay, 2020). In this way, domestic workers cater to a wide range of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) that facilitate independent living in India. This arrangement is sustained by a large supply of untrained, informal, low-paid labor force. Currently, over 90% of India’s labor force is

employed in the informal sector (Mehrotra, 2009). The number of domestic workers is pegged at 4 million by official estimates and 50 million by unofficial estimates; two-thirds of domestic workers are women (BBC, 2020).

Around the world, “aging in place” is considered a desirable arrangement at older ages as it promotes a sense of familiarity, security, comfort, independence, and autonomy (Wiles et al., 2011). Efforts are also being made to plan age-friendly environments so that older adults are able to remain in their communities (WHO, 2007). In India, aging in place is woven into traditional norms that dictate intergenerational caregiving within the home. However, demographic and sociocultural changes; the dearth of affordable, good quality care homes; and lack of social security measures such as pensions are altering the nature of aging at home through dependence on domestic help rather than family caregivers for immediate, physical needs. In the data, this type of living arrangement was considered “living alone” even if more than one older person resided in the same house. This not only points to the predominant sociocultural norms surrounding intergenerational caregiving, but also to societal perceptions of older adults solely as recipients of care. Older adults living alone, however, is a relatively new phenomenon in India, and although the physical needs of this population may be met by domestic workers, emotional needs arising from social isolation and loneliness may be neglected (Grover, 2019). That older adults need more than just physical support may be construed from the descriptions of care recipients in the data as “lone”, “ailing”, and “grieving”.

A month into the lockdown, the challenges of the pandemic were complicated by the cyclone. In the aftermath of the relentless 9-hour-long battering by the equivalent of a grade 5 hurricane, survival assumed greater importance than protection against Covid-19 as people rushed out of their homes to find essentials. It is well-documented that older adults around the

world are disproportionately affected by natural disasters due to age-related limitations, income limitations, mobility issues, and social isolation, among other factors (Klinenberg, 2003; Cherry, Allen, & Galea, 2009). This was evident in the case of the cyclone as well. In addition to the multiple stresses of losing electricity, water supply, and mobile network for several days, older adults were also advised to remain at home as streets were flooded and blocked by uprooted trees, lamp posts, and electric cables. Moreover, other people had thrown caution to the wind by gathering in large numbers, often without masks, to demand immediate restoration of essential services. These factors created unsafe environments for older adults both inside and outside their homes. Consequently, numerous requests for help were posted for older relatives who were struggling to cope.

Although this study provides crucial insight into the challenges experienced by older adults and their caregivers during the lockdown period, it is not without limitations. We recognize that 242 messages posted on a social media group cannot adequately represent the lives of millions of older adults in the country. Moreover, the care recipients of this study likely have greater access to material resources than do others, and therefore their needs may differ from those of others. Even then, it may be safely assumed that older adults have been significantly affected by the pandemic and lockdown due to the double threat of vulnerability to Covid-19 and loss of in-home supports for independent living.

The findings of this study are important as they highlight the lack of elder-specific supports and services in India. For the last few decades, family caregiving roles, especially in urban areas, are on the decline whereas dependence on domestic workers for daily assistance is on the rise (Gangopadhyay, 2020). However, when neither family nor domestic workers were able to provide care, older adults were left to fend for themselves. Fortunately, the unprecedented

nature of the crisis mobilized volunteers to perform acts of kindness for strangers. This, although laudable, is not sustainable and cannot be a long-term strategy to meet the needs of millions of older adults. State intervention, financial safety nets, and collaborative partnerships between governments, NGOs, civil society, communities, and families are the need of the hour. The findings of this study are also important as they strengthen aging literature from the perspective of a developing country. Compared to the West, little is known about the lived experiences of older adults in low and middle-income countries (LMICs), including in the emerging literature on the effects of Covid-19 on the lives of older populations in such countries. The on-going pandemic is likely to strain the largely vulnerable healthcare systems of LMICs, and older adults may bear the brunt of healthcare inadequacies as they are more susceptible to Covid-related mortality (Llyod-Sherlock et al., 2020). It is, therefore, important to record the needs and experiences of the older population during this time so that societies can be prepared for future exigencies.

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Table 1. Categories and sub-categories of requests, with examples.**(Number of requests; percentage)**

Category	Sub-categories	Example (edited for length and clarity)
Home delivery of essentials (70; 28.92%)	Everyday essentials (51)	Need grocery delivery options for my elderly relative who cannot use online websites or apps. Her building has been sealed due to a Covid-19 case.
	Freshly cooked meals (19)	A senior couple is under significant stress owing to multiple chronic health issues and restrictions on movement of domestic help. Is there a service that can deliver diabetic-friendly meals?
Health needs (66; 27.27%)	Healthcare recommendation (37)	Please recommend a neuropsychiatrist who is seeing patients under lockdown. My 69-year-old father with Parkinson's, diabetes, and pressure ailments is suffering from severe delusions and hallucinations recently.
	Help with treatment (12)	My friend lives abroad. Her senior citizen father fell today and needs medical attention. There is no one to take him to the hospital. Can someone please help?
	Blood donation (10)	Need 2 units of A+ blood for 77-year-old father undergoing dialysis. Unable to arrange due to lockdown, please help.
	Home healthcare (7)	24-hr nurse needed for 74-year patient recovering from hip surgery.
Miscellaneous (30; 12.39%)		My 34-year-old friend died yesterday and his elderly mother has not been answering calls since receiving

		news of his death. Can somebody please check on her just to see if she is okay?
Home-based services (24; 9.91%)	House-help (15)	Daily help needed for upkeep of house and food supplies for severely handicapped 70-year-old male.
	Home caregiving (9)	Seeking 24-hour caretaker for my 80+-years-old grandmother with mobility, memory, and temper issues.
Travel (23; 9.50%)		My 70-year-old diabetic mother with Alzheimer's problems has to travel alone after being stranded for 2 months. Can anyone help or advise how to go forward at the airport?
Cyclone (22; 9.09%)		There are 4 senior citizens with chronic conditions in one house and only one caregiver with a small child. Can someone arrange for a Genset as there's been no electricity for 4 days and, consequently, no water for consumption?
Elder services (7; 2.89%)		Looking for a good dementia care home for my 81-year-old mother. This is very urgent as all attempts at caregiving at home have failed due to lack of trained caregivers.