APPENDIX 3

Parental employment and child health and wellbeing

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Executive summary

The NCB Research Centre was commissioned by the UCL Institute of Child Health to carry out a qualitative study exploring the links between parental employment and child health[1]. The study is part of a larger investigation on the topic being carried out by the Public Health Research Consortium (PHRC). The two key aims of the study were to:

- explore the mechanisms through which relationships between parental employment and child health arise
- draw out how policy and practice might use this information to promote child health.

The data for the study were collected by conducting in-depth interviews with parents (mainly mothers) between October 2012 and May 2013. The study focused on low income families living in London and on parenting children up to the age of seven.

The study explored:

- How mothers conceptualise child health, their efforts to safeguard and promote their children's health and who helps them in this area.
- How becoming a mother affected the relationship to paid employment.
- Mothers' perceptions of how their decisions in relation to paid employment (i.e. whether to work or not, and the type of work) affected their children's health.
- What mothers believed could be done to help parents to keep their children healthy.

Parenting and child health

The study found that mothers conceptualised health broadly: children's emotional wellbeing was as prominent in their thinking as was physical health. Alongside happiness, key issues which dominated discussion were diet, exercise, developmental progress, confidence and social skills.

Minor illness in childhood was considered normal. However, some mothers had been sensitised by episodes of serious ill-health, particularly those affecting babies, and felt they were more anxious about their children as a result. In general, health problems were evaluated in terms of the extent to which they caused distress to children, interfered with the child's daily life, and were understood or under control. Current challenges for those we spoke to included

[1] The PHRC is funded by the Department of Health and brings together senior researchers from 11 UK institutions in a new integrated programme of research, with the aim of strengthening the evidence base for interventions to improve health, with a strong emphasis on tackling socioeconomic inequalities in health. For more information see: http://phrc.lshtm.ac.uk/

fussy eating, speech and language delay, and sleep problems. In some cases, children were receiving extra help at nursery or school, though not all of them had Statements of Special Educational Needs.

Mothers were generally confident that they were doing what they could to prevent and manage ill-health, within the family, with support from professionals when required.

Respondents were familiar with key public health messages, particularly around healthy eating, and to some extent, physical activity. They described making efforts to ensure their children achieved a balanced diet and lived an active life, though the costs of healthy food and taking part in certain physical activities were highlighted as barriers for some.

'Being there' for children was a recurrent theme when talking about children's health. Mothers emphasised the contribution made by the routine care involved in preparing meals, ensuring children got enough sleep, or benefitted from a safe home environment. They also highlighted the importance of quality time – not just to enable bonding with babies, but in providing security for older children. Time with children was also used to instil healthy habits and support their learning and development.

In our mother-dominated sample, fathers' roles tended to be portrayed as supportive rather than equal, particularly in terms of practical day-to-day oversight of children's health and wellbeing. 'Motherly instincts' were highlighted as helping with sometimes unfamiliar parenting tasks, and even 'nervous' mothers recognised themselves as experts in relation to their own children's health and wellbeing. The most common external source of advice and support were women's mothers, who were credited with teaching 'proper' cooking, and guiding mothers through essential health-related tasks, such as bathing, weaning and judging when symptoms required professional help.

While some mothers felt they had already gained relevant experience through work or training, (e.g. in social care), other less confident mothers had benefited from health-related courses and advice provided by Children's Centres. Children's Centres were also one place where mothers met and exchanged tips and support with other parents, something which was seen as invaluable in helping them to look after their child's health – and their own.

Good nurseries, childminders and schools were also reported to play a positive part in supporting children's health. In the main, this involved providing healthy menus, opportunities for exercise, supporting children's learning and their social skills, though provision of information to parents was also appreciated.

The extent to which respondents felt supported by health services varied, partly as a function of the need they had experienced, and partly in terms of the quality of service received. Health visitors' sensitivity and the trust they were able to inspire seemed to be an important factor, alongside any practical assistance they were able to offer. Although some described helpful, accommodating GPs, others recalled with considerable frustration having difficulty obtaining appointments or accessing specialist treatment.

How mothers reconcile their roles as parents and workers

Mothers' decisions about paid work were strongly influenced by whether and under what circumstances they believed a 'good mother' could share the parenting role and delegate parenting responsibilities to others. Three themes emerged from respondents' narratives of how being a 'good mother' affected decisions about (paid and voluntary) work or study:

- children's age and stage of development
- the acceptability of different carers
- the kind of parenting tasks and aspects of the parenting role they were prepared to delegate or share with others.

Predictably, views on the extent to which parenting responsibilities could be shared and parenting tasks delegated varied with children's ages. There was a consensus that under the age of one full-time parental care was best for children, even if not all mothers in the study were able to do this. Past the age of one, mothers' narrative was more likely to be dominated by the perceived acceptability of different carers and how much time (and at what times of the day) it was acceptable for a 'good mother' to be away from the children. The 'free time' that mothers had when children started pre-school and school was a clear trigger for starting to think about work options. While having free time seemed to be a key trigger, there was also a more subtle acceptance of letting go of the children and the fact that it was the 'norm' for others to look after and teach children once they reach the age of three and started pre-school.

Mothers' work decisions were also strongly influenced by the availability of what they considered to be suitable childcare providers.

- Fathers were typically considered as good as mothers at caring for the children, apart from a few exceptions when they had been violent or very disengaged. Some families had 'shift parenting' arrangements, whereby one parent worked while the other looked after the children, and vice versa. For some mothers these were the only acceptable caring arrangements, at least while children were small. An additional advantage of fathers looking after the children was that this reduced or even eliminated the high costs associated with using nurseries and childminders. There were fathers in the sample who did very little or no childcare at all, thus limiting mothers' work options, but this was due to pragmatic reasons that led couples to decide that fathers had the role of breadwinner and this limited their involvement in caring for the children, and not because they were not seen as suitable carers.
- Typically care provided by the family (mainly grandparents) was seen as the 'next best thing' to parental care and again seen by some mothers as the only acceptable option, particularly for small children. Family members were implicitly trusted, were seen as loving children as much as parents did, and it was seen as desirable for grandparents to form a special bond with the children. As with fathers, another advantage of family care was that it was typically free. Mothers' accounts of (the potential for) relying on family care were linked to practical constraints, such as whether grandparents lived sufficiently close; their limited availability as they were

working or had other caring commitments; or the fact that they were too old or unfit to help.

- Views on formal childcare providers varied considerably with the greatest differences between the overwhelmingly positive views mothers had about school based nursery classes, compared with the more mixed views reported about day nurseries and childminders. Nursery classes were seen as providing early education/pre-school to children when they start formal education at the age of three and their suitability was typically not questioned. On the other hand, day nurseries and childminders were seen by some as being largely used by and for the benefits of working parents, and as not being very beneficial or even potentially damaging for (young) children. Other respondents believed there were 'good' and 'bad' childcare settings and the criteria they used to judge their suitability were clearly linked to children's physical and emotional health (e.g. quality of interaction between children and staff, hygiene and cleanliness, how children development was supported, the food provided).

We found that mothers who decided to use non-parental care to take up paid employment believed that the task of keeping children healthy could be shared with others, although how they did this was mediated by a child's age and the availability of 'acceptable' care providers. The importance of a secure bond to underpin the healthy emotional development of young children was emphasised by those relying on carers with whom young children could establish this bond, typically fathers and grandparents, less commonly childminders. Mothers typically ensured children were fed healthy food, did sufficient exercise and were taught healthy routines by choosing childcare settings that shared mothers' views and practice in relation to these. A key benefit of maternal employment was seen as the opportunity for children to socialise with other adults and their peers.

The study found that the conceptualisation of a 'good mother' was mediated by how paid work was viewed in relation to mothers' self-esteem, emotional wellbeing and financial independence (from partner and/or the state). As has been noted elsewhere (Bell et al 2005), mothers with a strong orientation towards work reported greater conflicts in balancing their child rearing responsibility with paid employment. Reported difficulties related to the cost and availability of childcare; access to family friendly employment; the sacrifices mothers had to make (e.g. in terms of pay and type of work) to get a job that fitted with their childcare arrangements; and, the compromises they had to make in relation to parenting practice (e.g. missing key developmental stages). However, even among mothers whose narratives seemed to equate a 'good mother' with being a 'stay-at-home' mother (at least while children are young), pragmatic factors, such as the cost and availability of childcare, seemed to have played a role in shaping their views about paid employment. As these were all low income families, living in London where childcare costs are the highest in the country, childcare facilities are in short supply and family care is less likely to be available (La Valle et al 2008), pragmatic factors seemed to have reinforced views that it is best for mothers to stay at home while children are small.

It should be noted that when talking about their role as parents and as workers, and how their decisions about paid employment affect their children, mothers

may have wanted to present themselves on their best, rather than worst days. Although they were willing to talk about the challenges of both work and parenthood and occasions when things had not gone well, they felt that over time they had made choices that benefitted their children. It may be that those who felt they had not managed to balance these roles were less willing, or possibly less able while juggling multiple tasks, to speak to us. We can only say that, in their interviews, mothers were positive about their roles as both mothers and (where appropriate) workers.

How decisions about work affect children's health

Mothers' narratives about the effects of their work versus non-work decisions and resulting caring arrangements centred around 'doing the right thing' for the children. While some mothers talked about the experiences of different caring and work arrangements (e.g. being stressful, being good for the children, fitting with their child's world), they less commonly mentioned examples of how their decisions may have affected children's outcomes in the long term, particularly in relation to physical health and development. Furthermore it seems that mothers developed strategies that compensated for any potential problems associated with certain decisions (e.g. finding cheap but nutritious food and free activities if they were struggling financially because they were not earning any money; giving children a packed lunch if they were not happy with the food provided by the nursery).

Mothers saw more explicit links between parental employment and children's emotional wellbeing, compared to their physical health, though the experience of the parents of children with disabilities or long term health problems was rather different. Indeed, for mothers of disabled children, providing care, liaising with services, and attending hospital appointments had limited the work they could do, or even ruled out paid employment altogether.

Across the sample, it was largely felt that paid work was important for mothers' mental health and wellbeing, which impacted strongly on that of their children. Furthermore, mothers' perceptions of what was good for children's development were very broad and included, for example, the need to instil in children a work ethic and a desire to succeed in life. Having working parents (and not relying on benefits) was seen as key to transmitting these values to children. However, the benefits of working in relation to maternal and children's wellbeing partly depended on the ability to find the right balance between work and family life, which mainly meant finding a job that allowed parents to have enough time and energy to fulfil their parenting role, and to a lesser extent not having to sacrifice too much in terms of pay and type of work in order to secure a job that could 'fit with the children'.

Keeping children healthy: what support parents want

The study found that being a 'good mother' is part of mothers' identity with keeping children healthy considered a key responsibility of a 'good mother'. While mothers varied considerably in terms of attitudes to and decision about paid employment, they were all influenced by the belief that they played a key role in ensuring their children's health and wellbeing, and their caring (and working) arrangements were strongly influenced by what mothers believed

children would be able to benefit from, cope with or at the very least not be damaged by.

The study showed that the extent to which mothers and children (and the family as a whole) could benefit from maternal employment depended on securing what mothers considered to be suitable working and caring arrangements. However, judging from mothers' accounts, there is much to be improved in terms of employment and childcare policies, including: giving families adequate financial support to enable a parent to stay at home in a child's first year of life; ensuring all parents have access to flexible working arrangements and are able to take time off work when children are ill; and, better and cheaper childcare facilities. Much of what mothers suggested in relation to family friendly working arrangements is already covered by employment legislation and EU regulations but mothers did not seem to benefit from these entitlements. This could partly reflect the fact that our sample included many parents in a weak labour market position (e.g. with low qualifications, low skill levels) and, as noted elsewhere (La Valle et al 2002; La Valle et al, 2008), parents' ability to secure family friendly working arrangements can largely depend on having a strong labour market position. Consequently some mothers in the study seemed to be faced with the option of: a) working arrangements that could result in high levels of stress for mothers and their children; or b) not working or accepting a job which 'fitted with the children' but was at a lower level and less well paid than those mothers could have secured with their qualifications and experience.

While the findings on how parents in paid employment can be supported to keep children healthy have implications mainly for employment policies and childcare support families need, parents' accounts suggested that changes in other areas could support families. First, Children's Centres, which were reported as playing an important role in helping parents to support children's health, might be made more accessible to working parents (e.g. open at the weekend) and to families with children over the age of five. Second, there seems to be the potential for nurseries and childminders to get *more* involved in public health promotion campaigns. While the Early Years Foundation stage requires settings to promote good health[2], our research suggests that there may be scope for some childcare providers to do more in relation to heath promotion, as their role in this respect did not feature very prominently in mothers' accounts. Strengthening the role of childcare settings in relation to health promotion could be particularly beneficial at a time when free early education for disadvantaged two year olds is being considerably expanded[3].

[2] http://media.education.gov.uk/assets/files/pdf/eyfs%20statutory%20framework%20march%202012.pdf

[3] In September 2013 20 per cent of the most disadvantaged two year olds will be entitled to a part-time childcare place, and this will be extended to the 40 per cent most disadvantaged two year olds in September 2014.

1. Introduction

The NCB Research Centre was commissioned by the UCL Institute of Child Health to carry out a qualitative study exploring the links between parental employment and child health[4]. The two key aims of the study were to:

- explore the mechanisms through which relationships between parental employment and child health arise
- draw out how policy and practice might use this information to promote child health.

One of the mechanisms through which relationships between parental employment and child health are created and maintained (or undermined) is through the explanations parents give about their decision-making. We therefore explored parental narratives on employment and child health, in particular the ways in which parents justify to themselves, to their children and to others the decisions they take about employment in relation to their children's health.

In the rest of the chapter we present a summary of some elements of previous research related to this work and then outline the methodology used for the study.

1.1 Background

Debates relating to paid employment, child health and wellbeing and parenthood, in particular motherhood have a long history. 'The family' is a longstanding focus for historical (Badinter 1980), economic (Zelizer 1994) and sociological study (Graham 1984; Gittins 1985), and a source of political and journalistic rhetoric including 'fly on the wall' TV depictions of family lives.

The second wave feminist movement in the 1970s influenced, and was influenced by scholarly production, particularly in the social sciences (Barker and Allen 1976a; 1976b). This was accompanied by a narrower but important strand of work on fathers (e.g. Bell et al 1983) and more recently, grandparents (Clarke and Roberts 2002). Although there has been a burgeoning literature on children's agency as well as children as recipients of the decisions of others, with some important exceptions, e.g. Madge and Willmott 2007; Lovell 2001, there has been relatively little work on the views of children on parenting, including their views on parental employment and the ways in which they perceive it affects them. Children's main concerns reported in the literature

[4] The PHRC is funded by the Department of Health and brings together senior researchers from 11 UK institutions in a new integrated programme of research, with the aim of strengthening the evidence base for interventions to improve health, with a strong emphasis on tackling socioeconomic inequalities in health. For more information see: http://phrc.lshtm.ac.uk/

have been having access to loving parents, and parental time; they were concerned if they felt that their parents were stressed or working too hard.

While we came to this study aware that mothers are not the sole providers of parental care, it was mainly mothers who took up our invitation to be interviewed, perhaps reflecting the fact that by and large they retain the main responsibility for child rearing in most cases. The British Social Attitudes survey, which has charted a decline over the last three decades in traditional views about gender roles (Crompton and Lyonette 2008), has also found that the majority of day-to-day responsibility for children lies with mothers. Catherine Hakim (Hakim 2000) argues that this is a choice (and there is evidence in other fields that choice supports health and wellbeing), while Macrae (2003) although finding support for Hakim's argument that employment is core for only a minority of women, found little evidence that *preferences* distinguish the minority from the majority. She argues that women may have similar preferences but differing capacities for overcoming constraints. What does seem to have changed is the availability of information on childcare choices – something lacking when Brannen and Moss (1988) wrote on employment and childcare, with one mother complaining that the health visitor was unable to provide her with relevant advice.

In the late 1970s, the 1915 *Letters from working women on maternity* (Llewellyn Davies 1978) and the 1931 accounts of *Life as we have known it* were re-published. In both cases, the accounts were collected by the Women's Co-operative Guild. As Anna Davin points out in her introduction to *Life as we have known it*, (Llewellyn Davies 1977) our understanding of history is largely based on archives and is information collected by outsiders and coloured by their assumptions and beliefs. Then as now, even where there is direct evidence from those living in poverty, the questions tend to be defined by the interests of the more powerful. The original editor, Margaret Llewellyn Davies, describes how the Women's Guild supported the establishment of school clinics, they worked for the inclusion of maternity benefit in the Insurance Act, and secured maternity benefit as the property of the wife. Virginia Woolf, who wrote the preface put her finger on the difficulty of being an outsider looking in. In one of the letters typical of many, Mrs Wrigley describes the way that mothers in poverty protect and promote the health of their children: '*We did our best for our children. I have gone without my dinner for their sakes. Just a cup of tea and bread and butter*'.

Mothers – still the major carers for children - tend to attract adverse press and sometimes professional comment in relation to the health and general wellbeing of children. In the early 1940s, following the publication of *Birth, Poverty and Wealth* (Titmuss 1943), newspapers reported *'Babies beware of poor parents.*' Titmuss had suggested that children's deaths were related to the occupations of their fathers, and that the gap between the life chances of working class and middle class infants was increasing. Some found his conclusions unpalatable. A reviewer for the *Evening Citizen* suggested that the book ignored *'the criminal ignorance and neglect of many mothers*' inclined to give their babies *'fish and chips, pickles, strong tea, lollipops, chocolate biscuits and toffee apples'* (Oakley 1996). A review of the first version of the British Medical Association's *Growing up in Britain* suggested a different answer to the question. '*Why do children from poor families consume such a lot of sweets, fizzy drinks, milk and white*

bread? Penny for penny, a chocolate bar provides more calories than carrots, even from a market stall' (BMA 1999; Thurlbek 2000*).*

Debates relating to motherhood and paid employment certainly pre-date Bowlby's influential *Child Care and the Growth of Love* (1953). Building on a World Health Organisation (WHO) report on the post war settlement of children (Bowlby 1951) Bowlby's work had significant political and policy influence. His observation that '*the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment'* was a powerful one, used to support arguments discouraging mothers from taking paid employment in the post war economy when servicemen were returning to civilian life, though as Wootton (1962) and others (Comer n.d.) have pointed out, the empirical basis for Bowlby's work was children who were deprived of a good deal more than their mother's time. Wootton wrote with typical acerbity that the Lancet correspondence on Bowlby's work was unhelpful and that the work '*…is to be valued chiefly for its incidental exposure of the prevalence of deplorable patterns of institutionalized upbringing and of the crass indifference of certain hospitals to childhood sensitivities*'.

A groundbreaking piece of empirical work was the 1980 Women and Employment survey (Martin and Roberts 1984) exploring the place of paid work in women's lives and the extent to which a paid job was important for women. Reflecting back over twenty years later, the authors report that in the four years between the survey and its publication, policy priorities had changed, with a greater emphasis on unemployed youth than women in the labour market.

Studies carried out when the employment situation was somewhat different to that experienced now include Blaxter and Patterson's (1982) study of *Mothers and Daughters*, commissioned as part of the Department of Health and Social Services (DHSS) and the Social Science Research Council (SSRC) Studies in Deprivation and Disadvantage series supported by the Joint Working Party on Transmitted Deprivation.

This early mixed methods study which consisted of 58 three generation families included careful work on the 'triggers' which for mothers and others indicated that something was not quite as it should be (though sometimes falling short of illness). Blaxter and Patterson describe these in terms of the way in which they were experienced by the mother:

- heard: including 'girning' 'whining' or 'sobbing' and in terms of symptoms such as coughing 'croupy' 'sore' or 'bark'
- felt: 'cold to touch' 'fevered'
- smell: 'bad breath'
- seen: including 'pale' 'white', 'weepy eyes' 'limpness' 'stary'
- behaviour: 'She holds her head on one side in a funny way'

They write:

> *'Most of the women would claim some privileged knowledge of the child's physical and emotional state, because of their special relationship; as they said 'a mother knows' 'you know when your child's not right.'* (pp.50-51)

Hilary Graham and others have pointed out that the 'bad mothers' message derives a lot of its power because:

- It draws on a centuries-long discourse that mothers are either madonnas or villains at the root of poverty and poor children's poor outcomes. 'I blame the mothers' statements can stand alone, as everyone knows the 'truth' of it.
- There is a slippage between relative and absolute risk (what starts off as evidence that children of poorer mothers are at greater risk when in fact relatively few mothers, poor or otherwise, engage in 'bad' mothering ends up being an explanation for why there are gradients in children's cognitive/emotional/or social development).
- The evidence on parenting and child outcomes draws disproportionately on quantitative studies, distancing policymakers and others from the nature of disadvantage and its impacts on the lives of mothers and their children.

Graham's (1984) work on women and smoking and Roberts et al (1996) on safety as a social value demonstrate mothers trading off one risk against another. A cigarette could give a mum a moment of peace and sanity *'I'll be with you when I've finished this fag'* or a mother might trade off leaving children alone for a few minutes if she lives in a tenement four floors up, and she needs to hang the washing out on the green. *'Do I put the wains under my arm and go down the concrete stair, or do I leave them here*?'

In a context where paid employment for mothers was becoming more common, much of the next generation of studies (e.g. Skinner 2003; Bell and La Valle 2003) refer to the complex management tasks of co-ordinating care for children, and the different pressures on mothers choosing self-employment as an option. Fiona Williams *Rethinking Families* (Williams 2004) brought together findings from the ESRC funded CAVA (Care Values and the Future of Welfare)programme. She describes Simon Duncan's work in this programme exploring how mothers understand 'the proper thing to do' in relation to taking up paid work and caring for children. He looks at the processes and meanings which attach to and shape the decisions women make when faced with this issue. Williams writes on the basis of empirical findings: '*being a mother is not something you do only when you are with your children. Nor are mothers transformed into workers only when in employment; rather* '*they* [children] *sort of occupy most of your psyche all the time.*' A conclusion of this group was that being a good mother is central. Money matters but being 'a good mother' matters more.

The social science work over the last decades, despite a changing policy context, suggests that there is some traction in our hypothesis that one of the mechanisms through which relationships between parental employment and child health are created and maintained (or undermined) is through the stories parents tell themselves and others about their decision-making in relation to employment. Eliciting parental (largely maternal) narratives on employment and child *ill health*, in particular the ways in which parents justify to themselves, to their children and to others the decisions they take about employment in relation to their children's health, may be particularly interesting in a context where employment opportunities are reducing but employment is seen as the only way out of poverty.

1.2 Methodology

The data for the study was collected by conducting in-depth interviews with parents (mainly mothers) between October 2012 and May 2013. The study is part of a larger research programme which includes quantitative analysis of children from the Millennium Cohort Study (MCS) from infancy to age seven, and therefore this study has focused on parenting children within this age range. The study focused on low income families living in London. While this focus was partly dictated by resource constraints, it has allowed us to explore a key group of interest in terms of health and employment policies i.e. low income families. It has also allowed us to explore parental employment decisions in an area of the country where families face greatest difficulties in terms of support with childcare, as childcare costs are the highest in the country; childcare services are over-subscribed; and, support from the extended family is less likely to be available (La Valle et al 2008).

The study was also informed by two NCB groups: the Families Research Advisory Group and the Young Researchers Advisory Group[5].The former was involved at the design stage; the group helped to identify strategies for talking to parents about the links between child health and employment, and for recruiting parents. The young people were involved in a later stage of the study and commented on what they saw as important health issues for children and young people, and how these related to parental employment.

In this section we outline the sample composition, the recruitment strategy, the fieldwork and analysis procedures. The research design and procedures were approved by the UCL ethics committee (Reference 2853/001).

1.2.1 The sample

Our sample included 27 parents (25 mothers and two fathers) from 26 low income families (i.e. with an annual household income below £25,000, in most cases below £22,000), living in London. The study focused on families with children up to the age of seven[6] and all respondents had a child in this age group. Some also had older children, but in the interviews we focused mainly on views and experiences of parenting for children up to the age of seven.

Purposive sampling was used to select respondents to ensure the sample included the range and diversity of the dimensions likely to affect parents' experiences, behaviour and attitudes, and to include key sub-groups of interest.

As set out in Appendix A.3, the sample included:

- Five families[7] with pre-school age children only, 14 with school age children only, and seven with both pre-school and school age children.
- Families of different sizes including nine with one child, eight with two children and nine with three or more children.

[5] For more information about these groups see http://www.ncb.org.uk/research
[6] In one case, the relevant child had just turned eight by the time of the interview.
[7] A father and a mother from the same family were interviewed, so when counting families (rather than respondents) the total sample size is 26.

- At time of the interview, families had a range of care arrangements: 12 were using formal childcare (e.g. a nursery or childminder) and 12 had regular informal childcare (provided by family and friends). Eleven families were using neither, although in some cases, they had used formal and/or informal childcare in the past.
- Five families included a disabled child or a child with mild special educational needs (SEN).
- Eighteen respondents were white, while nine were from ethnic minority groups (i.e. from Black British/ Black African, Asian and Mixed backgrounds).
- At the time of the interview 11 respondents were lone parents, while 16 were from a dual parent family. Among the former, seven mothers had lived with the children's father in the past and therefore were able to talk about experiences of parenting both while living as a lone parent and in a dual parent family.
- At the time of the interview six lone parents were in paid employment and five were not. In six dual parent families both parents were in paid employment, while in nine only one parent was in paid employment. There were no dual parent families where neither parent was in paid employment. Many families had experienced different working patterns in the past.
- At the time of the interview 11 respondents were working part-time and five full-time. Among the 11 respondents who were not working when interviewed, five had previously been in paid employment after having children, and all but one had worked *before* having children.

As the sample included largely mothers, who mainly responded to our invitation to take part in the study, our findings represent their perspectives and experiences. We cannot know whether a sample of fathers would have expressed similar or different views, so we have made a pragmatic decision throughout to refer to mothers when we are reporting the dominant themes, drawing out the views of the two fathers we spoke to where appropriate.

1.2.2 Recruiting parents

Parents were recruited through:

- Children's Centres and schools: leaflets were sent to children's centres and schools to pass on to parents, often a researcher also visited the sites to recruit parents.
- NCB networks, including the Council for Disabled children to recruit families with disabled children.
- Specialist services catering for particular groups, including Coram (low income families) and Centre404 (families with disabled children).
- A recruitment agency (Ipsos MORI) carried out door-to-door recruitment. This method was introduced in the late recruitment stage as it proved difficult to reach some parents, for example finding dual working parent families with an income below £25,000.

A screening questionnaire was administered to parents before they were recruited to ensure the sample reflected the mix of characteristics we were aiming to achieve. The recruitment questionnaire and leaflet are included in Appendix A.

In line with our standard practice, we made a payment of £20 (in the form of a voucher) to all research participants, to thank them for their contribution to the research.

1.2.3 Fieldwork and analysis

A topic guide (see Appendix B) was used for the interviews to ensure that the research questions were covered consistently, while allowing for flexible responses to individual circumstances. The content of the topic guide was informed by the NCB Families Research Advisory Group.

With respondents' permission, interviews were digitally recorded and transcribed verbatim. In the early stages of qualitative fieldwork, recordings of fieldwork were discussed within the research team to assess how the topic guide was working and to ensure fieldwork was carried out to consistent and high standards.

The data were analysed using the Framework option in NVivo, the framework that was generated to analyse the data is included in Appendix B.

1.3 Report outline

The report discusses the following topics:

- In Chapter 2, we consider ways in which parents conceptualise health and health problems; their efforts to safeguard and promote their children's health; and the attributes, experiences and services which appear to influence or support them in this area.
- In Chapter 3, we explore how becoming a mother affected respondents' relationship to paid employment. We focus on how decisions about work related to children's age and stage of development, the acceptability of different types of carers, and what kind of parenting tasks and what aspects of the parenting role mothers were prepared to delegate or share with others. The chapter also explores the influence of more pragmatic factors (e.g. cost and availability of childcare, family friendly employment); what were the choices and constraints mothers faced when considering if and how to reconcile paid employment and motherhood, and what compromises seemed more or less acceptable.
- In Chapter 4, we analyse mothers' perceptions of how their decisions in relation to paid employment (i.e. whether to work or not, and the type of work) affected their children's health.
- In Chapter 5, we conclude by considering the policy implications of the findings and report what mothers believed could be done to help parents to keep their children healthy.

2. Parenting and child health

In this chapter we consider ways in which mothers conceptualise child health and health problems; their efforts to safeguard and promote their children's health; and the attributes, experiences and services which appear to influence or support them in this area.

2.1 Conceptualising health and health problems

We begin by exploring mothers' conceptualisations of child health, considering what it means for them, and its importance. We compare factors identified by mothers in our sample with those highlighted by parents in NCB's Families Research Advisory Group and the Young Research Advisors. Subsequently, we consider their perspectives on child health problems, and how these are categorised as significant, trivial or normal.

2.1.1 Conceptualising child health

Across the sample, and throughout their interviews, respondents demonstrated broad conceptualisations of child health, referring to emotional wellbeing or happiness as well as physical health and safety. Consistently, they represented children's health and wellbeing as their top priority. Some delineated different aspects of health more precisely than others, referring, for example, to physical, emotional, intellectual, social and spiritual components. Regardless of labels, however, the same issues tended to arise:

- diet and, to a lesser extent, exercise
- happiness or contentment
- immunity or recovery from minor illness
- learning and development goals
- confidence and social skills.

Other issues were mentioned in particular cases, and each of those in Box 2.1 were highlighted as markers or attributes of healthy children.

Box 2.1. Attributes of healthy children

Physically healthy children are…	*Emotionally healthy children are…*
• Well fed, with a balanced, safe diet	• Happy/not distressed
• Not overweight or underweight	• Securely attached/bonded to parent(s)
• Fit, energetic and physically active	• Engaged or interested
• Sleeping well	• In a routine
• Growing and developing normally	• Enjoying a balanced range of activities
• Not chronically sick	• Well behaved and able to concentrate
• Able to fight off germs	• Confident, with good self-esteem
• Clean and adequately clothed	• (Increasingly) independent (not 'clingy')
• Well housed in a warm home	• Displaying good social skills
• Looked after in a safe environment	• Eager to learn/aspirational
• Living in a pollution-free area	• Given enough attention or 'quality time'
• Taught healthy habits by parent(s)	• Provided with good parental role models
• Served by good health services	• Guided morally/spiritually
• Up to date with checks/vaccinations	• Cared for by happy parents

Some mothers also highlighted links between different aspects of child health and wellbeing. For example, avoiding sugary foods and taking exercise were seen as helping children to sleep more soundly, which in turn helped them to learn. Secure relationships with mothers were considered to make children less 'clingy' and more able to cope with separation on entry to pre-school or school.

Key health preoccupations varied to some extent according to children's age and stage of development, as this mother pointed out:

> *'Obviously there's stages like when they're like six months they should be able to do this, they should be able to do that, as long as they're developing well, they've got good social skills, they look healthy... they've got a good healthy diet, lots of exercise, then that's healthy innit?'*
>
> (Lone mother, in paid employment, one child aged three)

When referring to babies, there tended to be more of an emphasis on the importance of bonds with parents – generally mothers; a secure baby was a happy baby, and a happy baby was (almost always) healthy. Although happiness was also prominent in discourse around older children, social skills and child health behaviours naturally assumed greater prominence as children spent more time out of the home, and with their peers.

Typically, parents focused on what was good for children there and then, for example, with a good diet enabling better concentration. Some also referred to reaping the benefits expected later on, for example:

- Breastfeeding was believed to boost the immune system long-term.
- Watching mum read was felt to instil a love of learning which would help children achieve in later life.
- Learning to socialise early on was seen as giving children an advantage on entry to school, making it less stressful and more enjoyable.
- Becoming accustomed to healthy eating and being active was seen as protecting children from becoming overweight:

  'It's just easier just to give them this and to give them that. But then you have got persevere, because like you can't just feed your kids crap all the time, because they'll all end up clinically obese, won't they?'

  (Lone mother, not in paid employment, two children aged five and ten)

Some interviewees – including those in couples and lone mothers – stressed the importance of relationships with both parents for children's wellbeing:

> *'OK, a healthy child to me is obviously having their parents around, so both the mum and dad. Even if you're single, fair enough, you can still have family support...but for a child to be healthy they'd have to be happy from both parents, and... expect much from both of them. So in terms of support with, like their meals and their homework and taking them out and playing in the park and stuff like that would make them really happy, and obviously in turn it would like do much to their health... So long as they've got family and love, and that's all they need, and a warm home.'*
>
> (Partnered mother, in paid employment, two children aged three and five)

Individual parents also picked out aspects of children's wellbeing which were of particular importance to them, including those rooted in religious or spiritual beliefs, or challenges they had faced in the past:

- For some parents, it was important not only that children were brought up within the moral framework provided by their religion, but that this was reinforced at school.
- Adequate housing was a particular concern for parents who were currently in hostel accommodation and/or had previously lived in damp, cramped homes. A number of parents attributed child health problems – such as asthma and bronchitis – to having lived in such poor conditions.

Not surprisingly, child health was partly understood as the absence of problems, or recovery from illness. Some initially defined health as simply 'not being ill':

> *'What's healthy? They don't get colds, don't have to take them to the doctor's basically. That's about it.'*
>
> (Partnered father, in paid employment, two children aged six and eight)

Commonly, mothers also referred to meeting, exceeding or catching up on development goals as evidence of their child being healthy. The mothers of a disabled girl defined a healthy child as one free from the type and severity of problems her daughter experienced.

> *'For me actually the child is healthy if he can do like normal human being can, does in his life, like walking, talking and proper speaking and doing the normal activities, using her brain, exploring the things, laughing, giggling. All those things. And for the eating, if he's not going to the hospital all the time, if he's fit and if the child's immune system is strong and not falling sick every month and always on antibiotics, that means the child is healthy. If he's suffering from cold and flu like once in three or four months, it's fine, it's like a normal child, it's still healthy. But if he's eating healthy, and I think… if the child is not going to the GP and hospital every week, so that means the child is healthy.'*
>
> (Partnered mother, not in paid employment, one child aged five)

Notably, like some parents we interviewed, NCB Young Research Advisors (YRAs) stressed that disabled children could be healthy, active and happy. More broadly, the range of issues set out in Box 2.1 corresponded with those raised by the YRA and by parents within the NCB Families Research Advisory Group (FRAG). One issue which was discussed by both groups and did not come through as clearly with families in our sample was the danger of excessive (academic) pressure on children. To some extent, this is likely to reflect that the YRAs were of secondary school age and that FRAG members also tended to have older children. A few of the parents we interviewed who had school age children did express concern about low standards of teaching, due to inexperienced or overstretched staff. However, concerns around achievement tended to relate to children meeting expected targets for their age, rather than worries about the effects of pressure to perform. In one exceptional case, a mother expressed mixed feelings about having sent her daughter to school when she had been very tired after an illness, simply in order to maintain her 100% attendance record.

For their part, the YRAs stressed that parents should encourage hard work, and emphasise that 'doing your best' was more important than the grades achieved. This was one way in which they felt parents could motivate their children and encourage them to believe in themselves, without instilling a fear of failure, or of disappointing their mum or dad through not being 'good enough'. Similarly, they believed it was essential for children's wellbeing for parents to teach them about what was right and wrong, healthy and harmful, but also to think for themselves, rather than be 'indoctrinated', to stretch themselves, and to learn from mistakes. While parents needed to protect them from danger or unsuitable material in the media, young people also felt they should not be 'wrapped in cotton wool' or prevented from having challenging new experiences. Setting a good example, as opposed to simply lecturing, in relation to healthy eating, exercise and work-life balance was seen as vital by the young people. They also argued that, while financial constraints might limit the range of activities parents could offer their children, discouraging materialism was a good thing for children's wellbeing, and that making the effort to provide stimulation and support was what mattered:

> *'Spend time with them.... watch something with them, make something with them – if you can't afford to take your child somewhere, you shouldn't just say "oh well, too bad", you should try to think of something or they'll think they're being given up on, or abandoned.'*
>
> (Young Research Advisor)

Repeatedly, the YRAs emphasised secure relationships and quality time with parents as key to children's emotional health, and as affecting their confidence and ability to succeed in other areas.

> *'Some parents can be quite obsessed with work... Like they might push their child away and say "oh go and do this, I'm busy, I don't want to talk to you at the moment" – and that's going to hurt a child. So at school they might feel lonely and feel they've no-one to comfort them, and that's going to affect their school life, social life and friends. So you need to be there for them because their relationship with their parents is going to affect a whole lot of other things as well.'*
>
> (Young Research Advisor)

2.1.2 Perspectives on child health problems

As noted in the previous section, experiences of child illness informed mothers' perspectives on health. There was a broad consensus that minor illness was normal and not something to worry about unduly. A number of children had experienced more serious or persistent health problems, however, and in some cases this was associated with greater parental anxiety about their wellbeing. Mothers' efforts to address health problems are considered later in this chapter; here we focus more on the range of experiences, and highlight some of the factors which may play a part in shaping mothers' behaviour and beliefs.

Box 2.2 below illustrates the range of past and ongoing child health problems or concerns reported by our sample.

Box 2.2 Child health problems or challenges as reported by parents

Acute or minor illnesses

- Coughs and colds
- Conjunctivitis
- Earache
- Tonsilitis
- Chickenpox, measles
- Chest infections
- Urinary infections
- Viral infections (inc. Norovirus)
- Vomiting and diarrhoea
- Rashes
- Cold sores
- Respiratory problems
- Tooth problems
- (Benign) growths

Emotional/behavioural concerns

- Fussy eating
- Sleep problems
- Enuresis (wetting themselves)
- 'Clinginess'/not settling at nursery

Chronic or serious health problems

- Allergies (dairy, nut, hayfever)
- Asthma
- Talipes (club) foot
- Cleft palette
- Down's syndrome
- Balanced translocation of chromosomes
- Gastric reflux
- Glue ear
- Hole in the heart
- Colic
- Digestive problems (stomach acid)
- Convulsions after premature birth
- Undiagnosed, unresolved eye problem

Accidents requiring hospital treatment

- Cuts to lips, gums, head
- Burns
- Broken teeth

Child development concerns

- Delayed speech
- Poor concentration

Commonly, when asked about children's health problems or experiences of illness, mothers prefaced their replies with 'nothing serious', or a similar caveat. They frequently went on to say that the child experienced 'the usual coughs and colds'. Even where a child had had quite a few episodes of ill health, mothers could be relatively sanguine. For example, in her first year of school, one child had coughs, colds, the norovirus, an itchy rash and a recent phase of wetting herself in class, and yet her mother described her as 'healthier than average'. In this case, the child's health issues were seen in the context of her being otherwise fit and well, and – crucially, perhaps – happy and performing well at school, with a good group of friends. Mothers generally recognised that children would inevitably be exposed to infections, especially when interacting with others at school or in childcare settings, and that as long as they recovered fairly quickly, this would do them no harm in the long term, and might even help develop their immune systems.

Similarly, when children had chronic conditions such as allergies or asthma, respondents' level of concern generally seemed to reflect the severity of symptoms, the degree to which they were manageable, and specifically the extent to which they felt they were in control of the situation. For example, one mother of two sons had been very concerned about one of them, whose dairy and nut allergies appeared to be worsening despite her being very strict with his diet. However, her other son's mild asthma was not disruptive, and she did not see this as a significant problem.

There was a degree of variation by child age, with mothers describing having experienced some of the greatest anxiety around babies' health problems. In some cases, this reflected the fact that respondents were new to motherhood, and lacked confidence at the time. More generally, however, it seemed to stem

from awareness of their limited ability to alleviate the distress caused, for example, by colic or gastric reflux. Also relevant was the fact that these conditions had deprived mothers as well as children of sleep, affecting their stress levels and in some cases, they felt, the extent to which they had felt able to bond with their babies.

Generally, while these experiences had been upsetting, even overwhelming at the time, mothers seemed able to relax afterwards, rather than remaining on high alert. To some extent, the memories of what they had gone through seemed to provide helpful perspective on relatively trivial current concerns. There were exceptions though. For example, one mother whose baby had respiratory problems requiring hospital treatment had since then sought reassurance on a regular basis about the health of all of her children:

> *'Since my eldest was ill that time, in the hospital, she was about, like I said, about 16 months old, I, if they're ill, if I think they've got a cough or a cold or a temperature, I do ring the doctor.'*

(Lone mother, currently in paid employment, three children aged four, six and eight)

In some cases, parents were concerned or anxious about current or ongoing health problems, including:

- Delayed development; most commonly with respect to speech and language, but in one case a risk of late walking, stemming from a foot problem at birth.
- Fussy eating.
- Ongoing, unresolved health issues including undiagnosed eye and sleep problems which were causing distress to children, including those who were otherwise healthy and those who were severely disabled.

Mothers generally seemed satisfied that they were 'doing the right things', in relation to preventing or managing ill-health, whether with regard to diet, exercise, routines or care more generally. Some emphasised this with reference to other parents who they believed were *not* so attentive, failing to set a good example or attend to children's needs. A few acknowledged their own past failings, in relation to enforcing rules around healthy eating, or ensuring their home was hazard-free, and were able to describe how things had improved.

However, as discussed later on, a few parents were extremely frustrated with what they experienced as inadequate health services, and saw these as exacerbating problems which could and should be better addressed.

2.2 Protecting children's health

In this section, we focus on the steps mothers took to look after their children's health. We begin by focusing predominantly on physical health, before turning to social and emotional wellbeing, whilst acknowledging the links between the two. Finally, we briefly consider similarities and differences between maternal and paternal roles in relation to child health within their families.

2.2.1 Physical health and development

Here, we consider parental efforts in relation to two main areas; children's diet and physical activity. We look at how mothers described safeguarding children's health and key factors or influences on their decisions or behaviour.

Healthy eating

All mothers we interviewed were concerned to ensure their children were not just well-fed, but adequately nourished. Key topics of discussion in this area were breastfeeding, weaning and healthy eating.

Some mothers had breastfed their children, citing health reasons and in some cases advice from health visitors, although one said that convenience was the main factor, and that making up bottles would have been harder. Convenience was also cited by some who had combined breast and bottle feeding, or moved to the latter:

> *'At first, I did breastfeed for a little while. Then I, it just got too much, like I wasn't all prudish and that, but visitors all the time. And it was just inconvenient or, for me to get my boob out in front of everyone.'*
>
> (Lone mother, not in paid employment, two children aged five and ten)

However, moves to bottle feeding were also prompted by health concerns and perceptions of babies' needs in some cases. For example, one mother described her anxiety that her hungry and windy baby was not getting enough milk or sleep, and was relieved when he appeared more comfortable, satisfied and rested once on the bottle. Just two mothers in our sample had not tried breastfeeding at all. Although one regretted her decision, neither of them felt that this had adversely affected their children. This young mother defended her choice, offering her healthy child as proof that the 'facts' about breast milk were wrong:

> *'I think the breastfeeding stuff, I think it's a load of rubbish about they become more intelligent off of breast milk because I didn't breastfeed and he's fine. And it helps their immune system more, I think that's rubbish, it's wrong because he's fine. He's never hardly ill, do you know?'*
>
> (Lone mother, in paid employment, one child aged one)

Introducing solid foods was recalled as a challenging task by some first-time mothers, and one with which they had needed advice and guidance. A few well-informed parents highlighted that government guidance had changed, advising parents to introduce solids from six months, rather than four. While this was confusing for mothers, it seemed to reinforce that there was no absolute right or wrong timing, and they described taking their cue from the baby's apparent needs and preferences. Some mothers had been more anxious about this with their first child, and for example relying completely on baby jars, or preparing things 'from the books' but described becoming more confident in their ability to prepare and store suitable home-made food:

> *'With my eldest, well, she was my first, so I didn't really know as much. So when she was going on to solids I was buying like the baby food that you buy in the tins and stuff. But with my youngest, I was making obviously my food, and I was mincing it down like with a blender.'*
>
> (Partnered mother, not in paid employment, two children aged six and nine)

Although their knowledge of nutrition varied, mothers seemed familiar with key public health messages around healthy eating, such as the 'five-a-day' campaign promoting fruit and vegetables. Individual mothers also mentioned, variously, the health benefits of fish, water, vitamins, a varied diet and 'proper protein', and the dangers of sweets, fizzy drinks and juice for teeth. One respondent referred to the horse-meat scandal[8], which was a live issue during fieldwork, and said that as a result she would not feed her child beef.

Among those who were most confident or enthusiastic in relation to healthy eating, some referred to having learned to cook 'proper meals' from their own parents, while others had read up on it, talked to other parents or practitioners, or gone on courses to find out more – as discussed further later. A mother of a child with Down's syndrome had read that people with this syndrome were at higher risk of becoming overweight due in part to thyroid problems but also as a result of parents providing too many 'comfort foods', which she was careful to avoid.

While some mothers were keen to provide their children with similar healthy diets to those they had experienced as children, others wished to improve on what they saw as their previously unhealthy habits, for the sake of their children's health. In particular, a number of respondents referred to the danger of obesity as a motivating factor for taking care with children's diets. One mother mentioned her own weight problem as a worry, and was determined to ensure her children did not follow suit:

> *'I don't know how, why I'm this size but I'm quite conscious of my children being obese as well. So I try.'*
>
> (Lone mother, not in paid employment, two children aged three and five)

She – like other mothers in our sample – had struggled with children's 'fussy eating', but was taking steps to address it. In her case, as for others, this involved seeking information, preparing home-cooked meals with plenty of vegetables, being stricter with treats, ensuring packed lunches contained healthy snacks, and asking staff to monitor what children ate at school. Other mothers described 'hiding' healthy food in dishes popular with children.

While it was not necessarily the key factor governing choice of childcare or schools, parents were very conscious of how the food provided in these settings helped – or hindered – their efforts to look after children's diets. Again, this issue is discussed further later on.

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[8] In early 2013, horsemeat was found in a number of products in UK supermarkets http://www.guardian.co.uk/uk/2013/may/10/horsemeat-scandal-timeline-investigation. This continues to be a news item https://www.gov.uk/government/news/processed-beef-products-and-horse-meat

The cost of healthy food was raised repeatedly. In one case, a mother described struggling to feed her family well during a difficult period when money worries were acute. Typically, parents said that quality, nutritious food was more expensive. Some referred to having appreciated receiving free milk, fruit, or school dinners for their children – or envying others who benefitted in this way.

However, some respondents maintained that eating healthily and cooking 'from scratch' could be cheaper than buying ready-meals, as long as you shopped carefully and strategically, in the right places, and at the right times:

> *'I think it's actually quite expensive to have a shitty diet... To go and sit in, even have takeaways from any of those fast food places or going into Iceland or going into any, even your ordinary supermarket where they do all the pies and it's got a tiny bit of meat and a bit of pastry and what you get in that you can go and you can buy enough meat and pastry to make four of those flaming pies. You do. I get a packet of mince, get rid of the fat and I make a ruddy great big lasagne and the mince has only cost two quid… Yeah, fruit in supermarkets and stuff it can add up... So I do tend to buy quite a bit of fruit and veg from the seller down here… I think he buys the fruit and veg when it's just at the end. The supermarket doesn't want it anymore because it's too old so it's got to go that day. So you can buy, go down there and buy like five avocados for £1…'*
>
> (Lone mother, in paid employment, one child aged five)

As some advocates of home cooking pointed out, however, particularly if you were not used to doing so, preparing healthy meals for the family took time, effort and planning, and was not always easy to fit into a busy schedule.

Physical activity

In general, physical activity seemed less of an emotive issue than healthy eating, in terms of mothers' priorities or concerns, despite most seeming aware of its importance.

With few exceptions, respondents described children as taking part in exercise of some sort, although their own part in supporting this varied. Mothers of older children frequently mentioned them going to clubs or sessions at or outside school, and were pleased with the opportunities these provided. In one case, a respondent told us that the range or activities on offer had been one of the main factors in her choice of school. In other cases, particularly when mothers showed more enthusiasm for exercise or fitness themselves, they described children taking part in more family-oriented activities. These involved mothers and/or fathers and sometimes siblings taking exercise together, for example going for walks, swimming, cycling or playing football, or playing in the park.

Box 2.3. Children's physical activities

- Walking
- Cycling
- Playing on scooters
- Playing in the park
- Soft play
- Swimming
- Tennis
- Football
- Multi-sports
- Basketball
- Adventure playground
- Tumble-tots
- PE (various activities)
- Dancing
- Keep-fit
- Swimming
- Gymnastics
- Ballet

In one case, the mother of a child with Down's syndrome described trying to ensure he was involved in physical activities alongside other children.

> *'No one wants to be on the team with a person with Down's syndrome because they're slower.... I make sure he does lots of running around and activities and sports and gets included. Although I do find myself saying to other children, give him a chance – I'm like a broken record.'*
>
> (Lone mother, in paid employment, two children aged seven and ten)

Money seemed to be less of a barrier to physical activity than to healthy eating (although it was mentioned by some). To some extent, this may have reflected that provision at school or sometimes other childcare settings was seen to cater for children's needs in this respect. However, while mothers generally identified that families could exercise for free, for example, by going for a walk, or a 'scoot around the park' they had on occasion ruled out or struggled to afford activities because of the costs. Some welcomed concessionary schemes which had made activities such as swimming more affordable, although the conditions attached could be problematic:

> *'Yeah, well they do on the Kellogg's Cornflakes boxes they do free swimming lessons but then you can't go with two children by yourself, so I don't know, I can't even go swimming with her… It has to be two persons with two, like two adults with two children... She loves swimming but I can't go with her because I can't take him as well.'*
>
> (Partnered mother, not in paid employment, two children aged four months and three years)

One working mother ruefully reflected that while she made sacrifices to afford swimming lessons and lunches, others received free school meals and other subsidies. As a result, she felt families on benefits might find it easier to give children some opportunities than she did as a working mother on a low income.

Some mothers pointed out that not everyone in London had easy access to a local park, let alone a garden in which children could play. For example, one mother who was very aware of the benefits of exercise, for fitness, confidence and enjoyment, lived in an urban area with no green space and a lot of traffic pollution. For her, trips to a park or similar facility were a major expedition, rather than something that could easily and cheaply be fitted into an average day. Another respondent who lived very close to a park and was very keen to be active also faced challenges going out, as she lived in a flat with no lift and had to carry her disabled daughter up and down steep flights of stairs.

Just one other mother – of a three year old – cited the child's lack of interest in physical activity as a barrier; she said he was 'quite lazy' and liked to be in his pram when they were out, but she was not concerned about this. Another mother explicitly said that her own shortage of time or energy limited the extent to which she engaged in physical activity with the children; when they were younger, she took them to the park a lot during the day, and felt they slept better as a result. However, she was less keen to do this after school or at the weekend when she had been working and wanted a break.

2.2.2 Cognitive, social and emotional health and development

In this section, we consider mothers' efforts to safeguard children's social and emotional wellbeing and their developmental progress, as well as behaviour in relation to 'healthy routines'.

Developmental progress

As noted previously, mothers recognised the links between looking after children's physical health – via healthy eating, exercise or sleep – and promoting their intellectual and emotional development. Here we focus specifically on parenting behaviour in relation to helping children achieve developmental goals. Some mothers portrayed supporting children's cognitive development, particularly in the early years, as a very important part of their parenting role. This was the case regardless of whether children had particular difficulties in any area, or were advanced for their age.

One mother of a child with Down's syndrome had secured as much specialist input as possible through charities, local disability services, schools and Children's Centres. She had also attended courses and learned the Makaton method of signing, to help him communicate. Another mother in our sample had a severely disabled child who experienced significant and wide-ranging problems and was unable to walk, talk, wash or feed herself at the age of five. With the help of school staff, her mother had secured further home-based assistance from social services, along with support at school from a team of professionals who provided physiotherapy and other stimulating activities. In both of these cases, the mothers, who were very health conscious, were actively collaborating with carers and staff to maximise their children's abilities to communicate and enjoy a range of activities – including through careful attention to their diet, sleep and exposure to infection - but meeting standard development goals was not a realistic prospect.

Some mothers in our sample described children as being just slightly behind in aspects of their development, particularly in relation to speech and language. Each of them had taken steps to help them 'catch up' with their peers, including in the following ways:

- seeking advice from GPs or other community health settings
- accessing speech and language therapy at nursery or school
- arranging cranial massage
- reinforcing professionals' input with activities at home
- searching the internet and libraries for advice and ideas.

Mothers who had no such concerns about their children's progress also described supporting their development, including by:

- taking a course on child development to learn more about what to expect
- accessing playgroups to allow children to learn from others, for example, about eating habits, behaviour and drawing
- using techniques used in school at home, such as flash cards or phonetics
- teaching children the alphabet and counting before they started school.

Healthy routines

Mothers mentioned supporting children's health in various other ways, in some cases stimulated by advice from health visitors, GPs or childcare providers. They described, for example:

- teaching children to brush their teeth on the arrival of their first tooth
- teaching them to wash their hands after using the toilet
- using baby wipes when children have got dirty playing outside
- choosing childcare providers who emphasised and taught cleanliness
- ensuring children went to bed early except on special occasions
- addressing sleep problems by tweaking the bedtime routines.

Social and emotional wellbeing

Aside from routine care, ensuring children got enough sleep and providing a safe home environment, one factor typically stressed as key to children's health and wellbeing was the bond with their mother, established in the first weeks and months after birth. This stage in a child's life was seen as vital in order for the child to 'know who its parents are'. For babies, it was felt that happiness was inextricably linked to interaction and close contact with their mothers. For some, breastfeeding was an important facilitator of this relationship. In a number of cases, mothers had longer at home with one baby than another, and judged that those who had less time with them had suffered as a result:

> *'I thought he was very happy at day nursery, but the difference between my two children and their emotional health is marked... One's grumpy as hell, the other's nice and friendly… I blame that on childcare, early years childcare. When all a little baby wants is their mummy and to just sit being cuddled all day long, to put him in childcare from eight till six, how could I do that to a baby? But I just didn't think anything of it."*
>
> (Lone mother, in paid employment, two children aged seven and ten)

Several of those we spoke to stressed that 'being there' for the child even after early infancy was important. This message came from mothers (and a father) in a range of situations – lone mothers and in couples; working full-time, part-time and not at all. Regardless of how they managed it, the goal was providing sufficient love, attention and 'quality time' to support the child's sense of security, self-esteem and confidence:

> *'Instead of both of us working, why give the children a hard day, you are not there for them... It's better you are there for them now, and then later if you want to go back to work then at least you have the, they will see you are around when you're needed most.'*
>
> (Partnered mother, not in paid employment, three children aged two months, three and nine years)

However, even some of those who put great emphasis on bonding with mothers in the early months believed it was important to provide opportunities for children to mix with others. Whether these came through use of nurseries, childminders or family care, or through attending playgroups with mothers, they were seen to help children become less shy and more independent, to

develop social skills and have fun while having new and stimulating experiences.

Choosing the 'right' childcare provider (discussed further in Chapter 3) or school was also a decision geared to ensuring children were happy as well as safe and well-educated. As noted previously, for some mothers, the ethos of the school was important. This was not just about ensuring continuity of moral or spiritual guidance between work and home, but about making children comfortable.

> *'I figured she went to a small nursery, I want her to go to a small school…. … I did find a church school that was very current in its approach, very family orientated…. She goes bouncing in. She goes bouncing out. She can't wait until I've gone…. It's lovely, lovely, the ethos, polite kids, well behaved kids, her reading, her writing, everything's come across, come across really well... She's learning the academics, but her emotion - everything that I've wanted to happen has happened.'*
>
> (Partnered mother, in paid employment, one child aged five)

A number of mothers acknowledged that their own need to bond, or simply be, with their child, and to personally support them through key developmental phases was an important driver of their choices. Equally, others explained that they wanted to have time away from their children – not just to help their development, but for their own wellbeing and sense of self. Either way, mothers described having to look after their own happiness and wellbeing in part *because* it enabled them to be a better parent; more fulfilled, less tense or liable to snap and more able to engage with their families. They described making decisions about work, earning, learning or volunteering to minimise stress and make for happier family life.

> *'I do laugh when I get the wage slip and think that's what I earned, it was like 24 years, 23 years ago.... But it's about the health and wellbeing of my child. Emotionally and physically I want to be there for him and now I'm going to go into teacher training and be a teacher so that I can be with him for those 13 weeks of the holidays. And plus, yeah, I know that I'm going to end up working of a night but I know that I'm going to make his dinner. I'm going to give him his dinner. I'll prepare his uniform. I'll sort him out and then I might have to sit up all bloody night doing work, but as long as I know that I'm doing it all I will, it's a reward for me.'*
>
> (Lone mother, in paid employment, one child aged five)

2.2.3 Maternal and paternal roles in child health

In this section we briefly discuss differences between the roles of mothers and fathers. It must be borne in mind that our findings are based largely on mothers' rather than fathers' perspectives, as only two fathers were involved in the research.

It was clear that lone mothers in our study overwhelmingly made decisions in relation to their children's health, and were responsible for it. This was the case even where fathers were in regular contact with the children. However, mothers in couples also typically played the major role, including when children were unwell. Partly this reflected that they were predominantly acting as primary carers, and were more likely not to be in paid employment or to work shorter

hours than their partners. However, even where both parents were employed full-time, it would seem mothers were typically the ones taking time off, if required (this issues is explored further in Chapter 3).

In some cases, the division of parental roles was very stark. For example, after the birth of her Down's syndrome son, one mother took unpaid leave to extend her maternity leave and, on return, had to take extensive time off for his hospital appointments. Faced with a choice between downgrading her role or leaving, she abandoned her established career in favour of low-paid part-time work which could fit around his needs. Her husband's career was unaffected; even before his wife gave up her job, he worked long hours, and left decisions about their health and care to her:

> *'We had a really distinct definition of roles, so he was the earner who brought the money in and who used to work long hours.... or he'd be away from home, so he was never was there for bedtime or bath time or, so as far as he was concerned we didn't have any children.'*
>
> (Lone mother, in paid employment, two children aged seven and ten)

Similarly, in another case where the child had a serious disability, the mother provided full-time one-to-one care despite having a postgraduate degree and teaching experience, with earnings potential on a par with that of her husband. Though he was able to carry out tube-feeding and other such tasks, he rarely looked after the child for longer than half an hour and his input was most vital when the health of his wife was suffering:

> *'He goes to work, when sometimes he comes back he says, "Oh I'm tired, I'm tired"... He tries to help... Actually he doesn't look after, he looks after her but not all the time, but when I'm really, really... like, I can't stand... I will say, "Oh can you just sit with her, I'm going up just for half... half an hour's sleep", because like every morning, my head is heavy because she wakes up so many times.'*
>
> (Partnered mother, not in paid employment, one child aged five)

Indeed, fathers' input in terms of their children's wellbeing was often described as giving mothers a break, or making *their* task easier. However, there were some families in our sample where fathers did more childcare and were more implicated in looking after their health as a result. Despite working full-time, one father was described as 'hands on' and 'a big help' including in relation to babies' night feeds and outdoor activities with older children.

> *'We done everything together really when they was little, and even the feeding through the night as well, we even shared that. It was, well, it's good when you've got like a partner that wants to do that sort of stuff, it really is, it's a lot easier... and I think our family life, the way we are, is what makes our children the way they are... You have to back the other one up sort of thing. It's what helps them to learn as well... So he'd take them out, go to parks and stuff like, just things like that. Just doing everything, feeding them and all that sort of stuff, just normal stuff that I would do if I was there.'*
>
> (Partnered mother, not in paid employment, two children aged six and nine)

Other fathers were described as preparing meals for children, reading to them, and taking them to and from various activities. Where fathers were not working (generally attributed to health problems) they tended to be more involved in looking after children, and in joint activities with mothers, such as viewing potential nurseries. 'Shift parenting' was particularly apparent in these cases, but also in one instance where the husband was self-employed and could look after children in the mornings. Notably, however, although it was usually easier for him to arrange time off if their children were sick, both he and his wife preferred that she be the one to look after them. It was she who decided whether her children were well enough for school, who ensured they ate a healthy diet. His role was to provide backup, and on her account, the children recognised her authority rather than his in relation to mealtimes and other routines.

Interestingly, both of the fathers we interviewed described themselves as more lax with children's diets or other health-related issues than their partners. In one case, a father told us that he was less averse to junk food being consumed than his partner, and happier to stay indoors and relax rather than take exercise. He bowed to her lead, however, in relation to the family's diet and exercise habits. Similarly, another father told us that his children's mother was more concerned with hygiene and enforcing bed times than he was.

Mothers tended to be represented by both fathers and mothers as 'the boss' or at least the more responsible adult when it came to children's health. Even in one instance where a father was said to worry more about children's health and to want them taken to the doctor more frequently than she thought necessary, it was the mother's role to take children for the appointment, and ultimately it was her decision – taking into account the need to reassure him. For the most part, mothers welcomed fathers' input and stressed the benefits of their involvement with children, including in relation to enjoyment and emotional wellbeing, over any perceived shortcomings in relation to looking after their health.

2.3 Supporting parents in relation to child health

In the following sections, we consider the extent to which mothers felt able to look after their children's health, and the personal and other resources they drew on to assist them in this task.

2.3.1 Parental knowledge and self-efficacy

Before turning to support received from others, we explore the extent to which mothers felt personally qualified or competent to look after their children's health – or to 'trust their own instincts'. We consider how their existing life or work experience informed their efforts in this area, and whether they consulted written or online reference material and found it helpful.

Trusting their own instincts

Respondents talked about their 'motherly instincts kicking in', and that when faced with a crying, hungry baby or sick child, they trusted their own judgement. Some were conscious that official advice changed and varied between sources, and others were dissatisfied with professional help – all of which reinforced a view that there was no infallible source of advice, and that learning from experience provided the most reliable guide to what worked for their son or daughter.

In line with previous research, highlighted in the literature review in Chapter 1 (Blaxter and Patterson 1982), some mothers emphasised that no-one knew their children and their needs, better than they did. Partly on that basis, it seemed, they asserted an entitlement and a duty to ensure that others charged with caring for their children fell in with their ways of looking after them. They emphasised that while they might welcome advice, decisions about their children's care were theirs to make:

> *'If you'll advise me then, yeah, I'm going to take it on board but as soon as you come in and you start telling me what to do with my child then I'm not going to do it. But if you say to me, "This, we think if you tried this, this could work," then, yeah. But, yeah, if someone starts to tell you, then your back's going to be up straightaway.'*
>
> (Lone mother, in paid employment, one child aged two)

As detailed below, in some cases parenting was informed by relevant training; in others it was supported by experience with younger siblings, their own, or their partner's older children, or from observing others, including family members. As in relation to weaning, mothers described becoming more confident in various aspects of parenting with second and subsequent children, and learning to worry less about things which no longer seemed important:

> *'I'd iron all his vests - pathetic stuff when you're absolutely exhausted.... I was so proud and wanting my baby to be pristine. Yet with my second, he'd wear a baby grow from the day before, if it wasn't absolutely food smeared.'*
>
> (Lone mother, in paid employment, two children aged seven and ten)

Other mothers, however, were less confident in their knowledge and ability to look after their children's health without more external input.

Learning through education, training, employment and volunteering

A number of those we interviewed had a fairly detailed understanding of child care, health and/or development as a result of courses they had undertaken (e.g. in childcare or social care). Some mothers had experience of working as childminders, nursery staff or classroom assistants. In some cases, their existing knowledge about health was reinforced when they came across more information through work or volunteering, for example, encountering the Change4Life campaign while working in a school office, and seeing the effects of healthy school initiatives on other people's children, as well as their own:

> *'I see it because I work in a school and I see it on a daily basis and I've had it myself. I'm trying to explain to a parent about healthy eating or*

something - because obviously I do lunchtimes, as well, so I see all of it - If I say to them "this is healthy for your child's packed lunch" and just show them, then they will get it, and, "Yeah, that is better for my child", and then they see, because if a child is eating healthy and stuff like that, as well... you can see an improvement in behaviour. Not, obviously not with every child but... because a lot of children have high sugar intake and if you take that out they do calm down a bit and it can make a difference.'

(Lone mother, in paid employment, one child aged two)

Other occupations had also given parents useful insights, including: retail work in a health food shop; training in sports science; catering with its emphasis on nutrition; and, massage and holistic therapies. As discussed further below, some mothers who had felt less equipped as parents had taken courses through children's centres and been provided with support and tips in relation to health.

Books and the internet

It seemed common for mothers to search books or the internet for information about child health. The extent to which publications on child rearing and development were perceived as useful varied a great deal. For some, including an anxious young mother who had left school early, they were unhelpful:

'It was so stressful at the start because obviously it was all new to me and... Like there's hundreds of books but none of them are helpful, do you know what I mean? Like every child's different.'

(Lone mother, in paid employment, one child aged three)

One degree-educated mother also described her baby book as 'gobbledegook', but then sought out others to help with specific challenges:

'I bought a book which showed me how to do it do it because I remember thinking, how in God's name do you teach your child how to read?'

(Lone mother, in paid employment, one child aged five)

Similarly, another mother acquired several textbooks on Down's syndrome and had learned a lot from them about the condition and her son's needs. Although none presented books as their main source of information, some were very positive about them; one mother had books 'coming out of her ears' and learned a lot from them; another recalled copying bedtime routines from NHS publications covering baby's first year, and years two to five. One interviewee told us that when her baby was unwell she phoned her mother, who consulted a tried and tested book on her behalf.

The internet seemed a more popular option than books, particularly among working mothers, to access material including:

- Ofsted reports on nurseries and childminders
- details of local playgroups or free activities
- techniques to help children with aspects of their learning
- potential diagnoses for children's ailments before consulting a GP.

As detailed in later sections, information presented in accessible leaflets and distributed in various settings was also welcomed by mothers.

2.3.2 Grandparents and other family members

Mothers reported turning to their own mothers, as a 'first resort', when in need of advice on child health. While grandmothers' opinions were also sought in relation to older children, they were particularly in demand when it came to babies' care, routines and weaning, especially among first-time mothers.

A few of the younger mothers in our study had lived with their own parents – or in one case own grandmother - after the birth of their first child and had continued to receive a great deal of support from them even after moving out. One mother's 'nan' had looked after the baby and taken him for premature baby checks, allowing her to attend college. Some had had their mothers come to stay for the first few weeks or visit regularly. In contrast, others had mothers in other countries, who had provided support over the telephone. One woman described how her mother had calmed her panic and talked her through her baby's first bath from 4000 miles away:

> *'I didn't even know how to bath the baby so I was on the phone with my mum, she [child] was actually crying... I was on the phone talking to her, "How am I supposed to bath her?" She said "OK…'Put the water on the side and then sit and put your leg in the basin and put the baby on your lap because when a baby is, like very sleepy..." So she's giving me instruction on the phone on how to do it and then that's how I learn...'*
>
> (Partnered mother, in paid employment, three children aged two, five and seven)

In some cases, grandmothers' advice was relied on quite heavily; for example, one mother described depending on hers for advice about the birth, colic and fevers, and 'not bothering' with antenatal classes. Like others, she said that when her child was unwell, she would always talk to her mother before contacting the GP.

For the most part, those who had taken advice from their mothers reported benefitting from it; in at least one case, however, a woman regretted doing so. Although she maintained that her children had not suffered from being bottle-fed, she wished she had tried breastfeeding, having talked since to other parents who had done so.

> *'My mum put me off of the whole breastfeeding thing... Why, I don't know. She don't know herself... I wish I did, like now, personally, from people that I know that have breastfed. Like I don't think it makes a difference in... health and stuff, because my children are quite healthy and they was bottle fed.... I just would have liked to experience it myself.'*
>
> (Partnered mother, not in paid employment, two children aged six and nine)

Grandmothers were also credited by mothers with teaching them to cook, or at least setting a good example with regard to home-cooked food. One father recalled his healthy, active childhood, with his mother cooking from scratch playing a central role, and wanted to replicate that for his own children.

> *'When I was growing up, … we never got no packaged food, nothing from, that you stick in a microwave or anything like that, no. Everything that we, I ate, was home cooked food. Whether you want to say a curry is*

good or not because it's quite greasy, but you still had your salad with it... To have something that's quick food it's very, very rare... So that's how they eat... through knowledge of how we were brought up.'

(Partnered father, in paid employment, two children aged six and eight)

In contrast, some mothers mentioned wanting to give their children a healthier childhood than the one they had known. Some were more equivocal, saying that they 'might' ask family for advice if needed. Although some mothers trusted their own judgement over their mothers', when it came to health-related decisions and care, this did not rule out accepting their practical support occasionally. In a number of cases, mothers had also appreciated their own mothers *not* stepping in too often, encouraging them to have faith in their own abilities.

None of our interviewees mentioned *grandfathers* – i.e. their own fathers – as sources of advice*,* specifically, though one mother had gained an understanding of nutrition from hers, who had trained as a chef. Some respondents mentioned their *sisters* as key sources of advice, particularly when they had slightly older children and were able to compare similar experiences. In one case, the relevant sister also worked in childcare and her opinions gained additional credence on that basis. Other family members who were cited as helpful were *mothers-in-law* and – as noted above - *mothers' grandmothers* - in one such case, 'nan' was a former nurse, and particularly valued when children were unwell or had accidents.

Even when family members constituted the main source of advice or support, there could be tensions or anxieties around their roles in looking after children's health in situations where:

- they provided food which mothers considered unhealthy
- relationships with partners' families were strained already
- they failed to reinforce mothers' own rules, e.g. by allowing children treats regardless of whether they finished their main course.

This issue is revisited in Chapter 3, when discussing mothers' views on acceptable childcare providers.

2.3.3 Friends and other parents

Some mothers described their own longstanding friends as playing a significant role in helping them look after their children, either because of their experience as parents or knowledge of healthy living. Others had friends further away, whose input was presented as less relevant, because they were either childless or had families at a different stage.

More typically, mothers described talking to other parents – some of whom became friends – who they met at Children's Centres, playgroups or baby clinics. They described it as invaluable to be able to discuss and compare their experience with others, picking up tips or advice and observing how other mothers interacted with and looked after their children.

One mother of a disabled child, who greatly valued support from professionals, explained how advice from other parents was particularly useful, as they were experienced in dealing with a wide range of systems and situations.

> *'Speaking to parents of older children was far more helpful than text book stuff, because they'd been through that two years previously. So I first of all went to a group for parents of Down's syndrome children, and I got very pally with a woman whose son was about five years older than mine and she helped me fill out my first DLA form... So we got free nappies, I got a cinema card so basically I go the cinema for free with him.... So all these things are little benefits and parents tell you about them, professionals don't... Professionals don't really help with disability, not everybody knows everything about the subject. So the paediatrician knows a bit, the social worker knows a bit, the education service knows a bit... but another mum knows everything."*
>
> (Lone mother, in paid employment, two children aged seven and ten)

For others, too, key benefits of this exchange with other parents included reassurance, peace of mind and a reduced sense of isolation or failure. As one mother indicated, what she had learned from others, she had then been able to pass on in turn:

> *'You get like a little social group around you. Where you can talk to other mums, different ages, younger, older. You know, "Well mine is doing this." "Oh, mine done that six months ago"... All kids go through that finicky, "I won't eat" stage, and you think it's your own, you're the only one in the world that's going through this.... until you speak to loads of mums and they all tell you the same thing... I had one mum that her child was refusing to eat anything but crisps and baked beans, and it was like, put the crisps and baked beans on the plate but still put all the vegetables and everything you're eating still on the plate and they might pick it up. And I've always done that with mine... Whether he ate it or not it was still there and still encouraged to eat it, and I sort of learnt that off a few other parents along my journey of becoming a, being a parent... So in that way it's good because you get to know different strategies and stuff.'*
>
> (Lone mother, not in paid employment, two children aged three and seven)

2.3.4 Health services

In this section, we discuss mothers' experiences of accessing support from a range of health services and professionals. We begin with health visitors and GPs, with whom interviewees had the most contact.

Health visitors

For the most part, mothers described positive experiences with health visitors. However, the extent to which they had relied on the service and felt it made a real difference to them as new mothers varied – mainly as a function of their own confidence and parenting experience.

Some felt that in the absence of any particular concerns, the service had not had much impact. In contrast, others described 'lovely' or 'approachable' health visitors who had made a real impression by:

- Being compassionate, welcoming questions, providing reassurance and avoiding undermining their confidence.

  'Well at that time my local health visitor and centre, I found them very useful. If they said that I was doing something wrong or anything like that they would tell me, they wouldn't just bomb me down.'

  (Lone mother, not in paid employment, one child aged five)

- Providing advice on breastfeeding, weaning, child development, teething, checks-ups, dental health, and symptoms.
- Providing helpful leaflets with information about immunisations, services and healthy eating.
- Being flexible, available at clinics, on the phone or for home visits when required, for example, if a child was really unwell.
- Getting to know families and signposting them to relevant services, e.g. Gingerbread, providing support and holidays for lone parents.
- Engaging with other services on their behalf, helping them to make appointments and effecting significant change – e.g. enabling one family to move from a damp home.

  'I had a lot of damp in my property and we got moved twice because of damp because of the health visitor came round and she said this is terrible. I had mould growing on my clothes. Anything leather as well it just, it attracted to so we were moved twice, literally within I think two days, two days of health visitors seeing the property.'

  (Partnered mother, in paid employment, three children aged four months, seven and nine years)

Some mothers – including those who were otherwise complimentary about the service – also criticised individual health visitors, describing, for example:

- Being made to feel 'like a bad mum' when their child had a rash.
- Reactive rather than proactive care, with health visitors failing to pick up on child health problems, such that mothers taking the initiative was vital.
- Conflicting advice from different health visitors in the same area.
- Bad advice, including in one case discouraging a mother from bathing her new baby, resulting in a skin problem requiring treatment.
- Inadequate support e.g. with postnatal depression going unnoticed by the health visitor.
- Difficulties getting time with health visitors when they were busy at clinics or centres where lots of mothers were looking for help.

When mothers had genuinely felt in need of support, health visitors' sensitivity and the trust they were able to inspire seemed to be an important factor, alongside any practical assistance they were able to offer.

General Practitioners

As with Health Visitors, parents' experiences with GPs were mixed. Some were very positive about their local surgery, describing, for example:

- An accessible and accommodating practice, open until 8pm, where doctors 'go out of their way' to help, directing parents to walk-in-clinics when same-day appointments were unavailable.
- A surgery sending out a two year old screening form allowing parents to register any worries, which they responded to with helpful advice.
- Being able to get appointments at short notice.
- Other services on-site, including baby clinic and one o-clock clubs.
- GPs recommending very good health visitors and providing helpful information sheets about breastfeeding or nutrition.

Others were more negative, describing a lack of confidence and frustration with GPs. They reported bad experiences in relation to:

- Booking appointments for children or outside working hours for parents.
- A lack of continuity, with constantly rotating GPs who fail to engage with families and seem reluctant to treat even persistent symptoms, to the extent that parents were tempted to go straight to A&E.
- Dismissive attitudes towards mothers who had legitimate concerns about their children's health, and an apparent lack of knowledge, for example of disability, mental health or digestive problems such as gastric reflux.

One mother, who eventually received a referral to a specialist and effective treatment for her baby, described months of worry and sleepless nights after her GP refused to take seriously her own assessment of the child's symptoms:

> *'You go in and say, "I think my daughter's got this"... And then they go... "It's completely impossible"... "Baby's sick, she's got reflux. She's vomiting that far." "She hasn't." "She has." And then they've ended up, "Yes, she has, we'll give her something." And then five months in, and my life just turned around...'*
>
> (Partnered mother, in paid employment, one child aged five)

Hospitals and other health services

While not all those we interviewed felt able to comment on other health services, a few did have relevant experiences to report on. For the most part, they were positive about the staff and facilities in question. Some had found hospital treatment around the birth of their child or for subsequent treatment of a high standard. Others reported being given useful information packs, or free gifts and vouchers at antenatal scans. A couple of parents had called NHS Direct and found them very helpful.

Problems were reported by some mothers, however, including in relation to:

- Inadequate antenatal care, with information about scans confusing, and delivered by students more often than consultants.

- Long waits for appointments for speech and language therapy, counselling, dieticians or dentists.
- Support for postnatally depressed mothers, withdrawn at six months.
- Baby clinics run at restricted times which were not convenient, with long waits on arrival, although for others, they were easy to access.
- Special needs dentists who provided excellent care for disabled children but would not see their siblings, forcing parents to register them elsewhere and make additional journeys.

As was the case in relation to support from health visitors and GPs, where problems arose they tended to affect both working as well as non-working parents, and to reflect variation in the nature and quality of provision between services and individual professionals. Several of those we spoke to highlighted that they had received better – or in some cases, worse - care in the past, or that they knew things were different for friends in another area.

2.3.5 Children's Centres

Children's Centres figured prominently in respondents' accounts, and were reported to have made a real difference to some mothers in their attempts to look after their children's health. Interestingly, whereas they aired plenty of complaints about GPs and other services, none had anything negative to say about their experiences of Children's Centre facilities or their staff. Indeed, one mother argued that limiting services to those with children under five was a mistake, as she felt parents of older children could also benefit.

Mothers described gaining from children's centres in the following ways:

- receiving comprehensive booklets listing local activities
- being able to access different services on-site, including baby clinics
- having the chance to share advice and experiences with other mothers
- being signposted to other services, such as drop-in speech therapy
- attending courses on aspects of parenting including safety at home, children's learning, healthy cooking, fussy eating and baby massage
- accessing playgroups and a range of activities for children, such as messy play, which allowed them to mix with others and have fun.

  'When [child] had his two year old place it was for disabled kids, now it's for low income kids…. It was a Children's Centre, a council run Children's Centre and they were fantastic for special needs... The first event that we went to was messy play... We did lots of activities, we went to sing and sign, we went to group called Extra Boost which was fantastic, so it was a special needs group... There were two stay and play workers, so I would hand him over, they would sit and stimulate him for two hours, you know puppet shows and all sorts. I'd sit have a cup of tea... have a biscuit, have nap and it was lovely...'

  (Lone mother, in paid employment, two children aged seven and ten)

Some mothers highlighted how helpful it was to have a crèche available. This allowed them to talk to professionals or participate in courses, knowing their children were safe nearby, and being gently introduced to other carers.

> *'Parents did the courses and the children go to the crèche. So that was one of the courses I did and they taught about schools and nurseries ... And then there was... just playgroups where we played together with the children. So yeah, I did both of them so she, she got used to the crèche and to being alone... So many different courses... different schemas of the children.... Baby and Me... and they were free.... Safety at Home, so they taught us how we can get our home safe to prevent accidents.... Every second Friday there's a nutritionist come in and then we cook with her.'*

(Partnered mother, not in paid employment, two children aged four months and three years)

2.3.6 Childcare settings

The role of nurseries and childminders is discussed more fully in Chapter 3. Here we simply highlight some of the main ways in which mothers felt that these providers helped to promote child health, including by:

- promoting healthy eating
- developing children's social skills
- encouraging and enabling physical activity, including outside
- developing their immune systems, through interaction with other children
- demonstrating and encouraging hygienic behaviour and habits.

Using childcare could indirectly support children's health when it looked after that of mothers. As discussed previously, some drew links between their own emotional health, their parenting, and their children's happiness or welfare. Being able to leave the child in a safe, stimulating environment allowed them to focus more fully on other activities vital to fulfilling their own needs - whether this involved paid work, study, housework, or simply a much-needed break. In one case, a mother explicitly likened a childminder to a mother figure, in the nature of the care provided for her, as a tired parent.

> *'She was like a mummy to me. There was a time I used to go there I would be so tired I'd start crying - she would just hug me and tell me, "Don't worry"... sometimes she would tell me, "Go and do shopping, leave her here, do shopping and go home and freshen up and then I will bath her and then you come and pick her up just to go and sleep'".*

(Partnered mother, in paid employment, three children aged two, five and seven)

2.3.7 Schools

As with childcare providers, schools were seen to promote children's health to varying extents. In this section, we consider ways in which schools and their staff supported child health, and how parents responded to any problems.

Health benefits of school provision

For the most part, mothers were satisfied with school policies and provision in relation to health and wellbeing. For some, the range of activities or ethos had played an important part in their choice of schools, although there were other factors. One key issue was proximity to the child's home, but as one father pointed out, this also had health benefits: having a school next door meant that children could get more sleep and walk rather than having a long, tiring journey in the morning.

In many respects, schools were described as performing the same health functions as good childcare settings, playgroups and Children's Centres, namely:

- promoting and enabling healthy eating
- ensuring children took regular exercise
- supporting learning, development and social skills
- reinforcing parents' moral codes or religious beliefs
- engaging and working in partnership with parents to protect child health.

In Box 2.3, we provide examples of schools' contributions in each area.

Box 2.3. School contributions to child health

Area	*Activity*
Healthy eating	✓ Educating children about food and healthy eating ✓ Introducing them to new foods, addressing fussy eating ✓ Providing nutritious, tasty, affordable school dinners ✓ Distributing healthy snacks and/or water in class ✓ Banning unhealthy foods such as sweets, reducing peer pressure
Physical activity	✓ Compulsory PE lessons twice weekly ✓ Free swimming lessons ✓ Free or affordable clubs or after school activities
Learning	✓ Providing one-to-one assistance in class e.g. with reading ✓ Hosting specialist support from other services on school premises, e.g. physiotherapy or speech and language therapy
Social skills	✓ Actively encouraging children's friendships and socialising ✓ Enabling those accessing additional support with communication to improve through practice with their peers
Ethos or morality	✓ Helping instil values consistent with the family's ✓ Reinforcing behaviour such as prayer before meals
Partnership with parents	✓ Providing information on menus and healthy eating, ✓ Holding tasting sessions where parents can try school food ✓ Monitoring children's intake at mealtimes and updating parents, particularly where there were identified problems or allergies ✓ Signposting and supporting parents to access other services ✓ Noticing if children are ill or unhappy and alerting parents ✓ Responding to parents' concerns about inadequate teaching

Shortcomings of health initiatives in schools

Parents who had complaints about schools mentioned problems in a range of areas, but focused most often on food. Several were dissatisfied with school menus, meals or information provided about these, and as a result provided their children with packed lunches instead. In some cases parents acknowledged that the meals were healthy, but not to their children's taste, or even theirs: one mother told us that she had gone along to taste their curry and decided that the food was 'awful'. Others were critical of the portion sizes, believing them too small.

> *'And they give you like two little potatoes, like really small ones. And they give them like half a slice, you know like this, really thin slices of beef you get in the packets of beef and gravy? … And a little spoonful of peas and carrots mixed together …. And that was all that they give them. And I thought to myself, that's ridiculous. I know it's all, don't make the children, make them healthier and stuff, but that's just, that's ridiculous. And my kids eat, my kids are skinny anyway. They're really skinny. But they eat twice as much as that like for their dinner.'*
>
> (Partnered mother, not in paid employment, two children aged six and nine)

These respondents tended to be stay-at-home mothers for whom personally looking after their children's health and wellbeing was a priority. For one, however, it was simply that the school was unable to tell her what her daughter had eaten at lunchtime; had they been able to satisfy her about this, she would have allowed her to continue having school dinners. Finally, one mother of a disabled child felt she ate less well at school than with the family, attributing this to staff providing less encouragement than she would herself. Her response was to compensate by being even more careful with nutrition at home.

A number of mothers objected to schools' assessments of their children's weight. One child had been found obese, and another 'nearly overweight'; in both these cases mothers disputed the judgements made, although their reactions differed. In the first case, the mother was quite combative, feeling it was unhelpful and ludicrous to label the child in this way, when he only had a 'tiny pot belly'; whereas in the latter, the mother acknowledged that her daughter had been less physically active over the winter and may have put on a little more weight than was ideal.

For the most part, mothers were impressed with the physical activities on offer at school. However, some felt that the costs of extra, after school sessions were prohibitive.

Other problems mentioned by parents related to the following:

- Road safety and supervision: one mother felt staff were not providing adequate supervision at times when children might be arriving at or leaving the premises and when there was danger from traffic.
- Neglecting individual children: one mother felt that her son should have received help with his reading difficulties at an earlier stage. Conversely, another considered that her child received little attention because teachers were preoccupied with the more pressing needs of others, including those with English as a second language.

- Hygiene and cleanliness: some parents, while conscious of the demands on busy staff, wished that they could make more effort to halt the spread of germs e.g. by a greater focus on hand-washing. This was a particular concern to those whose children were vulnerable either through low immunity or minor health conditions which could be exacerbated by prolonged contact with dirt, paint or other craft materials.
- Pastoral issues: for some mothers, a truly healthy school would have a greater focus on children's emotional health and wellbeing, as opposed to simply their physical health. This implied greater awareness of home life and links between issues within the family and at school.
- Obtaining Statements for disabled children: some mothers had difficult experiences battling to ensure their children were entitled to sufficient one-to-one support to enable them to fully participate at school, to have their health needs met, or even to be welcomed there in the first place.

2.4 Conclusion

On the whole, mothers conceptualised health broadly. Emotional wellbeing was as prominent in their thinking as was physical health. Alongside happiness, key issues which dominated discussion were diet, exercise, developmental progress, confidence and social skills. Others concerns such as attachment, housing and morality were identified by individual parents, reflecting the ages of their children, their priorities and their experiences.

Minor illness in childhood was considered normal, although in some cases mothers had been sensitised by previous health scares, particularly with babies, and felt they were more anxious about their children as a result. In general, health problems were evaluated in terms of the extent to which they caused distress to children, interfered with their daily lives, and were understood or under control. Current challenges for those we spoke to included fussy eating, speech and language delay and sleep problems. Mothers were generally confident that they were doing what they could to prevent or manage ill-health, within the family, and with support from professionals where required.

Respondents were familiar with key public health messages, particularly around healthy eating, and to some extent, physical activity. They described making efforts to ensure their children achieved a balanced diet, and lived an active life, though the costs of healthy food and taking part in certain sport activities were highlighted as barriers for some.

'Being there' for children was a recurrent theme. While mothers emphasised the contribution made by the routine care involved in preparing meals, ensuring children got enough sleep, or benefitted from a safe home environment, they also highlighted the importance of quality time – not just to enable bonding with babies, but in providing security for older children. Time with children was also used to instil healthy habits and support their learning and development.

In our mother-dominated sample, fathers' roles tended to be portrayed as supportive rather than equal, particularly in terms of practical day-to-day oversight of children's health and wellbeing. 'Motherly instincts' were highlighted as helping with sometimes unfamiliar parenting tasks, with even

nervous mothers recognising themselves as experts in relation to their own children's health and wellbeing. By far the most common external source of advice and support were women's mothers, who were credited with teaching 'proper' cooking, and guiding mothers through essential health-related tasks such as bathing, weaning and judging when symptoms required professional help.

While some mothers felt they had already gained relevant experience through work or training, for example, in social care, other less confident parents had taken health-related courses through children's centres and been provided with support and signposting to additional services. Children's Centres were also one place in which mothers met other parents. The resulting exchange of tips and support was seen as invaluable in helping them to look after their child's health – and their own.

Good childcare settings and schools were also reported to play a positive part in supporting children's health. In the main, this involved providing healthy menus, opportunities for exercise, and supporting children's learning and their social skills, though provision of information to parents was also appreciated.

The extent to which mothers felt supported by health services varied, partly as a function of the need they had experienced, and partly in terms of the quality of service received. Health visitors' sensitivity and the trust they were able to inspire seemed to be an important factor, alongside any practical assistance they were able to offer. Support from GPs was less memorable than frustration associated with difficulties making appointments or accessing specialist treatment.

3. How mothers reconcile their roles as parents and workers

As indicated in the literature reviewed in Chapter 1, research has shown that being 'a good mother' is central to mothers' lives and even if they go out to work, children continue to occupy most of their psyche all time (Williams 2004). As one of our respondents put it:

> *'It is hard to be passionate about work once you have a child, not what you live for anymore.'*
>
> (Partnered mother, in paid employment, one child aged five)

Although becoming a mother has a long lasting and profound influence on women's conceptualisation of their role in relation to paid employment, there are considerable variations linked to views on what a good mother is, and in particular to what extent child rearing can be shared and some parenting tasks can be delegated. All mothers in our study saw themselves as playing a central and unique role in ensuring their children's wellbeing, happiness and health. However, central to their narrative about paid work was the extent to which they believed that this role and a range of parenting tasks could be shared with, or delegated to, others. These views influenced decisions on if and when respondents should take up paid employment, and what working arrangements were considered suitable (e.g. location, working hours). To some extent these views also influenced decisions around voluntary work and training. The latter was typically linked to future career plans, while the former could be related to mothers' need to socialise and 'keep the brain working', in addition to or instead of being clearly linked to a future career.

Three themes emerged from the respondents' narratives of how being a 'good mother' affected decisions about work or study:

- Children's age and stage of development.
- The acceptability of different carers, that is: the children's father; family and friends; and, formal childcare, i.e. early years settings and childminders.
- What kind parenting tasks and what aspects of the parenting role mothers were prepared to delegate or share with others.

These are discussed in turn in this chapter, where we also explore the links between these influences and more pragmatic factors (e.g. cost and availability of childcare, family friendly employment). We look at the choices and constraints mothers faced when considering if and how to reconcile paid employment and motherhood, and what compromises seemed more or less acceptable.

3.1 Children's age and stage of development

Predictably respondents' views on using non-maternal care in order to take up paid employment, voluntary work or training, depended on the child's age and needs. Views about the age at which it would be appropriate to leave children in

the care of others varied from six months to ten years (when children start secondary school). However, the ages mothers typically mentioned seemed to relate to parental leave and (early) education policies, as well as what children would be able to benefit from, cope with, or at least not be damaged by, at different developmental stages.

3.1.1 The first year

Some mothers felt very strongly that the use of non-parental care in the first year of a child's life would not be appropriate. As discussed in Chapter 2, this was linked to the bonding a child requires with the main carer in their first year, which was seen as essential for children's emotional wellbeing, and not something that could be shared with or delegated to others (apart from perhaps the father – as discussed later on):

> *'Yeah, it's like the mums that have their babies, push them out and then they're back to work the next day, I don't agree. Like, I know everyone [has to] earn a crust and all that, but I just think then, I don't find that they've got their bond between mother and child, like I have with my kids.'*
>
> (Lone mother, not in paid employment, two children aged five and ten)

> *'I think it's important that a child knows who its parents are and I think if you if you go back to work too quickly after having a child, then you lose the...bond because you are always going to be the child's parent but then they'll have that bond with somebody's else. That's not right.'*
>
> (Lone mother, not in paid employment, one child aged one)

The importance of a mother being with the child in the first year was also linked to issues such as breastfeeding, weaning and establishing 'healthy' routines (e.g. sleeping patterns). As this mother, who went back to work when her child was six months but found the breastfeeding rather difficult recalled:

> *'I wouldn't get back home until six, and then I could see him waiting for me. … And then when I came home it was like he would pretty much wait for me. And then the minute I'd like clean myself and breastfed him, he was just so hungry, he was just like, he was waiting for me to actually breastfeed him and I felt really bad, … he is grown up, and obviously he was taking a bottle at that point but he wasn't used to the bottle as much and he'd just wait for me to come home.'*
>
> (Partnered mother, in paid employment, two children aged three and five)

Mothers who went out to work before their child was one year old seemed to have done so mainly because of financial necessity, for example, if they could not afford not to work once paid maternity leave ended, or were not entitled to maternity pay because they had not been employed long enough to qualify. They did not really mention any advantages of childcare in the first year and some were open about the difficulties this created. Some mothers had to give up breastfeeding in order to go to work; experienced difficulties with introducing solid food; found that working (particularly full-time) stressful for both children and parents; and, missed not spending time with the children – as one mother put it: '...*completely gutted when I've to work on Saturday'*.

But mostly these mothers focused on how they made sure (and reassured themselves) that non-parental care would not 'damage' their children. As discussed later, this was largely done by choosing what were considered to be appropriate carers (e.g. a family member rather than formal childcare; a childminder rather than a group setting). Mothers also opted for working arrangements that got as close as possible to what, in their view, provided the best care arrangements for the children, which included:

- working part-time to ensure they could spend enough time with the children
- being self-employed as this gave them more control over how much and when they worked
- working when their partner was not working (i.e. shift parenting) in order to minimise or eliminate the need for non-parental care.

The cost of childcare, which for small children is typically high, was also an issue that shaped mothers' decision about the 'best childcare arrangements'. Mothers who used or considered using formal childcare wondered if '*it was worth bothering*' as a great proportion of their income went to pay for childcare and other work-related costs (e.g. travel), and they were hardly financially better off working.

As noted in the discussion of the literature, mothers also traded off one risk (or a less than ideal situation) against possible benefits (Roberts et al 1996). For example, the financial benefits for the family of maternal employment were seen as offsetting some of the difficulties associated with non-parental care at this early stage. As a mother who went back to work when her child was six months old explained:

> *'I've missed out on some things, his first steps, his crawling, … although I don't t work a long time every day I've still managed to miss it all, so that was quite hard, and obviously that's something that you're never going to get back …. And can be quite upsetting, so that's just me feeling like I'm missing out with him but in the long run it's going to be worth it.... we'll go swimming and we'll go up London to the Aquarium and stuff like that, whereas if I wasn't working I wouldn't be able to afford to do all that...we would just be stuck in the same four walls quite a lot, because there's not really a lot that you can do around here for free, either, so it would mean going out and out of the area, which obviously costs more, and then by the time you get there, then you've got to pay for what it is you want to do.'*
>
> (Partnered mother, in paid employment, two children aged three and five)

Interestingly the view that children need to be with their parents in the first year is in line with maternal leave provision in the UK. This is for one year (although only part of it is paid) and this policy decision was based on evidence of the benefits for children to be cared full-time by a parent in the first year[9].

[9] Families in the Foundation Years – Evidence Pack, Department for Education and Department of Health, July 2011: https://www.gov.uk/government/publications/families-in-the-foundation-years-evidence-pack

3.1.2 One to three year olds

Some respondents did not use or would not consider using childcare till children were able to talk and communicate to parents their experience of being cared for by others and children could communicate with the carer. This view was closely linked to the fact that 'strangers' would not be able to understand the child's needs and mothers needed to be reassured by their children that they were happy in their care. As discussed later, this was something that mainly (but not exclusively) applied to nurseries and childminders, as trust and 'not leaving a child with strangers' were key reasons for using family care. As this mother explained about the fact that her family looked after her child:

> *'So that's why [child is looked after by the grandparents] I wouldn't want to put him anywhere just yet because he can't tell people what he wants. He can't, whereas they've [grandparents] had him whilst I'm at work since he was five months old, they've learnt along the way like I have what he wants and what he needs and different ways for him to tell you stuff.'*
>
> (Lone mother, in paid employment, one child aged two)

Some of the issues that emerged in relation to childcare for children under the age of one, also applied to two and three year olds, although there was more diversity in how mothers' viewed these. For example, issues around feeding children were again mentioned as reasons for using or not using childcare. Mothers who stayed at home and for whom healthy food was important, tended to stress the fact that being at home meant that they could cook healthy meals, ensure children did not eat junk food and deal with 'fussy eaters'. They thought that childcare providers (particularly, but not exclusively formal providers) may not share the same views and practice in relation to food. On the other hand, some mothers who used childcare to go out to work and for whom healthy eating was important, said their income allowed them to have more options when shopping, including buying more expensive but healthier food. Furthermore, if they had any concerns about the food childcare providers offered (e.g. not sufficiently healthy or worried that may not meet their child's specific dietary requirements), they would provide a packed lunch and snacks.

Similarly, in relation to children's needs to socialise (seen as key as this stage in a child's life – see Chapter 2), mothers explained their respective decisions to use or not use childcare in opposite ways. Mothers who were not in paid employment tended to say that because they were at home they had time to provide children with opportunities to socialise that a working mother may struggle to offer in terms of range and frequency. For example, they mentioned 'stay and play' groups, going to the park, and frequent visits to family and friends. On the other hand, mothers who were in paid employment believed it was beneficial for children in this age group to be looked after by others, have the opportunity to socialise and not to be with their mothers all the time. Some mothers who were not in paid employment shared this view, and would have liked to use childcare but could not afford it, and/or had no or limited access to family support.

Views on the (in)appropriateness of delegating some parental tasks to others were still evident when discussing childcare for this age group, as it was for under one year olds. However, the perceived inadequacy of specific childcare

providers (e.g. a grandmother who would not provide sufficient intellectual stimulation; childminders who do not have enough space; staff in some day nurseries who are too young and inexperienced) also became more apparent, suggesting perhaps that childcare would be considered if the carer had the level and type of competence that mothers' expected. Furthermore, cost came up as an issue again and again, with some mothers not even bothering to explore formal childcare options, as they had already concluded from what they heard from families and friends that these would be out of their financial reach. As this mother explained about her decision to stay home till all her children were at school:

> *'Well when I, because my sisters which are older than me, they themselves had three children and I saw what they went through going back into full time work. And I knew the cost, how much it was costing them. I thought, well it might be cheaper if I stay home.'*
>
> (Lone mother, in paid employment, three children aged six, eight and 12)

3.1.3 Three and four year olds: pre-school

The benefits of (part-time) early education when children turn three were recognised and valued by mothers (and fathers) in the sample[10]. This was generally viewed as 'normal', what children do in the two years preceding school, and essential to establish firm foundations for their future academic performance.

While support of pre-school at the age of three was generally recognised, mothers in the study differed in relation to how this may provide an opportunity to seek paid employment, voluntary work or training. Those who saw their role as primary nurturer did not really seem to have considered how this 'free time' may change their role. For example, for a respondent who believed that mothers should focus entirely on their children till they go to secondary school, the 'free time' she had when they started pre-school did not trigger any thoughts about paid work at the time or in the immediate future. However, it was more typical for mothers to start considering how best to use this free time, particularly as this would increase once children started primary school. Options considered more or less appropriate (e.g. finding a voluntary job that fitted with the pre-school hours versus combining the free pre-school with some additional childcare to take a 'proper job') were again influenced by what a good mother should and should not delegate to others. However, pragmatic factors (e.g. cost of additional provision, availability of flexible employment) became more evident at this stage. When talking about younger children a recurrent theme was *if* children should be cared for by others to enable mothers to go out to work. However, from this stage, having accepted that it is normal and desirable for children be looked after and taught by others, mothers' narrative switched to talking about in *what circumstances* it would be desirable for them to go out work.

[10] All children in England are legally entitled to free part-time early education when they reach the age of three and take-up is very high, with 93 per cent of three and four year olds in early education (Department for Education 2012).

The universally held view that at the age of three children are ready to be looked after and taught by others, even among mothers who strongly believed it was their responsibility to look after and teach their children, is again linked to and possibly influenced by policy developments. It has been the norm for children in England to be in pre-school at the age of four for some time. However, a high level of participation at age three is a relatively recent development, which reflects the introduction of the first Childcare Strategy in England and a range of early education initiatives introduced since the late 1990s to increase provision and take-up of early education (which is now seen as combining both 'care' and 'education'). As it has been noted elsewhere (La Valle and Smith 2009), these policy developments have had the effect of 'normalising' take-up of (part-time) early education among three year olds.

3.1.4 Age five plus: primary school

As with pre-school, when children start primary school it is generally accepted that they will be away from their mother and it is considered 'normal' for schools to start playing a key role in educating children, albeit with parents continuing to have a role in supporting their academic development. So mothers in the study found themselves again with 'free time' and more than before as, while pre-school is usually part-time, children are in school for a full day. Issues mothers typically considered were: whether this free time could be used to go out to work (be it paid or voluntary) or do some training; and, if they did, whether the care of children when they were not in school could be shared.

While there were exceptions, it was typically considered appropriate for a 'good mother' to go out to work when children start primary school. However, some mothers did not consider it appropriate not '*to be there for the children'* when they came home from school to feed them, talk about the day at school and help them with their homework. As a respondent explained when talking about the children of her friend who worked:

> *'Because like her mum's never around, and they get pushed to clubs after school. And I just think like in a family, not that's being old fashioned, but like the dad goes to… work, the mum stays at home and looks after the kids and stuff, to, and I always want to be here when they come home from school. And, yeah, it's just what mums do, isn't it?'*
>
> (Lone mother, not in paid employment, two children aged five and ten)

Similarly, while after school activities (e.g. sport, music) were seen as desirable, for some mothers the range and frequency of these activities needed to be determined by children's needs rather than a mother's work patterns. For example, some mothers did not think it was suitable for children to go to an after-school club every day so they could go out to work, because children also need time to rest after a day at school. As one mother explained '*My job fits with his world'* and in order to work school hours she had to settle for a job that was considerably less paid and lower level than what she could have secured with her qualifications and experience. As another mother, who had a very part-time job, explained:

> *'I will not work beyond what's necessary so that I can be here for her until she probably goes to secondary school when I've got to let her go a little bit.'*
>
> (Partnered mother, in paid employment, one child aged five)

However, the willingness to consider a range of *ad hoc* or more regular childcare arrangements grew with children's age, and mothers who did not consider using childcare for pre-school children, were more open to a range of options that would enable them to go out to work once children started school. As with the pre-school stage, pragmatic factors dominated thinking about maternal employment and return to work options. While childcare cost did not appear to be a big obstacle, as it was in relation to pre-school children, the availability of jobs that fitted with school hours and the availability of out of school childcare for those who wanted to work longer hours were the main issues emerging. How to cover school holidays presented a particular challenge for both mothers who wanted to work part-time, as well as those who worked full-time, with cost and availability of holiday provision considered equally problematic. Furthermore finding a job with annual leave that matched school holidays was reported to be even harder than finding a job that matched school hours.

3.2 Suitable childcare providers

In line with much research in this field[11], in our analysis of mothers' perception of suitable childcare providers we distinguished three types:

- Fathers, whether living with the mother or not.
- Informal carers such as family members and friends, where care is privately arranged and is not regulated (or funded) by the state in any way, and often does not involve any monetary transactions.
- Formal childcare which is regulated, inspected and can be funded by the state; this includes group settings (i.e. day nurseries, play groups, nursery classes and schools, crèches) and registered childminders[12].

The extent to which mothers believed that their mothering role and tasks could be shared with or delegated to these different carers, and how this affected their views about paid work are discussed in the rest of the section. As before, while discussions focused on the link between care providers and conceptualisation of paid work, the links with voluntary work and training are also explored.

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[11] See for example the *Parents Early Education and Childcare Survey* series funded by the Department for Education http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/RSG/EarlyYearseducationandchildcare/Page2/DFE-RR240

[12] Nannies would also come under the definition of formal childcare. However, they are not regulated in the same way as other formal providers (e.g. they do not have to deliver the Early Years Foundation Curriculum to pre-school children) and very few families use them. For these reasons nannies are usually not (extensively) explored in research on childcare providers.

3.2.1 Fathers

Fathers could play an important role in enabling mothers to reconcile what they thought was best for their children with paid employment, and they were typically not seen as 'other carers'. An in-depth exploration of how mothers perceived their mothering role to be different from that of the father was beyond the scope of the study. However, what transpired from mothers' narratives and from the two fathers we interviewed was that for pragmatic reasons they had typically (but not in all cases) decided on a traditional division of roles, with mothers being the ones who stayed at home or worked part-time to look after the children, while fathers had the role of 'breadwinner', which could considerably limit the time devoted to children's care.

Even within a traditional division of child rearing responsibilities, where fathers were breadwinners and mothers the main carers (even if they worked full-time), fathers' contribution varied considerably. At one end of the spectrum there were fathers who worked very long hours and were often away from home and therefore contributed very little to caring for children. At the other end of the spectrum, there were fathers who were unemployed or had flexible jobs (e.g. self-employment, part-time job) and were able to do a considerable share of the childcare. There were also examples of couples who run a business together and arranged their working hours around the children.

While there were exceptions, typically a father's ability and suitability for looking after children (while the mother worked) was not questioned. In fact for some mothers a shift parenting arrangement, whereby they worked while the father looked after the children, was the only acceptable childcare solution, and they would have not considered going out to work if that involved non-parental care, particularly while children were small. Some lone mothers who did not take up paid employment because they did not want to rely on non-parental care while the children were small, also said they would have considered going out to work if the father had been available to look after the children.

Another advantage of fathers looking after children was that it could considerably reduce or even eliminate the high costs associated with using formal childcare (e.g. a nursery or a childminder). While for some parents this was seen as an *additional* advantage, alongside the factors mentioned above, for others the need to minimise or eliminate childcare costs was the main reason of relying on fathers to look after the children.

The main issues with fathers looking after the children so that mothers could go out to work centred around practical considerations, such as finding jobs that allowed parents to have a shift parenting arrangement. The strain that shift parenting arrangements put on a family (e.g. not having enough time as a family) was also reported by some.

As this mother, who took up paid employment when her daughter was a baby but then gave up because it was too stressful, explained:

> *'Money was tight, so we thought, I'll get a job as well, so it's extra money. But I didn't like being away from her, and my partner was finding it hard as well...like me being away from him, because I was never seeing him. He was at work all day, and when he come back I was at work. And I was*

working weekends as well on his days off... he was finding it hard, and like my little daughter … she was finding it hard… I was finding it hard being away from them, they was finding it hard being away from me, so.'

(Partnered mother, not in paid employment, two children aged six and nine)

The extent to which fathers' were able or willing to make adjustments to their working arrangements was also an issue, and predictably shift parenting seemed more difficult to arrange if parents were separated.

The unsuitability of fathers to care for their children was limited to cases where fathers were very disengaged from their parenting role (with examples in both dual and one parent families), and in one case where the father had been violent towards the mother and contact with the child was therefore very limited.

3.2.2 Informal childcare providers

Typically care provided by the family (mainly grandparents) was seen as 'the next best thing' to parental care, as family members were not 'strangers' and could be implicitly trusted. They were seen as loving and caring for the children as much as parents did, and it was seen as appropriate or even desirable for children to form a special bond with their grandparents. Relying on family care was also seen as the only non-parental care option among those who did not trust formal childcare (e.g. nurseries and childminders), as this mother explained:

'I would never trust any like, I wouldn't go to, I know they always pay childcare people. But I would never, and even like the people they, the Jobcentre and that, say, oh, we'll give you half the money. ..I'd rather leave them with my like parent, like my mum...'

(Lone mother, not in paid employment, two children aged five and ten)

Some mothers who had tried both formal childcare as well as informal care provided by family and friends tended to judge the latter as better for children.

As well as regular childcare, family and friends provided support with *ad hoc* care, for example, during school holidays or to enable mothers to attend training courses. As with fathers, another advantage of informal care was that, by and large, it was free or (e.g. in the case of friends) involved some reciprocal childcare arrangements (e.g. sharing the school pick-ups).

Mothers' accounts of (the potential for) relying on family care were linked to practical constraints, such as whether grandparents lived sufficiently close; their limited availability as they were working or had other caring commitments; the fact that they were too old or unfit to help. The suitability of grandparental care was not typically questioned, but there were exceptions. These tended to be linked to specific aspects of parenting (e.g. grandparents giving unhealthy food to children or not providing sufficient intellectual stimulation) and would not generally mean that mothers would not use (or considering using) grandparental care, but perhaps limit to what extent they relied on it.

3.2.3 Formal childcare providers

Views on formal childcare providers varied considerably with the greatest differences between the overwhelming positive views mothers had about school based nursery classes, compared with the more mixed views reported about day nurseries and childminders.

Nursery classes

Nursery classes cater for children from the age of three and it is in these settings that most children receive their free education entitlement (Butt et al 2007). While children can, and many do, receive their free education entitlement in a day nursery, and these are regulated in the same way as nursery classes attached to primary schools[13], some mothers in the study saw these two types of setting as serving very different purposes. Day nurseries were seen as providing 'childcare' for young children and where typically children spent a long time, while they saw nursery classes as providing (part-time) early education in the pre-school phase. Criticisms of day nurseries (e.g. staff are too young and inexperienced) did not seem to apply to nursery classes. Parental assessments of these two types of early years setting is partly supported by research, which has shown that compared with day nurseries, nursery classes have higher qualified staff and deliver better quality provision, which results in better cognitive and social outcomes for children (Sylva et al 2004).

Within a framework where day nurseries equalled childcare, while nursery classes equalled early education/pre-school, the former were seen as largely used by and for the benefits of working parents, while the latter were seen as being provided for the benefits of children. This may also have contributed to how mothers viewed the acceptability of these two settings.

Day nurseries

Some mothers had never used and would be unlikely to consider using a day nursery as it was seen as a poor substitute for parental care (particularly when children are small). Criticism of day nurseries focused on:

- Lack or insufficient one-to-one support and attention, which means that staff do not have time to teach children the routines discussed in Chapter 2 that mothers considered to be very important (e.g. washing their hands after going to the toilet, brushing their teeth).
- Children who go to a day nursery may not be able to form the bond with the main carer that, as discussed in Chapter 2, was seen to be vital for a healthy emotional development.
- Day nursery staff were perceived to be young and inexperienced; staff: child ratios were seen as too high; and, day nurseries were seen as having '*too many children running around'*.

[13] It should be noted though that nursery classes need to be led by a qualified early years teachers, while this is not a requirement for day nurseries.

- Day nurseries do not provide healthy food; one mother, for example, said that in a day nursery she had used *'...staff talked about healthy eating but then gave jam sandwiches to children all the time'*.
- There were also more generic concerns about child safety. News stories about child porn, abuse and accidents in day nurseries seemed to contribute to these fears.

Some mothers had more positive views about day nurseries, these were mothers who had used them, would consider or would have liked to use them if they could afford them. While these mothers were not necessarily uncritical of day nurseries and may have shared or even experienced some of the problems listed above, they thought that there were 'good' nurseries and 'bad' nurseries. In searching for a 'good' nursery and the 'right' place for their children, these mothers thought that parents need to consider:

- Staff's experience, qualifications and observe how they interact with children were seen as key and one would not choose a setting unless they were satisfied with these. As this father recalled about visits to day nurseries considered for his children:

  'Yeah, they [the children] were very happy. That was my biggest factor, how do they relate with the staff? Let me see if they warm up. And there was one lady there that was brilliant and she treated my daughter like she was her own, and I think she just fell in love with her as well.'

  (Partnered father, in paid employment, two children aged six and eight)
- Environmental factors, such as hygiene and cleanliness and adequate space for children to run around, were also considered important in choosing a setting.
- Good childcare was also described as supporting children's development and learning, particularly once they were beginning to talk, as a result of the additional attention from skilled staff, and interaction with their peers.
- The kind of food the nursery provided was seen as more 'negotiable', as if the food was not considered healthy or did not meet a child's specific dietary requirements, mothers could provide a packed lunch and snacks.

Childminders

There was a limited discussion of childminders, as very few parents had experience of using them, and more generally take-up of childminding care is low which probably means that mothers have limited opportunities to learn from other parents about experiences of childminding care. The key advantage of childminders was seen as providing the one-to-one attention that children, particularly small ones, need. As with nurseries, mothers who had positive views about childminders, trusted their professional judgment about healthy routines and believed the task of teaching these could be delegated. As a mother said about a childminder she knew and had considered using:

> *'Yeah, and that's another thing, I know that ... she's put pictures in her bathroom and she makes the kids brush their teeth and to know that she's got all signs up, wash your hands after you've been to the toilet.'*
>
> (Lone mother, not in paid employment, one child aged one)

This mother had also looked into the food the childminder provided to see if it was healthy and the activities children were offered, and again was reassured from what she learnt:

> *'...I don't know whether any other childminder does because I've not looked into it. I just took one of her leaflets the other day ... it just says what she does, all the qualifications she's got, what she will do in a week, about what she'll try to do with the children and it also says that in the week, what she'll, what kind of food she'll be giving the children as well. I know that she don't give them juice. They're only allowed water or milk, so I think that's good yeah.'*
>
> (Lone mother, not in paid employment, one child aged one)

On the less positive side, childminders were seen as not having enough space, their houses were described as being 'cluttered', children could not run around and there was not dedicated room for them.

Relationship with formal childcare providers

For mothers, it was important for formal childcare arrangements to supplement, rather than replace, their role; securing good childcare allowed them to feel that far from abandoning their children, they were doing the best they could to broaden their experiences and help them flourish. In this context, mothers could feel proud and pleased, rather than upset or guilty, that other carers had something extra to offer their child. As one mother said:

> *'When I discovered childcare... I did think, this is brilliant, this is absolutely brilliant, because [child's name] really flourished in nursery. Because here even today I cannot give them my attention, I can't.'*
>
> (Partnered mother, in paid employment, two children aged two and four)

Mothers appeared most satisfied with childcare provision when childcare staff recognised and supported them as primary custodians of children's health and wellbeing. This was demonstrated in various ways:

- Respecting and adhering to parents' routines, for example, when a childminder fed children and then insisted they do homework.
- Keeping parents informed about their child's developmental progress and respectfully suggesting ways they could support it.
- Providing information on menus and what their child had eaten.
- Welcoming parents into settings, and to participate in activities such as food tastings.

3.3 What aspects of mothering can be shared or delegated

Some respondents stressed the need for mothers to stay at home with their children while they were young, as this was seen as the best solution for their general development and wellbeing. These mothers could not really see how that role could be shared with others: '*Only mum knows what's best for her children'* , '*It's no good to pass them from person to person*'. As we saw in

Chapter 2, the role of the mother was inextricably linked to children's health and happiness:

> *'A healthy child is happy child and for children under two this means being looked after by their mum.'*

(Partnered mother, not in paid employment, two children aged four months and three years)

While others shared the view that mothers are responsible for children's health, wellbeing and happiness and emphasised the need to have control over children's development, they did not see this as being incompatible with sharing the parenting role and delegating some parenting tasks to others, while they went out to work or study. How they did this was mediated by the factors discussed earlier, that is: a child's age and stage of development, and the acceptability, availability and cost of childcare.

In the rest of the section we first look at how mothers shared with others the job of keeping children healthy, and then we specifically look at whether they believed their mothering role could be shared when children were unwell.

3.3.1 Sharing the job of keeping children healthy

In Chapter 2 we discussed how mothers keep their children healthy. Analysis of the data also shows if and how mothers thought this aspect of parenting could be shared with childcare providers:

- Breastfeeding and weaning were aspects of mothering that were seen as most difficult to share hence the belief that maternal employment in the first year of life is not good for children. Even mothers who took up paid employment at this stage recognised the problems this caused.
- Healthy eating was something that some mothers believed they could ensure, which ever childcare provider they used, and at any stage in the child's development (after breastfeeding/weaning). What food children would be fed was something that mothers considered in choosing a childcare provider, and if they were unhappy with the food provided, they dealt with this problem by providing a packed lunch and snacks.
- Although mothers commented on the opportunities for physical activities that different carers provided, these did not feature very prominently in discussions about acceptable childcare options. As discussed in Chapter 2, mothers seemed reassured that their children were getting sufficient exercise, and this was regardless of whether mothers were working or not and the resulting care arrangements.
- Some mothers believed that teaching healthy routines could be shared with others. Fathers were typically seen as doing a good job in this respect as they shared parenting style and practice. Grandparents came a very close second for the same reason (although there were exceptions). When it came to formal childcare providers (e.g. nurseries and childminders), while mothers did not talk about 'sharing' parenting style and practice, they were nevertheless reassured that early years staff were aware of the need to teach children healthy routines. Nurseries' and childminders'

standards in relation to these were considered when assessing the suitability of formal childcare providers.

- The importance for a child to have a secure bond to underpin a healthy emotional development reflected decisions to avoid using non-maternal care when children were very young, and/or to rely instead on carers with whom children could establish this bond, typically fathers and grandparents.
- Socialisation, another aspect of emotional development mothers considered very important, was seen as very compatible with using non-parental care, whether this involved mainly adults (e.g. family) or also other children (i.e. nurseries and childminders).
- Another way respondents 'managed' the sharing of the mothering role or the delegation of parental tasks was by making a judgement not only about what could be delegated/shared, to whom and at what point in a child's life, but also for how long this could be done (e.g. hours in a day, or days in a week). This was most notable in relation to children's emotional needs, with mothers limiting their working hours to ensure they could spend time with children or be with them at important times of the day (e.g. breakfast, when they came home from school, bedtime).

3.3.2 Child's illness

There seemed to be a polarisation of views in relation to caring for children when they were sick, with some mothers believing that others can step in to help, while others thought that '*When you are poorly you need your mother'*. Both mothers who did and did not use childcare believed that this particular mothering responsibility could not be shared or delegated.

Fathers were not really seen as 'others' and were typically considered as good as mothers at caring for children when they were ill or to cover medical appointments[14]. To what extent they did this depended on parents' agreed division of labour in relation to child rearing, which in turn affected how willing and/or able fathers were to care for the children when they were not well. Paternal help in dealing with children's illnesses was seen as particularly important by some working mothers to limit the time off work they had to take. If there were recurrent health issues (e.g. in a large family), shift parenting arrangements could be seen as the only feasible option, as they considerably limited the time off work that parents had to take.

Where mothers worked but there was no shift parenting arrangement (and where mothers did not work), it was more typical to assume that the mother would take care of children when they were ill or needed medical attention. When these responsibilities were shared, negotiating who would look after children when they were ill or who would cover medical appointments could cause tensions between parents, when both felt this would create problems in their respective jobs.

[14] As with childcare support, this does not include fathers who were very disengaged.

Grandparents were also reported to help out when children were ill or needed to be taken for medical appointments. However, their role in this respect did not seem as predominant as that of fathers, although it is not clear whether this was due to practical constraints rather than perceived unsuitability.

There was no evidence that children were being sent to school or nursery if they were really unwell (e.g. they may be sent if they had a cough or a cold, but not if they had a temperature or were vomiting). And it seems that even if parents tried, children would be sent back home as soon as it was suspected that they were ill. As one mother said, '... *they* (school) *kick them out very quickly'*.

In their accounts mothers stressed that whatever the circumstances they would put their children first and do whatever was best for them, even if this could feel uncomfortable (e.g. taking time off work) or meant a considerable sacrifice (e.g. giving up work in case of long term illness or disability). The study included a mother with a severely disabled child whose entire life had been dedicated to the child's care (with limited support from the family and children's services). Another mother had to give up a well paid job and successful career when her second child was born with Down's syndrome explains:

> *'Well there was never any question of leaving work [after the first child] because I didn't even consider it, I just thought that because I'd got my degree and I'd worked so hard and I'd achieved a certain level at work, I just thought it was a lot to give up. And I thought children would just adapt to whatever I wanted to do, but then [second child] suddenly changed all that for me because he came along with his extra needs and I really, I then thought, is it all worth it?'*
>
> (Lone mother, in paid employment, two children aged seven and ten)

When considering the issue hypothetically respondents predicted that they would do what these mothers had done:

> *'If he did have any, any health or anything like that, if anything did come up then I wouldn't even think about it. I'd just leave work, because he is my priority. Anything, if he did need me then I'd be there. There'd be no question about it.'*
>
> (Lone mother, in paid employment, one child aged two)

Among working mothers there was an underlying tension between what they saw as their 'duty' as mothers to be with their children when they were sick and how 'uncomfortable' they felt about taking time off work. As a mother put it:

> *'I get nervous because of work, because phoning up work to say you've got to have time off because your little one's not well, but obviously he comes first so in the end I have just to make my apologies and take the unpaid leave and look after him.'*
>
> (Lone mother, in paid employment, one child aged five)

Some employers were reported to be sympathetic but '*up to a certain point'*, others were clearly not. One mother said that on returning from maternity leave she had to guarantee to her employer that she had arrangements in place in

case her child was sick, so she would not take time off work. This mother ended up pretending that she was sick when her child was sick and then went to work when she was ill, as she was concerned about her sickness leave record. Another mother who had to take considerable time off work due to a combination of her child's and husband's illness had to go through a disciplinary procedure to explain and deal with what her employer saw as excessive time off work. In another example, a mother who was doing an internship and had to take two weeks off work because of her child's illness was seriously worried about having damaged her prospects of securing a paid job with the same employer, because she would be seen as unreliable.

Taking time off work when children were sick could also have financial consequences as the time off would be typically unpaid (unless mothers used their annual leave). In one case of a couple who were running a business, the combination of various family members being sick meant that both parents could do very little work for almost a month with considerable financial consequences for the family.

Self-employment gave mothers more flexibility to take time off work when children were ill, particularly if children required long term care, as this mother, who was a self-employed therapist, explained:

> *'I could be making more, I could be and I probably will up the ante now that my children have just started school and my little one's just started full-time in September. But I have this issue [mental health problem] with my eldest daughter, so ... I just take the work when I can and on an ad hoc basis, so yeah.'*

(Partnered mother, in paid employment, three children aged four, six and 14)

3.4 Conclusion

We have seen that mothers' decision about work were strongly influenced by whether and under what circumstances a 'good mother' can share the parenting role and delegate parenting responsibilities. Predictably, mothers' perceptions of the available options grew with children's age: under the age of one there was a consensus that full-time parental care was best, even if not all mothers in the sample were able to do this. Past the age of one, mothers' narrative was more likely to be dominated by the perceived acceptability of different carers and how much time (and at what times of the day) it was acceptable for a 'good mother' to be away from the children. The 'free time' that mothers had when children started pre-school and school was a clear trigger for starting to think about work options. While having free time seemed to be a key trigger, there was also the more subtle acceptance of letting go of the children and the fact that it was the 'norm' for others to look after and teach children once they reach the age of three and started pre-school.

The conceptualisation of a 'good mother' was mediated by how paid work was viewed in relation to mothers' self-esteem, emotional wellbeing and financial independence (from partner and/or the state). As it has been noted elsewhere (Bell et al 2005), mothers in this study with a strong orientation towards work reported greater conflicts in balancing their child rearing responsibility with paid employment. Reported difficulties related to the cost and availability of

childcare, access to family friendly employment, the sacrifices parents had to make (e.g. in terms of pay and type of job) to get a job that fitted with their childcare arrangements, and the compromises they had to make in relation to parenting practice (e.g. missing key developmental stages). However, even among mothers whose narratives seemed to equate a 'good mother' with being a 'stay at home' mother (at least while children are small), pragmatic factors, such as the cost and availability of childcare, seemed to have played a role in shaping their views about paid employment. As these were all low income families, living in London where childcare costs are the highest in the country, childcare facilities are in short supply and family care is less likely to be available (La Valle et al 2008), pragmatic factors seemed to have reinforced views that it is best for mothers to stay at home while children are small.

It should be noted that when talking about their role as parents and as workers, and how their decisions about paid employment affect their children, mothers may have wanted to present themselves on their best, rather than worst days. Although they were willing to talk about the challenges of both work and parenthood and occasions when things had not gone well, they felt that over time they had made choices that best advantaged their children. It may be that those who felt they had not managed to achieve a balance in these roles were less willing to speak to us. We can only say that, in their interviews, mothers were positive about their roles as both mothers and (where appropriate) workers.

4. Perceptions of how decisions about work affect children's health

In this chapter, we explore mothers' perceptions of how their decisions in relation to paid employment (i.e. whether to work or not, and the type of job) affected their children's health. We have seen in the previous chapters that children's health dominated discussions of what it means to be a 'good mother', and to what extent a mothering role can be shared with and tasks delegated to others so that mothers can go out to work. When it came to assessing how mothers' decisions around caring arrangements and work affected (directly or indirectly) their children, mothers found it more difficult to identify the links. They were able to articulate the reasons that underpinned their decisions to stay at home, work or have particular working patterns, but it was more difficult for them to assess whether the resulting care and working arrangements had the intended benefits for their children, particularly on their physical health and development. On this issue we found that we had to prompt mothers more than on other topics.

In the rest of the chapter, we first discuss mothers' perceptions of the impact of their choices in relation to work had on their children's physical health and development, and then on social and emotional development.

4.1 Physical health and development

As discussed in Chapter 2, mothers' narrative in relation to physical health and development focused on two key topics: healthy eating and physical exercise.

4.1.1 Healthy eating

In relation to healthy eating, breastfeeding and weaning were mentioned as key reasons for staying at home in children's first year of life. As we have seen, some mothers who went out to work when children were very young reported difficulties with breastfeeding and weaning. These centred around the high level of stress for the mother and child, for example, with the timing of the feeding being determined by the mother's working hours rather when the child was hungry. Some mothers had also given up breastfeeding earlier than they would have liked because they went out to work. However, these mothers did not typically talk about any possible long term impact on children's outcomes. Similarly, mothers who stayed at home talked about how much easier the breastfeeding and weaning had been because they were at home, but did not typically mention any long term benefits specifically for their children, although some more generic benefits were mentioned:

> *'...the most important thing any society should be doing is helping young people and children to become responsible, to take ownership, to invest... The people that I want to help don't have the education but you've got to get them young. You've got to get them when they're babies. If all babies were breastfed and it was such a proactive breastfed society you would be breeding a healthier generation.'*
>
> (Partnered mother, in paid employment, one child aged five)

We have also seen that healthy eating was central to some mothers' narrative of how one keeps children healthy, in relation to this there was no consensus on whether maternal employment is beneficial or detrimental to children's diet. It seems that mothers recognised the pros and cons of working or not working and developed strategies to deal with what could be the difficulties associated with their choice to work or not work (or work a limited number of hours).

Mothers who went out to work said that their income gave (or contributed to giving) children a healthy lifestyle, and while the conceptualisation of the latter was not confined to food, the ability to buy healthy food was seen as important. As this mother explained about the decision to go back to work:

> *'For me I felt I had to because it was getting to the point where moneywise it was becoming a struggle, because I didn't want to go back to how we were before. And obviously if we don't have money then I can't give them a healthy life. It wasn't just we were on benefits, we wasn't always on benefits, he'd always be at work so we'd just, we'd always have some sort of money coming in … For food, definitely for food, so to make sure that they have like a good mixture of food... So in terms of food and, was my main priority for them. Yeah, and obviously if, I just feel in order for all of us, well for them to be healthy then you'd need income, need more money.'*
>
> (Partnered mother, in paid employment, two children aged three and five)

As we have seen, when considering childcare options, working mothers looked at what possible carers would be providing in terms of food and mothers who were not satisfied would provide a packed lunch and snacks.

The view that a family income affects how well one can feed their children was also shared by some mothers who stayed at home and believed that if they could work they would be able to give their children a better diet. As a mother who had to given up work to look after her severely disabled daughter explained about her hope that one day she may be able to work:

> *'I don't know if anything like ... [I] could do it from home, so that's the thing, so at least you know that sometimes we can earn extra money like you know that it's all, like we can afford a few things, even the necessities like nowadays food is so expensive ... I know she [child] needs, I try, you know my best, I know she's got problems but we are sometimes like I read in the internet, oh if you give this thing for child to have, it's like, so we try to give all those things, like fish is good for her brain development and all those things, but fish is so expensive. So normal meat, chicken breast and all those things, it's so expensive. ...if you have more choice you will go for chicken breast, we don't have like choice, you will go for chicken legs...'*
>
> (Partnered mother, not in paid employment, one child aged five)

There were also some extreme situations when the family could not afford basic necessities, as this mother recalled:

> *'...that was a tough time because I think my husband wasn't working. Money was low...there was a struggle just about feeding them. And I remember that was, I breastfeed, fed him till six months.... we really had terrible time. It was, oh my God, really, really a tough time. Financially it was horrible. And then we had the meter. Sometimes we didn't have money to, in the meter so we had to make sure the family was in one room and we had an electric heater and they were threatening to cut off the water and electricity and the gas. And it was, so it was keeping them warm in that cold house.'*
>
> (Lone mother, in paid employment, three children aged six, eight and 12)

Some mothers who were not in paid work argued that '*you don't need money to be healthy*' and in relation to food they pointed to a number of benefits of being at home. First, they had the time to cook meals from scratch and this was equated with giving children healthy food. Second, seeing the mother cooking, or even involving children in cooking, was educational because children learnt about cooking and healthy food. Third, being at home meant that mothers could control children's eating habits (e.g. avoid them having unhealthy snacks or becoming 'fussy eaters'). While some of these mothers recognised that healthy food can be expensive, they thought that 'intelligent shopping' enabled them to give their children the same nutritional value of a more expensive diet (e.g. buy cheap but still nutritious food, look for bargains, shop for fruit and vegetables in the market where they are cheaper).

Whatever the circumstances and strategies mothers developed to provide their children with a healthy diet, again mothers did not really mention the long term impact of their decisions – they believed they had done the 'right thing' but did not seem to link this to any specific health outcomes for their children.

4.1.2 Physical activity

As noted in Chapter 2, physical activity was less of an emotive issue for mothers in the study. This was also reflected in the fact that when discussing work decisions, children's physical activity did not feature as prominently as a healthy diet or emotional development (see Chapter 3). Nevertheless, some mothers did link children's opportunities for physical activities to maternal income or the decision to stay at home.

As with food, some working mothers said their income meant that they could pay for children's extra curricula activities (e.g. football, swimming lessons) that they would have not been able to afford if they had not been working. Some mothers who stayed at home also said that their children could not take up paid activities, unless they were very cheap or there were concessions. However, they typically said it was not hard to ensure that their children had sufficient exercise for free, as this mother explained:

> *'There's so much, parks are free, places to go, museums. And then when Ken Livingstone was around transport was a lot cheaper but we even use Boris Bikes and she [child] stands on the Boris Bike to get that but I never said that...There's a lot you can do.'*
>
> (Partnered mother, in paid employment, one child aged five)

4.2 Social and emotional development

As discussed in Chapter 2, in relation to social and emotional development mothers' accounts of what was important centred around:

- developmental progress
- healthy routines
- social and emotional wellbeing.

In this section we explore how mothers' believed their decisions around going or not going out to work had affected these different aspects of their children's lives.

4.2.1 Developmental progress

For some mothers being at home when children were little was seen as essential for their emotional development and some could link this decision to children's outcomes. However, it was more typical for mothers not to be able to really pinpoint to how their decisions had affected children's development; and even if they did, as in the example below, they could not be certain it was down to their decisions around working or not working:

> *'Yeah, no, I think it's important to be at home with your baby when they're young. They need their mum to be there. I think it's not fair to be passed around from, to, from person to person. I think it's important, especially in them early stages to have the mum around. And I'm not sure, like personally because I don't know anybody that has been to work when they've had a baby, like personally, but I only know mums that have stayed at home. So I can't really... compare it. But my children are good as gold. Like they've always been like that. When they were little they know when their bedtime is, they've always had a routine, and so to me, like that is important. To stay, to, for me, to be at home with them, it was important. It helped them to be as they are today really, and they're bright kids. They're top of their classes, they're. But I've been there to help them from when they was early age to teach them to do everything. I've been there for [them].'*
>
> (Partnered mother, not in paid employment, two children aged six and nine)

Mothers who had gone out to work, particularly when children were small, did not mention any detrimental long term impacts on their children's outcomes, even when they said that their return to work may have been stressful for them and the children. Mothers were more likely to mention the effects it had on them, for example, missing being there for some key developmental milestones (e.g. first steps), which was described as hard and upsetting.

On the other hand, there were mothers who seemed to lack confidence in their parenting skills (e.g. '*I was never very good with children'*) who believed that going to nursery was good for their children's emotional development. This was mentioned by both mothers who used a nursery to take up paid employment and those who did not because they could not afford it.

4.2.2 Healthy routines

While supporting children's healthy routines (e.g. tooth brushing, washing hands) was seen as an important part of being a good mother, both mothers who went out to work and those who stayed at home seemed happy with the strategies they had developed to ensure their children picked up healthy habits.

For mothers who stayed at home, being there to teach and ensure children followed certain routines was seen as important. Mothers who went out to work ensured that those who cared for their children would teach children healthy routines that were considered important. Neither group said much about how these routines impacted on children's outcomes, apart from perhaps indicating that their strategy had worked (e.g. child brushes her teeth because she was taught to do so by....). Although there were exceptions, as indicated by the quote above where a mother said her '*children were as good as gold'* because she stayed at home and got them into a routine (e.g. bedtime).

4.2.3 Social and emotional wellbeing

It was perhaps in relation to social and emotional wellbeing that mothers were more likely to provide examples of how their children had been affected by their decision to work or not to work, and the resulting care arrangements. As discussed earlier, some regarded the bond that mothers form with their young children as fundamental to their emotional wellbeing, and could link the decision to stay at home with positive child outcomes. As this mother explained about her decision to stay at home till her child was two and a half:

> *'...I said to myself ...if I can invest in her now, those early years, I will reap the rewards. It's an investment that you put into her, her psychological needs, her self-esteem, her confidence. In that first year that she was born, I said, if I can get to her before she cries, she has no reason to cry. If I can, because you see the learned behaviour of children and babies to get the attention, you'll go, you'll drop something, they'll go. They'll escalate from zero to nine very, very quickly. It's learned behaviour, and you know what a forced cry is. So, if I got to her by the time, if I could understand her, read her.... She had no reason to cry, she absorbed information, she took it, by nine months, she couldn't speak, but I could talk to her like I can talk to you and she would understand...But yes, separation anxiety from nine to 18 months can traumatise them. I kind of know from my own childhood, I was neglected a lot and left alone. And there's always, you feel there's always a continuous sense of loss.'*
>
> (Partnered mother, in paid employment, one child aged five)

Failure to establish a maternal bond in the early stages was also seen as potentially having long term consequences for mother-child relationship:

> *'Like one of my mates in particular, she went to work, like she didn't have her full maternity leave. She's not very maternal, so I thought it was really strange when she had a baby. Because I thought, why did you, if you're not like that? And, like her kid prefers to be with me, because obviously that I'm fun auntie [name], than with her own mum.'*
>
> (Lone mother, not in paid employment, two children aged five and ten)

Just 'being there' for the children (e.g. when they are little, when they need support with their school work) was seen as having considerable benefits in terms of their self-esteem and confidence:

> *'Even when my daughter started to go to school I don't know what she's doing but I've noticed even just sitting by her looking at the maths, like 'what's that?' and 'that's confusion'. It gives her good morale and builds up her self-esteem because just by being interested it gives her confidence, oh yeah. And then in that confidence she does well.'*
>
> (Lone mother, in paid employment, three children aged six, eight and 12)

But respondents also talked about the lack of work having detrimental effects on maternal wellbeing, which in turn negatively affected children's wellbeing. For example, a lone mother talked about a period in her life when she was not working, had to live in a hostel and really struggled financially. As a consequence, she became depressed and believed that the depression contributed (or even caused) her child's speech problems.

Conversely work was seen as benefiting maternal mental health, which in turn positively affected children's wellbeing. For some mothers paid work formed an important part of their identity and it was linked to:

- A strong work ethic and belief in the importance of instilling it in children and providing a positive role model. While this was seen as a reason for working (as the example below illustrates), it was also mentioned by non-working mothers, who either saw their partner as fulfilling this role or, particularly if they were lone mothers, saw it as something they aspired to do (e.g. they were looking for a job or planning to go back to work when children were older):

  'Yeah, but I also think it's [working] a good role model for your children because they grow up knowing, oh mummy goes to work and when they grow up they'll have the same thing of, oh I need to go to work.'

  (Partnered mother, in paid employment, two children aged two and four)

- Wanting to be financially independent (from the state and/or the partner), as this mother explained:

  'But I was obsessed with getting a bit of cash for myself. ...I want to be independent. I don't like relying on anyone. So the whole work thing for me it's having a job, it gives me a sense of wellbeing.

  (Lone mother, in paid employment, one child aged five)

- Being able to socialise and being valued for being more than 'just a mum':

  '...I love them so much, but …when you're just spending all day every day with them and ...say when she was ill and I was stuck in, not stuck in but if I was at home with her, I wouldn't talk to another adult all day… And so I was enjoying the fact that I was making friends through work… having adult conversations and doing something for myself. I wasn't just, mum. I was me again...I was getting a break from the household, I was getting a break from the kids... But like silly things, like when you're with a child that young you couldn't go to the toilet without them following you...'

> *'And everything was so focussed on the baby that you forget who you are. You're just mum. There to facilitate this child... There to do what they want. And so it was nice to be able to go to work. I could go and get a sandwich for my lunch and eat it by myself without someone else sharing it with me. I could go to the toilet without a trail of kids behind me... So for me to get away from that all I think was good for me and obviously if I'm happier and calmer then it passes on doesn't it, to the kids...'*
>
> (Lone mother, in paid employment, three children aged four, six and eight)

However, the impact of maternal employment could also be negative if juggling work and mothering proved very demanding. This was typically associated with working when children were small and/or working full-time. These mothers did not feel they had found the right 'balance' and work was very stressful:

> *'Well I'd leave work at half five, get to the nursery for six... be home - and I wasn't driving then- be home by half six but by the time you, if you hadn't made a meal, making a meal and making a meal that's obviously child friendly as well when they were younger. And then the bath, routine, just, even once you sit down and relax with them for 20 minutes. No it was just like you're always on the go, go, go, go, go.'*
>
> (Partnered mother, in paid employment, three children aged four months, seven and nine years)

Finally, as discussed in Chapter 2, mothers saw it as their responsibility to ensure that children had opportunities to socialise so they would become confident, independent and develop social skills. We have seen that mothers' views differed considerably in terms of whether working or non-working mothers were better placed to provide these opportunities. This diversity of views was reflected in the narrative about the impact that working versus not working had on children. Some mothers believed that leaving children in the care of others (e.g. in a nursery, '*passing them from person to person*') would undermine their confidence and they would become 'clingy'. However, others believed that giving children the opportunity to mix with others was important for their confidence and sense of independence. A few mothers provided examples of how working/not working can affect children:

- A 'stay at home' mother contrasted the confidence of her children when they started pre-school, with a clingy child of a mother she knew who had gone to work when the child was little.
- Another mother believed her child had not had enough opportunities to mix with others. This was due to the fact that she was not working and therefore could not afford to send him to a nursery; and, she and her husband had no family in London and very few friends. She explained, her child was very clingy and seemed scared of people, and she thought this was due to the limited opportunities he had had to socialise. This is how she explained how her child would benefit from going to a nursery:

  'They can have more, like more conversation, because it's just me... there [at the nursery] they're going to have more people to make more conversations, playing with him, he going to learn more things I think than the stay with me in home.'

  (Partnered mother, not in paid employment, one child aged one)

However, on the whole mothers offered few examples of how children's social skills and confidence had been affected by mothers' decisions around work and the resulting care arrangements.

4.3 Conclusion

As we have seen, mothers' narrative about the effects of their work versus non-work decisions and resulting care arrangements centred around 'doing the right thing' for the children. While some mothers talked about the experiences of different care and work arrangements (e.g. being stressful, being good for the children, fitting with their child's world), they less commonly mentioned examples of how their decisions may have affected children's outcomes in the long term, particularly in relation to physical health and development. Furthermore it seems that mothers developed strategies that compensated for any potential problems associated with certain decisions (e.g. finding cheap but nutritious food and free activities if they were struggling financially because they were not earning any money; giving children a packed lunch if they were not happy with the food provided by the nursery).

It was perhaps in relation to children's social and emotional wellbeing that mothers more explicitly saw the links between parental employment and child health. On the negative side there was the belief that, in the first year of life, it is much better for children to be cared for by their parents – a view that was shared even by mothers who went back to work and had to rely on non-parental care in the first year. On the positive side there was the view that work was crucial for maternal mental health and wellbeing, and that this in turn has a positive impact on children's wellbeing. Furthermore, mothers' perceptions of what was good for children's development were very broad and included, for example, the need to instil in children a work ethic and a desire to succeed in life; having (one or both) parents working (and not relying on benefits) was seen as key to transmitting these values to children. However, the benefits of working in relation to maternal and children's wellbeing partly depended on the ability to find the right balance between work and family life, which mainly meant finding a job that allowed parents to have enough time and energy to fulfil their parenting role, and to a lesser extent not having to sacrifice too much in terms of pay and type of work in order to secure a job that could 'fit with the children'.

5. Keeping children healthy: what support parents want

In this chapter we consider the policy implications of the research findings and report what mothers believed could be done to help parents to keep their children healthy. We first look at the role of health services, early years and education settings in supporting parents, we then explore other suggestions respondents said would help parents keep their children healthy. We conclude by looking at the role of family friendly working arrangements and childcare in supporting parents to keep their children healthy.

5.1 The role of health services

While mothers in the study talked about 'trusting their own instincts' and being supported by their mothers and other family members and friends in keeping their children healthy, predictably health services also played an important role. From mothers' accounts the kind of services they wanted were:

- Non-judgemental so they can be open about the support they needed and the difficulties they are facing without feeling a 'bad mum'. This was particularly important for mothers who were insecure about their parenting skills and/or did not have access to advice from family and friends.
- Holistic so that parents can get not only advice on a wide range of health issues (from breastfeeding to mental health), but also advice on or signposting to other family services (e.g. housing, employment, childcare).
- Consistent and good quality health advice and care, and levels of care matching needs rather than the availability of funding.
- Flexible, in terms of opening times and location (e.g. near where parents live) and responsive (e.g. being able to accommodate appointments at short notice). Flexibility was particularly important for working parents, as negotiating time off for children's medical appointments could add to the stress of the 'juggling act'.

5.2 The role of early years and education settings

Children's Centres were reported to make a real difference in terms of supporting some mothers to keep their children healthy, and were also seen as important in supporting mothers' wellbeing. Those who had accessed Children's Centres were very positive about the support received; as a mother explained when her second, disabled child was born and she stayed at home to look after him, and she: '*entered this whole new world of Children's Centres ... and it was fantastic*'. Features of Children's Centres mothers particularly valued were:

- Availability of (free) courses on different aspects of parenting and a range of information relevant to families.
- Access to various groups that gave both mothers and children the opportunity to socialise – this was particularly important for mothers who

did not go out to work, lone parents and those with no/limited social networks.

- Access on one site to a range of family services (including childcare) and being signposted to services not available on site.
- Specialist support and advice to families with disabled children, including, in one case, childcare facilities and the child:staff ratio required to look after a severely disabled child.
- It would appear that Children's Centres were mainly accessed by mothers while they were not working (i.e. 'stay at home' mums and mothers on maternity leave). Some working mothers commented on the fact that Children's Centres' facilities and activities were only available during the week and therefore not really accessible to parents who go out to work and would only be able to use them at the weekend. Respondents also commented on the fact that Children's Centres are only available to families with pre-school children, while families still need the kind of support and advice they provide when children are older.

Formal childcare providers (e.g. nurseries and childminders) were also seen as playing an important role, but this was seen as distinct from that of Children's Centres. While the latter mainly supported parents to enable them to keep children healthy, childcare providers directly supported children's health, through:

- the promotion of healthy eating
- helping children to develop their social skills
- enable children to engage in a range of physical activities
- developing their immune systems
- encouraging hygienic behaviour and habits.

The limited role formal childcare providers seemed to play in relation to advising parents on physical and emotional child health issues and routines was somewhat surprising. While childcare settings' primary role is to support children's learning and give advice to parents centres on this (e.g. how to improve the home learning environment), they are expected to work in partnership with parents to support all aspects of children's development[15]. Indeed in the recently introduced Early Years Foundation Progress check at the age of two, childcare providers must discuss with parents children's emotional and physical development. Furthermore providers are meant to share with parents health relevant information on a daily basis (e.g. what the child has eaten, if the child was not feeling well or was upset) and healthy eating is part of the Early Years Foundation Stage curriculum nurseries and childminders must follow. Given these expectations about the exchange of child health information with parents, it was somewhat surprising to find that nurseries and childminders were not reported to have a more prominent role in relation to health advice. For example, this was found to be the case in the evaluation of the pilot programme that provided free early education to the disadvantaged two year olds (Smith et al 2009). It is possible that this is due to the limited

[15] http://media.education.gov.uk/assets/files/pdf/eyfs%20statutory%20framework%20march%202012.pdf

time we were able to devote in the interviews on discussing parents' relationship with formal childcare providers. Furthermore, it may be that the focus on some health issues is more likely to be a feature of day nurseries and childminders who provide full-time care for younger children (e.g. when children need to be potty trained, may sleep and eat in the setting), and a limited number of mothers in our sample had accessed these. Our findings, therefore, are rather tentative but could point to 'missed opportunities' to provide parents with advice on child health and scope for all childcare settings to play a bigger role.

We have also seen that how nurseries and childminders supported children's health was an important consideration in choosing a childcare provider. Mothers seemed to obtain information on this mainly from providers' literature, their own observations of the setting and Ofsted reports. It would seem important to stress to providers and inspectors the value parents place on this information and consider opportunities for expanding what 'health related' information is made available to parents.

Schools were also seen as promoting and supporting children's health, and they were largely seen as performing the same health functions as childcare providers. However, there was dissatisfaction among some mothers with schools dinners and information provided about these. Criticisms tended to focus on the fact that they were not very healthy, but also that they were not to their child's taste and portions were too small. While parents seem to believe that school meals should be improved, research has shown that school meals in both pre-school and primary school are actually healthier than packed lunches, which could suggest that parents may need better information on the nutritional value of school meals (Nicholas et al 2013; Evans et al 2007). Furthermore, criticism of school meals was not universal, some respondents commented on local initiatives that provided free school meals to all children. They said these could support children's health in two ways: first, they ensured children had at least one healthy meal a day; and second, it meant families could afford healthier options as they had more money to spend on the food provided at home.

5.3 Other help to support healthy lifestyles

While views varied, the fact that healthy food (e.g. vegetables, fruit, fish) is expensive dominated mothers' accounts, which is not surprising given that our study focused on low income families. We have also seen that some mothers reported extreme situations when they did not have sufficient money to feed their children.

Suggestions respondents had for helping parents to keep children healthy included vouchers for milk, vegetables, fruit and other essentials. Some respondents who were aware of Healthy Start vouchers argued these should be more widely available, for example, they should be available to all low income families and not just those on benefits.

Other suggestions also closely reflected the support provided by other public health initiatives, such as Change4Life, which was specifically mentioned by

some mothers as the kind of support families need to support their children's health. But even mothers who did not seem to be aware of Change4Life mentioned the kind of support the initiative provides, that is free exercise classes for the whole family, as well as those specifically for children and adults, and healthy cooking courses and advice on healthy eating, as well as better access to open and green spaces.

5.4 Tailor work around the family

From respondents' accounts of their experiences of taking up paid employment and from what they said when specifically asked what could be done to support working parents to keep their children healthy, it clearly emerged that some mothers felt that : '*England is very backwards when it comes to being family friendly*'. Some respondents had experienced sympathetic employers when it came to negotiating working hours and time off when children were ill, and reported examples of good practice (e.g. employers providing childcare vouchers and information about local childcare options). However, other responders felt that much remains to be done to make workplaces more family friendly. Mothers' suggestions reflected very much the difficulties they had experienced and centred around the amount of time they are able to take off when they have a baby; the availability of flexible jobs; and, the availability and cost of childcare facilities.

Much of what mothers suggested in relation to family friendly working arrangements is already covered by employment legislation and EU regulations[16], but mothers in our study did not seem to benefit from these entitlements. This could partly reflect the fact that our sample included many parents in a weak labour market position (e.g. with low qualifications, low skill levels) and, as it has been noted elsewhere (La Valle et al 2002; La Valle et al 2008), parents' ability to secure family friendly working arrangements can largely depend on having a strong labour market position.

Parental leave

Suggestions about parental leave centred around two key times when inadequate leave arrangements could cause much stress for parents and children, namely in the child's first year of life and when children are ill.

While mothers are legally entitled to take a year's maternity leave (and now some of that leave can be shared with fathers) not all of this time is paid, and part of the leave can be paid at a level well below a parent's wage. Some respondents specifically mentioned the need for mothers to stay at home in the first year, but others just stressed the need for one of the parents (i.e. either the mother or father) to stay at home with the child and be given adequate financial support to do that and avoid the stress associated with going back to work 'too early'.

[16] For example, employees have a right to request unpaid parental leave, time off for family emergencies and flexible working arrangements. https://www.gov.uk/time-off-for-dependants

Respondents also said that the government should make it easier for parents to take time off when children are ill and employers should be more understanding as it could be very 'uncomfortable' to take time off, and parents should have a right to take time off when children are sick:

> *'Definitely give that parent the right to have the time off whenever their child's sick. It's not just sick in terms of the child's coughing and they're feverish for one day or two days, it's like if they have chicken pox, or if they've got like a disease, or just something where that parent knows that they have to be at home. So I think whether it be, getting a letter from the GP to say, look, this parent needs X amount of time off work, then it should be made allowed. … and then it's like you can only be so comfortable with your job up to a certain point when something happens at home... it's even worse if you're a single parent because obviously you can't….you've got the whole balancing thing to do with trying to arrange somebody with, to look after the sick child when you know you're going to lose your job.'*
>
> (Partnered mother, in paid employment, two children aged three and five)

Here the discussion was typically about parents (i.e. either mothers or fathers) having easier access to time off when children are ill, with no one suggesting that this right should be confined to mothers.

Flexible jobs

Respondents also said there should be more flexible jobs available, jobs that can fit around school hours and holidays and allow parents to be with their children at important times of the day (e.g. breakfast, when they come home from school). As we have seen in Chapter 2, the Young Research Advisors also stressed the need for parents to spend enough and quality time with children.

Flexible jobs were also seen as important because they avoid the complications, stress and costs associated with out of school care, particularly during school holidays.

Flexible jobs were believed to be in short supply and some mothers said that job applications stating a preference to work school hours are not seriously considered.

Childcare

As many other studies have found (e.g. Butt et al 2007; La Valle et al 2008; La Valle and Smith 2009) respondents wanted more support with childcare, both for pre-school children, but also when children start school, to cover school holidays and before and after school hours. The government was seen as mainly responsible for providing this help and particularly for ensuring that childcare is affordable. It was also argued that support with childcare should be provided to parents who are looking for a job and who want to enhance their employability (e.g. take up some training), as currently most schemes (e.g. childcare vouchers and the childcare element of the Working Tax Credit) are only available to working parents.

Some respondents also mentioned that employers (particularly large ones) should provide some support, for example, help with childcare costs[17] and workplace crèches. The latter were seen as desirable partly to increase provision, which was seen as being insufficient, but also because it was reassuring for parents to have the child nearby in case 'anything happened'.

As England has the highest childcare fees in Europe (Lloyd and Penn eds 2013), it was not surprising that cost of childcare featured very highly on the list of respondents' requests for help, particularly as the sample was made up of low income families living in London, where childcare costs are the highest in the country (La Valle et al 2008).

5.5 Conclusion

The study found that being a 'good mother' is part of mothers' identity with keeping children healthy considered a key responsibility of a 'good mother'. While mothers varied considerably in terms of attitudes to and decision about paid employment, they were all influenced by the belief that they played a key role in ensuring their children's health and wellbeing, and their caring (and working) arrangements were strongly influenced by what mothers believed children would be able to benefit from, cope with or at the very least not be damaged by. Some mothers believed that maternal employment did benefit children's health: maternal income could mean that the family could afford healthier food and sport activities for the children. However, it was in relation to social and emotional wellbeing that mothers identified the main benefits for children: work was seen as having a considerable positive effect on maternal mental health, which in turn had a positive impact on children's wellbeing.

The study has also shown that the extent to which mothers and children (and the family as a whole) could benefit from maternal employment depended on securing what mothers considered to be suitable working and caring arrangements. However, judging from mothers' accounts, there is much to be improved in terms of employment and childcare policies, and particularly to ensure these work for low income parents. Some mothers in the study seemed to be faced with the option of: a) working arrangements that could result in high levels of stress for mothers and their children; or b) not working or accepting a job which 'fitted with the children' but was at a lower level and less well paid than those mothers could have secured with their qualifications and experience.

While the findings on how parents in paid employment can be supported to keep children healthy have implications mainly for employment policies and for support provided to families with childcare, parents also described changes in other policy areas that could support families. First, Children's Centres, which were reported as playing an important role in helping parents to support children's health, might be made more accessible to working parents (e.g. open at the weekend) and to families with children over the age of five. Second,

[17] There is currently a government supported scheme which provides an incentive to employers to offer parents childcare vouchers.

there seems to be potential for nurseries and childminders to get more involved in public health promotion campaigns. While the Early Years Foundation stage requires childcare providers to promote good health[18], our research suggests that there may be scope for some settings to do more in relation to heath promotion, as their role in this respect did not feature very prominently in mothers' accounts. Strengthening the role of childcare settings in relation to health promotion could be particularly beneficial at a time when free early education for disadvantaged two year olds is being considerably expanded[19].

Finally, it would be useful to consider other research that can help to understand the relationship between parental employment and child health, and how working parents can be supported to keep their children healthy. This could include:

- A replication of this study focusing on fathers to gain an understanding of their role in supporting children's health, and the relationship between this role and paid work.
- Additional research with higher income families and with more geographically diverse samples to explore parents' experiences in different childcare and employment markets.
- Further exploring the links between health, wellbeing and parental employment from the perspectives of children and young people.
- Further exploring the links between health, wellbeing and parental employment for mothers and fathers of disabled children.
- Additional research on the associations between use of informal care and children's outcomes. There is a considerable body of evidence on the impact of nursery care on children, but little on the impact of grandparents or fathers caring for children; given mothers' strong preference for these options, it appears important to get a better understanding of their impacts.
- Research to gain a better understanding of the ways in which Children's Centres are used by working parents (both mothers and fathers) and whether there are benefits in making them more accessible to working families.

[18] http://media.education.gov.uk/assets/files/pdf/eyfs%20statutory%20framework%20march%202012.pdf

[19] In September 2013 20 per cent of the most disadvantaged two year olds will be entitled to a part-time childcare place, and this will be extended to the 40 per cent most disadvantaged two year olds in September 2014.

Appendix A. Recruitment documents

A.1 Screening questionnaire

Introduction:
As I mentioned, we want to talk to a wide group of parents to ensure we cover different views and experiences, so if you don't mind I'd like to ask you some questions about you and your family. Just to remind you that all the information you provide will be treated in the strictest confidence and will only be available to members of the research team.

Questionnaire:

1. How many children under the age of 8 live with you? ☐

2. What are their ages?

	Age
Child 1	
Child 2	
Child 3	
Child 4	
Child 5	

3. Do any of the children have a longstanding illness or disability? (By longstanding I mean anything that has troubled her/him over a period of time or that is likely to affect her/him over a period of time?)

	Disability/ illness
Child 1	
Child 2	
Child 3	
Child 4	
Child 5	

4. Do any of the **pre-school** children attend any of the following:

	Nursery	**Playgroup**	**Nursery class**	**Childminder**	**School (older)**
Child 1					
Child 2					
Child 3					
Child 4					
Child 5					

5. Are any children looked after by grandparents, other family members or friends on a regular basis, that is once a week or more often?

	Informal childcare
Child 1	
Child 2	
Child 3	
Child 4	
Child 5	

6. At the moment are you in paid employment?

Yes *(If yes, go to Q7)*	
No *(If no, go to Q10)*	

7. How many hours a week do you work on average, including paid and unpaid overtime? *[if unable to provide overall average, ask about average in last month]*

_____ hours

8. Do you regularly, that is once a month or more often, work at the weekend? *[If don't work regularly ask about the last month]*

Yes	
No	

9. Do you work before 7am and/or after 7pm once a week or more often? *[If don't work regularly ask about the last month]*

Yes	
No	

10. Do you live with a partner or wife/husband at the moment?

Yes (If yes go to Q11)	
No (If no go to Q 15)	

11. Is your partner/husband/wife in paid employment at the moment?

Yes	
No	

12. How many hours a week does s/he work on average, including paid and unpaid overtime? *[if unable to provide overall average, ask about average in last month]*

Yes	
No	

13. Does s/he work regularly, that is once a month or more often, at the weekend? *[If don't work regularly ask about the last month]*

Yes	
No	

14. Does s/he work before 7am and/or after 7pm once a week or more often? *[If don't work regularly ask about the last month]*

Yes (If yes go to Q11)	
No (If no go to Q 15)	

Is your monthly **family** income before tax below or above £ 25,000? [*including income from all sources for all family members i.e. from employment, benefits, tax credits*]

Above (if above go to Q16)	
Below (if below go to Q17)	

15. Are you or your partner/husband/wife in receipt of any of the following:

Income support	
Job Seekers Allowance	
Employment and Support Allowance	
State Pension Credit	

Child Tax Credit	

16. And finally can I just check your ethnic origin, are you:

White (including white British and other nationalities)	
Black (including Black African and Caribbean)	
Asian (including Indian, Pakistani, Bangladeshi and other Asian origin)	
Chinese	
Mixed ethnic origin	
Other	

17. *Record respondent's gender [Male/female]*

Male	
Female	

If the respondent meets our selection criteria/quota the researcher will arrange a time and place for the interview.

A.2 Recruitment leaflet

Page 1 of 4

What do YOU think?

It's hard to be healthy when you've got no money. I need to work.

It's hard to be healthy and hold down a job. I need to be at home to look after my kids.

We want to talk to parents working part-time or full-time about their views and experiences of work and their children's health. You can call **Jen** on 020 7843 6324, text 07528 381533 or email jgibb@ncb.org.uk to find out about taking part in our research.

If you take part you will receive a £20 high street voucher to thank you for your time. (It's fine for both parents to take part - we're keen to speak to mums and dads and will happily give you £20 each!)

Read on for more information….

Parental Employment And Child Health

Research Centre | ncb

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Research Centre | ncb

Who are we?

The National Children's Bureau (NCB) is a charity that works to improve different aspects of children's lives.

We want to hear your views so that we can help the government know what parents think about how to improve children's health.

Who can take part?

We would like to talk to mothers and fathers who:

- Are currently **in work**, full or part-time (we've already spoken to parents who are not working).
- Have a child between 6 months and 7 years
- Are **not** on maternity leave at the moment
- Live in London
- Have an annual household income of **below £22,000**
- Taking part in this research will **not** affect your benefits.

We know parents are busy so all those who take part will be given a £20 high street voucher as a thank you.

Page 3 of 4

What do I have to do?

①Get in touch with Jen (details on the back) who will tell you more about the study.

②Jen will ask you a few short questions. This will help us talk to a good mix of parents.

③Jen will arrange a time to talk to you in depth about any work you do, your views on childcare or school, and how these things affect your child's health.

Jen can come to your home, at a time that suits you, so you don't need to travel.

You don't have to answer any questions you don't want to and you can stop the interview at any time.

What will you do with the information?

With your permission Jen will record the interview and this will then be written up. The write-up will not include your name or contact details.

All the information you give us will be **confidential**. It will feed in to a report but this won't include anybody's name or other details. If you change your mind before it is written we can easily take your views out.

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If you would like us to, we will send you a summary of the research when it is written up.

More about the study

This study is being carried out by the NCB Research Centre. It is funded by the Department for Health and will feed into a larger study being carried out by UCL Institute of Child Health

For more information about the NCB Research Centre you can visit our website:

www.ncb.org.uk/research

We hope you will consider taking part in this important study.

Thank you!

Contact Jen to find out more:

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Parental Employment And Child Health Research Centre ncb

A.3 Sample characteristics

Table A.1: Profile of respondent characteristics

Criterion	Sample profile
Age of children	Five families[20] with pre-school age children only, 14 with school age children only, and seven with both pre-school and school age children.
Family size	Families of different sizes including nine with one child, eight with two children and nine with three or more children.
Care arrangements	Families had a range of care arrangements: 12 were using formal childcare (e.g. a nursery or childminder) and 12 had regular informal childcare (provided by family and friends). Eleven families were currently using neither.
Disability/ SEN	Five families included a disabled child or a child with mild special educational needs (SEN).
Ethnicity	Eighteen respondents were white, while nine were from ethnic minority groups (i.e. from Black British/ Black African, Asian and Mixed backgrounds).
Family form	11 respondents were lone parents, while 16 were from a dual parent family. Among the former, seven mothers had previously lived with the children's father.
Employment status	Six lone parents were in paid employment and five were not. In six dual parent families both parents were in paid employment, while in nine only one parent was in paid employment. There were no dual parent families where neither parent was in paid employment.
Working hours	11 respondents were working part-time and five full-time. Among the 11 respondents who were not working when interviewed, five had previously been in paid employment after having children, and all but one had worked before having children.

[20] A father and a mother from the same family were interviewed, so when counting families (rather than respondents) the total sample size is 26.

Appendix B. Fieldwork and analysis documents

B.1 Topic guide

Introduction

- Introduce self & NCB. Introduce study: aim and explain part of larger study being carried out by University College London and funded by the Department of Health, focusing on parental employment and child health
- Findings will be written up in to a report- due April next year.
- Digital recording – check OK, and reassure re: confidentiality
- Reminder of interview length (around 90 mins), can stop at any time if need a break or do not want to carry on with the interview. Can say as much or as little as they wish.
- Any questions/concerns?
- Sign consent form

Context setting

1. Firstly, as you know this study is about employment and **health.** But people have different ideas about what "health" is, so I wanted to ask about yours!
    - What do you think about when I say the word 'health'?
    - And how would you describe a 'healthy child'? What does being a healthy child involve?

[follow-up]. Then explain that, for **this** study, our definition of health includes **physical and emotional** health, for example **eating** and **nutrition**, healthy **hygiene** (e.g. hand washing), **check-ups**, **sleep**, **accidents** and tumbles, **illnesses** and infections, **happiness**, **teeth**, **exercise** and so on.
Now, we'll come back to health in a minute, but first of all – just a bit about you.

2. How long have you lived in this neighbourhood? Do you have family/close friends living nearby? (*would you say you have good network of people around you?*)

3. Who lives at home with you?

4. Has your child/ have your children ever had any health problems?

   - **Significant health problems** (e.g. requiring hospitalisation, long term). How disruptive have they have been for your child/ rest of the family? (e.g. absences from school/early years setting, time off work)

   - **Minor illnesses** (e.g. coughs, colds). How often does this happen? How disruptive they have been for child and rest of the family (e.g. frequent absences from school/early education setting, time off work)

Employment

5. At what age did you leave full-time education? What were you hoping to do at the time/ what were you plans when you left school/ college?

6. What you have done since leaving full-time education? What kind of jobs have you had? Have had and any times when you were not working? (check any voluntary work, caring responsibilities, own illnesses etc)

7. If relevant, can you tell me a bit more about your ***current/last job***? (What was your job? What were the working hours? What did you like/dislike about it? Why are you no longer in that job- if relevant.

8. How did **having your (first) child** affected decisions about work?

   - How much choice at this stage: (were you able to go back to the job you had before? Explore maternity leave arrangements briefly). What age did you think was the best time for you to think about work? Why?

   - If working was a consideration: What type of jobs were you thinking of? Were you looking for something with specific hours/ in a specific location? If yes, why, what did you think the benefits would be (explore in relation to babies health)?

   - If returning to previous job: what was it like going back in terms of fitting that in with family life? Is it easy to take time off if you need be at home with your child (explore in relation to health)?

   - What childcare options were available after having the first child. (e.g. formal and informal childcare, parenting arrangements). Was this a key consideration when thinking about going to work? What were your preferences at this point? (explore in relation to health)

   - Partners/ child's other parent role: are they involved much on a day to day basis? What kind of things do they do? Are they in work? How does this affect the amount of time they have or support they offer? Were they involved in decisions that relate to the health of your baby?

9. **We're interested in what parents see as being benefits or disadvantages in terms of their children's health if staying at home or working in the early stages,** when they're still a baby. What do you think?

    - E.g. food and nutrition, exercise or being active, sleep, dental health, happiness and emotional wellbeing, illness and infections, health check ups
    - Where do you get your information from about health for your baby? (explore role of Health visitors/ parents/ friends/ childcare)
    - How did you make decisions about different things to do with health? Was it easy to do things the way you wanted to do them? (explore how employment/ unemployment helped/ hindered this and other)
    - Who would parent turn to if you baby wasn't very well or if they wanted advice on something to do with health. Who looked after baby when they were poorly? What about if the parent was poorly?
    - If using childcare of any kind: what was their role in making sure your child is healthy in the early days? Did you like the way they did things? (explore how important this was/ differences, how parent would find out about routines, what they liked/ didn't like)
    - If child is disabled or has significant health problem: how did this influence decisions about working? How has being at home/ at work influenced the way they manage the health of their child? (what are you able/ not able to do? What do others do to support with this while you're at work? What particular needs/ caring aspects are most important in this scenario?)

10. How much did child's health and wellbeing influence what they were thinking about in relation to work?

11. **Influence of being at home/ going to work on <u>own</u> health and wellbeing?** (advantages and disadvantages in relation to health?)

    How did this affect babies health in the early days?

12. Have views and decisions about work changed **over time since you first had your child/you had your first child,** and, if so why?

    - Children getting older e.g. how this affects perception of links between working options/not working and different aspects of children's wellbeing
    - Family events e.g. having more children, becoming a lone parent, moving away from/near to family/social networks, sickness/disability in the family

- *If relevant* - Changes in partner's work
- *If relevant* - Change in their partner's role re: childrearing
- Own wellbeing
- Career aspirations/ambitions
- Availability of formal/informal childcare
- Availability of suitable jobs

13. So overall, thinking about your work decisions/decision to stay at home since your, do you think this has affected in any way your child(ren)'s health?

14. And overall, has your child(ren)'s health affected your decision to work or not to work?

- Explore direct influences and indirect influences (e.g. income from employment can enable to have healthier life style)

15. If living with partner/ spouse: Has your child(ren)'s health or concerns about their health influenced your partner/husband/wife's decisions about paid employment ?

Childcare and school

12. Check current and previous childcare arrangements (if any) for each child:
    - Type(s) of childcare used, how much and how regularly
    - Cost of childcare – if relevant

13. Why did you decide to use this/these forms of childcare? (location and times, how well meets needs of the child, one-to-one versus group care, informal versus formal, cost)

14. What influences does this childcare have on your child's health (likelihood of picking up illnesses, provider supports healthy lifestyle such as exercise and healthy meals, children learn about things from other children or adults)

15. If children at school: When you were choosing a school for him/her, to what extent were you looking for a school that would be suitable given his/her needs and wellbeing? How has the school had an influence on your child's health?

16. Childcare and school: **What happens/happened when child is/was sick?** (significant health problems and minor illnesses)
    - Check how often it happens(ed)
    - Explore how decided if child well enough to go to provider/school

- Explore role of others in this decision (partner, grandparents, health care advice or availability of GP)
- Explore arrangements if child can't/couldn't go to provider/school
- Explore implications of using different types of childcare provider e.g. formal and informal

17. Have the childcare providers you have used or school ever given you advice on how to keep your child healthy? In what way? How useful or relevant was this? Was this important to you in choosing that/ staying with that?

Support for parents

18. Do you think the government or employers could do anything to help working parents to keep their children healthy?

- Family friendly employment arrangements
- Childcare support generally and more specifically when children are ill
- Financial help to enable families to have healthier life styles
- Health promotion via early years settings, schools and children's centres

Conclusion

- Any other comments or questions about the research; anything else we should have asked?
- Debrief: I don't know if you have ever been involved in research before, and what you made of it, I just wanted to check how you found the experience and if you have any advice for us on how we should be carrying out interviews in future. Check about anything they may have found particularly positive or negative.
- Remind the report will be completed in late spring 2013 and we will send a research summary in the summer of 2013 to all parents who have participated in the interviews and are willing for their contact details to be used for this purpose.
- Give respondent payment; remind about confidentiality, thank, and close.

B.2 Analysis framework

Chart	Label	Content
1	**BACKGROUND**	
1.1	Household composition	Details of partner, children (ages), any other adults
1.2	Outline of parent's working arrangements	Brief details of **parent's** occupation: hours, working patterns.
1.3	Outline of partner's working arrangements (if applicable)	Brief details of **partner's** occupation: hours, working patterns.
1.4	Local support network	Length of time living in the area; friends and family close by
1.5	Child disability/ chronic health problems (if applicable)	Brief details of chronic health condition/ disability
1.6	Conceptualisations of health / healthy children	Views on what constitutes 'health' / 'healthy', particularly children's health (Responses to direct questions at start of interview, plus any later comments)
1.7	Moral imperatives re. parental responsibilities & related capabillities	Moral imperatives / rights/ responsibilities regarding children's care, health & wellbeing Also capacities or performance in line with these responsibilities (confidence, competence)
1.8	Parental health problems and their impact (parent / partner)	Parents' own health and effects on employment (parent and partner if applicable) Include pregnancy-related issues.
1.9	Other background information	Other background information
2	**EMPLOYMENT HISTORY, ASPIRATIONS & ATTITUDES**	
2.1	Education history & early work-related aspirations	Age of leaving full-time education. Work-related aspirations at the time.
2.2	Further education/ work-related training/ courses / volunteering	Previous and current involvement in training/ courses/ volunteering, and reasons for this
2.3	Employment history including current/ last job	Jobs since leaving FT education; Current/ last job: role, hours, likes/ dislikes, enjoyment/ satisfaction; reasons for taking it and leaving (if applicable)
2.4	Gaps in employment history	Reasons for gaps; activity during gaps (caring, own illness, volunteering, study?)
2.5	Maternity leave arrangements. Options for return to job / work.	(If applicable) Maternity leave arrangements for first (& later) children (If applicable) Feasibility of returning to previous job / work generally (and why).
2.6	Aspirations for (returning to) work after having baby	What parent wanted (job, hours, location), when and why
2.7	Attitudes to work and working (including 'work ethic')	Attitudes to working/ unemployment/ volunteering and conceptualisations of work
2.8	Other reasons for working or not working	Reasons for working/ not working (other than above re. work/ childcare ethics) – e.g. partner's job / other caring responsibilities/ lack of suitable jobs
2.9	Employment – other issues	Employment other – issues

3	**CHILDCARE HISTORY, CONTEXT and EFFECTS**	
3.1	Details of childcare **sought** by parent at particular stages Importance of childcare features to decisions about work	What parent <u>wanted</u> when seeking childcare (type of care, cost, hours, location, features); (Specify child age/stage) Importance of childcare features to decisions about work.
3.2	Actual childcare arrangements (past, present)	Providers of childcare actually used - previously and now - and why
3.3	Role of partner/ other parent in child care	Involvement in childcare, particularly around health (decisions/ care). Views on this.
3.4	Role of grandparents / other family in child care	Role and importance of grandparents/other family in relation to childcare
3.5	Views on childcare (beliefs, attitudes, experiences)	Views/beliefs/experiences of childcare (availability, cost, quality, benefits)
3.6	Effects of childcare arrangements on health, wellbeing, development	Views & experiences re. childcare's effects on child health, wellbeing and development (include informal childcare and 'shift parenting')
3.7	Child care when child has acute illness (experiences/ plans)	Acute illness, childcare and work. Ability to take leave when child sick. Any problems. (Including hypothetic situation where child is ill if no experience of this)
3.8	Child care when child has chronic illness (experiences/ plans)	Chronic illness, childcare and work. Ability to take leave when child sick with chronic condition. Any problems. (Including hypothetic situations if applicable)
3.9	Schools' effects on child physical health/emotional wellbeing	School effects on physical & emotional health (menus, health education, after school clubs) and parents' awareness of schools' healthy activities.
3.10	Childcare – other issues	Childcare – other issues
4	**CHILDREN'S PHYSICAL & EMOTIONAL HEALTH PROBLEMS & SOLUTIONS**	
4.1	Sources of advice and information on child health/ wellbeing	Sources of advice and its perceived value (GP; mum; HV; leaflets; other parents)
4.2	Access to child health **services**	Experiences / views of child health services; experience of problems & solutions (access/provision)
4.3	Emotional wellbeing/ happiness/ mental health	Perspectives on child's emotional wellbeing; experience of problems & solutions
4.4	Child development (e.g. potty training, walking, speech)	Perspectives on child illness; experience of problems & solutions
4.5	Food/ nutrition / allergies	Perspectives on child diet/ nutrition; experience of problems & solutions
4.6	Activity/ exercise	Perspectives on children's physical activity; experience of problems & solutions
4.7	Health hygiene behaviours	Perspectives on child hygiene behaviours; experience of problems & solutions
4.8	Safety/ accidents/ injuries	Perspectives on safety/ accidents; experience of problems & solutions
4.9	Illness / infections	Perspectives on child illness; experience of problems & solutions
4.10	Other child health issues	Any other specific health/health-related issues

5	**LINKS BETWEEN CHILD HEALTH , EMPLOYMENT and OTHER FACTORS)**	
5.1	Effects of parental work (or not working) on child health	(Perceived) effects of parental work on **child's** health / wellbeing; Instances of work **enabling (or constraining)** choices which promote child health
5.2	Effects of parental work (or not working) on parent's health	(Perceived) effects of parental work on **parent's** health / wellbeing
5.3	Effects of parent health (or health choices) on child health	Instances of parental health behaviour / wellbeing affecting children's health/ wellbeing (e.g. exercising/ eating healthily with the child OR being too tired from work to cook/ engage)
5.4	Effects of money/ lack of it on child health	Money (regardless of from work/ benefits/other source) affecting children's health
5.5	Effects of child health on parental choices around work	Views/ examples of how child health/ wellbeing affects parents' work choices (Including hypothetic situation where child is ill, particularly if parent does not work)
5.6	Impact of child health (problems) on childcare/work/parent	Child health problems (past/ present) and effects on school/ child care/ work
5.7	Tradeoffs/ prioritisation around work & child health	Instances where parents balance gains and losses from their work in relation to child health; decision making around this.
5.8	**Challenges** to/ difficulties with link between work & child health (or child care and child health)	Instances where interviewee challenges/ has difficulty understanding questions/the notion of employment/ childcare affecting child health; Any alternative constructions they offer.
5.9	Other links between child health & employment	Other links between child health & employment
6	**FUTURE PLANS AND POLICY IDEAS**	
6.1	Aspirations for children's futures (employment, health, other)	Hopes, fears, aspirations for children around health/ employment/ other
6.2	Aspirations for themselves (employment, health, other)	Hopes, fears, aspirations for themselves (parents) around health/ employment/other
6.3	Ideas re. employers' contribution to child health	Policy ideas re. employers' contribution to child health
6.4	Ideas re. childcare (especially when children are ill)	Policy ideas re. childcare (especially when children are ill)
6.5	Ideas re. financial support for families with healthy living	Policy ideas re. financial support for families with healthy living
6.7	Ideas re. health promotion via settings/ services	Policy ideas re. health promotion via settings/ services
6.8	Other policy/ practice ideas	Other policy / practice ideas re promoting child health
6.9	Charter's comments *(& possibly notes about memos)*	Charter's comments *(and possibly brief notes about any linked NVivo memos with thoughts on the interview linked to places in the transcript)*

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