

Stay Home, Sustain Lives: Pandemic Support Networks and Social Reproduction

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Abstract

During the COVID-19 pandemic of 2020–2021, voluntary and community networks in the UK mobilised to provide practical help in neighbourhoods and communities. This article locates these networks within longer-term historical trajectories of social care policy and provision. Drawing on data from a qualitative study from southern England, this article explores how pandemic community responses fulfilled and scaled up the pre-pandemic policy objective of expanding volunteer and unwaged community labour in social care provision. Feminist theories of social reproduction are applied to explore how this occurred in ways that were bound up with, and reproductive of, neoliberal capitalist social relations. Community and volunteer support networks sustained many lives through the pandemic, but they also shielded capital and the state from bearing the full costs of looking after people made vulnerable by the virus.

Keywords

community activism, COVID-19, mutual aid, pandemic, social reproduction feminism, UK, voluntary and community sector, volunteering

Introduction

The COVID-19 pandemic of 2020–2021 was a time of intensified voluntary and community activity in the UK. As the first wave of infections took hold from March 2020, followed by the first lockdown, many people faced challenges to sustaining themselves in day-to-day life, due either to their extreme vulnerability to the virus, or to the disruption wrought by lockdowns. In response to these acute challenges to households, care and social reproduction (Stevano et al., 2021; Wood and Skeggs, 2020) a large number of voluntary initiatives mobilised to provide practical help in neighbourhoods and

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communities. Unwaged volunteers coordinated efforts to help people struggling to access food, medicine and other essential supplies. By June 2020, the COVID-19 Mutual Aid UK website indicated that there were over 4200 support groups across the UK (COVID-19 Mutual Aid UK, 2020). While precise numbers of participants are difficult to quantify, it is clear that community-based initiatives provided essential support through the pandemic to a great deal of people (Marsh and Sabbagh, 2020).

Scholarly analyses of these community pandemic support networks have tended to approach them as exceptional and singular responses to the unprecedented circumstances of the pandemic. There has been little examination of how community pandemic support initiatives grew from care policies and arrangements that already existed, especially for people with chronic illness, disabilities and frailty in older age. Yet long before the pandemic, unwaged care from volunteers was becoming increasingly important to these sections of the population, who, during the pandemic, were disproportionately vulnerable to the coronavirus and more likely to need volunteer community networks to meet their day-to-day needs (Hodgson et al., 2021; Leyshon et al., 2018; Tew et al., 2019).

This article seeks to expand critical understanding of pandemic support networks in the UK by assessing them in the context of longer-term historical trajectories of social care. I first discuss how unwaged care and support provisions for older, disabled and chronically ill people, long part of social care provision, have intensified under more recent conditions of austerity. I then assess qualitative data gathered as part of research on waged and unwaged care and support activities in a coastal region of southern England during the COVID-19 pandemic in 2020–2021. Pandemic responses in this area, coordinated by charities, voluntary networks and local government, massively scaled up already existing volunteer capacity, successfully mobilising local people to offer support in their neighbourhoods and communities. Drawing on feminist theories of social reproduction, I argue that these caring practices were both bound up in, and reproductive of, neoliberal capitalist social relations. While acknowledging that neoliberalism is a contested concept (Kingfisher and Maskovsky, 2008), here I am concerned with certain broadly agreed-upon features of this regime of financialised capitalism, in particular state divestment and privatisation of public systems for social protection (health care, education, housing, etc.), and marketised models of emancipation (Fraser, 2022). In this context, I examine how pandemic support networks sustained many lives, but in delegating this work to volunteers and communities, these arrangements also shielded capital and the state from bearing the full costs of caring for people made vulnerable by the virus in the UK. I explore different volunteer and community pandemic support groups' activities during the COVID-19 emergency, comparing them as sites of entanglement in, and struggle over, the neoliberal organisation of social reproduction. The transnational dynamics of these processes are important to consider, but beyond the scope of this article, which focuses on the UK only.

Pandemic Community Support Initiatives and Social Care

In the still emerging scholarly literature assessing community support networks during the pandemic, two areas of debate are prominent (Rickford, 2023). The first draws on Putnam's (2000) theory of social capital and related concepts of social cohesion, community resilience and asset-based community development, in order to evaluate the effectiveness of pandemic support networks in supporting people and getting help where it was needed

(Borkowska and Laurence, 2021; Rippon et al., 2021; South et al., 2020). The second examines a subset of pandemic support networks associated with anarchist mutual aid principles and practices (Firth, 2020; Kavada, 2022; Rickford, 2023; Spade, 2020). As may be expected, these two perspectives are distinct. The first seeks to measure or evaluate the effectiveness of community responses to the pandemic. The second approaches pandemic mutual aid as a set of practices that are radically opposed to, and potentially transformative of, neoliberal capitalism and the state.

Notwithstanding the important differences between them, both approaches share a lack of attention to the specific ways in which pre-pandemic health and social care policies and institutional arrangements shaped the emergence and operation of the pandemic community networks. I aim to develop understanding of the relationships between pandemic support initiatives and the contexts from which they emerged in order to sharpen critical assessment of their social and political significance.

If we look at the groups of people most likely to need and benefit from pandemic support networks, we can trace how pandemic provisions overlap with the social care system in the UK. Of course, pandemic community groups supported many different people for a wide variety of different reasons, and some research suggests that levels of need varied by locality (Borkowska and Laurence, 2021; Hodgson et al., 2021). Nonetheless, certain categories of people were disproportionately likely to need support from community networks wherever they were. In spring 2020, two million people classed as clinically extremely vulnerable were advised by the UK government to shield (not leave their homes) due to having a health condition that made them particularly vulnerable to the virus. The majority of these conditions were chronic, more common in later life and likely to require ongoing health and social care support (Hodgson et al., 2021). People in these categories who lived either alone or with others equally vulnerable to the virus were likely to need the kinds of support offered by pandemic support networks – practical help with shopping, accessing medicine and other urgent errands, as well as some social support that could be offered in a socially distanced manner (by phone or online). Additionally, people living with physical or learning disabilities or age-related frailties who due to lockdowns were cut off from their usual support networks (family, friends, non-emergency services) were also more likely to need assistance. Thus, people who were likely to need support from pandemic community networks were also likely to use or need (adult) social care – a system of services, cash transfers, family care and community/volunteer provisions that aims to meet the day-to-day needs and support the well-being of people living with chronic illness, disability or frailty (Shakespeare et al., 2022). As later sections will show, some pandemic support networks also grew from social care provisions. The next section explores the wider historical context of UK social care, and develops an interpretation of it using feminist social reproduction theory.

Social Care and Marxist Feminist Theories of Social Reproduction

The key structural features of the present-day UK social care system date back to legislation passed in the mid-1940s that founded the modern British welfare state, including health, social security and education systems. Unlike health care, which was funded

centrally from general taxation and made universally available, social care was created as a localised and residual service. Local government (known in the UK as local authorities or councils) had responsibility for coordinating social care services, for which they could charge fees. This remains the case today, with social care funded through a complex mix of central government grants, local taxes and service user charges (Means et al., 2008).

Until the 1970s, community-based social care services for adults were meagre or non-existent. Older, disabled and chronically ill people who did not wish to enter, or did not qualify for residential care, were reliant on familial (typically female) care and support or private income to pay for the care services they needed to maintain themselves day to day (Finch and Groves, 1980; Means et al., 2008). From the 1980s and 1990s, new community-based services aiming to enable older, disabled and chronically ill people to live in their homes and communities became more widely available. But these took shape as part of a wider neoliberal restructuring of social care. The 1990 National Health Service and Community Care Act sought to reduce social care budgets, privatise local government social care facilities and force a stronger role for voluntary sector organisations in a market of social care providers (Means et al., 2008). The last four decades have seen a significant growth in day care centres, home (domiciliary) care and other services enabling older, disabled and chronically ill people to sustain their lives in communities, outside of residential institutions. However, free or subsidised access to these services has become increasingly rationed (Read and Fenge, 2019).

Government austerity since the 2010s has intensified the transfer of costs of social care to individuals, households and communities. As local government authorities (councils) bore the brunt of austerity (Grey and Barford, 2018), eligibility for publicly funded social care services was further reduced. As a result, only people with the highest levels of need and the lowest incomes or assets are eligible for public funding to meet their care needs (The Kings Fund, 2023). People with low to moderate social care needs must usually pay for all or most of the social care services they use. It is in this context that volunteer-run, community-led initiatives have developed in recent years. The 2014 Care Act provides a mandate for local government to develop ‘asset-based’ or ‘strengths-based’ approaches to assessing and meeting local needs for social care. These are premised on ‘building capacity in the community’ by enabling people to ‘do things with and for each other and . . . mobilise networks of practical and emotional support’. This activation of volunteer groups, civil society and families seeks to ‘reduc[e] people’s requirement for social care services’ (Tew et al., 2019: 19; see also Leyshon et al., 2018). As demographic ageing, and higher prevalence of disability and chronic illness in later life increase demand for social care services, local authorities attempt to mitigate this pressure by directing people with low to moderate levels of need to community-based social care initiatives, which rely heavily on volunteers,¹ such as community transport schemes, lunch clubs, food banks, befriending and community connection programmes.

Marxist feminist accounts of social reproduction provide a theoretical vantage point from which to critically assess social care. Social reproduction is a broad concept referring to processes of social cooperation that sustain life and meet human needs, both day to day and intergenerationally over time. These encompass a wide range of social relations, including kinship obligations, institutional arrangements and societal infrastructures extending across households, public services, markets and civil society (Katz,

2001; Weeks, 2011). Marxist feminist accounts of social reproduction propose that biological reproduction, socialisation and the daily sustenance of human beings are fundamental to capitalist accumulation and the regeneration of labour power on which capitalist profits depend (Bhattacharya, 2017; Ferguson, 2020; Fraser, 2022; Mezzadri, 2021; Vogel, 1983). They contend that there is an inherent tension between, on the one hand, the dependency of capital on life-sustaining social relationships, practices and institutions, and on the other, the requirement of capital to secure profits by transferring the responsibilities for, and costs of, social reproduction onto households, communities and workers. This tension is inherent to capitalist society, but its specific historical outcomes vary, producing contestation and transformation. The extent to which the capitalist class seeks to offload the social and material costs of sustaining life can alter, as it is met with historically differentiated levels of organised resistance from the working class, which may have more or less success in claiming a greater share of profits to support social reproduction. Patriarchy, heterosexism, ableism, racism and other socially oppressive relations may be recruited into and maintained through this conflict (Ferguson, 2020; Fraser, 2022; Vogel, 1983).

These theoretical propositions can be applied to deepen understanding of the social forces that have ensured that unwaged care work has remained such an important feature of social care throughout its post-war history. At key points in this history, the capitalist state implemented policies that pushed the responsibilities and costs of sustaining older, disabled and chronically ill people onto households and communities, in ways that also maintained social divisions and inequalities. In general terms, the post-war involvement of the state in social reproduction benefitted the working population at large. But as shown above, some areas of social reproduction were ranked of lesser concern for investment in the new welfare settlement. Older, disabled and chronically ill people's ability to sustain life outside of residential institutions was not prioritised and the costs of their day-to-day care and maintenance remained a private matter for individuals and households. As social reproduction feminists writing in the 1970s and 1980s argued, women's unwaged household labour, not only of raising new generations of workers, but also of maintaining older, disabled and chronically ill adults outside of the labour market, constituted a huge subsidy to capital. This arrangement was also naturalised through the patriarchal framing of women's duty to care for family members (Dalla Costa and James, 1972; Federici, 2012; Ferguson, 2020; Vogel, 1983).

Throughout the 1970s, 1980s and 1990s, various feminist, carer and disability movements were successful in advocating for new rights, entitlements and services for older, disabled and chronically ill groups in the UK (Clifford, 2022; Yeandle, 2016). However, under the conditions of neoliberalism and austerity, free access to these services has become increasingly limited, protecting capital's interests in not sharing profits to meet social reproduction requirements. As seen in the 'Big Society' policy agenda of the 2010s, austerity has been justified as the empowerment of individuals, families and communities to arrange for and personalise their own care needs, free from an overbearing state care bureaucracy (Alcock, 2012; Dowling and Harvie, 2014; Kisby, 2010). As disabled and chronically ill people's entitlement to resources from the state to enable them to live has been systematically removed and stigmatised over the past decade (Clifford, 2022; MacLeod and Emejulu, 2014), so greater community and volunteer involvement

in social care provision has been promoted, not least through asset-based approaches that position the state (rather than material inequalities) as the key agent of disempowerment (Friedli, 2013). These developments illustrate how, under neoliberal austerity in the UK, older, disabled and chronically ill people's lives are supposed to be sustained through the promotion and mobilisation of unwaged volunteer labour in community networks, to supplement that of the private family and household. This is the important historical context from which pandemic community support networks develop, as I explore in more detail below. First I set out my methodological approach.

Methodology

The primary data discussed in this article were gathered as part of a research project that explored unwaged and low-waged caring labour provided to people in their homes during the COVID-19 pandemic. This focused on three key groups – waged home care workers, family carers and volunteers active within local community pandemic support initiatives during 2020–2021. The research location was two neighbouring local authority areas on the south coast of England, referred to here as LA1 and LA2. The study used an exploratory, qualitative methodology, entailing in-depth semi-structured interviews alongside documentary research of secondary literature such as reports and briefings from central government, local government and non-governmental organisations. A total of 36 interviews were carried out, of which 15 were with volunteers and volunteer coordinators, from eight community support initiatives.² The remaining interviews were conducted with home care workers and managers (from three home care agencies) and carers (via two carer advocacy groups). Participants in all three groups were equally spread across LA1 and LA2. In keeping with pandemic restrictions in place at the time of research, interviews were not conducted face to face, but by telephone or online. As part of a purposive sampling approach, home care agencies, carer advocacy organisations and community initiatives from across the two LAs were identified and invited to take part in the study. Once this was agreed, gatekeepers within participating organisations circulated adverts for research participants via their staff, volunteer or client email. The study was approved by Bournemouth University Social Sciences & Humanities Research Ethics Panel on 20 October 2020. The data collection for the study was carried out between this date and 31 October 2021.

This article focuses on the primary and secondary data relating to community support initiatives. Semi-structured interviews with volunteers and volunteer coordinators incorporated questions aimed at gathering basic biographical circumstances (age, gender, ethnicity, nationality, disability, employment and education history, current household, family and financial circumstances) as well as open-ended questions about their activities and experiences during the pandemic. Analysis of interview transcripts and secondary data relating to community support initiatives were analysed inductively using thematic analysis (Ezzy, 2002; O'Reilly, 2011). Initial open coding was followed by a more focused, iterative process of sorting, categorising and thematising codes. Relationships between pandemic community groups and local government became a focus for analysis, as did alternative political and ethical ways of framing of pandemic volunteering.

Pandemic Community Support Initiatives and Social Care

As has been widely recognised, community and voluntary groups were quick to respond to the pandemic and develop much-needed forms of support, often with an agility and speed that larger state agencies and charitable organisations failed to match (Marsh and Sabbagh, 2020). Much less recognised is the fact that not all such community groups formed in response to the pandemic. Many already existed as providers of social care provisions to older, disabled and chronically ill people in local neighbourhoods, and were part and parcel of existing programmes to extend the participation of volunteers and community organisations in social care provision.

Of the eight pandemic support groups in my study across LA1 and LA2, five were already established and locally active for some years prior to 2020. Three were local branches of national charities, the other two were local charities. Before the pandemic, all provided support services to people who were older, disabled, socially isolated or in need of support with a chronic health condition. This included practical support such as help with shopping, errands, transport and social activities such as befriending, hobby or exercise groups, memory groups, lunch clubs, and other community links. These programmes depended heavily on volunteers, typically recruited and managed by waged volunteer coordinators, who stayed well informed about the social care priorities of local government and regional health authorities. Some coordinators had previously worked for LA1, LA2 or local NHS services, had personal contacts with relevant officials in these organisations and were receiving, or had previously received, local government funding for providing social care services.

All of these groups responded rapidly to the pandemic – altering their existing provisions to make it safe and socially distanced, while also maintaining services and contact with clients. In early spring 2020, for example, CareConnect³ closed all of its events and lunch clubs for older and isolated people, setting up in their place new telephone friendship groups run by volunteers, and coordinating volunteer deliveries of shopping, prescribed medicines and other items like (word searches, quizzes, memory puzzles) to maintain clients' health and well-being. Similarly, the Help4U and Ez'ra community groups offered telephone-based contact and befriending, and expanded their socially distanced practical support in the form of hot meals provision, shopping and prescription deliveries to clients' homes. Helping Heart, an organisation that already offered a volunteer befriending service by telephone, continued as normal, largely unaffected by the pandemic.

Other groups in my study formed in direct response to the pandemic. Evesham Community Kindness (ECK), based in a small town in LA2 with a population of around 12,000, was set up shortly after the March 2020 lockdown by Iris and a group of her local acquaintances. A retired teacher from the local secondary school, Iris was well known in the area. Her group decided to deliver cards through the letter boxes of local households inviting people vulnerable to COVID-19 and in need of help with shopping and urgent errands to make contact. Volunteers were then matched with people requesting assistance who lived close by. ECK set up a Facebook page in April 2020, which received large numbers of offers of help and requests for support. At its peak, ECK had 100 volunteers. Iris did the regular weekly shopping and essential errands for a total of 20 people over the course of 2020–2021.

Beaufort Mutual Aid (BMA), based in LA1, was cofounded in March 2020 by Rosa and her friend Anna. The aim of BMA was to support local residents struggling to access food and other essentials. By early March 2020, the group had a dedicated mobile phone line and social media presence, and was advertising for volunteers, to which 400 people responded within days. In the early months of 2020, the group coordinated socially distanced collection of food donation for local foodbanks. They persuaded a local supermarket to accept shopping orders and payment for shopping by phone, enabling shielded residents to call the shop directly and order what they needed, which a volunteer would later collect and deliver. BMA volunteers supported a total of 450 people through 2020–2021, many of these on multiple occasions.

Scaling Up Voluntary and Community Capacity: Local Government Interventions

Scholarly research on voluntary and community responses to the pandemic have tended to focus analysis on the activities of particular voluntary and community organisations, but have given much less attention to the involvement of local government in supporting and building the capacity of the community and voluntary sector to provide pandemic support. This section focuses on the interactions between local authorities and voluntary and community pandemic responses, further clarifying how these interventions were part of a longer-term policy trajectory of local government expanding community-based social care provision.

From early in spring 2020, local councils across the country were developing schemes to support vulnerable populations within their areas. By early April, 132 UK local authorities had set up support systems that could receive and respond to urgent requests for help (Local Government Association (LGA), 2020). In LA1 and LA2, as in many other local authorities across the UK (Gore et al., 2021), these systems relied on the participation of local voluntary and community sector organisations, as well as the effective harnessing, coordination and management of volunteer labour in order to support local residents with extreme vulnerability to COVID-19.

LA1 and LA2 developed new pandemic support hubs to receive and respond to requests for help from the local population. First, both local authorities opened contact centres, staffed by redeployed council employees, to triage incoming requests from local people with increased vulnerability to COVID-19, as well as elderly frail, disabled, homeless and insecurely housed residents, and people in immediate financial precarity. Staff in these centres also proactively contacted local residents categorised as extremely clinically vulnerable to check that their essential needs for food and medicines were being met. Second, LA1 and LA2 liaised with local voluntary and community organisations to create an infrastructure able to fulfil the demands for assistance received by the contact centres. This involved working closely with Councils for Voluntary Service (CVS), which provide training, legal advice and infrastructural support to local community and voluntary sector organisations and groups. LA1 and LA2 CVS activities depend to a large extent on council funding. These organisations played a critical role in scaling up the recruitment and deployment of volunteers as part of the pandemic response. In

LA1, nearly 2000 people responded to a call for volunteers within a few days in April 2020 – far exceeding the capacity of the council and its CVS to train and effectively deploy them as volunteers.

There were differences in approach between the largely (sub)urban, densely populated LA1 council, governed as a unitary authority, and LA2, with its population spread across a geographically large and predominantly rural area, and its governance split across tiers of county, town and parish councils. LA1 established tight, centralised control over its contact centre and referral processes. Once trained by the CVS, volunteers were directly managed through the LA1 council contact centre, which ensured that when a volunteer had to step down or was unable to cover a request, there were appropriately trained replacements ready to step in. In addition to regular volunteers who were matched to vulnerable clients, LA1 council also recruited a small group of ‘Emergency Response’ volunteers to take on urgent tasks at short notice. By September 2020, LA1 council had received just over 14,000 contacts, made active contact with around the same number of shielded residents and deployed 1800 volunteers to support over 4000 people with food and medicine deliveries and other essential errands. Additionally, volunteers had been recruited to manage queues at vaccination centres, GP surgeries and municipal waste centres, to provide company to isolated residents via telephone, deliver library books and carry out beach cleans.

LA2’s volunteer infrastructure and referral processes were more decentralised, entailing collaboration with a wider set of community organisations than in LA1. Investing in mapping the activities of voluntary and community organisations across the county, LA2 identified 160 groups and organisations in spring 2020, 60% of which had been set up in response to the pandemic. Its contact centres referred requests for assistance to these groups, depending on where they lived and the nature of the request. The council also commissioned the design of an extensive public website providing up-to-date, searchable information about the activities, locations, hours of operation and contact details of all LA2’s voluntary and community groups, in order to further expand local people’s awareness of and access to them. During the peak of the first lockdown in late spring 2020, an estimated 6000–7000 people across LA2 were volunteering every day for vulnerable people across the county.

Thus, local authorities sought to engage and encompass community networks that formed in response to the pandemic. For example, Evesham town council in LA2 effectively took over the day-to-day management of ECK volunteers from an early point. In April 2020, as the ECK Facebook page became busy, Iris and other group members were concerned about the group’s ability to securely manage the personal data of those requesting and offering help, and background check volunteers. Following a meeting with representatives from the town council, local schools, churches, community care organisations, foodbanks and charities, it was agreed that Evesham town council would coordinate pandemic support of these various organisations, by managing a volunteer database, providing volunteers with hi-vis jackets and volunteer identity cards, and relaying requests for help from local residents to relevant community organisations.

By enabling people with greater vulnerability to the virus to reduce their exposure to it and remain safe at home, and by assisting those cut off from their usual forms of support by lockdown restrictions, these scaled up voluntary and community initiatives saved

and sustained many lives through the pandemic of 2020 and 2021. But in facilitating and expanding the involvement of unwaged volunteers and community networks in providing care and support at a time of immense need, local government also shielded capital and state budgets from bearing the costs of supporting life (Ferguson, 2020; Fraser, 2022). Local councils did not need to hire and pay workers to do what unwaged volunteers were doing. Supermarkets and pharmacies did not have to recruit additional delivery workers to get their goods to customers. By enabling people with acute vulnerability to COVID-19 to remain safe at home, volunteers prevented the spread of infection and the acute demand this would place on emergency health services. They reduced the likelihood of hospitals becoming overwhelmed with infected patients in need of intensive care treatment. Had this unwaged support work not been performed, the costs to capital are likely to have considerably intensified, in the form of greater taxes on profits to reconstruct collapsed and depleted health care systems, as well as costs associated with disruption to the workforce from higher infection rates in the population and the requirement on employers to cover workers' sick pay while also recruiting replacement workers.

Even as the need for pandemic volunteer networks began to wane, as public restrictions eased and businesses reopened, local government leaders in LA1 and LA2 spoke of the need to retain volunteers in social care after the pandemic. In 2021, an LA1 local councillor announced that she would be leading a new volunteering strategy for the area, which would 'try and keep that broad range of volunteering going and expand it and make it much more coordinated in the future'. Similarly, a senior LA2 council official remarked on the importance of 'harness[ing] these volunteers, and get[ting] people to keep doing volunteering' in the future. She thought it unlikely that council-run day care centres for adult social care clients would re-open after the pandemic, since 'the voluntary and community sector is able to offer [services for this client group] in a much more cost-effective way'.

Representations of Pandemic Community Support

Public awareness of the value and importance of caring and other socially reproductive work was sharpened during the pandemic, especially during lockdown periods, as expressed in widespread participation in the weekly Clap for Carers (Wood and Skeggs, 2020). This wider public mood inflected the experiences of volunteers in this study who spoke about a heightened atmosphere of community togetherness and solidarity. Cerys, a retired nurse in her 60s, had volunteered for Help4U for some years prior to 2020, but felt that pandemic volunteering was unusual and special. She coordinated the preparation and delivery of hot meals during the first lockdown, reflecting that:

there was a great sense of achievement in getting those meals out and then getting the feedback from people saying . . . how much they enjoyed them. . . . The sense of community, of people working together . . . I think that's something I've never experienced before. (Cerys, Help4U)

Similarly, Iris of Evesham Community Kindness compared the pandemic to what she understood of Second World War community solidarity:

My parents had talked about the World War II spirit and I'd sort of heard this being mentioned [in Evesham] . . . I thought I wonder if it was like this in World War II? . . . I was very proud of the community and the way in which the goodwill was there.

The widely felt desire to be involved in care and support activities in local communities was nonetheless also useful to the broader project of transferring responsibilities and costs for social care to community organisations. Even before the pandemic, councils promoted volunteer-led social care intervention in order to protect their already highly rationed social care budgets, while some professional voluntary sector organisations and charities sought resources from councils to run volunteer-led projects for older, disabled and chronically ill people. So it was in the interests of both parties to present pandemic support networks in a positive light, as only having benefits for service users and communities, and carrying no significant costs to volunteers. During the pandemic, the community organisations closely allied to LA1 and LA2 tended to publicly represent pandemic social care and support as matters for communities and neighbourhoods to resolve among themselves. An email from coordinators of the LA1 support hub to volunteers in December 2020 emphasised the importance of continued community co-operation through the crisis:

Let's continue to be there for our neighbours over the festive period. There are a number of simple things we can all do to help people on our street which don't cost anything. We don't need to go out of our way to do them but they can make a huge difference. By everyone doing their bit, we will help to keep neighbourly spirit alive, show the people around us we care about them and reduce loneliness and isolation.

Looking after people with acute vulnerabilities to the virus was here represented as cost free. The implication is that if good neighbours are willing to help out, there is no need for funded community services to tackle social problems of isolation and loneliness.

The isolation and vulnerability of the local residents being supported by pandemic volunteers was also depicted as natural, random and unavoidable. This can be seen in the spring 2020 Evesham town council newsletter's description of its Community Kindness volunteers, who were:

providing much-needed help . . . to shielded, vulnerable and self-isolated residents, who have no one else to turn to, or sometimes talk to . . . We are so proud of a community that is so kind and compassionate and very grateful to our volunteers for stepping forward to help others during this difficult time.

Unmentioned here were structural conditions that contributed to these residents' vulnerability, in particular long waiting lists for domiciliary care workers and lack of available and affordable community social care provision.

In sum, some community support networks sustained life during the pandemic, and absorbed the costs of doing so in a way that protected the neoliberal capitalist organisation of social reproduction (Bhattacharya, 2017; Ferguson, 2020; Fraser, 2022). However, as the next section shows, some pandemic support groups wanted both to support life and resist this instrumentalisation of their activities.

Sustaining Lives and Anti-Neoliberal Activism

So far, my analysis has focused largely on voluntary and community initiatives closely linked to local government in LA1 and LA2. However, many pandemic support groups formed as loose neighbourhood-based associations linked through social media platforms. They neither received nor sought external funding for their activities and were less closely tied to local government policies and priorities.

Beaufort Mutual Aid (BMA) was an example of such an organisation. Its founders, Rosa and Anna, had previously been active members of the Labour Party, and firm supporters of its socialist leadership between 2015 and 2019. Following Labour's defeat at the December 2019 national elections, and growing public and media concern about COVID-19 in the early months of 2020, Rosa and Anna shifted their political energies from the Labour Party to their local community. Rosa explained:

One of the things that Corbyn [former socialist leader of the Labour Party] talked about . . . is how we need to be rooted in our communities you know and building connections . . . that is socialism, isn't it? Anyway so [my friend Anna] had the idea of . . . set[ing] up a mutual aid organisation . . . [to] give support, it's the right thing to do but actually it will also really help build our connections within the community.

Although it has roots in anarchist political practice (Firth, 2020; Kavada, 2022; Kropotkin, 1972; Razsa, 2015; Spade, 2020), Rosa and Anna practised mutual aid as an extension of their commitment to socialist principles. They aimed to build a social relationships and networks in part as a means to expand local support for leftist political campaigns. For example, the group's social media pages expressed solidarity with anti-racist Black Lives Matter protests, which had sprung up in the UK in the wake of the murder of George Floyd in the USA in May 2020.

For Rosa, practising mutual aid was about solidarity, not charity, and supporting political transformation that addressed social and economic inequalities. She said:

I absolutely recoil at the idea of charity for the poor . . . it just makes me sick . . . especially living in a Tory area where I mean there's this ethos of, you know, 'the poor will always be poor, we'll do our bit to help them'. [In BMA] everybody is equal.

Rosa's political convictions were shaped by her own experience as a single parent and carer to two teenage disabled daughters who lived at home with her. In 2015, as their health conditions had worsened, she gave up her job working for a housing charity to become their full-time carer. The family lived in precarious rented accommodation, surviving on the extremely low income of state benefits. For example, Rosa received Carer's Allowance, which at the time of the interview was £67 per week. To be eligible for this, applicants must spend a minimum of 35 hours a week caring for someone – generally accepted as the hours required for a full-time job. Her total annual income, which encompassed other benefits, was less than £10,000 per annum.

Rosa understood her constricted financial circumstances not as her own moral failing, but the result of a social security and care system that kept carers in poverty. She was

acutely conscious of the stigma of having no option other than to accept charity. Reflecting on this point in relation to foodbanks, she remarked that:

food[banks] do a great job but I find them incredibly depressing and undignified for the people that have to use them and you know, it just breaks my heart the thought that I might have to get a voucher from a referrer.

The BMA became a foodbank voucher referring organisation. In order to issue vouchers for the foodbank, BMA volunteers were obliged to ask what Rosa considered to be degrading eligibility questions, such as “‘can you tell me why you need to use the food bank?’ I mean they shouldn’t have to explain that to me or anyone.’ The idea of ‘hand-outs’ from ‘do-gooders’ was ‘just so undignified and awful’.

In effect, the situation presented BMA with a dilemma. On the one hand, Rosa and Anna wanted to extend as much help and solidarity as they could to local people requesting BMA support. This meant collaborating with foodbanks so that these residents could access emergency supplies of food. On the other, they saw the foodbank’s eligibility questions as holding recipients morally and individually accountable for their own dispossession. Rosa and Anna did not want to participate in the reproduction of these degrading and stigmatising practices of assessing need, which were contrary to the leftist principles that led them to found BMA in the first place.

What distinguished BMA from other pandemic community support networks in my study was its members’ recognition that sustaining life could become bound up with oppression. The group had to choose between two political tactics advocated by social reproduction feminists (Ferguson, 2020). These were on the one hand the politics of solidarity – the building and expanding of grassroots networks and support, and on the other, the strike – the refusal to participate in life-making practices that strengthen capitalist domination. In the end, the BMA chose solidarity, reasoning that in the pandemic emergency the need for food to meet material needs was more the greater priority. Its members continued nonetheless to wrestle with the problem of how to strategically combine sustaining life and challenging oppression.

Discussion

Social reproduction in capitalist society is a site of struggle. Capital needs human lives to be sustained, but seeks to offload the associated costs – a process facilitated by the capitalist state and resisted by the working class, to varying degrees in different historical contexts. Marxist feminist scholarship on social reproduction has shown that caring labour in the private family and household plays a critical (but by no means exclusive) role in socially reproducing capitalism by absorbing the costs of maintaining current and future generations (Dalla Costa and James, 1972; Ferguson, 2020; Fraser, 2022; Vogel, 1983). In the UK, under state-managed and neoliberal capitalism, unwaged or low-wage carers in the private family and household, particularly women, have borne significant responsibility for sustaining the lives of older, chronically ill and disabled people (Finch and Groves, 1980; Means et al., 2008). This article has expanded the theoretical insights of social reproduction feminists, by identifying how neoliberal austerity depends on the

intensification of unwaged caring labour, through drawing volunteer initiatives and relations of cooperation within communities directly into the process of sustaining the lives of older and disabled people. These developments, long underway before the pandemic, provided the conditions from which pandemic community support networks emerged – a point that has not been adequately recognised within scholarship of pandemic community support groups (Firth, 2020; Kavada, 2022; Rickford, 2023; South et al., 2020).

Thus, the social relationships of cooperation and mutual support embodied in community and voluntary initiatives that sustained many lives during the pandemic were also structured and inhabited by neoliberal capitalist social relations, albeit incompletely (Ferguson, 2020). The local state sought to mobilise, instrumentalise and scale up volunteer activity in order to meet social care needs. Not all community support networks were caught within this dynamic to the same degree. But even those with the most political distance from it (the BMA) had to weigh the risks, in their practice of supporting local people, of reinforcing forms of oppression that advance capital's domination of social reproduction. Although the emergency phase of the pandemic has waned, the offloading of social care responsibilities onto unwaged volunteers and community networks looks set to remain in the UK.

Conclusion

In this article, I have traced how pre-pandemic policy agendas shaped the emergence and coordination of voluntary and community pandemic support initiatives. My theoretical framework has drawn on feminist social reproduction scholarship, which examines how care and other life-sustaining practices are constituted in and reproductive of capitalist social relations and antagonisms. I have argued that voluntary initiatives that sustained people made vulnerable by the pandemic helped to expand pre-pandemic political projects to involve volunteers and community groups in delivering social care, thereby shielding the state and the capitalist class from bearing the full cost of supporting the lives of older, disabled and chronically ill people. Marxist feminist social reproduction theory provides a critical tool for assessing struggles around life-sustaining activities within voluntary and community social care.

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Notes

1. Following Taylor (2005), I define volunteering as unwaged work in the public sphere. See further Read (2021).
2. Of the 15 volunteers in the study, two were also carers.
3. Pseudonyms have been used for all individuals and organisations.

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