Tower Hamlets children and young people's healthy weight insight

Headline findings

1. Introduction

The main aim of this research is to improve the LBTH public health team's understanding of the key target audience - parents and children and young people – in relation to achieving and maintaining healthy weight. The findings from this insight will be used to support the co-production of a children and young people's healthy weight strategy.

This document outlines the initial headline findings ahead of the full report being provided with recommendations.

1.1 Methodology

We designed and developed different research methods to gather insight for the different audiences. We developed qualitative research approaches to gather insight from parents and children. The final research approach for different groups was:

- Six mediated children's discussion groups with:
  - 8 boys aged 14-15 in the Bethnal Green area
  - 14 Bangladeshi boys aged 14-15 in the Bethnal Green area
  - 9 girls aged 14-15 in the Bethnal Green area
  - 6 boys aged 10-11 in the Poplar area
  - 6 girls aged 10-11 in the Poplar area
  - 6 Bangladeshi boys aged 10-11 in the Poplar area
- Twenty four parent interviews with:
  - 16 mums (14 Bangladeshi, 2 white British)
  - 8 dads (5 Bangladeshi, 1 black British, 2 mixed race)
- Ten interviews with stakeholders engaging schools, children, parents and families, and experts.

We developed tailored topic guides for the discussion groups and depth interviews that ensured we captured:

- current behaviours and attitudes towards physical activity and diet and potential enablers to support positive action
- individual, social and environmental influences (positive and negative) on health behaviour
- the relationship between a healthy lifestyle and connection, control and confidence in children and young people
- trusted communications channels, message carriers and opinion formers

2. Headline findings from stakeholder insight

2.1 Introduction

As part of this research, 10 depth interviews were conducted with a number of stakeholders who:

- represented some of the universal services provided by Tower Hamlets to support families and children in healthy lifestyles; or
- had access to the target audience (children and young people); or
- had subject matter expertise in the issue of childhood weight management in Tower Hamlets

The purpose of the interviews was to obtain their expert or professional insight on the opportunities and barriers that exist in supporting children and young people to achieve and maintain a healthy weight. The details of the stakeholders are listed in the table below:

Organisation	Role of participant in organisation	Role in healthy weight management across Tower Hamlets
Stakeholders that influence parents and families		
Tower Hamlets Community Engagement Team (Parent & Family Support Service)	*Family support and engagement practitioner*	*Provider:* Parent & Family Support Service (across the borough)
Poplar Abertots	*Early Years Playgroup Manager*	*Channel:* Access to parents of 2-5 year olds (in E14 Aberfeldy Estate)
Stakeholders that influence schools		
Tower Hamlets Healthy Lives team	*Head*	*Provider:* Healthy Schools programme (across the borough)
School Food Matters	*Founder and Chief Executive*	*Provider:* Food education programmes in schools (operate across England and with a number of (self-selected) schools in the borough)
Mytiime Active	*Programme co-ordinator / nutritionist*	*Provider:* Free healthy lives services in children's centres and schools (across the borough)
Stakeholders that have direct access to target audience		
Voluntary Sector C&YP Forum	*Development Worker*	*Channel:* Access to C&YP in community settings (across the borough)
Manorfield Primary	*Head-teacher*	*Channel:* Access to primary school children
Experts		
TH Food Partnership / Sugar Smart	*TH Food Partnership Co-ordinator*	*Provider:* Provide advice and guidance to influencers and target audience (across the borough)

Organisation	Role of participant in organisation	Role in healthy weight management across Tower Hamlets
Public health lead on TH C&YP strategy	*Retired former Associate Director in Public Health*	*Decision-maker*
TH Community Dietitian GP Care Group	*Public Health dietitian*	*Provider:* All residents (across the borough)

2.2 Summary findings

An overview of the findings from this insight is summarised below.

Attitudes towards healthy weights

- There was widespread recognition that childhood obesity was a serious problem for Tower Hamlets and that the problem was worse here than in other London boroughs. Many stakeholders also noted that being underweight was also an increasing problem.

- Stakeholders recognised that both deprivation and ethnicity (particularly within the Bangladeshi community and among Bangladeshi boys in particular) were determinants of childhood obesity in the borough. However, there was acknowledgement that, increasingly, deprivation had a bigger impact on obesity among families and that more should be done to support families experiencing poverty.

- Other local factors that impacted on childhood obesity included:
    - The prevalence of 'chicken shops' and the difficulty in finding healthy foods
    - Lack of green and open spaces for families to exercise and the lack of affordable places for children and young people to do physical activity
    - Entrenched cultural practices around food and feeding habits within the Bangladeshi community that are difficult to change

Equipping influencers

- Parents and schools were identified as the most important influencers on childhood weight and a number of suggestions were made on how they should be equipped or educated to support children in achieving a healthy weight. This included:
    - Providing accessible and affordable health promotion services to families in a non-judgemental way
    - Understanding some of the cultural differences and barriers within the Bangladeshi community and encouraging "food providers" (generally mothers or grandmothers) to make small changes that could make a big impact (eg reducing salt; not using ghee, etc)
    - Educating parents in their own wellbeing so that they can role model healthy behaviours

  - Encourage shared 'healthy' activities within families from cooking together to exercising together
  - Equip schools to provide healthy lunch options or snacks at breaks
  - Educate teachers, dinner ladies and other school staff on how to promote healthy behaviours
  - Focus on prevention at early years stages so that parents and children can develop healthy habits at an early age

- Parents were viewed as the main barriers and enablers to achieving and maintaining healthy weight in children so a number of suggestions were made to equip or educate parents with the skills and knowledge to overcome these including:
  - Educating parents to budget for healthy food and /or teach them how to cook cheap and healthy meals
  - Promoting strong parenting skills to help parents resist 'pester power'
  - Change cultural habits such as 'rewarding through treats'

Working in partnership

- It was recognised that there were a lot of agencies across the health, educational and voluntary sectors that worked to support families in trying to achieve and maintain a healthy childhood weight. It was felt that they could probably work better together to share some of their (limited) resources, information and expertise and to make sure that this information was up to date. Having a database or dedicated website with service provider details – across all sectors- was suggested by a number of stakeholders.

- Some stakeholders felt they got asked to intervene too late – there should be more prevention activities. Many felt that there were fewer prevention activities now than in previous years because of public sector cuts

- Some felt that the Council had a key enabling role to play to promote partnership working and equip partners (eg schools, healthcare professionals, voluntary sector) and should show more visible leadership – if this is an important priority for the Council then they need to make difficult (financial) decisions to support it.

3. Headline findings from children and young people insight

3.1 Introduction

Six discussion groups were held with 49 children and young people aged 10-11 and 14-15 years old, these consisted of the following:

- 8 boys aged 14-15 in the Bethnal Green area
- 14 Bangladeshi boys aged 14-15 in the Bethnal Green area
- 9 girls aged 14-15 in the Bethnal Green area

- 6 boys aged 10-11 in the Poplar area
- 6 girls aged 10-11 in the Poplar area
- 6 Bangladeshi boys aged 10-11 in the Poplar area

3.2 Summary findings

An overview of the findings from this insight is summarised below.

Attitudes towards healthy weights

- Whilst many children had an understanding of the issue of obesity, it still felt like a very abstract concept for most, or at least one that would affect others and not them.
- Some, in particular those of Bangladeshi background, were aware of the risks, such as diabetes, which may only present themselves in adulthood and younger age groups, in particular boys, felt that they would begin to grow out of any additional weight they had ('puppy fat').
- Others were as concerned about the issue of being underweight, particularly amongst older girls. A finding reflected by both stakeholders and parents with teenage daughters.
- There is a key difference with regards to the motivation of being of healthy weight between girls and boys: where boys are more likely to be interested in body image and girls describe wanting to feel better and healthier.

Healthy weights behaviour

- Diet and eating habits are heavily influenced by parents at a very early age. This is both in the type of food offered and the way it is cooked but also the timing and structure of meals. Many Bangladeshi children in particular are being offered four meals a day (breakfast, lunch at school, after school meal and a later evening meal) and this is a habit that continues through later childhood years.
- The transition from primary school to secondary school is a key point in a child's life where the balance of control shifts from parent to child in how they spend their time and, linked to this, in the food they eat. Many parents and children reported this age as being the time when they allowed children to visit PFCs on their own with friends, and this is particularly the case for boys, as well as fewer children reporting eating breakfast as they get older.
- Boys are much more likely to pursue exercise as a route to maintaining a healthy weight, whereas girls favour eating healthily. This is broadly in line with the findings from earlier adult healthy weight insight in Tower Hamlets.

Barriers and enablers

- Strong correlation between cooking confidence and ability to make healthy compromises. Young girls were most likely to help their parents in the preparation of meals - this had given them a more pragmatic knowledge of what goes into food and where they could make compromises to prepare healthier versions of food that they're used to.

- Low uptake of school dinners has a knock-on effect, contributing to after-school meals of PFC and rice and curry. However, dislike of school dinners is only one cause, as trust is developed in parents' food from a young age, and PFC shops provide a warm dry social space for connection, especially for boys.
- Girls are far more severely disadvantaged by opportunities for physical activity. Seeking their preferred sports - dancing, swimming - requires sports centres, but they are often denied entrance without adult supervision. For less formal exercise, girls are rarely allowed to be active without the company of an older family member.
- Among boys, cheap and improvised physical activities like football and basketball are still an important part of the social life of boys, although gyms are becoming a preferable social space, seemingly due to the increased emphasis on strength-building and body image.

Support services

- Health professionals were identified as the preferred communicator of any personal health diagnosis, as teachers, parents and friends were perceived as too personally involved and could easily cause offence.

4. Headline findings from parent insight

4.1 Introduction

It is widely recognised that parents have a critical role to play in identifying, achieving and maintaining healthy weights in children. As part of this research, depth interviews were carried out with 24 parents to explore their attitudes towards healthy weights in children. This consisted of 16 mothers and 8 fathers from British Bengali, Bangladeshi, White British and Mixed Race backgrounds.

4.2 Summary findings

Attitudes towards healthy weights

- Whilst many parents described their family's diet as fairly healthy, most of these were also aware that improvements could be made to the way they eat and what they eat. For example, introducing vegetables, reducing oil in cooking and swapping to semi-skimmed milk.
- Parents are largely aware of the future risks of their child/ren being an unhealthy weight, with most mentioning that healthy weight in childhood leads to prevention of associated risks and conditions later in life. A smaller number mentioned the immediate impact on a child's health, such as difficulties breathing and taking part in every day activities.
- Describing what a healthy weight looked like seemed to be challenging for some parents, with some stating that it depended on the child and their age. Many do not

think their child has a weight problem until there is a physical problem, for example breathing difficulties).

Attitudes to diet and eating habits

- As described in the key findings from children and young people, diet and eating habits are strongly influenced by parents especially for younger children. This is both in the type of food offered and the way it is cooked but also the timing and structure of meals.
- There are some key differences around eating habits within the Bangladeshi community. Children will tend to have four (and sometimes five meals) a day – breakfast, school lunch, a 4pm 'lunch' of rice and curry, and an evening meal (often rice-based). This is the cultural norm and is seen as being a healthy / balanced approach. Parents of secondary school children acknowledge that sometimes their child may have been to the chicken shop before their "late lunch" but they are still expected to eat their planned meals at home.
- At home, mothers, or grandmothers in extended families, tend to take control of decisions relating to the food that is cooked and eaten by everyone in the family. Some parents described sharing responsibility for food shopping, which could be a route to engaging fathers in making small changes to diet and eating habits at home.
- As children move through primary school it appears that the level of pushback, or 'pester power', increases and the biggest changes in control of what is eaten on a daily basis follows the transition to secondary school. This is evident in the changes to breakfast habits, snacks that are consumed and the ability, particularly of Bangladeshi boys, to attend fast food outlets alone with their friends.
- This transition of control also appears to influence the diet of younger siblings in the household, with many following the lead of older siblings in either refusing to eat certain foods, following unhealthy breakfast patterns and expectations to eat outside of home regularly.
- Parents of younger children tend to have a more favourable view of school dinners, with many describing them as an opportunity to have fruit and vegetables and easier than providing a packed lunch. However, parents feel that choice should be offered as part of the school meal.

Attitudes to physical activity

- Most parents rely on the school environment to provide physical activity for their child and walking to and from school appears to be a core part of the physical activity for children of all ages.
- Parents will take responsibility for making sure that their children go for walks, go to the park or undertake light exercise (eg through playing outside) when they are younger. This is often part of family or weekend time and, as such, control over this time is lost as children get older.
- Parents also control 'screen time' of younger children although they feel they start to lose this control when their child starts secondary school. Some parents use 'extra screen time' as a reward mechanism (and this is seen as being a healthier alternative than food-based treats).

Responsibility and influences

- Parents recognise that they have responsibility for ensuring their child's healthy weight although a number do not think this is an issue to worry about.
- Many parents see the responsibility for being physically active as sitting firmly with schools. However, parents who are health conscious for themselves tend to do more physical activity, for example swimming or cycling with their children. This tends to be seen with younger parents across all ethnicities.
- Parents also recognise that their children have agency which they, as parents, cannot often control in both what they eat ("My child will refuse to eat fruit or vegetables") and who they would listen to with regards to healthy weight ("My child won't listen to the GP").
- Some of the barriers to ensuring healthy weight for their children identified by parents include time and money.

Sources of advice and support around healthy weights

- Many parents do not think their child has a weight problem until there is a physical problem, for example breathing difficulties. Many recognise that they do not spend a lot of time thinking about healthy weight and would not necessarily be able to tell if there was a problem. There were mixed views about the role of teachers but most say they would rely on a trusted professional (GP or teacher) to let them know.
- Many parents say they would turn to their GP to seek advice if they thought their child had a weight problem, and some had already done so.