INTERIM BRIEFING REPORT

The First 500: The impact of Covid-19 on families, children aged 0-4 and pregnant women in Tower Hamlets

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Summary of key findings

Families in Tower Hamlets is an ongoing research project led by University College London into the impact of the Covid-19 pandemic on the lives of families with young children and pregnant women. This report is of initial findings from the 'first 500' respondents, who completed the survey between July and September 2020. We present findings in terms of three main ethnic groups that broadly represent proportions in the local population: one third of the population identify as White British and White Irish; a further third identify as Bangladeshi; and a final third identify with a wide range of other ethnicities which we have had to present as 'Other ethnicity' in this report and we acknowledge this is unlikely to do justice to the range of experience within this group.

With this lens of ethnicity, combined with analysis by household income, we can see certain clear patterns arising. Here, we focus on five main areas: family livelihoods; housing and environment; supporting children at home; health and social support services; and participants' own health and mental health. Subsequent outputs will present findings in more detail.

Livelihoods

Income precarity was escalating for survey respondents. The onset of pandemic related restrictions on employment and mobility was associated with a decline in employment and receipt of in-work benefits (decrease in 6 points to 60%) and an increase in unemployment and non-working self-employment (increase in 8 points to 40%).

Livelihood precarity was ethnically patterned: 46% of Bangladeshi respondents were unemployed/ unemployed receiving benefits/ non-working self-employed in contrast to 25% and 39 % of White and Other ethnicities. The financial benefits of employment were most fragile for Bangladeshi respondents, who were most likely to rely on income support and in-work benefits: 29% of Bangladeshi respondents were Universal Credit recipients in contrast 16% and 21 % of White and Other ethnicities. All recipients of furlough were Bangladeshi or of Other ethnicities.

Housing

Sixty three percent of survey respondents rented their home, compared to 19 percent who were buying their home with the help of a mortgage. Renting was much more likely among Bangladeshi (83%) or Other ethnicity (57%) respondents than among White respondents (38%). About one third of survey respondents had major problems with housing quality.

Supporting children at home

About half the children in the survey had attended nursery or other formal early childhood education service prior to lockdown in March 2020 but at the point of completing the survey only about a third were attending. Most children were at home, being supported by parents, or other family members, for many more hours than was usual. Nearly all children were read to, taught to the alphabet or to

count on at least some days of the week; this was more common among White families than Bangladeshi or Other ethnicity families. About half of families had access to outdoor space and around half of those whose children were 12 months and older said their children were physically active every day or most days. Most parents were confident in their abilities to support their children at home. More Bangladeshi families than others expressed concerns about their abilities in this regard. Most parents said they had reduced time for themselves during this time.

Health and support services

Access to health appointments for pregnancy and new babies was ethnically patterned. While three quarters of respondents had access to routine midwifery appointments, fewer Bangladeshi respondents (65%) did so than Other ethnicity (87%) and White respondents (73%). The same patterning held for other health appointments such as child development checks, but where health visitors were accessed, nearly all respondents said the help was highly valued.

Health, Mental Health and Social Support

While general health was on the whole rated as good or better, Bangladeshi families rated their health as less good than respondents from other groups. In relation to mental health, 30% of respondents reported symptoms consistent with mild depression across gender and ethnic groups. Just under a fifth (18%) reported moderate and 14 percent reported moderate-severe depression. A small number reported symptoms consistent with severe depression.

Mental health difficulties were more common and of higher severity among those on lower household incomes. Just over half (52%) of respondents had received some kind of support from outside the household such as from neighbours and wider kin and this was more common among Bangladeshi respondents than respondents in other ethnic groups. Loneliness was an issue reported among all income groups.

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1. Introduction

Family life in Tower Hamlets has experienced an unprecedented economic and health shock in 2020 due to the Covid-19 pandemic and associated measures to control the spread of the virus. With its pre-existing stark income and health inequalities, Tower Hamlets was already a high-risk inner city area, placed in one of the richest global cities. This briefing reports interim findings from the first 500 respondents in a community survey of parents with children under five, and pregnant women, that took place between July and September 2020. The survey is part of a wider mixed methods study in the borough and follows the design of a parallel study taking place in Bradford, as part of the renowned Born in Bradford cohort studies. Both city locations are characterised by being highly ethnically diverse and vibrant communities. One of the aims of the study is to adopt an assets based approach that documents pathways to recovery that build on community strengths and help the borough adapt service provision to new needs and circumstances (Kretzmann & McKnight, 1996). A further context for this study is its location within the ActEarly programme, a UK Prevention Research Programme aiming to find ways to intervene early in children's lives to avert later adverse health outcomes (Wright et al., 2019).

Tower Hamlets, like everywhere in the UK, began its lockdown on 23 March 2020, with closure of nurseries and other preschool provision, schools, workplaces, non-essential shops and businesses and reduced health and social care provision, and restrictions placed on daily activities. From 1 June, schools, early childhood education and care (ECEC), and workplaces gradually reopened. Mobility restrictions were eased and replaced by localised restrictions at times of high rates of virus transmission. By early September there were escalating concerns about rates of transmission, and new restrictions began to be introduced, notably the 'rule of six' on 14 September which legally limited associating to six people, whether in or out of a household. By this point, rules had diverged across the four nations of the UK. In England, in a further response to escalating Covid-19 cases, a three tiered approach to restrictions came into force on 14 October, and Tower Hamlets, along with the rest of London, entered Tier 2, defined as 'high alert' on 17 October. At the time of writing, Tower Hamlets had 166 Coronavirus cases per 100,000 population over the previous seven day period, compared to 147 per 100,000 in London as a whole. These measures, aimed at preventing spread of the virus and consequent deaths, have had negative impacts on mental health and economic security and may have exacerbated existing inequalities and vulnerabilities.

1.1 Population profile

The population profile in Tower Hamlets is young, diverse and mobile. There are approximately 295,200 residents, of which about 43 percent were born outside the UK. The last census, in 2011, provides the most reliable population data, but is acknowledged to be out of date. According to this source, two thirds of the borough's population are from minority ethnic groups and it is the 16th most ethnically diverse local authority in England. Inward migration to the borough has taken place over decades; around a quarter of those born outside the UK arrived before 1991 (Tower Hamlets 2017). In recent years, Tower Hamlets has had the highest population growth of any local authority in

England and this trend is projected to continue (ibid.), drawing in new residents through international rather than internal migration. Most of the new arrivals came from Europe and over sixty percent were children or young adults up to the age of 30 (ibid.). Data from registrations for National Insurance numbers shows that new registrants in Tower Hamlets came predominantly from Italy, France, Spain, Romania and India and are mostly under the age of 35 (ibid.). The overall pattern is that about one third of residents are white British, one third are Bangladeshi in origin and one third are either non-British white or non-Bangladeshi BAME in origin (Tower Hamlets Council 2018).

In 2017, there were 22,200 children aged 0-4 resident in the borough, a 26% rise over the preceding ten years (Tower Hamlets 2018). Just over a quarter (27%) of households contain at least one child. Ethnic diversity is particularly pronounced among school aged children. Nearly two thirds (63%) of school children are from a Bangladeshi background; and Tower Hamlets children come from over 100 different countries in total. Recent data suggests nearly 1000 children are of Italian-Bengali heritage. About one third (34%) of residents use a main language other than English and about one in ten adults have low levels of proficiency in English; this is particularly the case among older women who are recent Bengali and Somali migrants (Tower Hamlets 2017).

About 30 percent of children in Tower Hamlets live in low income households compared to 19 percent in London and 17 percent in England (PHE fingertips data 2019). The local deprivation score is 35.7 compared to 21.8 for England. Health indicators suggest that children are more at risk in Tower Hamlets, especially with regard to childhood obesity, and smoking prevalence in adults, than in London and England as a whole, but there is some protection through higher than average rates of breastfeeding by mothers in Tower Hamlets, less than average smoking during pregnancy and children's school attainment at GCSE is also better than average (PHE 2019).

In primary schools, three quarters (75%) of Tower Hamlets children have a main language which is not English, compared to 54% in London and 21% in England as a whole (Tower Hamlets Children and Families Strategy 2019-2024). Compared to other areas of London and England, there are disproportionately more children with special educational needs, and young people in the criminal justice system. Only about half of eligible two year olds access early education (ibid.).

1.2 Local impact of the Covid-19 pandemic

Early, borough led, scoping of the impacts of the Covid-19 pandemic, found that there were significant numbers of Covid-19 related deaths and infections, and that existing mental health difficulties including stress, anxiety, loneliness and grief were exacerbated by the reduction in support service provision at the time of lockdown. A second issue was the economic shock of lockdown on businesses and concomitant employment, leading to precarity and uncertainty for many, with government financed protections perceived as temporary. In relation to education and learning, the borough identified concerns about consistency and quality of home learning while schools were closed, and the potential exacerbation of digital and social inequalities in access to learning, with potential for longer term impacts on children's wellbeing and attainment. Alongside these major concerns was a recognition that the pandemic lockdown enabled some positive changes

to occur in the local environment and particularly with regard to community mobilisation and cohesion (Starkie 2020).

1.3 This interim report

This report focuses on survey findings in relation to livelihoods and employment, housing, supporting children at home, accessing health and social support services, and health including mental health among families with young children, and pregnant women, who responded to our survey. Respondents were predominantly women, mothers or mothers to- be, although there were 61 male respondents, either fathers or fathers to- be. We give a snapshot of their lives between 23 March and 28 September 2020. We continue to recruit to the survey, aiming to reach 1600 respondents by end of November 2020.

1.4 The study

The study on which this briefing is based is a multi-method, three phase investigation of the impact of the Covid-19 pandemic on the lives of families with young children in Tower Hamlets taking place during 2020-2021. It starts from the position that recovery from pandemic will require harnessing all possible resources to support families with young children to avert lasting damage to health and development since health and equality are linked (Marmot 2020). It aims to provide new and detailed knowledge to support service delivery in the local authority, and to disseminate this widely, to promote economic regeneration, social cohesion and addressing polarised inequalities. The study is place based, aiming to inform and learn from its inner city location, where the intersections of household demographic characteristics are multiple, diverse and challenging to study or to describe simply. A location such as Tower Hamlets can be seen as an important exemplar for multiple issues faced in similar locations across the country. Our main conceptual focus is young children, including those about to be born, and the reports of parents and other community stakeholders about the social, health and economic consequences of the pandemic on children's and families' lives and livelihoods. We anticipate that ethnicity and income are inter-related and structure the experience of the pandemic. We also anticipate, following the results in Bradford on a similar sample, that mental health difficulties is a significant outcome. We present results using these major variables.

Study objectives are to:

- understand how families, including those defined as vulnerable, deploy their interpersonal, economic and social resources to manage risks associated with living in lockdown restrictions and its aftermath
- provide new and detailed knowledge to support service delivery in the local authority to promote economic regeneration, social cohesion and address polarised inequalities
- seek evidence of localised adoption and potential of peer, familial and community mutual aid strategies that aid personal and structural recovery pathways as well as identifying need.

2. Study Design and Methods

2.1 Research design

The study is comprised of three main phases 1) a longitudinal community survey of parents with children under five, and pregnant women, in two waves approximately six months apart; 2) a longitudinal qualitative panel of 20 households sampled from the survey responses carried out in two waves six months apart and 3) a desk-based community assets mapping to ascertain how the local service landscape had changed during the summer of 2020. Ethical approval was awarded by the UCL Institute of Education Research Ethics Committee and by the Health Research Authority Research Ethics Committee.

2.1.1 Phase 1

For phase 1, in the absence of a community sampling frame, parents with children under 5, and pregnant women resident in Tower Hamlets were invited to complete an online survey about their household, the impact of Covid-19 on their family and what life has been like living through Covid-19. Wave 1 of the survey took place between July-November 2020 with the second wave of the survey planned to run from April to June 2021. Recruitment for wave 1 of the survey is still ongoing at the time of this report; the target sample for wave 1 is 1600 respondents, with a target of 2000 respondents for wave 2.

Given the heterogeneity of the population of the borough, the survey aims to represent major ethnic groups on the basis of 30% White British, 30% Bangladeshi and 40% 'Other' including Somali families.

The secure survey platform Qualtrics was used to administer the survey via weblink and QR code. Qualtrics is available in many languages commonly found in the borough (but not Somali). We also made provision for the survey to be completed by telephone.

Domains covered in the wave 1 survey included:

- Home and housing
- Financial situation including job security
- Food poverty and bills
- Mental health
- Physical health including exercise, drinking, smoking
- Accessing health services
- Childcare
- Community support (giving and receiving)
- Family life and home learning
- Work-life balance
- Relationships within the household
- Division of domestic labour

- Worries and concerns

2.1.2 Phase 2

The second phase of the research is a repeated longitudinal qualitative panel of 20 households purposively sampled from the Wave 1 survey to represent different household structures and types. In-depth interviews will be conducted via videocall or telephone with up to 3 adults per household, including fathers and wider kin. Wave 1 of the panel interviews will take place in November and December 2020 with wave 2 in June to July 2021. Our sampling strategy was carefully constructed to ensure representation of the following dimensions:

- Household type (single, couple, multi-generational)
- Income (low, moderate and high)
- Ethnicity (White, South Asian, Other ethnic groups)

The qualitative interviews will deploy supporting interactive activities and will focus on children's development in the context of family's everyday lives at this moment in time, how parents and kin support each other emotionally and practically, and how families are engaging in their communities during the Covid-19 era.

2.1.3 Phase 3

The main activity of the third phase of this study took place between July and September 2020, and was a desk-based community mapping exercise of the assets or services (broadly defined) for families with young children, using Internet tools (websites, Facebook pages) and with help from key individuals in voluntary sector organisations. The specific objectives of this phase of the study were:

- to establish a list of all relevant services and support aimed at families and children in the borough including both statutory provision as well as support from the voluntary sector.
- to closely map changes to support services available to families, including the emergence of new forms of support (e.g. mutual aid)
- to visualise findings using mapping techniques.

Analyses of changes to service delivery will be triangulated with respondent accounts from phase 1 and 2 of the research and used to contextualise findings.

The mapping dataset was developed through a combination of website trawling all children's centre websites, and those of health centres, leisure facilities, faith-based organisation, and other support offers aimed at families with young children run by the council and the voluntary sector, including services aimed at supporting those in poverty e.g., welfare advice and employment. The dataset was reviewed as it was developed by key stakeholders in the borough including community researchers, voluntary sector representatives and public health. This work is ongoing and expanding its reach

through working with a social prescribing team and a parents' Covid-19 support group to develop and maintain the map.

2.1.4 Statistical analysis

This briefing paper presents statistical analysis of the first 500 survey responses. Descriptive statistics are presented on key demographics including ethnicity and household composition. Cross tabulations have been used to explore four key areas: i) livelihoods (income, employment and benefits), ii) housing, iii) supporting children's learning at home; and iv) social support, by ethnicity and gender. We report sample size and percentages with 95% confidence intervals in parentheses. We conclude the analysis with a comparison between loneliness and mental health outcomes of the key areas mentioned above. Missing data is charted below as well as percentages of heavy data loss. We have deliberately adopted a cautious approach to reporting data at this early stage of analysis. Future publications will report on the whole dataset. We report two decimal points in tables and use a rounding convention in the text. Values of less than 5 are indicated by -.

2.2   Recruitment and Survey Sample

A multi-pronged, opt-in recruitment strategy was adopted, in partnership with our stakeholders in Tower Hamlets, to recruit participants for the online survey. A borough wide social media campaign was launched to promote the study via official Tower Hamlets communication channels that included residents' magazines and newsletters, Tower Hamlets websites and associated social media feeds.

Invitations to participate were also sent out via the borough's child-facing services which spanned Clinical Integrated Services, such as Health visiting and Family Nurse Partnership, Children's Community Health Service, Primary Care and Barts Maternity Service; the Integrated Early Years' Services such as childcare teams, nursery and primary schools, children's centres and many other education and partnership services. Other sectors through which the study was promoted and sought to recruit participants included civil society organisations, voluntary and community-based organisations, housing associations and faith-based organisations. In addition, we arranged for a postcard to be sent to 6585 families with young children who were registered with the local authority dashboard – a database holding details of all those claiming a wide range of welfare benefits. In order to support the inclusion of non-English speaking Somali residents in the survey we worked with specialist voluntary organisation WIT to target recruitment on Somali participants in the later stages of the survey.

Figure 2.1 describes the status of survey respondents in terms of gender and parenting. Of 522 respondents, 104 were excluded due to incomplete data, leaving 418, of which 303 respondents were female and had a child aged 0-4, 26 were pregnant and had a child under five, and 21 were pregnant women. In addition, there were 57 male respondents who had a child aged 0-4, 3 were partners of a pregnant woman and had other young children, and one was a partner of a pregnant woman.

Figure 2.1
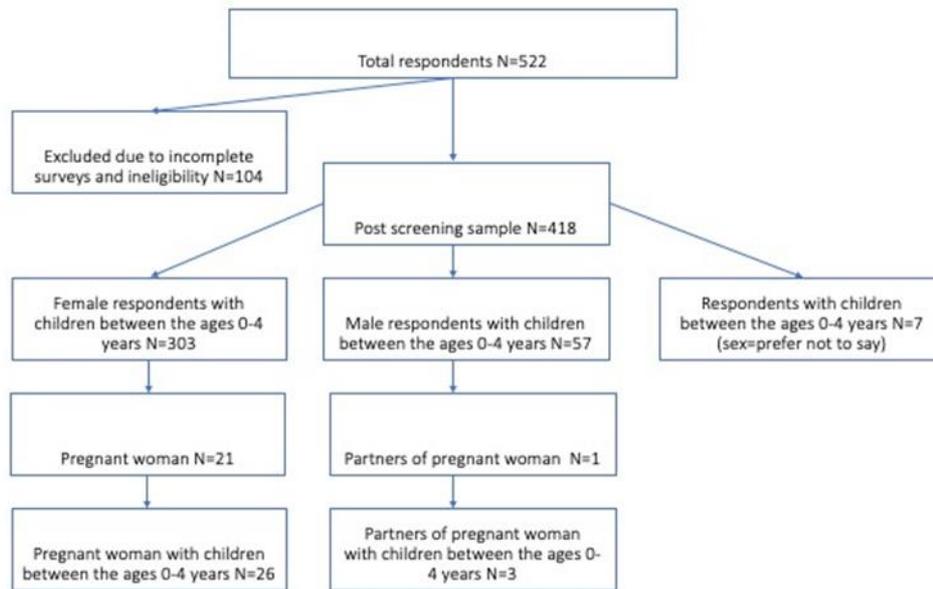
2.3 Survey Sample Characteristics

The great majority (84%) of survey respondents were female, while 15 percent were male (Table 2.1). The ethnic group categories used were those adopted by the borough; they reflect, but do not do justice to the very many cultural backgrounds represented in the borough. Just over one fifth of respondents were White British, compared to about one third in the borough as a whole (Table 2.1). On the other hand, 41 percent were from Bangladeshi backgrounds, which is an over-representation compared to the borough as a whole[1].

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[1] For the purposes of analysis in the remainder of the report, we have divided the survey respondents into larger categories following ONS guidance: White British/White Irish, Bangladeshi, and Other.

Table 2.1: Ethnicity and gender

Table 2.1	Male		Female		Prefer not to say		All participants	
	N	%	N	%	N	%	N	%
White British	12	2.90	81	19.4	0	0.00	93	22.2
White Irish	0	0.00	3	0.70	0	0.00	3	0.70
Gypsy/Roma	2	0.50	0	0	0	0.00	2	0.50
Any other White background	5	1.20	48	11.5	0	0.00	53	12.7
Mixed: White and Black Caribbean	0	0.00	2	0.50	0	0.00	2	0.50
Mixed: White and Black African	0	0.00	2	0.50	0	0.00	2	0.50
Mixed: White and Asian	2	0.50	7	1.70	0	0.00	9	2.20
Any other Mixed background	0	0.00	5	1.20	0	0.00	5	1.20
Asian/Asian British: Indian	5	1.20	13	3.10	2	0.50	20	4.80
Asian/Asian British: Pakistani	1	0.20	10	2.40	0	0.00	11	2.60
Asian/Asian British: Bangladeshi	31	7.40	135	32.3	4	1.00	170	40.7
Any other Asian background	1	0.20	4	1.00	1	0.20	6	1.40
Black/Black British: Somali	0	0.00	5	1.20	0	0.00	5	1.20
Black/Black British: Other African	0	0.00	4	1.00	0	0.00	4	1.00
Black/Black British: Caribbean	0	0.00	3	0.70	0	0.00	3	0.70
Chinese	1	0.20	13	3.10	0	0.00	14	3.30
Vietnamese	0	0.00	1	0.20	0	0.00	1	0.20
Any other ethnic group	1	0.20	10	2.40	0	0.00	11	2.60
Prefer not to say	0	0.00	4	1.00	0	0.00	4	1.00
Total	61	14.6	350	83.7	7	1.70	418	100

We report findings in three main ethnic categories: White British/White Irish, Asian/Asian British Bangladeshi, and Other ethnicity. We followed the ONS convention of combining White British and White Irish and refer to it below as 'White'. We summarise the Asian/Asian British Bangladeshi as "Bangladeshi". While the Asian/Asian British Bangladeshi category is reasonably precise, albeit heterogeneous, we acknowledge that the aggregated category 'Other ethnicity' represents a wide range of experiences and that it is difficult to draw firm conclusions about the implications of membership of a particular ethnic status for pandemic experience from this data when representation in the survey is very low.

In terms of household composition, around two thirds (66%) of survey respondents lived in two adult households while nearly one quarter (24%) lived in one adult households (Table 2.2). However, among Bangladeshi families, eight percent lived in households with more than two adults.

Table 2.2 Household composition

	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total	
	N	%	N	%	N	%	N	%
1 Adult HH	21	5	41	9.8	37	8.85	99	23.7
2 Adult HH	70	16.7	95	22.7	110	26.3	275	65.8
Other/ 2+ Adult HH	5	1.2	34	8.1	5	1.2	44	10.5
Total	96	22.9	172	40.6	154	36.35	418	100

Table 2.3 Parental stage of household respondent

	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Has a child under 5	81	84.3	151	88.8	135	88.8	367	87.7
Pregnant with no other children	5	5.20	8	4.70	9	5.90	22	5.20
Pregnant and has a child under 5	10	10.4	11	6.40	8	5.20	29	6.90
Total	96	100	170	100	152	100	418	100

Table 2.3 shows that over eighty percent of households in each ethnic category (and nearly 90% of the total) had a child under five, while around five percent were parents to be and slightly more (7%) were both pregnant and had a child under five.

3.   Livelihoods: finances and employment

This section examines the financial livelihoods and household income strategies adopted by the families of Tower Hamlets as they experience the first wave of the economic and health shocks of the pandemic. It profiles how respondents earn their livelihoods and get by to sustain their well-being and that of their young children, children- to- be and wider families.

At this first 500 survey stage the full 80 per cent income replacement from the national Coronavirus Job Retention Scheme furlough (to a ceiling of £2,500 a month), was available for employed respondents whose employers had to pause their active work. Although markedly more generous than welfare related benefits to the unemployed and sick, the design of furlough, with its requirement that employees needed to be in work by March 19th for a minimum of 3 weeks, is less favourable for insecure workers on irregular schedules such as zero hours contract or those working in the gig economy. Similarly, respondents who had been primarily self-employed in March, would not have been eligible for income support through furlough, but would have to use Universal Credit (UC), the UK's welfare "safety net".

Whereas income recovery through the furlough scheme gave individuals, of most income levels, a degree of financial continuity and security with its ceiling slightly higher than an average national wage (£30,000), UC is a significantly less generous scheme. In part recognition, a Covid-19 UC supplement of £20 per week was introduced nationally for new and existing claimants on 6 April 2020.

Even with the Covid-19 UC supplement survey respondents reliant on this benefit and living in a couple household, 25 years or over, with two children would be trying to get by on a maximum of £680.71 per month or £170.17 per week, excluding housing costs.

3.1 Household Finances

Survey respondents began the pandemic with a great diversity in gross yearly household income ranging from less than £5,200 (9% of respondents) to £78,000 or more (21% of respondents). The pan-London historic pattern of rich and poor living side by side, has long been a feature of Tower Hamlets with its proximity to the City of London wealth and linked jobs despite deep levels of chronic poverty (Tower
Hamlets Fairness Commission, 2011). In the year prior to June 2020, 86% of men and 65% of women living in Tower Hamlets were economically active, representing more men than nationally and fewer women than nationally. Seventy percent of jobs were managerial and professional, considerably more than nationally (49%), while 11 percent were administrative and skilled trades (vs 20% nationally) and 11 percent were service jobs (vs 16% nationally). Only eight percent were operatives and elementary occupations (vs 16% nationally) (Nomis 2020).

Income polarisation is further displayed when income and ethnic diversity are profiled (Table 3.1). Forty-one per cent of White respondents' household income is £78,000pa or above while this was the case for 1% of Bangladeshi respondents and 28 % of those in Other ethnic groups. Bangladeshi respondents were far more likely to report the lowest levels of yearly household income (up to £20,799) than respondents from other ethnic groups. This low level contrasts sharply when compared with the average UK household disposable income after taxes and benefits (pre-pandemic) of £30,800 (ONS 2020).

Table 3.1 Gross current household income by ethnicity

Current Household income	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total participants	
	N	%	N	%	N	%	N	%
Less than £5,200	-	-	15	10.5	14	10.6	34	9.20
£5,200-10,399	-	-	20	14.0	7	5.30	29	7.80
£10,400-15,999	-	-	19	13.3	7	5.30	30	8.10
£16,000-20,799	-	-	21	14.7	9	6.80	31	8.40
£20,800-25,999	5	5.50	10	7.00	7	5.30	22	5.90
£26,000-36,300	10	10.9	17	11.9	8	6.00	35	9.40
£36,400-51,999	9	9.90	17	11.9	17	12.8	44	11.9
£52,000-77,999	18	19.7	7	4.90	18	13.6	43	11.6
£78,000 or more	37	40.6	-	-	37	28.0	76	20.60
Prefer not to say	-	-	15	10.5	8	6.10	25	6.80
Total	91		143		132		368	
Missing total	5		23		22		52	
Grand total	96		168		154		418	

3.2 Managing work and benefits

Prior to March 2020 two-thirds (66%) of survey respondents were employed or on leave from employment with in-work benefits: 48% were employed, 7% were actively self-employed and 11% were on maternity/ parental leave (Table 3.2)[2]. The remaining third (34%) were unemployed or not working despite a self-employed status. That is, employment activity was precarious for a significant minority of the sample at the start of the pandemic. Again, employment precarity was ethnically patterned: 39% of Bangladeshi respondents were unemployed or non-working self-employed in contrast to 21% and 31% of White and Other ethnicities. The financial benefits of employment were

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[2] Employed refers to the following categories: Employed, Self-employed and working, maternity/ par leave (as an in-work benefit); Unemployed refers to: Unemployed, unemployed and not receiving benefits, self-employed not working.

most fragile for Bangladeshi respondents, although across the sample pre-pandemic unemployment rates were high.

At the point of survey, employed levels had slightly dropped (to 61% of all respondents) and unemployment had slightly increased (to 40% of all respondents). Of those who were employed, a small proportion had moved to furlough (6%) and there was an uplift on those reporting being on maternity/ parental leave (17%). All of those on furlough were from Bangladeshi or Other ethnicities. Unemployment remained ethnically patterned but with more deterioration for respondents from Other ethnicities (increase in 8 points to 39%), Bangladeshi respondents (increase in 7 points to 46 %) than White respondents (increase in 4 points to 25%).These findings need to be set against the national UK unemployment rate which was 4.5% at this time (ONS 2020).

In this income and employment context, it is of no surprise that at the point of survey, 51% of the sample required some form of income support benefit to maintain livelihoods for their family (Table 3.3). Again an ethnic patterning is found with a 67% of White respondents *not* requiring benefits, in contrast to 33% of Bangladeshi respondents and 53% of respondents from Other ethnicities (Table 3.3). However, the precarious situation of those from Other ethnicities is shown as it includes a minority (8%) who have "no recourse to public funds" due to their asylum/ refugee status.

Of those on benefits, 23% were receiving UC with a similar ethnic patterning: 29% of Bangladeshi respondents were UC recipients in contrast to 16% and 21% of White and Other ethnicities. The Covid-19 UC supplement of £20 per week is due to expire in April 2021.

Table 3.2 Employment status now and prior to March 2020, by ethnicity

Employment status prior to March 2020	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Employed	54	56.2	71	44.1	68	47.5	194	48.2
Self employed and working	8	8.30	6	3.70	13	9.10	27	6.70
Self employed and not working	-	-	-	-	-	-	6	1.50
On maternity or parental leave	12	12.5	20	12.4	14	9.80	46	11.4
Unemployed	8	8.30	40	25.2	28	19.7	79	19.6
Unemployed and on benefits	12	12.5	21	13.6	16	11.2	50	12.4
Total	96		159		142		397	
Missing total	0		11		10		21	
Grand total	96		170		152		418	

Current employment status	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Employed	43	44.8	48	29.6	45	31.4	136	34.0
Employed but not working (on furlough)	-	-	11	6.80	9	6.30	23	5.70
On maternity or parental leave	18	18.7	24	14.8	25	17.4	67	16.6
Self employed and working	7	7.30	-	-	7	4.90	17	4.20
Self employed and not working	-	-	-	-	5	3.50	7	1.70
Unemployed	11	11.4	45	28.0	33	23.2	91	22.8
Unemployed and receiving benefits	13	13.5	29	17.9	18	12.6	60	14.9
Total	96		161		142		399	
Missing total	0		9		10		19	
Grand total	96		170		152		418	

Table 3.3 Benefits receiving currently, by ethnicity

Benefits	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Universal credit	14	16.2	34	28.6	26	21.1	74	22.7
Child Tax Credit	8	9.30	28	23.1	17	13.8	53	16.2
Jobseeker's Allowance	-	-	0	00.00	-	-	-	-
Employment and Support Allowance	0	0.00	-	-	0	0.00	-	-
None of these	58	67.4	40	33.0	66	53.2	164	49.2
No recourse to public funds	-	-	-	-	10	8.00	17	5.20
Prefer not to say	-	-	11	9.10	-	-	15	4.50
Total	86		119		123		328	
Missing total	10		51		29		90	
Grand total	96		170		152		418	

In this context of livelihood insecurity 13.5% of respondents had used a foodbank in the past 4 weeks, including 5% reporting four times or more over this period. Similarly in response to a general survey question asking respondents to list their three biggest worries, financial and employment related worries was ranked second, closely following the top ranked worry about COVID-19 health risks.

For example, one said:

> *Husband lost job, no help, and on maternity leave so reduced pay. Uncertainty of future.*

3.3   Paid work and care responsibilities

Around half (52%) of respondents said it was quite or very difficult to combine paid work and care responsibilities at the point of survey completion. Mothers found reconciliation of work and care harder than fathers.

Responses to a survey question about what was difficult at the moment referred to combining work and care during the pandemic. For example:

> *It is hard to look after newborn and working as NHS worker at the same time. Worries of bringing the virus home.*

> *I struggle with working from home, there are too many responsibilities and distractions (childcare, chores) and I cannot concentrate and get work tasks done.*

> *Having to be silent for large periods of time when my husband is on a work call.*

4.   Housing

Sixty three percent of survey respondents rented their home, compared to 19 percent who were buying their home with the help of a mortgage (Table 4.1). Borough data for Tower Hamlets, derived from the 2011 census, found that 73 percent of residents rent their home while 16 percent had a mortgage. This is the reverse of the UK as a whole, where 64 percent have a mortgage and 35 percent rent (Tower Hamlets 2015).

More respondents of Bangladeshi (83%) origin or Other ethnicity (57%) rent their home whereas among White respondents approximately equal proportions rent (38%) and own with help of a mortgage (39%). About 6 percent of respondents were in precarious housing, either living rent free or squatting or in temporary accommodation. Nearly 17% of respondents reported that their home needed major repairs and 31% reported damp or mould in their home. These housing deficiencies were more commonly reported amongst the Bangladeshi group (21% and 39% respectively). According to the English Household Survey (2018), 5% of households with a child under 5 and 3% of all households have damp or mould.

Table 4.1 Housing circumstances by ethnicity

Do you (or your household) own or rent the home you live in?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Own it outright	11	11.5	-	-	14	9.10	28	6.60
Buying it with the help of a mortgage/loan	37	38.5	10	5.80	33	22.1	80	19.3
Part own and part rent (shared ownership)	8	8.30	-	-	8	5.20	20	4.70
Rent it (includes all those who are on Housing Benefit or Local Housing Allowance)	36	37.5	140	83.3	85	57.0	261	63.2
Live here rent free (including rent-free in relative's/friend's property but excluding squatters)	-	-	6	3.50	-	-	10	2.30
Temporary accommodation (B and B, hostel etc)	-	-	5	2.90	6	3.90	13	3.10
Squatting	0	0.00	0	0.00	-	-	-	-
Total	96		168		149		413	
Missing	0		2		3		5	
Grand total	96	100	170	100	152	100	418	100

Does your home need any major repairs doing to it right now?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Yes	15	15.6	36	20.9	18	12.2	69	16.6
No	81	84.4	132	78.6	129	87.8	342	83.2
Total	96	100	168	100	147	100	411	100
Missing	0		2		5		7	

Grand total	96	100	170	100	152	100	418	100

Do you have any damp or mould in your home?	White British/White Irish		Asian/Asian British: Bangladeshi		Other Ethnicity		All participants	
	N	%	N	%	N		N	%
Yes	22	22.9	65	38.7	38	26.0	125	30.5
No	74	77.1	103	61.3	108	74.0	285	69.5
Total	96	100	168	100	146	100	410	100
Missing	0		2		6		8	
Grand total	96		170		152		418	

5. Supporting children at home

This section discusses the findings relevant to children's activities at home. During the period of fieldwork, schools and early childhood education services were open, during term time. Prior to fieldwork, educational provision had been closed, between 23 March and 1 June, except for children of key workers and vulnerable children. Between 1 June and end of summer term in late July, there was a gradual transition back to schools for children in year 6 and those in reception and year 1. Schools fully reopened in early September, with extended transition periods in some cases. Five children's centres in Tower Hamlets stayed open throughout lockdown and offered family support and play support via online sessions, and kept in contact with families considered vulnerable and those who were shielding. They also offered individual and group workshops to help prepare children for beginning school in September.

Among other early years settings, for example those in the private and voluntary sector, most closed during lockdown; only seven of 82 settings were open from 30 March. Places were offered to all the children of key workers and vulnerable children. Fifteen childminders were open and caring for key worker and vulnerable children. Services began to re-open from 1 June, and by the end of that month, 37 settings were catering for 788 children. By mid-October, there were 80 open settings (3 closed permanently, 2 new ones), and 2447 preschool aged children attended group settings and 167 children were cared for with 57 childminders.

5.1 Accessing Early Childhood Education and Care

About half the children in the survey, all preschool age, usually (i.e., pre 23 March 2020) attended nursery or other formal early childhood education facility but at the point of completing the survey only about a third were attending. Most children were at home, being supported by parents, or other family members, for many more hours than was usual.

Anxieties about Covid-19 and following official advice were among the reasons for supporting children at home rather than sending them to early childhood education provision:

> *We were eligible because my husband is an essential worker; however, the initial advice was to keep children at home if we were able, which we were since I am a stay-at-home mum.*

> *Not a key worker, but anxieties about COVID*

> *Nursery closed.*

5.2 Home learning

We asked parents how they were supporting children's learning during this time. Reading to babies from birth is associated with cognitive and developmental benefits (Council on Early Childhood 2014). Nearly two thirds (63%) of White respondents were reading to their child every day, and this

was the case for nearly half (48%) of those in Other ethnic groups and a quarter (26%) of Bangladeshi families (Table 5.1). Nearly all (93%) of children were read to on at least some days of the week.

Table 5.1 Reading to children, by ethnicity[1]

How often has someone at home been reading to your child?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Every day	55	63.2 (50%-76%)	36	25.7 (8.8%-43%)	60	47.6 (40%-56%)	151	42.7
Most days	16	18.3 (-.60%-37%)	47	33.5 (18%-50%)	34	26.9 (18%-36%)	97	27.4
Some days	12	13.8 (-5.7%-33%	45	32.1 (16%-48%)	25	19.8 (11%-28%)	82	23.2
Not at all	-	-	12	8.50 (-10%-27%)	7	5.50 (-3.8%-15%)	23	6.50
Total	87	100	140	100	126	100	353	100
Missing total	9		30		26		65	
Grand total	96		170		152		418	

1 95% confidence intervals in ( )

More than four fifths of Bangladeshi (80%) and Other ethnicity (82%) respondents were helping their child learn the alphabet and similar proportions were helping them to count (Table 5.2). Later analyses will disaggregate these findings by the child's age to ascertain proportions of children under and over two being supported in this way.

Table 5.2 Helping children with learning the ABC and counting, by ethnicity

Has anyone at home been helping your child to learn the ABC?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Yes	56	64.3 (52%-77%)	107	80.4 (73%-88%)	101.	82.1 (75%-90%)	264	76.9
No	31	35.6 (19%-52%)	26	19.5 (4.3%-35%)	22	17.8 (1.8%-34%)	79	23.0
Total	87	100	133	100	123	100	343	100
Missing	9		37		29		75	
Grand total	96		170		152		418	

Has anyone at home been teaching your child numbers/counting?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
	64	74.4 (64%-85%)	107	78.6 (71%-86%)	109	88.6 (83%-95%)	280	81.1
No	22	25.5 (7.3%-44%)	29	21.3 (6.4%-36%)	14	11.3 (-5.3%-28%)	65	18.8
Total	86	100	136	100	123	100	345	100
Missing	10		34		29		73	
Grand total	96		170		152		418	

1 95% confidence intervals in ( )

More than half (52%) of survey respondents said they had access to an outdoor space. Moreover, most children did some kind of physical activity, which we defined as running around, playing football, cycling, using playground equipment or similar. Among children aged 12 months and over, over half (53%) reported that their children did some physical activity every day or most days, while one quarter (25%) said this happened on one or two days a week. Twelve percent said their children never did any physical activity.

In response to a question about respondents' confidence in supporting learning at home most (72%) agreed or strongly agreed (Table 5.3). Twelve percent were not confident in their abilities. More White respondents (80%) reported confidence in supporting learning than Bangladeshi (62%) or Other ethnic (76%) groups. Men were marginally more confident than women (74% vs 71%).

Table 5.3 Confidence in supporting child in learning at home by ethnicity and gender[1]

I feel confident in my ability to support my children's learning at home	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
	N	%	N	%	N	%	N	%
Strongly Agree	32	37.2 (20%-54%)	29	21.4 (6.5%-36%)	39	32.5 (18%-47%)	100	29.3
Agree	37	43.0 (27%-59%)	55	40.7 (28%-54%)	52	43.3 (30%-57%)	144	42.2
Neither agree/disagree	10	11.6 (-8.3%-31%)	31	22.9 (8.1%-38%)	15	12.5 (-4.2%-29%)	56	16.4
Disagree	7	8.10 (-12%-28.3%)	20	14.8 (-.76%-30%)	14	11.6 (-5.2% -28%)	41	12.0
Total	86	100	135	100	120	100	341	100
Missing	10		35		32		77	
Grand total	96		170		152		418	

1 95% confidence intervals in ( )

I feel confident in my ability to support my children's learning at home	Male		Female		Prefer not to say		All participants	
	N	%	N	%	N	%	N	%
Strongly Agree	19	35.8 (14%-57%)	80	28.1 (18%-38%)	-	-	100	29.3
Agree	20	37.7 (16%-59%)	122	42.9 (34%-52%)	-	-	144	42.2
Neither agree/disagree	8	15.1 (-9.7%-40%)	47	16.5 (6.0%-27.1%)	-	-	56	16.4
Disagree	6	11.3 (-14%-37%)	35	12.3 (1.4%-23%)	0	0.00	41	12.0
Total	53	100	284	100	4	100	341	100
Missing	8		66		3		77	
Grand total	61		350		7		418	

1 95% confidence intervals in ( )

5.3 Parents' time for themselves and as a family

Supporting children who are primarily at home may be consequential for parents' time for themselves (Table 5.4). Nearly three quarters (72%) of respondents said they had much or slightly less time for their own leisure interests compared to prior to lockdown in March 2020. This was the case for both male and female respondents.

Table 5.4 Time for self by gender[1]

Leisure time for yourself	Male		Female		Prefer not to Say		All participants	
	N	%	N	%	N	%	N	%
Much less time than prior to COVID	28	54.9 (37%-73%)	167	54.7 (47%-62%)	-	-	196	54.3
Slightly less time than prior to COVID	8	15.6 (-9.5%-41%)	55	18.0 (7.9%-28%)	0	0.00	63	17.4
Just as much time as prior to COVID	9	17.6 (-7.3%-42%)	38	12.4 (1.9%-23%)	-	-	49	13.5
Slightly more time than prior to COVID	6	11.7 (-14%-37%)	22	7.20 (-3.6%-18%)	-	-	29	8.00
Much more time than prior to COVID	0	0.00	23	7.50 (-3.3%-18.3%)	-	-	24	6.60
Total	51	100	305	100	5	100	361	100
Missing total	10		45		2		57	
Grand total	61		350		7		418	

1 95% confidence intervals in ( )

For some parents, family life under lockdown had positive benefits with strengthening relationships due to spending more time together as the quotes below illustrate:

Our overall domestic life is more settled and happier in some ways. We are all less busy, and our relationships are stronger within our household. We are enjoying more "slow/home" type activities together- e.g. tending houseplants, baking bread.

My husband is around all day as working from home, which makes life a lot easier with two small children.

Spending more time with my children has been a blessing.

It was ok at first being at home with the family getting some quality family time but there is only so long before you want some normality.

6. Health and Social Support services

The extent of restrictions on health services between March-September 2020 was far reaching, with the potential to affect the care, support and connectedness parents and pregnant woman need. In line with the rest of the UK, health and social support moved to predominantly virtual delivery from 23 March, with restrictions on face-to-face interaction between patients and GPs, health visitors and midwives. Many support services closed, reduced their services or moved online.

In Tower Hamlets antenatal contact and new birth visits were continued during lockdown. Early indications were that contacts and immunisations were maintained with around 90 percent of mothers and pregnant women, with particular focus on those women considered vulnerable (Gilmour, p.c). The mode of delivery moved to telephone and digital consultations. For those women in 'compelling need', face to face appointments were offered in children's centres, under infection control regimes (ibid.). Routine child development appointments at 3-4 months, 8-12 months, 2-2.5 years and the heel prick test at 28 days continued to be available.

6.1 Support during pregnancy

Three quarters of respondents had access to routine midwifery appointments; fewer among Bangladeshi respondents (65%) and more among respondents from Other ethnicities (87%) and White respondents (73%). One fifth (20%) of Bangladeshi respondents said they did not have access to maternity scans; many more than White (7%) and Other ethnicity women (14%). Over half (58%) of Bangladeshi and White (60%) women did not have access to non-routine midwife appointments. One third of Other ethnicity (33%) women had this problem.

6.2 Access to routine health appointments for children

Less than half or half of respondents who had had a baby since March reported having access to newborn hearing screening (50%), new baby check (47%), 6-8 week check (36%), immunisations at 8 weeks (42%), immunisations at 12 weeks (37%) and immunisations at 16 weeks (33%) (Table 6.1). There was ethnic patterning to this finding, with more White respondents reporting access to new baby checks than Bangladeshi or Other ethnic groups.

Table 6.1 also shows that 40% of respondents were able access a health visitor when needed, while a fifth (22%) had not and a just over a third (38%) had not tried. Over ninety percent had mostly or definitely received the support they needed. Finally, Table 6.1 also reports that under half of children were accessing routine health and development checks during this period. Forty four percent had accessed 8-12 month checks with a health visitor, 48 percent had had immunisations at 12 months, and 41 percent of children had had 2 year checks. The same ethnic patterning occurred in relation to accessing child development checks with White respondents more likely to access reviews and immunisations than other groups.

Table 6.1 Routine screening and checks for newborns, health visitor support and child development checks[1]

If you had a baby since lockdown in March, have you been able to access….	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total participants	
	N	%	N	%	N	%	N	%
Newborn hearing screening								
Yes	17	68.0 (46%-90%)	25	41.7 (22%-61%)	23	48.9 (28%-69%)	65	49.2
No	8	32.0 (-3.3%-64%)	35	58.3 (42%-75%)	24	51.1 (31%-71%)	67	50.8
Total	25	100	60	100	47	100	132	100
Missing	66		102		95		263	
Grand total	91		162		142		395	
Blood spot by midwife								
Yes	18	72.0 (51%-93%)	23	39.7 (20%-60%)	23	52.3 (32%-73%)	64	50.4
No	7	28.0 (5.3%-61%)	35	60.3 (44%-77)	21	47.7 (26%-69%)	63	49.6
Total	25	100	58	100	44	100	127	100
Missing	66		104		98		268	
Grand total	91		162		142		395	
New baby check								
Yes	15	60.0 (35%-85%	23	40.4 (20%-60%	22	47.8 (27%-69%)	60	46.9
No	10	40.0 (9.6%-%-77%)	34	59.6 (43%-76%)	24	52.2 (32%-72%)	68	53.1
Total	25	100	57	100	46	100	128	100
Missing	66		105		96		267	
Grand total	91		162		142		395	
6-8 week check								
Yes	11	47.8 (18%-77%)	16	28.6 (6.5%-51%)	17	40.5 (17%-64%)	44	36.4
No	12	52.2 (24%-80%)	40	71.4 (57%-85%)	25	59.5 (40%-79%)	77	63.6
Total	23	100	56	100	42	100	121	100

	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total participants	
	N	%	N	%	N	%	N	%
Missing	68		106		100		274	
Grand total	91		162		142		395	

Immunisations at 8 weeks

	N	%	N	%	N	%	N	%
Yes	12	52.2 (24%-80%)	21	37.5 (17%-58%)	17	41.5 (18%-65%)	50	41.7
No	11	47.8 (18%-77%)	35	62.5 (46%-79%)	24	58.5 (39%-78%)	70	58.3
Total	23	100	56	100	41	100	120	100
Missing	68		106		101		275	
Grand total	91		162		142		395	

Immunisations at 12 weeks

	N	%	N	%	N	%	N	%
Yes	10	50.0 (19%-81%)	16	30.8 (8.2%-53%)	15	38.5 (14%-63%)	41	36.9
No	10	50.0 (19%-81%)	36	69.2 (54%-84%)	24	61.5 (42%-81%)	70	63.1
Total	20	100	52	100	39	100	111	100
Missing	71		110		103		284	
Grand total	91		162		142		395	

Immunisations at 16 weeks

	N	%	N	%	N	%	N	%
Yes	8	42.1 (7.8%-76%)	13	25.5 (1.8%-49%)	15	37.5 (13%-62%)	36	32.7
No	11	57.9 (29%-87%)	38	74.5 (61%-88%)	25	62.5 (44%-81%)	74	67.3
Total	19	100	51	100	40	100	110	100
Missing	72		111		102		285	
Grand total	91		162		142		395	

1 95% confidence intervals in ( )

Were you able to access support from a Health Visitor?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total participants	
	N	%	N	%	N	%	N	%
Yes	10	35.7 (6%-65%)	12	36.4 (9%-64%)	20	46.5 (25%-68%)	42	40.4
No	5	17.9 (-16%-52%)	10	30.3 (1.8%-59%)	8	18.6 (-8%-45%)	23	22.1
Haven't tried	13	46.4 (19%-74%)	11	33.3 (5%-61%)	15	34.9 (11%-59%)	39	37.5

	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total participants	
Total	18	64.3	21	63.6	23	53.5	62	59.6
Missing	73		141		119		333	
Grand total	91		162		142		395	

Did you receive the support you needed (from HV)?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total participants	
	N	%	N	%	N	%	N	%
Definitely	7	77.8 (47%-97%)	6	40.0 (.08%-79%)	-	-	17	39.5
Mostly	-	-	8	53.3 (19%-88%)	14	73.7 (51%-97%)	23	53.3
No	-	-	-	-	-	-	-	-
Total	7	77.8	14	93.3	14	73.7	40	92.8
Missing	84		148		128		355	
Grand total	91		162		142		395	

Has your child had their routine health checks/immunisations since lockdown in March?	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		Total participants	
	N	%	N	%	N	%	N	%
Routine contact with HV at 8-12 months								
Yes	11	57.9 (29%-87%)	23	39.0 (19%-59%)	19	44.2 (22%-67%)	53	43.8
No	18	42.1 (19%-65%)	36	61.0 (45%-77%)	24	55.8 (36%-76%)	68	56.2
Total	29	100	59	100	43	100	121	100
Missing	62		103		99		274	
Grand total	91		162		142		395	
Immunisations at 12 months								
Yes	11	78.6 (54%-102%	19	37.3 (16%-59%)	15	53.6 (28%-79%)	45	48.4
No	-	-	32	62.7 (46%-79%)	13	46.4 (46%-79%)	48	51.6
Total	11	78.6	51	100	28	100	93	100
Missing	80		111		114		302	

Grand total	91		162		142		395
Child health review at 2 to 2.5 years							
Yes	8	36.4 (3%-70%)	18	36.0 (14%-58%)	22	48.9 (28%-70%)	48	41.0
No	14	63.6 (38%-89%)	32	64.0 (47%-81%)	23	51.1 (31%-72%)	69	59.0
Total	22	100	50	100	45	100	117	100
Missing	69		112		97		278	
Grand total	91		162		142		395	

1 95% confidence intervals in ( )

Some respondents mentioned worries about lack of support from maternity and child health services during lockdown. They included:

> *Being pregnant - not having health care professionals to speak about certain worries. My partner not being able to attend hospital appointments i.e., scans. Taking public transport worries me as people don't comply with wearing masks and authorities not taking action*

> *Sleepless nights and anxiety. Going through pregnancy appointments alone as no one is allowed to accompany me*

> *Leaving work to go on MAT leave was stressful. Worried about giving birth during Covid and not being able to have visits from my husband after baby arrives and being alone in hospital during recovery.*

7. Health and Mental Health

We move lastly to consider the health and mental health of survey respondents. Mobility restrictions during the initial phase of lockdown meant that residents could only go out of the house for essential shopping and exercise once a day. Subsequently, on 13 June, 'support bubbles' were introduced that enabled two households to mix and to stay overnight in the homes of the other. Later, social mixing in restaurants and pubs was encouraged, and then withdrawn. Social and community life has been particularly adversely affected during the pandemic. In Tower Hamlets there is a vibrant community sector that became even more dynamic during lockdown.

We consider how these changes, as well as financial insecurities and social support have impacted mental health and loneliness below. We distinguish mental health from loneliness with loneliness as a perception of being isolated and alone rather than a physical manifestation of being alone.

7.1 General health

Nearly three quarters (73%) of respondents said their health was good, very good or excellent with little difference by gender (Table 7.1). When examined by ethnicity, Bangladeshi and Other ethnicity respondents tended to rate their health as less good than White respondents.

Table 7.1 Self-reported health by gender and ethnicity[1]

Health by gender	Male		Female		Prefer not to Say		All participants	
Would you say your health is….	N	%	N	%	N	%	N	%
Excellent	7	12.2 (-12%-36%)	30	9.10 (-1.2%-19%)	0	0.00	37	9.40
Very good	15	26.3 (4%-49%)	83	25.2 (16%-35%)	-	-	100	25.5
Good	19	33.3 (12%-54%)	126	38.3 (30%- 47%)	-	-	148	37.7
Fair	9	15.7 (-8%-39%)	67	20.3 (11%-30%)	-	-	77	19.6
Poor	6	10.5 (-14%-35%)	22	6.70 (-3.7%-17%)	0	0.00	28	7.10
Prefer not to answer	-	-	-	-	0	0.00	-	-

	N						
Total	57	100	329	100	6	100	392	100
Missing	4		21		1		26	
Grand total	61		350		7		418	

1 95% confidence intervals in ( )

Health by ethnicity	White British/White Irish		Asian/Asian British: Bangladeshi		Other ethnicity		All participants	
Would you say your health is…	N	%	N	%	N	%	N	%
Excellent	14	14.6 (-4.0-33%)	-	-	19	13.5 (-1.9%-29%)	37	9.40
Very good	33	34.4 (18%-51%)	30	19.4 (0.5%-34%)	37	26.2 (12%-40%)	100	25.5
Good	32	33.3 (17%-50%)	66	42.6 (31%-55%)	50	35.5 (22%-49%)	148	37.7
Fair	14	14.6 (-4.0-33%)	38	24.5 (11%-38%)	25	17.7 (2.7%-33%)	77	19.6
Poor	-	-	16	10.3 (-4.6%-25%)	9	6.40 (-9.6%-22%)	28	7.10
Prefer not to answer	0	0.00	-	-	-	-	-	-
Total	96	100	155	100	141	100	392	100
Missing	0		15		11		26	
Grand total	96		170		152		418	

1 95% confidence intervals in ( )

The great majority of Bangladeshi respondents did not drink alcohol (98%) whereas this was the case for around 40% of White respondents and two thirds of respondents from Other ethnicities (65%). The vast majority (over 90%) of respondents did not smoke tobacco.

7.2 Mental health

Nationally, the Covid-19 pandemic has influenced mental health (ONS 2020). O'Connor et al. (2020) found that women, those living in conditions of social disadvantage, and with pre-existing mental health conditions, experienced worsening mental health during the initial phases of lockdown. O'Connor et al. (2020) predict that the pandemic will lead to profound and long lasting effects on mental health and wellbeing.

We asked respondents to assess their mental health using the Patient Health Questionnaire depression scale (PHQ-8) (Kroenke, Strine and Spitzer, 2009) well as the General anxiety disorder

(GAD-7) (Spitzer, Kroenke and Williams, 2006)[3]. One third (34%) of survey respondents had no symptoms of depression. Just over a quarter (27%) reported symptoms consistent with mild depression across gender and ethnic groups. Just under a fifth (18%) reported moderate and 12 percent reported moderate-severe depression. A small number reported symptoms consistent with severe depression. Both men and women reported symptoms of depression, particularly among Bangladeshi respondents although numbers are low and this finding requires revision with a larger data set (Table 7.2).

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[3] The PHQ-8 is an 8 item instrument with a 4 item scale (not at all, score=0, one or two days, score=1, more than half the days, score=2, nearly every day, score =3). A score of 0-4 = no depressive symptoms, 5 to 9 =mild depression, 10 thru to 14 =moderate depression, 15 -19= moderately severe depression and 20 to 24 =severe depression. The GAD-7 is a 7 item instrument with a 4 item scale (not at all, score=0, one or two days, score=1, more than half the days, score=2, nearly every day, score =3). A score of 5=Mild anxiety, 10 =moderate anxiety, 15 or more =severe anxiety.

Table 7.2 Self-reported depressive symptoms by ethnicity and gender [1]

Depressive symptoms x ethnicity	White British/White Irish				Asian/Asian British: Bangladeshi *				Other ethnicity**				Total participants			
	Male		Female		Male		Female		Male		Female		Male		Female	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
No depression	6	50.0 (10%-90%)	32	38.6 (22%-55%)	7	25.0 (-7.1%-16%)	30	24.8 (9%-40%)	7	43.8 (7.1%-81%)	43	32.5 (12%-53%)	20	35.7	105	32.5
Mild depression		-	28	33.7 (16%-51%)	-	-	37	30.6 (16%-45%)	5	31.3 (-9.4%-72%)	37	31.6 (6.3%-57%)	13	23.2	102	31.5
Moderate depression	-	-	14	16.9 (-2.7%-37%)	6	21.4 (-11%-54%)	24	19.83 (.9%-36%)	-	-	21	18.3 (-5.7%-42%)	10	17.8	59	18.2
Moderately severe depression	0	0.00	7	8.40 (-12%-29%)	5	17.9 (-16%-52%)	25	20.7 (4.8%-37%)	-	-	12	13.6 (14%-41%)	6	10.7	44	13.6
Severe depression	0	0.00	-	-	6	21.4 (-11%-54%)	5	4.10 (-13%-21%)	-	-	6	4.00 (-11%-19%)	7	12.5	13	4.00
Total	12	100	83	100	28	100	121	100	16	100	119	100	56	100	323	100
Missing	0		0		3		14		2		13		5		27	
Grand total	12		83		31		135		18		132		61		350	

[1] 95% confidence intervals in ( ) *2 participants' gender 'prefer not to say' **3 participants' gender 'prefer not to say'

Resources make a difference to mental health. We found that respondents with more severe symptoms of depression were more likely to be in the lower income brackets while those with fewer symptoms were in the higher income brackets (Table 7.3).

Table 7.3 Mental health and household income[1]

Mental health x finance	No depression		Mild depression		Moderate depression		Moderately severe depression		Severe depression		Total participants	
	N	%	N	%	N	%	N	%	N	%	N	%
Low income	29	25.0 (9.2%-41%)	30	27.2 (11%-43%)	22	34.9 (15-55%)	21	44.6 (23%-66%)	13	68.4 (43%-94%)	115	32.4
Mid-income	27	23.2 (7.3%-39%)	31	28.1 (12%-44%)	21	33.3 (13%-53%)	16	34.0 (11%-57%	-	-	98	27.6
High income	53	50.0 (37%-63%)	44	40.0 (26%-54%)	15	23.8 (2.3%-45%)	-	-	-	-	118	33.2
Prefer not to say	7	6.00 (-12%-24%)	5	4.50 (-14%-23%)	5	7.90 (-16%-32%)	6	12.7 (-14%-39%)	-	-	24	6.70
Total participants	116	32.6	110	30.9	63	17.7	47	13.2	19	5.30	355	100
										Missing total	63	
										Grand total	418	100

1 95% confidence intervals in ( )

Low income (Less than £20, 799); Mid income (£20,800-£51,999); High income (£52,000 and above)

Turning to social support, we asked respondents about help from outside the household, from family, neighbours or friends (Table 7.4). Just over half (52%) had received some kind of support. Between 50%-55% of respondents from the three groups (respondents with a child under 5 years of age, pregnant with no children, pregnant and has a child under 5 years of age) received support from friends, neighbours and family members outside of the household. More Bangladeshi pregnant respondents (25%) received support from friends, neighbours and family members outside of the household, than other ethnicities. However, due to small sample size this finding should be treated with caution and reviewed once a larger sample size is available.

Table 7.4 Receiving support from outside the household, by ethnic group[1]

Since lockdown in March, did you receive any support from family, neighbours or friends who do not live in the same house/flat as you?	White British/White Irish*				Asian/Asian British: Bangladeshi **				Other ethnicity***				All participants				Total	
	Received support		No support		Received support		No support		Received support		No support		Received support		No support			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Respondents with a child under 5 years of age	44	13.0 (3.1%-23%)	36	10.7 (.60%-21%)	70	20.7 (11%-30%)	64	18.9 (9.3%-28%)	62	18.3 (8.7%-28%)	62	18.3 (.58%-36%)	176	52.1	162	47.9	338	100
Pregnant with no children	-	-	-	-	5	25.0 (-13%-63%)	-	-	-	-	-	-	10	50.0	10	50.0	20	100
Pregnant and has a child under 5 years of age	8	27.6 (-3.4%-58.6%)	-	-	5	17.2 (-16%-50%)	6	20.7 (-12%-53%)	-	-	5	17.2 (-.63%-35%)	16	55.2	13	44.8	29	100
Total	54	14.0	41	10.6	80	20.7	73	18.8	68	17.6	71	18.3	202	52.2	185	47.8	387	100
															Missing total		31	
															Grand total		418	100

1 95% confidence intervals in ( )
*1 'White British/White Irish' missing   **17 'Asian/Asian British: Bangladeshi' missing ***13 'Other ethnicity' missing

Table 7.5 shows that among those who reported anxiety, the same proportion, around half (46%-54%) received support from friends, neighbours and family members outside the household. Again, Bangladeshi respondents, particularly those with severe anxiety, more frequently reported this type of support (27%) than other ethnicities (White respondents: 7%, respondents from Other ethnicity: 13%). There was a similar pattern among those who reported depressive symptoms: between 45 percent and 62 percent reported support from family and friends, and this was more likely among Bangladeshi respondents than among those from other ethnic groups including White respondents.

Table 7.5 Social support by mental health (depression and anxiety)[1]

Anxiety X Support X Ethnicity

	White British/White Irish*				Asian/Asian British: Bangladeshi**				Other ethnicity***				All participants			
	Received support		No support		Received support		No support		Received support		No support		Received support		No support	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Mild anxiety	33	18.97 (5.6%-32%)	17	9.77 (-4.3%-24%)	28	16.09 (2.5%-30%)	27	15.52 (1.9%-29%)	32	18.39 (5%-32%)	37	21.26 (8.1%-34%)	93	53.45	81	46.55
Moderate anxiety	14	12.17 (-5.0%-29%)	15	13.04 (-4%-30%)	25	21.74 (5.6%-38%)	19	16.52 (-.02%-33%)	23	20.00 (4.5%-40%)	19	16.52 (-.02%-33%)	62	53.91	53	46.09
Severe anxiety	7	7.45 (-12%-27%)	9	9.57 (-9.6%-29%)	25	26.60 (9%-44%)	26	27.66 (10%-45%)	12	12.77 (-6.1%-32%)	15	15.96 (-2.6%-34%)	44	46.81	50	53.19
Total	54	14.10	41	10.70	78	20.37	72	18.80	67	17.49	71	18.54	199	51.96	184	48.04
											Missing (all responses total)	35				
											Grand total	418	100			

1 95% confidence intervals in ( )

*1 'White British/White Irish' missing   **20 Asian/Asian British: Bangladeshi missing   ***14 'Other ethnicity' missing

Depression X Support X Ethnicity

	White British/White Irish				Asian/Asian British: Bangladeshi				Other ethnicity				All participants			
	Received support		No support		Received support		No support		Received support		No support		Received support		No support	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
No depression	23	18.25 (2.5%-34%)	15	11.90 (-4.5%-28%)	15	11.90 (-4.5%-28%)	23	18.25 (2.5%-34%)	23	18.25 (2.5%-34%)	27	21.43 (6.0%-37%)	61	48.41	65	51.59
Mild depression	19	16.10 (-.43%-33%)	13	11.02 (-6.0%-28%)	29	24.58 (8.9%-40%)	13	11.02 (-6.0%-28%)	25	21.19 (5.2%-37%)	19	16.10 (-.43%-33%)	73	61.86	45	38.14
Moderate depression	9	13.24 (-8.9%-35%)	7	10 (-12%-33%)	13	19.12 (-2.3%-40%)	16	23.53 (2.7%-44%)	10	14.71 (-7.25%-37%)	13	19.12 (-2.3%-41%)	32	47.06	36	52.94

	n	% (95% CI)	n	% (95% CI)	n	% (95% CI)	n	% (95% CI)	n	% (95% CI)	n	% (95% CI)	n	%	n	%
Moderately severe depression	3	6.38 (-21%-34%)	4	8.51 (-19%-36%)	17	36.17 (13%-59%)	13	27.66 (3.3%-52%)	4	8.51 (-19%-36%)	6	12.77 (-14%-39%)	24	51.06	26	48.94
Severe depression	0	0.00	2	10.00 (-32%-52%)	4	20.00 (-19%-59%)	7	35.00 (-.33%-70%)	5	25.00 (-13%-63%)	2	10.00 (-32%-52%)	9	45.00	11	55.00
Total	54		41		78		72		67		67		199		183	

Missing (all responses total)	39
Grand total	418

1 95% confidence intervals in ( )

*1 'White British/White Irish' missing   **20 Asian/Asian British: Bangladeshi missing   ***18 'Other ethnicity' missing

7.3 Loneliness and household income

Loneliness is defined as a perception of being isolated and alone rather than a physical manifestation of being alone. Respondents were asked if they were lonely during the past week, and 207 said they were. Respondents from low-middle incomes (24%) were more likely to report feeling lonely most of the time than respondents from higher incomes (5%).

Table 7.6: Loneliness by financial circumstances[1]

Income X how often have you felt lonely during the past week?	None or almost none of the time		Some of the time		Most of the time		All or almost all of the time		Total participants	
	N	%	N	%	N	%	N	%	N	
Low income	22	22.0 (4.7%-39%)	43	43.0 (28%-58%)	24	24.0 (6.9%-41%)	11	11.0 (-7.5%-29%)	100	31.0
Mid income	26	28.8 (11%-46%)	42	46.6 (32%-62%)	13	14.4 (-4.7%-33%)	10	11.1 (-8.4%-31%)	90	27.9
High income	54	48.2 (35%-62%)	50	44.6 (31%-58%)	6	5.3 (-13%-23%)	-	-	112	34.8
Prefer not to say	9	45.0 (13%-78%)	8	40.0 (6.1%-74%)	-	-	-	-	20	6.2
Total participants	111	34.4	143	44.4	45	13.9	24	7.4	322	100
Missing										318
Grand total										418

1 95% confidence intervals in ( )
Low income (Less than £20, 799) Mid income (£20,800-£51,999) High income (£52,000 and above)

8. Concluding reflections

This interim report of the first 500 respondents reflects residents' material circumstances, perceptions and experiences at a particular moment in time, in a particular place, Tower Hamlets, and in a particular life circumstance: having young children, or expecting a baby, during a public health emergency and associated severe economic shock. Survey respondents largely reflected the ethnic profile of the borough, although we have taken steps to increase the representation of some groups through targeted recruitment in the latter stages of data collection. In terms of income, our respondents in the first 500 represented a wide range, but perhaps over-represents households in higher income bands. We took steps to address this by sending a recruitment postcard to all families in receipt of housing benefit in the latter stages of data collection. The results of these two measures will be reflected in subsequent analyses.

Early data presented here shows that in almost all dimensions examined, Bangladeshi families were experiencing more adverse impacts and more difficult lives than respondents from other ethnic groups, and particularly in contrast to respondents from White British or Irish backgrounds. Bangladeshi families had less income security, were less likely to be employed and more likely to be unemployed and more likely to be receiving Universal Credit than participants in other ethnic groups. Bangladeshi families were much more likely to be renting their homes, although they were less likely than other groups to report housing quality difficulties such as needing repair or damp or mould. Most parents were supporting children's learning at home, but fewer Bangladeshi respondents reported reading to children than in other ethnic groups, although more said they helped children to learn their ABC and to count. More Bangladeshi respondents reported doubts about their confidence with supporting children's learning. Fewer Bangladeshi respondents reported access to routine antenatal and child health and development checks than in other ethnic groups. Bangladeshi respondents were more likely to evaluate their health status as poor than other respondents. However, their health behaviours such as smoking and alcohol intake were protective. Self-reports of depressive symptoms among Bangladeshi respondents appear to indicate more likelihood of moderate-severe depression and this point needs follow up with the larger sample. As might be expected, depressive symptoms were more common among those in lower income brackets, which were more likely among Bangladeshi families. Finally, just over half of respondents, and marginally more Bangladeshi respondents than others, reported support received from people outside the household which may be a health protective factor. Our ethnicity focus has allowed us to see great inequalities but also protective factors in households. For example, the abilities of culturally defined groups, such as Bangladeshi families, where the needs of the group are valued over the desires of individuals, to offer protection to children and mothers during the restrictive environment and economic shock of lockdown are worth exploring in subsequent research. Finally, we should reiterate that inequalities among minority ethnic groups who are less well represented in the survey than the Bangladeshi community may be less visible in the initial findings of this study. We will develop recommendations for policy in discussion with borough stakeholders and as subsequent data analyses confirm the preliminary findings reported here.

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