THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

Covid and Care Research Group

LSE Anthropology

Social Infrastructures

for the post-Covid recovery in the UK.

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Abstract

The central conflict facing policymakers, the voluntary sector, and communities during the Covid-19 pandemic has been keeping safe from a virus that is transmitted interpersonally while also providing vital support to those in need. The report presents the findings from 12 months of ethnographic, participatory, and quantitative research, which has revealed that people have fallen back on their families, neighbourhoods and communities in order to navigate new challenges and burden. We call these networks of kinship and care within and between families, friends, and communities "social infrastructures" and argue that economic life and pandemic recovery relies on the strength of these foundational relations. In the UK, local and rapid response initiatives saved lives as voluntary sector, religious organisations, and Community Champions built on these relations of care to encourage vaccine uptake. These innovative social projects also helped people to grieve and recover from losses of life and livelihoods. We argue that both short- and long-term investment in these integrated social infrastructures is crucial for the post-Covid recovery in the UK.

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Locals go about their grocery shopping inside the Fresh and Fruity greengrocers in Stamford Hill, 6th November, 2020. 'Fresh and Fruity' have recently launched Street Box to help fight food poverty in London through their 'buy a box, give a box' scheme. For every food box bought and delivered, they deliver another for free to a family in need. To scale up in this way they partnered with Edible London, a nonprofit launched in 2018 by Sunny Karagozlu and tackles food poverty across the capital. Since the start of the pandemic Edible London have distributed a million meals worth of ingredients and saved 304 tons of surplus food.

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Executive Summary

The central conflict facing policymakers, the voluntary sector, and communities during the Covid-19 pandemic has been keeping safe from a virus that is transmitted interpersonally while also providing vital support to those in need. The report presents the findings from 12 months of ethnographic, participatory, and quantitative research, which has revealed that people have fallen back on their families, neighbourhoods and communities in order to navigate new challenges and burden. We call these networks of kinship and care within and between families, friends, and communities "social infrastructures" and argue that economic life and pandemic recovery relies on the strength of these foundational relations. In the UK, local and rapid response initiatives saved lives as voluntary sector, religious organisations, and Community Champions built on these relations of care to encourage vaccine uptake. These innovative social projects also helped people to grieve and recover from losses of life and livelihoods. This report makes three key arguments:

- **Changing Relations and Burdens of Care:** The ways in which people relate to and care for each other has changed during the pandemic in the UK, generating new forms of mutuality, burdens, stigma, and mental health concerns.
- **Changing Communities and Dis/Connection:** Social infrastructures have been imagined and acted on in new ways during the pandemic. Some groups have become more connected to social infrastructures of care, and others have become less connected or even excluded. This has exacerbated societal inequalities and directly affected inequality, health outcomes (including mortality), and social cohesion.
- **Building Social Infrastructures**: Local Authorities (LAs), third sector, faith-based and grassroots organisations have come together in new ways to meet the emerging needs of families and communities. Opportunities for various groups to become part of these new networks, and barriers preventing them from forming, are unequally distributed.

Hence, this report makes a call for these social infrastructures of care to become a focus for recovery from the Covid-19 pandemic. In the long term, we argue this can be achieved through:

1. **A Royal Commission on Social Infrastructures,** drawing on a wealth of expertise across the country. The Commission would inform the foundation of a permanent advisory agency similar to the National Infrastructure Commission. This would provide strategic advice on how to design, plan, and fund *social* infrastructures, as well as the best ways to assess and anticipate needs at national and local levels.
2. **A National Care Service** that provides funding for social infrastructures at the local level, while continuing to address issues generally impacting "carers" or "social care".
3. **Decentralised Funding for Local Community** Initiatives, as has been done for the Community Champions Initiative. National and local third sector organisations and can be consulted in designing funding and provisioning schemes based on their practical experience working with fragile communities.
4. Systematic funding and integration of **ethnographic "social listening**" and co-production at municipal and national levels in order to generate pragmatic interventions tailored to locally specific problems in accessing health and social care.

These ambitious schemes will require careful planning and gradual implementation; in the short-term more immediate, emergency measures are needed to jumpstart recovery:

1. Reopening of **community centres** and central government grants for the construction of Community Hubs in areas disadvantaged during the Covid-19 pandemic (areas of enduring transmission and/or local interventions).
2. National level funding targeted to national and **local voluntary sector** and third sector organisations, especially

those run by minority and disadvantaged groups.

3. Systematic and frequent **mapping of the forms of informal and formal care** at community level in order to make targeted investments in local social infrastructures, especially to serve disadvantaged groups.
4. Expansion of the **Community Champions** programme, with funding to support coordination efforts between groups at the local level.
5. **National and local recognition,** through awards and honours, of the hidden work carried out by the voluntary and community organisation sector during the pandemic.
6. Prioritised funding for locally provided **mental health, childcare and eldercare services,** particularly through community organisations.

Beautine Wester sorts through donations in the back of the Clapton 7th Day Adventist Church, Hackney, 21st October, 2020. Beautine is a paediatric nurse who set up the E5 Baby Bank in June 2020 after witnessing an alarming increase of families without basic clothing, food, nappies, toys, and other essential items. Places of worship like this church have been closed throughout the pandemic, providing a space for the Baby Bank to operate from and an opportunity for the church to renovate.

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Introduction: Social Infrastructures of Care

The Coronavirus pandemic has made our dependence on social infrastructures visible. Social infrastructures are the networks of kinship and care within and between families and friends; and the networks of formal and informal support within and between communities.[1] When nurseries, schools and universities closed in lockdowns, when young adults lost their jobs or elderly relatives needed help, imagine if we did not have these ties to fall back on. Or if, as charities shut their doors, no mutual aid groups and voluntary sector organisations had stepped in to deliver food parcels or medicines, or to offer practical and mental health support. Without this work we would have no society left to rebuild, and the unwell and disadvantaged would have fared even worse. In the UK, these initiatives saved lives as voluntary sector, religious organisations and community champions built on these relations of care to encourage vaccine uptake. They also helped people to grieve and recover from losses of life and livelihoods.

This report makes a call for these social infrastructures of care to become a focus for recovery from the Covid-19 pandemic. By "care" we do not only mean the usual policy term as used in "social care" or "children in care" or "unpaid carers". This is a state definition related to specific policies that are sometimes experienced negatively by families and communities as a kind of "policing" or scarce resource. Instead, we expand "care" to mean all the relationships of *caring for*, and *caring about*, provided by families, friends, communities, the voluntary sector, and local and national government. These social infrastructures are part of a single system of provisioning. Connections to, and disconnections from this network, produce direct effects on inequality, health, and cohesion. For the past decade, there have been few attempts at holistic policy that builds these relationships, but the Covid-19 pandemic has made this approach essential.

The key problem of the Covid-19 pandemic for policymakers, the voluntary sector and communities has been how to restrict the kinds of social interaction that exacerbates viral transmission while also providing support, and there has been a huge amount of innovation against the odds to achieve this end. Online forums, Community Champions programmes and new kinds of neighbourhood, sports and faith-based initiatives have been launched. Many have mobilised to overcome an unbearable loss of normal life and its relationships; many others were held back by the absence or dissolution of vital safety nets. In this report we call this loss a "death of the social", or a breaking of ties and stalling of life progression. Denied normal education, family and friendship interactions, access to community centres, the ability to mourn, marry or forge relationships, as well as experiencing reduced access to advice and services, people have found creative solutions. Essential social infrastructures, which are the relationships through which we care for the young, the unwell, the elderly and recreate the fabric of society, have only been maintained through these efforts. Unintentionally, indirect funding from the government through furlough, unemployment payments and SME grants has enabled this. Direct funding such as that for Community Champions, Near Neighbours and Strengthening Faith Institutions has sustained this mobilisation .

A systematic approach to sustainable provisioning for social infrastructures is required for recovery to occur. This systematic approach has been lacking as siloed government ministries have focused on single policies around vaccination uptake, NHS Test Track and Trace, enforcing restrictions and dealing with 'enduring transmission.' They often worry about the 'lack of trust' that prevents engagement with such initiatives. But as the Community Champions policy and the vibrant activity all around the country shows, it is only by supporting social infrastructures and targeting inequality with funding over the long term that recovery in the UK will be achieved. From our research we understand 'lack of trust' in government as disillusionment with the long-term effects of poor provisioning for communities and the voluntary sector over the past decade, along with experiences of inequality, stigma, harsh pandemic-related interventions and alienating political narratives. Trust is not the problem, but experiences of abandonment by the state or lack of recognition of needs by local

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[1] Simone, A. 2004. *For the city yet to come: Changing life in four African cities*. Durham: Duke University Press.
Creating a Caring Economy: a call to action 2021. Women's Budget Group (available on-line: *https://wbg.org.uk/wp-content/uploads/2020/10/WBG-Report-v10.pdf*, accessed 8 July 2021).
Elyachar, J. 2010. Phatic labor, infrastructure, and the question of empowerment in Cairo. *American Ethnologist* 37, 452-464.

authorities are significant issues. People care most about their neighbourhoods, friends and communities. Therefore, it is only by supporting them in their efforts to maintain these foundational relationships that other policies will be effective.

This revitalisation of social connections and investment in them is especially important because, as our evidence demonstrates, the Covid-19 pandemic has created extra burdens on people who sustain these and has made social cohesion fragile. Voluntary sector organisations, community activists, unpaid carers, middle-aged women, and young adults have picked up the responsibilities of forging and maintaining ties of support. These exertions have taken their toll, and many members of these groups are fatigued or worried about their own mental health. Small pots of short-term funding have also led at times to competition rather than collaboration between community groups. Uncertainty about the risks of Covid-19 and the lack of shared public spaces has eroded social cohesion, especially in places that have experienced local interventions over the long-term. New stigmas within and between groups are being reinforced that could be overcome by cooperative connections. New burdens of food poverty, strained finances, debt, domestic violence, and coercive relationships have also intensified as the pandemic unfolded. All the evidence points towards the need for more sustained funding for social infrastructures and incentives for collaboration between smaller and larger organisations. This would make permanent the new connections that have emerged and would amplify them, with the potential to assist with Covid-related legacies of food poverty, poor mental health, delayed medical treatment and inequality.

In the report that follows we were able to navigate these crucial issues through rapid action research, often co-produced with communities and organisations. Our approach was ethnographic in its methods and involved participant observation in online forums, as well as interviews. We also carried out a survey based on the issues raised in our fieldwork. It was distributed along the networks of our research collaborators and through targeted social media campaigns. Altogether, this combination of methods provides a new model for policy research grounded in collaboration. Our focus was not on a top-down approach to solve a particular government defined concern. Instead, we allowed people to speak of what they needed most and the challenges they faced. Our insight fall within three broad categories:

1. **Changing Relations and Burdens of Care**

   The ways in which people relate to and care for each other has changed during the pandemic in the UK; generating new forms of mutuality, burdens, stigma, and mental health concerns.

2. **Changing Communities and Dis/Connection**

   Social infrastructures have been imagined and acted on in new ways during the pandemic. Some groups have become more connected to social infrastructures of care and others have become less connected or even excluded. This has produced direct effects on inequality, health outcomes (such as mortality) and social cohesion.

3. **Building Social Infrastructures**

   Some Local Authorities (LAs), third sector, faith based, and grassroots organisations have come together in new ways to meet the new needs of families and communities. There are unequally distributed barriers and opportunities for various groups to become part of these new networks.

Radical communities and social ties have been generated during Covid-19, producing new possibilities. Investment in these is critical to alleviating inequality, solving emerging mental health crises, building health initiatives, and fostering social cohesion. Social infrastructures are at the core of an inclusive recovery.

Melissa Francis by Clapton Ponds in Hackney, 11th August, 2020. Melissa recently started Bridge The Gap - Families In Need, an organisation helping families struggling with digital poverty by distributing laptops, tablets and phones. Melissa has been volunteering in the community most of her adult life, and she recently quit her job as a carer to spend more time at home with her 2 autistic children.
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For Rapid Ethnographic Research

This report provides a model for the systematic integration of rapid ethnographic research into emergency response and policy making. We see the current evidence base used by government and local authorities as partial in two key ways.

First, current statistical polling, focus-group and activity data tracks broad groups that face Covid-19 related problems and is driven by top-down questioning. If these datasets address community issues at all, they tend to frame society as a collection of bounded, homogenous groups. On its own, these statistical approaches cannot contextualise how multiple factors interact to produce inequality and how observations apply (or fail to apply) across disparate populations. The way in which social groups are imagined as "actors" and characterised according to assumptions of behaviour and belief has worked to stereotype and stigmatise certain groups for rule-breaking and transmission. Homogenous labels such as Black and Minority Ethic (BAME) work to render invisible differentials of gender, class, religion and ethnicity. Ethnic classifications such as "Indian" work to elide multiple differences of migration, generation, cultural orientation and status. There is a need to appreciate the diversity and heterogeneity of perspectives, needs and attitudes within ascribed identity markers. Such analysis will equip us with more nuanced assumptions for quantitative and predictive modelling. Importantly, tailored evidence can be used by individuals to make claims about their specific needs to authorities.

Second, participatory research and co-creation of policy have long been central to public health interventions worldwide and to the NHS, Public Health England, and Community Resilience Forums. Yet, we lack protocols for these that relate to the fast-moving but ongoing crisis of Covid-19 as it unfolds in waves. The challenge that faces central government, local authorities and civil society organisations is how to quickly design evidence-based policy that does not exacerbate the situation over the long term, inspires public cooperation and relates to real-life unforeseen circumstances.[2] There is a sense of frustration at community level that processes of consultation and co-design are shot-sighted, shallow and cursory, "tick-box" exercises that draw on only select opinions, which force them to share their experiences without "getting anything back".[3] This is particularly true for minoritised groups who exist in asymmetric power dynamics with local authorities, the voluntary sector or have experienced historical oppression within their region or locality. For good policy, we need immersive and sustainable infrastructures of social listening and continuous feedback.

Ethnographic methods are built on principles that prioritise the understanding and knowledge of diverse groups, develop the relationships necessary for deep engagement, and co-design local experiments and policies to improve health and social cohesion. The strength of this method derives from careful attention to the effects of the specific contexts within which policies might be embedded, simultaneous awareness of how practices in a particular time and place are connected to economic, political, and historical forces, and a close focus on encounters with the government or health system.[4] The anthropologist can work as a mediator, understanding and integrating diverse perspectives across communities by encouraging people to reflect on their positionalities within networks of relationships.[5] When deployed in a multi-sited and multi-team model, ethnographic studies can produce (general and detailed) insights on forms of continuity or difference of need, as well as mutuality or tension, within and between communities; these can be scaled up to propositions for system changes.[6] The real-time nature of ethnographic fieldwork allows a sensitive and adaptable perspective on the impacts of rapidly changing policies, responding to the imperative of a "social calculus" for policy-decision making, even in such a dynamic situation as a pandemic.[7] Location-specific fieldwork sets the foundation for a more targeted approach connected to issues such as: test, track, trace and self-isolation; public health communication; regional restrictions; long-term transmission of Covid-19 and social and economic recovery.

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[2] Burgess, R. & N. Choudary 2021. Time is on our side: operationalising 'phase zero' in coproduction of mental health services for marginalised and underserved populations in London. *International Journal of Public Administration* 44, 753-766.

[3] Mobley, C. 1997. Toward a New Definition of Accountability: Using Applied Ethnography as a Tool for Change in the Voluntary Sector. *Journal of Contemporary Ethnography* 26, 75-97.

[4] Jain, S. & D. Orr 2016. Ethnographic perspectives on global mental health. *Transcultural Psychiatry* 53, 685-695.

[5] Abram, S. 2001. 'Amongst Professionals': Working with Pressure Groups and Local Authorities. In *Inside Organizations: Anthropologists at Work* D. Gellner & E. Hirsch(ed) , 183-204. Oxford: Berg.

[6] Orton, L., R. Ponsford & M. Egan et al. 2019. Capturing complexity in the evaluation of a major area-based initiative in community empowerment: what can a multi-site, multi team, ethnographic approach offer?. *Anthropology & Medicine* 26, 48-64.

[7] Graham, J., S. Lees & F. Le Marcis et al. 2018. Prepared for the 'unexpected'? Lessons from the 2014–2016 Ebola epidemic in West Africa on integrating emergent theory designs into outbreak response. *BMJ Global Health* 3.
Nyqvist, A. 2013. Access to all stages? Studying through policy in a culture of accessibility. In *Organisational Anthropology: Doing Ethnography in and among Complex Organisations* C. Garsten & A. Nyqvist(ed), 91-105. London: Pluto Press.

Methods

This report is based on 13 months (April 2020 - April 2021) of ongoing anthropological research conducted collectively and collaboratively by the Covid and Care Research Group. Its insights are drawn from an intensive period of ethnographic fieldwork conducted by eight ethnographers over a period of four months between January and April 2021, in specifically chosen research sites. This research was linked directly to real-time policy responses through the involvement of Professor Bear in SPI-B and Ethnicity subgroups of SAGE and her work with the Ministry of Housing, Community and Local Government (MHCLG) on the Community Champions scheme.

Our approach is founded on two principles. First, a unique combination of methodologies; and second, a strategic selection of microcosmic sites for analysis to produce better data on, and interventions in, Covid-19 impacts and patterns of disadvantage. This local approach was essential to understand the ways in which structural factors played out differently in particular regional settings and to understand the impacts of distinct social infrastructures. Our research was conducted in four sites that are representative of patterns of disparity and hotspots of Covid-19 transmission across the UK. These included:

> **London borough of Ealing,** including wards of Northolt, Acton, Greenford and Southall, where an affluent middle class lives alongside super-diverse established and recent migrant communities and white working classes. This was able to address micro-geographies of inclusion and exclusion from social infrastructures.
>
> **East London,** across the boroughs of Hackney, Southwark, and Tower Hamlets. These are again super-diverse areas with established and recent migrant communities with a particular focus during the pandemic on investment in social infrastructure through funding community groups and mutual aid. This allowed us to explore the successes and limits of such experiments.
>
> **Leicester City and Surrounding Counties,** where analysis was focused on a super-diverse place of enduring transmission that was under permanent restrictions and was badly hit during the second wave. Here we wanted to understand the impact of long-term restrictions on social infrastructures, relationships of stigmas in a situation of uncertainty, and how these were overcome by community groups. We also wanted to compare the urban to rural context.
>
> **North-East England**, with focus on South Tyneside and South Shields, where we sought to understand the experiences of white working-class groups in a place hit hard by Covid-19 and a site of enduring transmission. Here we, in particular, spoke to formal service providers and community groups to understand local concepts of social infrastructures, distrust of formal statutory "care" and the importance of regional identities to social cohesion.

Overall, these have given us different vistas on the same problem: the making and breaking of social infrastructures during Covid-19 and how different experiments and experiences have generated or broken vital bonds. For full methodological reflections from each researcher and statements on sampling strategies, please see Appendix 1.

However, communities during the pandemic have not only been broken or forged locally; they are also shaped by kinship and community networks across space, extending beyond boundaries of regions and outside the UK. Online forums have been instrumental, of course, including networks of information and care in WhatsApp groups, support groups and Zoom meetings organised for Community Champions, carer support, activists, or bereaved people. These networks have been creative and diverse, and been given new energy by experiences of exclusion, stigma, or poor health care. We followed these networks and their experiences in communities across the UK, especially with pregnant women and mothers, people of East Asian Gujarati heritage, people of Black British heritage, people of East and South-East Asian heritage, younger generations and with health and Community Champion initiatives. We engaged with people embedded in long-term community groups who were channeling existing projects in new directions, forming new connections with each other. These cross-spatial identities and online communities are often understood as sites of "misinformation", but we found that, while allowing different kinds of news to spread largely unchecked, they have provided support and radical interpretations of the suffering caused by the pandemic. They illustrate the double-edged nature of all community mobilisation, that it involves inclusion and exclusion, but also that it is only by amplifying such efforts to forge connections and generate challenging dialogue that policies of any kind can succeed.

These microcosms all gave different insights on key structural inequalities emerging in the context of Covid-19 of race, gender, region, class, and religion. Unlike the recent Sewell report[8], we do not try to "separate out" these different factors. Instead, we examine how they interact to produce burdens and strains on groups and sub-groups. We also, importantly, track how the accessibility or inaccessibility of social infrastructures impacts the inequalities faced. Lastly, we offer a positive account of ways forward.

Within each of these sites, multiple methods were deployed. These included:

> **Ethnographic open-ended interviews with local experts.** Rather than trying to find a representative cross-section of respondents, as in Office of National Statistics (ONS) survey data collection or citizen juries, our sampling strategy involved identifying these "local experts" who were at the centre of dense networks of social interaction and had access to a large amount of information on experiences changing in real time. They were recruited through the research team's existing personal or professional networks. Our questions focused on the health, social, economic, and cultural impacts of the pandemic, with particular attention to mortality and morbidity, stigma, precarity, formalised care (welfare systems and new treasury policies), and informal care (kinship and friendship).
>
> **Participatory engagement in community forums and congregations.** This involved both active and passive attendance of community consultations, co-design workshops, information, and engagement briefings, focus groups, town hall discussions and engagement in virtual or online communities. Most of these events were held over Zoom or WhatsApp and were focused on the Covid-19 recovery and vaccine roll out, though some were related to specific interests such as parenting, racism, care, or bereavement. Some were run by LAs or counsellors, and others by Voluntary Community Sector (VCS) organisations or grassroots groups. Engagement in these forums allowed us to track communications within and among organisations, and discern key tensions and the intersections of interests in decision-making.[8]
>
> **A survey**. In May 2021, we launched an online survey with the aim of gaining wider insights into the emergent themes of the Research Group's ethnographic inquiries. The survey comprised multiple-choice and open-ended questions on UK residents' experiences of seeking and receiving social, emotional, financial, and health-related support during the pandemic, as well as their imaginings of the future. The survey was disseminated via the social networks and media platforms of the group's interlocutors and through Facebook ad campaigns, resulting in 2,170 responses. These were analysed using Excel and Nvivo software. Survey insights have been integrated throughout our report to complement ethnographic data and are not to be interpreted as population-level claims about the status and experience of entire regions or groups of people. The survey was designed to examine issues that had emerged from our ethnography in situations of participant observation and co-production.
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> **Secondary analysis using ONS and Covid-19 statistics, deprivation, and mortality data.** We seek to scale up our insights by comparing and contextualising them with quantitative data generated at the local, regional and national levels.

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[8] *Commission on Race and Ethnic Disparities: The Report* 2021. Commission on Race and Ethnic Disparities (available on-line: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf*, accessed 4 July 2021).
Gibson-Graham, J. K. 2014. Being the Revolution, or, How to Live in a "More-Than-Capitalist" World Threatened with Extinction. *Rethinking Marxism*, 26:1, 76-94.

Andrew Gordon, a volunteer with Melissa's organisation Bridge The Gap - Families in Need, delivers a free laptop to Romulo and his daughter, 18th August, 2020. So far, Bridge The Gap has been awarded almost £13,000 in grants, enabling them to help over 60 low-income families gain access to digital devices such as laptops, tablets, and phones. As well as grant money, Melissa also relies on donations from the public who've heard about her work.

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I | Changing Relations and Burdens of Care

Introduction: A Death of the Social

Our research has overwhelmingly found that essential networks of social support and care work have been severed by successive lockdown periods in the UK since March 2020, producing effects over the long-term. These networks sustain all aspects of life — economic, social, and political — and their truncation has significant psychological and practical effects. As measures have eased, this "death of the social" has left a legacy of inequality and public distrust of Government measures. This is particularly intense in areas where social restrictions have never been lifted or have been reintroduced and for groups who have experienced high rates of mortality from Covid-19. While the interventions were necessary, we need investment that supports people in recovering from their effects.

Insights from the survey: Accessing Care

Relationships Disrupted: Essential networks of care that sustain life have been disrupted for everyone.

→ 40% of respondents felt socially isolated.

Loss: Mortality and morbidity has impacted some more than others, especially certain ethnic minority groups such as the Bangladeshi and Pakistani communities.

→ 29% had experienced a bereavement.

Unequal Burdens: Across care networks, burdens of responsibility have fallen on some more than others (essential workers, women), and left some more isolated than others (elderly, disabled, lone parents).

→ 26% of essential workers mentioned "Relationship tension or strain", and 11% mentioned "Difficulty caring for children" as new stressors experienced during the pandemic.

Mental Distress: The psychological cost of these disrupted relationships is great, unequally distributed, and will leave a legacy of trauma.

→ 81% of respondents had experienced new stressors during the pandemic.
→ 34% experienced poor mental health.

Disrupted Time, Precarity and Loss

The way in which people have navigated their position within disrupted kinship networks — as daughter, mother, father, neighbour, etc. — is dependent on their age, gender, and household composition. As networks have been disrupted, leaving some more vulnerable, the usual expectations of such roles have also shifted. Our research has worked to map these shifts in care networks, and in expectations placed on individuals within them. We have also charted how they differ across cultural and ethnic groups depending on their ethical values and kinship structures. We have observed increased dependence on the part of the elderly, disabled and sick relatives, whose needs are absorbed by younger and middle-aged people with increased caring responsibilities; still, support often flows in both directions, and mental health concerns related to isolation and "loneliness" emerged as constants across age groups.

The disruption to these social roles is exacerbated by the disruption to the normal flow of the life course.[9] The absence of important markers of time — such as ritual events (weddings, funerals, christenings) — and markers of progress in the life course — such as examinations, renting homes, choosing to have children — is highly disturbing to the sense of wellbeing and agency that people experience.[10] Instead, there is a sense that time has slowed down, been suspended, or has met an impasse in the crisis of Covid.[11] Across social groups, people have expressed that they have entered a kind of "waithood", wherein there is no possibility of planning for the future.[12] The outcome of such temporal and relational disruption for many is a sense of mental distress or even mental ill health, expressed differently across social groups and generations as fatalism, depression, anxiety, exhaustion, and fear.[13] This is compounded for some groups, such as essential workers and people who live in areas of enduring transmission, who experience stigma and discrimination as their relatives and friends attempt to mitigate risks by avoiding or blaming them. The mental impact is most acute for those who have experienced bereavements in their family or community, including for larger groups or communities who have sustained significant losses to Covid-19.[14] For these groups, the impossibility of a "good death", due to the suffering experienced by those affected and the suspension of normal mourning rituals, leave the living unable to move on from the death and creates legacies of trauma.

Insights from the survey: Mental Health

Respondents mentioned 2.52 new stressors on average. Most notably, 40% of respondents experienced social isolation, and 34% experienced poor mental health (see Table 1 and Figure 1).

These stressors were multiple, intersecting, and bound up with perceived disruptions to the life course. For instance, one female respondent expressed: "*[I am concerned about [my] adult daughter who moved back in with Mum and Dad having her life on hold doing a job she had when she was 17 for pandemic income; and my granddaughter - now 19 months development being hindered [due to] lack of socialisation with other small children*." When asked whom they were most concerned about when looking toward the future, several survey respondents emphasised the poor mental health of their children and grandchildren. By interlocutors and survey respondents alike, declining mental health was cast as a "second pandemic" that would continue to exacerbate the inequalities highlighted by Covid-19 and would overstretch health and social care services indefinitely.

The risks of an impending mental health crisis were often assessed relative to age; here, however, the young, rather than the old, were deemed most susceptible. Survey respondents under the age of 45 were much more likely to mention mental health issues as new stressors arising during the pandemic and to elaborate on personal experiences of depression, loneliness, and anxiety. Parents were particularly aware of mounting pressures on mental wellbeing, for themselves and those in their care; one mother shared *"My husband works all day so just because he lives with me doesn't make him supportive. I homeschooled 2 children and needed respite for my mental health."* The division of labour (including care work) in and outside the household was cited as a source of "relationship strain" by younger survey respondents, and those most responsible for daily childcare often elided their children's mental health with their own.

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[9] See McKinnon, S. & F. Cannell 2013. The Difference Kinship Makes. In *Vital Relations: Modernity and the Persistent Life of Kinship* S. McKinnon & F. Cannell(ed) , 3-38. (1st edition). SAR Press.
Rutherford, D. 2013. Kinship and Catastrophe: Global Warming and the Rhetoric of Descent. In *Vital Relations: Modernity and the Persistent Life of Kinship* S. McKinnon & F. Cannell(ed) , 261-282. (1st edition). SAR Press.

[10] Bear, L. 2014. Doubt, conflict, mediation: the anthropology of modern time. *Journal of the Royal Anthropological Institute* 20, 3-30.

[11] See Berlant, L. 2011. *Cruel optimism*. Durham, NC: Duke University Press.
Bubandt, N. 2014. *The Empty Seashell: Witchcraft and Doubt on an Indonesian Island*. Ithaca: Cornell University Press.

[12] See Crapanzano, V. 1986. *Waiting: The Whites of South Africa*. London: Paladin.

[13] Rose, N., N. Manning & R. Bentall et al. 2020. The social underpinnings of mental distress in the time of COVID-19 – time for urgent action. *Wellcome Open Research* 5, 166.
Simpson, N. 2021. Tension: An ethnographic study of women's mental distress in rural north India. PhD Thesis. *London School of Economics*.

[14] Simpson, N., M. Angland & J. Bhogal et al. 2021. 'Good' and 'Bad' deaths during the COVID-19 pandemic: insights from a rapid qualitative study. *BMJ Global Health* 6, 1-6.

New stressors experienced during the pandemic	Count	Percent of respondents who mentioned stressor
Feeling socially isolated	874	40%
Poor mental health	617	34%
Fear for safety due to Covid-19 transmission	537	30%
Relationship tension or strain	417	23%
I haven't experienced any stressors	339	19%
Illness or poor physical health	314	17%
Difficulty caring for elderly or dependent relatives or friends	248	14%
Other	239	13%
Difficulty with homeschooling	212	12%
Lost employment	204	11%
Lost educational opportunities	172	10%
Difficulty meeting basic needs	158	9%
Difficulty caring for children	108	6%
Difficulty paying rent mortgage or debts	100	6%
Total	**4539**	

Table 1

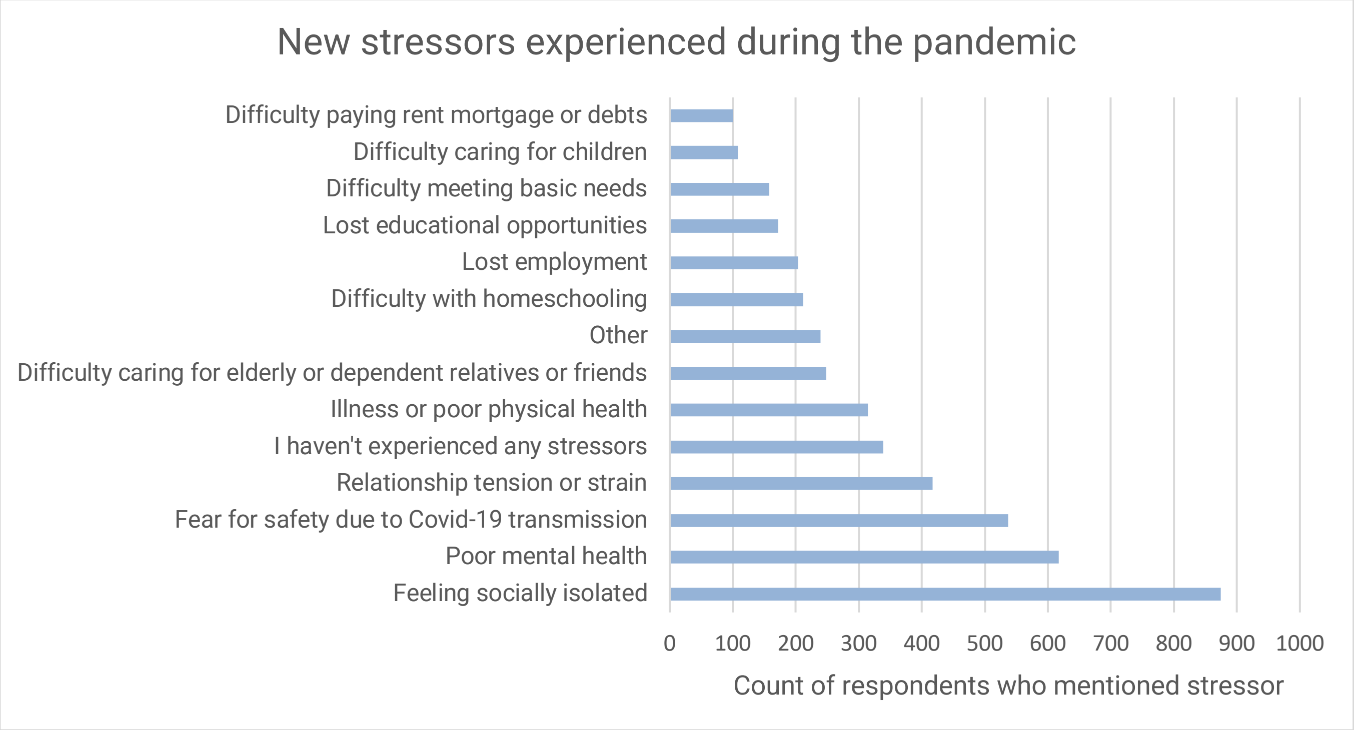

Figure 1

Insights from the survey: Stressors and Age

The percentage of respondents in each age group who mentioned **“Poor mental health”** as a stressor was highest amongst those 18-25 (65%) and lowest amongst those 75+ (5%), with a steady decrease between (see Figure 2).

“Relationship tension or strain” was reported by 44% of 18–25-year-olds, 24-29% of respondents 25-55, and 11% or less by those over 55.

‘Fear for safety due to Covid-19 transmission’ was mentioned by 23-26% of those in each age category under 55 (including 18-25), but only by 16% of those 55-65, 11% of those 65-75, and 7% of those 75+.

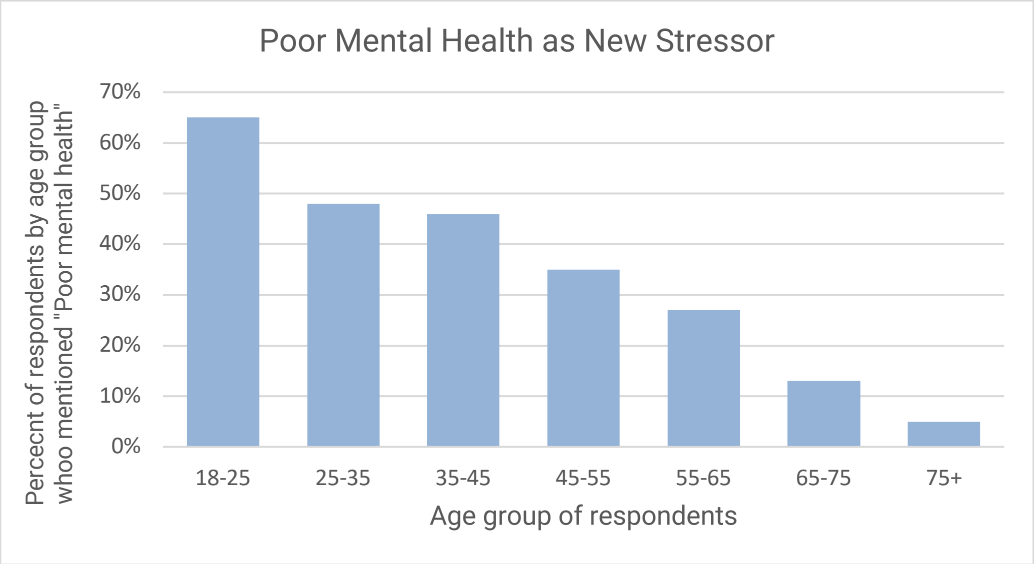

Figure 2

The Psychological Cost of the Pandemic

Our survey and qualitative research revealed that the term “mental health” has become an increasingly capacious category during the crisis, enfolding a range of concerns. For many, it has become the grounds on which to articulate difficult experiences and the costs of the loss of social connections and infrastructures. However, many also experience unease with its current breadth as a category, pointing instead towards state and local authority failures to provision their needs or properly care for them. These people argue that discussions of ‘mental health’ places the responsibility of recognizing and treating its varying effects on the individual, reinforcing the very dynamics of isolation that produce these difficulties. So “mental health”, like community mobilization, can de-radicalise demands for better provisioning of social infrastructures, as well as potentially energizing and radicalising calls for action.

Mental health allows people to talk about the pandemic as a time of “fear, isolation and loneliness” the cost of which, for some, has been greater than (but not mutually exclusive from) physical detriments.[15] For some informants it has been a watershed moment for discourse around mental health across generations. Though speaking about it is considered taboo

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[15] Carr, M., S. Steeg & R. Webb et al. 2021. Effects of the COVID-19 pandemic on primary care-recorded mental illness and self-harm episodes in the UK: a population-based cohort study. *The Lancet Public Health* 6, e124-e135.
Newlove-Delgado, T., S. McManus & K. Sadler et al. 2021. Child mental health in England before and during the COVID-19 lockdown. *The Lancet Psychiatry* 8, 353-354.
Winkler, P., Formanek, T., Mlada, K., Kagstrom, A., Mohrova, Z., Mohr, P., & Csemy, L. (2020). Increase in prevalence of current mental disorders in the context of COVID-19: Analysis of repeated nationwide cross-sectional surveys. *Epidemiology and Psychiatric Sciences* 29, E173.

in some communities and generations, there was consistent discussion of the way in which mental health has been impacted by successive lockdowns. Our interlocutors stressed that it is not the “kind of mental health that needs tablets” but the kind that requires people to talk about and share their problems, introduce structure to their days, and seek out moments of joy amidst the “doom and gloom”. On the other hand, people also indicated that it had not been possible to take care of friends or family members without the chance to assess their mental health needs face-to-face and medication use increased during the pandemic, especially amongst young people.[16] Those who have experienced conflict or tension, or even violence, in their relationships and homes are seen to have suffered the greatest cost to their mental health.

Those involved in local government and charities supporting families described how lockdown had intensified financial, relational, and emotional burdens on families, particularly those in precarious employment. A trifecta of “mental health, alcohol, and domestic violence” was commonly cited as issues that had intensified during the early pandemic and combined to produce volatile situations during lockdown. Domestic violence had “sky-rocketed”, and support workers expressed concerns that “vulnerable children are witnessing it”.[17] *“By last September [2020] the pressure cooker started to blow”*, a support worker described, and was wary this would happen again.

The survey demonstrated the ways in which vulnerabilities often intersected and compounded one another, especially in extreme cases of physical insecurity. *All* survey respondents who reported needing “Support dealing with violence” lived alone or as a “lone parent with dependent children”; five of nine also mentioned “Difficulty meeting basic needs”. *All* respondents who reported needing support dealing with violence also mentioned needing mental health support. Future outlooks were largely pessimistic; one respondent shared, “*I think if another lockdown [happens] then I could end up seriously depressed”,* and several echoed the sentiment that things “*won’t change*” over the next months, even as social restrictions are eased.

The normal stages of support provided to people registering health distress with their GP or local health services were disrupted, along with informal referral processes through community or religious groups. Mental health, domestic violence, drug and alcohol, women’s and children’s support groups, in particular, were interrupted. Links dissolved between healthcare providers, informal support services, and households through which respite, practical help and signposting could occur. The closure of community centres had a disproportionate effect on minority and disadvantaged subgroups, especially women and the elderly. Several interlocutors involved in local government anticipated that this interruption in support services would bring an increase in more dramatic interventions later. Their emphasis was on the need for ongoing support measures and a future-orientated policy (with guaranteed funding) to prevent this.

For people experiencing severe distress or with acute need, it became increasingly difficult to navigate support services. For example, one female respondent from Ealing explained; “*I was suicidal, with no job, living on my own in a tiny flat far from my family. I tried so many times to reach out to get mental health help and yet I wasn't provided with anything - I was too serious for 1 place and 'not serious enough' for the next level up, as I didn't have a disorder like bipolar or anything, my depression was 'circumstantial' - when I wanted to kill myself. I kept being advised that I could go to private health care, when I was out of work and extremely worried about money/holding on to my flat.*”

As talk of reopening replaced the panic of the second wave, mental health was increasingly raised by those working in health and social care as a daunting hurdle for their communities to overcome. Increasingly, “mental health” was no longer being used as a way of problematizing government-enforced isolation, but instead as a way of sustaining dialogue around issues of health and inequality. “Mental health” has emerged as a way of coding for unresolved (and still largely undefined) problems and calling for continued conversation when it seems authorities have tired of engaging. It is a way of pointing past the vaccine to an uncertain future and demanding continued accountability from government “partners”. Our evidence suggests that there is a demand embedded the language of mental health for a more relational form of community provisioning to overcome the long-term effects of social and service disruptions during Covid-19. It is a call for better social infrastructures all round and greater investment to sustain them.

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[16] Robinson, J. 2021. A perfect storm: the impact of COVID-19 on the mental health of young people - The Pharmaceutical Journal (available on-line: https://pharmaceutical-journal.com/article/feature/a-perfect-storm-the-impact-of-covid-19-on-the-mental-health-of-young-people, accessed 7 July 2021).

[17] ONS 2020, *Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales: November 2020* https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020

Spotlight: Grief and Bereavement

Rebecca Bowers and Nikita Simpson

29% of respondents to the survey reported that they had experienced bereavement during the pandemic. Two-thirds of these respondents mentioned "Family and friends" as a "most important" source of support, while the second most-cited was "Faith group", indicating that most respondents received support through non-formal networks of care. The degree of help accessed or available was incredibly varied, with some respondents reporting they had been adequately assisted throughout the experience of a loved one's death by charities, medical staff, and funeral service providers, and others feeling in one respondent's words, *"Completely isolated"*.

Regardless of the death or its nature, experiences of grief were amplified during the pandemic. Frequently arising themes in the survey data include the dismay of respondents at funeral restrictions and the inability to spend time with a loved one before they died. Even when respondents reported what they perceived as less traumatic instances of death during this period (for instance, when death was expected or it was not seen as preventable or Covid-19 related), being unable to provide appropriate funerals remained a source of grief and guilt. The loss of pivotal moments in the life (and death) course has considerable ramifications for the mental health of respondents. As one bereaved respondent answered *"It was very hard having a loved one become ill and die, without being able to see or talk to him. It was distressing to think that he thought we'd abandoned him"*. It was particularly difficult for a number of respondents who were affected by restrictions around care homes, with many expressing sorrow that they had not been able to visit or access family members who had passed away. One respondent stated, *"My […] 95-year-old father died in April 2021. I had not held his hand since March 2020"*.

Communities have adapted their funerary rituals to the pandemic restrictions.[18] Some have cited the benefits of such adaptations. Being able to have face-to-face end of life care through hospital chaplains has been critical to the grieving process. For instance, one Hindu man who lost his wife cited the smaller circle of people who he was able to grieve with as being an amazing support. The fact that he did not have lots of people visiting gave him and his children "time to grieve"; however, his extended network was also able to share in the mourning through online platforms. Others, however, described a significantly *more* complex process of mourning. There is a sense that the trauma is being "postponed" or prolonged.[19] This will leave a lasting impact of emotional distress and confusion on the bereaved and on communities that lack the language or the rituals to absolve these traumas. Being prevented from seeing one's family and friends is itself a form of grief, compounded by fear for the loss of relational culture in groups for whom this is vital.[20] In some instances, gathering for funerals has also offered the opportunity to connect with friends and relatives and has reminded people of their networks of care during a time characterised by physical and emotional distance. A woman in Scotland noted that, following the death of her father, she was able to rebuild connections with her extended family with whom she reconnected at the funeral, reminding her of the availability of these networks when she herself needed support. The effects of bereavement have been particularly concentrated in minoritised groups experiencing disproportionately high mortality rates. In the first wave, Afro-Caribbean and Black British groups were especially hard hit; during the second wave, the impact was highest among Pakistani and Bangladeshi British groups.[21]

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[18] Burrell, A. & L. Selman 2020. How do Funeral Practices Impact Bereaved Relatives' Mental Health, Grief and Bereavement? A Mixed Methods Review with Implications for COVID-19. *OMEGA - Journal of Death and Dying*.
Carr, D., K. Boerner & S. Moorman 2020. Bereavement in the Time of Coronavirus: Unprecedented Challenges Demand Novel Interventions. *Journal of Aging & Social Policy* 32, 425-431.
Simpson, N., M. Angland & J. Bhogal et al. 2021. 'Good' and 'Bad' deaths during the COVID-19 pandemic: insights from a rapid qualitative study. *BMJ Global Health* 6, 1-6.

[19] Kokou-Kpolou CK, Fernández-Alcántara M, Cénat JM. Prolonged grief related to COVID-19 deaths: Do we have to fear a steep rise in traumatic and disenfranchised griefs? Psychol Trauma, 2020;12(S1), S94-S95.

[20] Goveas, J. & Shear, K. Grief and the COVID-19 Pandemic in Older Adults Am. J. Geriatr. Psychiatry. 2020;28(10):1119-1125.

[21] COVID-19 Ethnicity subgroup: Interpreting differential health outcomes among minority ethnic groups in wave 1 and 2, 24 March 2021
https://www.gov.uk/government/publications/covid-19-ethnicity-subgroup-interpreting-differential-health-outcomes-among-minority-ethnic-groups-in-wave-1-and-2-24-march-2021

Community organisations involved in the Community Champions programme stated that an important part of their work was helping people deal with the trauma of losing of family members. This was particularly acute for the fearful, shielding elderly, or those from migrant families who had lost relatives abroad. Personalised attention and flexibility were qualities that set community-based and voluntary bereavement services apart in survey respondent's experiences of loss; one respondent reported that those who took care of her mother at *"the local community hospital… were so approachable and allowed us to be with her"*, in comparison with the *"major hospital"* from which she was discharged. Another respondent, reflecting on the loss of her elderly father, expressed relief at getting help from *"community nurses, who were wonderful"* after their GP referred them to a more general ambulance service.

The use of online resources for support during the pandemic has provided solace for those unable to grieve or mark a loved one's passing together. During the second wave especially, the uptake of online bereavement support has increased exponentially; as one service provider verified, *"People are a bit more willing to take up different forms of support in that way"*. Such is the demand for online support that a US organisation has reported an influx of users from across the world, including the UK, dropping into its open Zoom group sessions. While both formal and informal providers have developed innovative ways to comfort the bereaved in lieu of face-to-face or extensive contact, government-funded and charitable service providers alike have struggled to meet demand due to their already underfunded statuses. There is a significant fear of the challenge that lies ahead in terms of delivery and resources; "*What we want is for services to be available to everybody that does need them, and […] we're very far from that at the moment,"* the head of a large UK support network stated. It is important to note that these services also include financial advocacy and assistance, as well as emotional support.

Finally, there is also the need to recognise the collective grief that the UK, as a nation, has experienced.[22] While strangers have been reaching out and comforting each other through newly emergent Covid-19 grief forums there has also been anger, as well as immense sadness, expressed in the online public sphere, including in social and news media. Both public memorials and calls for enquiries into the handling of the pandemic are growing, as bereaved families across the UK, seek recognition for the magnitude of their loss, and answers for the reasons behind it. These examples point to the need to validate expressions of collective grief while providing a renewed call for government accountability amidst the ending of lockdown and vaccine-inspired optimism. It is therefore vital, as one service-provider framed it, to acknowledge the "*parallel sense of incongruence […] between a country that is jubilant and a family that is grieving"*.

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[22] Harrop E, Mann M, Semedo L, et al. What elements of a systems' approach to bereavement are most effective in times of mass bereavement? A narrative systematic review with lessons for COVID-19. Palliat Med. 2020 Oct;34(9):1165-1181.

The pavement of Dunsmure Road in the heart of Stamford Hill’s Strictly Orthodox Jewish neighbourhood gets crowded easily as people hurry past shoppers queuing to get their groceries, 15th May, 2020.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

Disruption Across the Life Course

The following sections present evidence on the form and acuity of disruption that people at different stages of their life in the UK have experienced during the pandemic. Taking a convergent life course perspective to understanding mental distress offers a unified perspective to tie together findings emerging from social science, biological sciences, and epidemiology.[23] It suggests that the genes, brain, body, and social environment interact and shift in relative importance at different stages. An anthropological perspective on this approach appreciates the ways in which people themselves experience shifts across the life course as moral and embodied.[24] This approach is productive, because it allows us to link social and biological dimensions of disruption as they are configured differently across time. Most importantly, it allows us to understand the nuanced ways in which groups have been impacted and experienced disadvantage with respect to their expectations and needs. The following sections look at different roles and positions in the life course and how this is related to Covid-19 impacts.

The Elderly and Exclusion

Our research revealed that the elderly, across communities, are experiencing isolation, exclusion (especially digital), and shame at their dependency. Interlocutors wished to remain independent and to avoid burdening the health system or their families because of their vulnerability to Covid-19, but often had few resources to find the appropriate support. The inability to attend social activities such as lunch clubs, sports, day centres, temples and games clubs that provide coincident care has been extremely difficult for many isolated elderly people. Carers have noticed significant cognitive decline during this period, even in situations when elderly people are well cared for. However, many of the older generation display exceptional resilience, relating this pandemic experience to previous experiences of war, economic crisis, or migration. Elderly people also feel more dependent on younger people for information and advice as to how to navigate this uncertain present. They are exposed to news significantly through social media and engage younger generations in verifying sources. However, at the time of survey analysis, it was indicated that the risk of viral infection was not as prominent of a concern as for younger generations, perhaps due to a combination of vaccination and a more fatalistic attitude to mortality at a later age.

Insights from the survey: The Elderly

On average, retired respondents mentioned *26% fewer* needs than the average survey respondent. Only 7% mentioned needing mental health support, compared with 21% of the total surveyed sample, though ethnographic research suggests that this might not be a category that elder generations deploy.

- 62% of respondents who mentioned *"care homes"* recounted traumatic experiences, especially of family members *"dying alone"*, broken communication with those inside, and unsafe conditions for care workers.
- On average, retired respondents mentioned 24% fewer sources of support than the average survey respondent.
- Most who elaborated on positive experiences of support mentioned their local community, outreach by friends and family, and emotional support via phone/internet. There were no descriptions of support from local or national government, though many mentioned GPs and NHS services.
- The main barriers or challenges mentioned were issues accessing health and government services and broken communication. For example, respondents reported, *"Could not get NHS dental services, had to go private"*; *"GP services were restricted and slow to act"*; *"we were never able to talk to our GP face to face*".

Our research further revealed that, as the pandemic had worn on, many elderly people have drawn on fatalistic thinking to cope with the disruption to their lives. Amongst elderly people from Hindu, Sikh, Christian and Muslim denominations, there is a sense that the high rates of transmission and associated mortality are a divine test. Some Christian communities have also identified the Covid-19 pandemic with the book of Revelation. The response to everyday restrictions is hence perceived in relation to this test of faith. This means people might either see themselves as guided to wait, display patience, and follow the rules as an act of faith, or to yield to the gravity of the situation, accept predestination, luck or "kismet", and continue to live given their lives are temporary and they will move on to another life or an afterlife. This sense of fatalism helps people to rationalise and cope with traumatic incidents.

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[23] Patel, V., S. Saxena & C. Lund et al. 2018. The Lancet Commission on global mental health and sustainable development. *The Lancet* 392.

[24] Lamb, S. 1997. The Making and Unmaking of Persons: Notes on Aging and Gender in North India. *Ethos* 25, 279-302.

The loss of social infrastructure provided by faith spaces has been felt particularly keenly by the elderly, some of whom *"would rather go to their place of worship and risk death than die without being able to practice their faith"*. For many elderly people, faith institutions were a core source of support. For example, one respondent from East London indicated *"[the] church quickly stepped up to address social isolation and ensure everyone was known and cared for, including any practical things if needed… [I] continued to work and be part of a supportive faith community so though I live alone, I haven't been too lonely. They even supported me through a relationship breakdown that occurred during lockdown."* People related the extreme uncertainty of the situation to moments in their life course when they had lost everything and indicated that the only solution was the growth of social infrastructures. For example, one woman who was a Gujarati refugee from East Africa described the experience of fleeing her country of birth in parallel with the pandemic. The only way to overcome these trials, past and present, was to intensify her community work and the connections it provided. Frustrated in attempts to do so by national interventions, digitally literate people joined creatively in online WhatsApp and other groups. If encountered digital barriers, interlocutors described their isolation as complete, even hopeless. Community groups across the country report that many elderly people remain afraid to reconnect with society as national restrictions ease. It is hard to feel safe again, especially as familiar spaces such as community centres and face-to-face meetings in places of worship are still only partially re-opened. This loss of social connection needs to be addressed through systematic investment in face-to-face facilities and contexts for engagement that would be most effectively led by faith and community organisations.

Gender and The Squeezed Middle

Our research revealed that the burden of care generated by Covid-19 restrictions is falling to the "squeezed middle", a generation taking care of both the elderly (often relatives or close friends) *and* their children. These unequal burdens have been greatest for women (mothers and young grandmothers) and key workers, who have absorbed risk for their families through increased management of domestic space and caring for vulnerable relatives and friends. This group wanted affordable, accessible local childcare, flexible employment for parents, and mental health support for children and relatives (much more often than for themselves). Their demand was for a joined-up approach to the labour of care; this would recognize their extra work during the pandemic and would relieve it in the future by building social infrastructures of child and elder-care and investing in education. Many reported that their employment efforts, and indeed the wider economy, could not continue without these measures and that employers and the government should bear greater responsibility to keep society going by supporting valorizing and compensating caring activities outside the workplace. Overall, the pandemic has seen a radical politicisation of hidden care work across all classes and groups. Unless governments and local authorities respond with active measures of provisioning, they will not meet people's core demands.

Insights from the Survey: The Squeezed Middle

Those who described their households as "Couple with dependent children", "Lone parent household with dependent children", or "multigenerational household" mentioned 3.01 new stressors on average, 20% more than the average.

- → 39% mentioned "Difficulty with homeschooling", a percentage three times higher than in the total surveyed sample. 23% mentioned "Lost educational opportunities", compared with just 10% of total surveyed sample.
- → Despite mentioning more new stressors, those who described their households as 'Couple with dependent children', 'Lone parent household with dependent children', or 'multigenerational household' mentioned *fewer* needs on average (10% fewer) and sources of support (16% fewer), compared with the sample mean.
- → Continuity (e.g. of income, routine, relationships) and social connections (e.g. support with childcare/homeschooling) were most often mentioned as positive aspects of the pandemic experience. Those who classified their experience as "somewhat better" or "significantly better" than others' in their local area often used collective pronouns (e.g. 'we have a house, garden and good income'). Those who selected 'somewhat worse' or 'significantly worse' rarely used the collective pronoun; these respondents mentioned deaths, illnesses (Covid-related and otherwise), intense isolation, and unavailability of financial support. The experience of a death or illness in the family was often compounded by separation (e.g. 'My elderly mother was in rehabilitation due to catching covid and i was unable to visit her').

- When asked who they are most worried about, this cohort overwhelmingly mentions children, both as in ‘my children’ and ‘my grandson’s generation’.

Unpaid Carers

For some people who were caring informally for their elderly relatives, disabled relatives, or children before the pandemic, this period has cemented their roles and intensified demands placed on them. Particularly for middle-aged women, the need to care for their elderly relatives is an acute burden that they take on or absorb into existing caring arrangements. Many have shaped life decisions to accommodate these needs, for instance moving in with those they care for. The protectiveness of elders is seen as a cultural factor, where many communities (such as South Asian communities) uphold the care of elderly relatives as an expression of intergenerational respect and continuity. This kind of care is often prioritised over strict compliance with restrictions and has at times contributed to fear around vaccination.

One woman, for example, described the living situation of her niece, who was caring for three children and a mother-in-law with dementia. Her husband was working from home and was too scared to have any carers enter the house. Her mother-in-law was in and out of hospital, and private carers required regular payment. Her mother-in-law was sleeping next to where her husband was working, and when she called out for help, he would be disrupted. Their marriage suffered as she attempted to manage the space. This situation was significantly different to non-pandemic times, when, though her caring responsibilities would be great, her aunts and sisters would be able to provide respite care. She has lost weight, experiences anxiety and other physical problems, and feels she is *“ready for a breakdown”*.

There was increased demand for foster care and other forms of support provision for children, as families were disrupted and relationships were strained. Simultaneously, carers were finding it more difficult to accept children as they had new caring responsibilities of their own and were unable to safely send their children to school. There were also fewer families seeking to adopt foster children, meaning those in foster care were more likely to be passed around between households.

Insights from the survey: Unpaid Carers

- Around 50% of respondents who identified themselves as “unpaid carers” or “looking after the family / home as a full-time job” were in the 55-65 age category. *None* were over 65 or under 25, and only two (of 25) fell in the 25-35-year-old age range.
- 90% identified themselves as women.
- 60% of unpaid carers (15/25 respondents) mentioned ‘Difficulty caring for elderly or dependent relatives or friends’ as a new stressor.
- Unpaid carers expressed dissatisfaction with the central government, with over half reporting they had not received support or that the support they received was ‘not at all’ satisfactory. Just under half received no support from their local authority. One explained *“Being compelled to send my children to school during a pandemic put strain on the family as due to pre-existing medical conditions we had to isolate from our children in the home in an attempt to keep safe, which has impacted on our relationships.”*

Spotlight: Unpaid Carers from Tower Hamlets

Jordan Vieira

During the pandemic, help for unpaid carers in Tower Hamlets was provided in part through securing digital resources for those in need, providing a regular forum for discussion and to address concerns, and hosting daily activities to create a sense of community and boost mental health amidst lockdowns.[25] Such actions highlight how, in the words of the Carers Network Director, "*the voluntary and grassroots groups just got on with it – they knew their people, knew what was what*", an idea echoed throughout this report in other contexts. Yet over a year into the pandemic, carers agreed that "*the initial goodwill is coming to an end*", as they experienced intensified fatigue and endured both the realities of austerity measures and the differential treatment between informal and formal carers that have been magnified by the pandemic. The mood of the group was perhaps summed up best when one woman suggested that "*policy would change tomorrow if the policymakers had to be a carer for just one day*" and later proposed a UK-wide carers' strike to draw attention to their need for an adequate wage, signposted resources, and respect and recognition. Indeed, while all agreed with the sentiment, expressed by one carer, that *"the NHS is the greatest achievement of this country"* and is under threat of increased privatisation, there were concerns about a lack of resources available to informal carers.

Several interlocutors noted that medical personnel will not speak to informal carers if the carer is not related to the patient. One woman, for example, cared for her son who turned 18 during the pandemic. After, she needed to obtain his permission to make decisions and receive medical information, which posed various challenges and delays in required treatment. Another woman had a 19-year-old son with autism and did not receive support from any services. She had to break shielding in order to leave her home for supplies and emphasised repeatedly that having someone from the state phone up once per week to check-in would have been incredibly helpful and appreciated. This service could simply signpost carers towards appropriate resources and avenues of help. A middle-aged Bengali man emphasised this point when he noted that the ability to provide care is challenging if there is no network for advocacy, a common issue expressed by informal carers. If it were not for the carers' network through our interloctors were affiliated, for example, many stated they would have experienced difficulty in obtaining the necessary digital equipment that they feel the state "*assumes we have*". Despite support from the network, the Bengali man expressed his feeling of personal inadequacy in caring for his mother and other loved ones due to a lack of resources, compounded by the fact that he himself is classified as vulnerable and had to separate from his mother. This physical separation rendered adequate care impossible. He stressed that this situation has led to mental health issues.

Another woman, who cared for her wheelchair-bound mother, had to arrange for private care for a punctured eardrum due to an *"unhelpful GP*". Describing her general interaction with state care services, she asserted that *"they speak to you like you're an idiot"*, underscoring a more general frustration that carers felt in the absence of state recognition and appreciation. Indeed, all carers agreed that **a carer's wage** is essential and would help provide such validation and recognition that is currently missing. As one woman phrased it, carers *"are tired of being told we are just a carer"*. The carers agreed that they would be hard-pressed to find regular employment with a lack of 'official' qualifications, despite their many informal qualifications gained through years of care work. Moreover, informal carers reported that they were turned away from receiving priority doses of the vaccination. Their collective experiences highlight the 'squeezed middle' that the Covid and Care group has identified repeatedly in various contexts throughout the pandemic; middle-aged people are struggling to provide both financial support and physical care to elderly parents and other older relatives on the one hand, in addition to their children on the other.

Austerity policies also presenteed issues for carers. They received £67.60 in the form of a carer's allowance per week, yet a carer vented her exasperation that not only was this sum insufficient compensation for the emotional and physical labour she provided (equivalent to a full-time job at 35 hours per week), but the sum was also deducted from other benefits to which she was entitled. These concerns are part of a larger issue of time-reckoning in informal care labour as a balancing

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[25] Jordan Vieira, Nikita Simpson and Laura Bear conducted a focus group with five unpaid carers from diverse ethnic backgrounds who were part of a carers' network in Tower Hamlets, which provides support and resources to informal carers.

act between part-time jobs, other family commitments, rest, and meeting the required 35-hours-per-week in order to receive any compensation.[26] Moreover, one woman explained that she would soon retire and receive her pension, but that the carer's allowance would then cease, depriving her of compensation for the care she would continue to provide. If such austerity measures were not egregious enough, a woman reported that a vulnerable elderly woman under her care was forced to relocate amidst the pandemic after she lost her partner and had to subsequently contend with the bedroom tax, another result of austerity policy.[27] These experiences underscore the precarious and difficult positions people already occupy and stress the existing, urgent need for increased resourcing (rather than any heightened or extended austerity measures) in post-pandemic provisioning.

Mothers

Within the home, mothers have felt concern for their own mental health with new stresses relating to childcare, work, and the absorption and mitigation of risks for those they feel responsible to protect. The arrangement of domestic spaces, with the mother often working in more public rooms (e.g. the dining or living room) in contrast to men who more often cited working in designated workspaces, has meant they have had to juggle competing demands from their children and employment. For homeschooling parents, the closure of public educational spaces (such as museums) has caused difficulties in engaged learning. Many women have been working longer hours during the pandemic to acccomodate expectations of childcare. Although some mothers noted their children's potential for severe illness if they contracted Covid-19, many mothers felt there was a balance in risk in sending children to school despite risk of contraction for their children's social development or stable mental health, and for their own. This was particularly the case for mothers who lived a long distance from key relatives, such as grandmothers or siblings, who could help with childcare during the working day. In almost all cases, however, mothers felt this juggling act was their obligation, and narratives evoked notions of the strong mother mustering a brave face for the benefit of their children and partners: "*it's a job, and it has to be done*". Social media and online groups offered opportunities for mothers to vent frustrations and share the burdens of maintaining this image.

Throughout the Covid-19 pandemic, parents, and especially mothers, have been hard-hit by the closure of Early Years provision. With increased workload at home, from childcare and the blurred lines between home and work, often women face redundancy or making the (enforced) choice to leave their careers to balance childcare.[28]

The household tasks, including boundary-making tasks to keep the home virus-free (such as deciding who to allow into the house), plus additional cleaning (of packages, online groceries, etc) and increased cooking as everyone is home for lunches, have tended to fall on women. One woman said she cleaned every packet and food item from her shopping every day and could take up to an hour to wipe it all down. She avoided shops and relied entirely on online shopping. As a key worker, she feared spreading the virus. Having caught Covid-19 in Summer 2020, she was particularly risk-averse, and her partner worried about her going to work. In the current climate of economic downturn, those who work from home are putting in more hours (at all hours of the day and night) in order to keep their jobs secure and manage the redundancies in their working world. *"What is a weekend? I work all the time", "I took a day off, but ended up working. I'm taking on the work of the whole team since people got let go", "I wake up two hours before the children to work then work until midnight most nights,"* and similar sentiments expressed in interviews (mostly with women but also some men) show the increased workload without a reflection in pay. Women at work still face a gender pay gap that is likely widening through the course of the pandemic.[29]

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[26] Vieira, J. 2021. The austerity of time: living with neoliberalism, financialization, and difference in London's Docklands. PhD thesis. London: The London School of Economics.

[27] Koch, I.L. 2018. *Personalizing the state: an anthropology of law, politics, and welfare in austerity Britain*. Oxford: Oxford University Press.

[28] See Women's Budget Group, UK Policy Briefing, *Childcare, Gender and Covid-19 November 2020* https://wbg.org.uk/wp-content/uploads/2020/11/childcare-with-cover-1.pdf

[29] See Women's Budget Group, *Spring Budget 2021 Pre-Budget Briefings: Women and employment during Covid-19* https://wbg.org.uk/wp-content/uploads/2021/03/Women-and-employment-during-Covid-19-1.pdfW

Spotlight: Schools, Nurseries and Working from Home

Anishka Gheewala Lohiya and Caroline Bazambanza

Many mothers worry about their children's social and educational development, particularly mothers who are working full-time or feel they do not fully understand the school's expectations. An interviewee reported regularly calling her brother, a headmaster at another school, for advice relating to her children's work. However, she still found it difficult to understand the work assigned by her child's school and felt there was little support from the school itself in providing parents with the resources and tools to support their children's learning.

Mothers with children in state-schools felt there may be a growing gap in educational attainment for their children compared with children attending fee-paying schools. Some mothers with children at private schools also expressed this concern as they reflected on the commitment of their children's teachers in ensuring engagement with and completion of work at home.

A woman working from home in Northeast London described how the division of working space impacts the household dynamic. Her partner converted the spare room in an office, as he took the most calls, while she worked at the kitchen table. This meant she was often distracted by her children who turned to her for entertainment and assistance with schoolwork throughout the day. When she spoke to her children's teachers, she did not get satisfactory guidance on their work or development. Though some mothers were concerned about sending their children back to school for fear of contracting the virus, most mothers wanted schools to reopen as soon as possible and to stay open.

Nurseries have taken steps to ensure parents feel comfortable leaving their children in their care. These included greater investment in cleaning and sanitation products, wearing facemasks, and educating children about the importance of cleanliness. One nursery reported concern with the distance needed to travel to receive a lateral flow test, noting many staff had to use public transport to reach the site. Staff from this nursery recognized parents' anxieties regarding children's social development, yet stressed that there would be no long-term negative implications of young children staying at home if they eventually returned to the classroom.

The closure, due to Covid-19 outbreaks, of nurseries that cater to 0-4 age ranges caused many anxieties for parents, as this age group needs constant care and attention. Perceived risk was higher for potential transmission because of the necessity of physical contact. This impacted women especially, when returning to work as well as assessing their children's' developmental needs. Provisions for this age group did include television such as "The Baby Club" but this remained insufficient to occupy a pre-walking toddler for a working day.

Insights from the survey: Women

Women mentioned *19% more* stressors on average than men.

- → The percentage of women who mentioned 'Fear for safety due to Covid-19 transmission' (31%) was *more than twice as high* as the percentage of men (15%) who mentioned the same.
- → The percentage of men who responded, "I haven't experienced any stressors" (23%) was almost double the percentage of women (12%) who said the same.
- → The percentages of women who mentioned "Difficulty with homeschooling" and "Difficulty caring for children" were both twice as high as the percentage of men who mentioned the same (12% and 6%; 6% and 3%, respectively).

Pregnancy and Birth

Pregnant, birthing, and new mothers have faced unanticipated challenges during the pandemic. A charity supporting pregnant women's choices based in North London noted that women facing the prospect of motherhood have had to consider novel questions in relation to the continuance of a pregnancy, including a closer assessment of their individual ability to care for their newborns. Abortion was becoming an increasingly private decision, which was described as a "double-edged sword". On one hand, privacy offered women the opportunity to make independent decisions with fewer pressures from kin or friends; on the other, it created a space of heightened emotions and feelings of isolation related to the woman's material and relational capacity to mother a child. The lack of in-person support before and following a procedure was keenly felt, particularly for single women.

For women who chose to carry a pregnancy to term, the landscape of birthing they expected based on previous births or the experiences of others shifted. Most women birthing in the NHS have been accompanied by one guest, often their partner, for a limited time period. In one case, a single woman reported choosing to birth alone to spare her family the worries associated with visiting the hospital; during the birth, however, she called her mother, who was refused access to the birthing room until the infant was born. Women have also reported difficulty in choosing whether to be accommodated by a doula (a non-medically trained midwife) or partner during labour. All women interviewed wanted to leave the hospital as soon as possible after the birth to be closer to extended kin networks, even where women were experiencing bodily pain.

Having left hospital, many new mothers carefully selected a number of family members to draw into childcare support bubbles. These decisions were complicated by physical distance, vulnerabilities of family members and potential risks of contracting illnesses for newborns. NHS postnatal healthcare, for both infant and mother, were seen as inadequate in Covid-19 conditions. New mothers were particularly concerned about lack of advice and support around their children's vaccinations, counselling or therapy, and infant bodily and social development. Many mothers turned to online platforms including Mumsnet, Instagram, and pregnancy-specific social apps for information surrounding their rights during the pandemic and information on their local Trusts' policies for birthing.

Spotlight: The Black Maternal Experience

Caroline Bazambanza

In 2018, MBRRACE-UK reported that black women were five times more likely than white women to die during childbirth, marginally closing to four times in 2021.[30] The Covid moment has been characterised by increased vocality about injustices in healthcare for minority ethnic groups.[31] Interviews with black mothers, birthing women, and ethnic minority birthing practitioners revealed a tangible perception of how race affects maternity care. One woman noted that after a planned Caesarean section she was left alone in a room with her infant, unable to sleep for fear of dropping her child. When she rang for assistance from midwives, the hospital staff presented themselves as too busy to watch over the infant and returned the child back to the mother after ten minutes. During prenatal visits and in previous births, this woman had noted the difference in the care provided by NHS staff in the presence of her white husband. She had ensured he was available to attend all visits. However, due to Covid restrictions on visiting hours she was unable to ensure his consistent presence after birth and felt this impacted the staff's inability to take her concerns seriously during and after labour. After taking her newborn home, she felt she had been pushed into the position of the "angry black woman", insisting her infant receive vaccinations and health check-ups. She made very real speculations about the NHS's ability to punitively control her frustration through continued delays or threat of police if she arrived at the hospital. Whether or not these situations had taken place, her existing experiences of interacting with state institutions as a black mother shaped her navigation of birthing and maternal health during the pandemic.

Another black woman, recounting her birth story, noted that she never expected her birthing experience would be affected by the colour of her skin. During her birth, she remembers struggling with pain and feeling close to death, but she was told by midwives that there was nothing that could be done to relieve her pain. She "begged" for pain relief but was denied. She called her mother to report that she was not being listened to and felt she could not go on any longer, and requested that her mother come to the hospital. After finding out about the call, the midwives administered an injection (the name of the injection was unknown to the woman) to aid in the labouring process. Her mother arrived but was not let into the room. Only after the child was born was her mother granted entry. *"I felt like a burden that day and I would now never advise anyone to give birth alone, I only did it because of the pandemic. This experience may not be solely down to the colour of my skin, but it is my experience as a black woman nonetheless."*

Covid-19 restrictions in hospital, ante- and pre-natal provision have been felt particularly harshly by minority groups, confirming existing experiences of stigma in relation to institutional and statutory provision. It is only through greater inclusion of such groups in a more relational community-based health care and statutory provision that such experiences are likely to change.

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[30] Knight, M., K. Bunch & D. Tuffnell et al. 2020. Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. MBRRACE-UK (available on-line: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10_ONLINE_VERSION_1404.pdf, accessed 11 July 2021).

[31] See https://www.bbc.co.uk/news/uk-england-47115305

Young People and Loss

The insecurity that young people experience in normal times is amplified by Covid-19.[32] They are experiencing disruption in their life course due to suspension of exams and friendships. There is a decline in independence because of lost earning ability, educational opportunities and employment, and an increase in their caring roles. But their existential worries are leading to positive activism, for instance around climate change.[33]

Insights from the survey: Young People

Those under 35 and living in a “one person household”, “couple” (without children), or “flatshare/houseshare” mentioned *10% more* new stressors than the average survey respondent.

→ When asked about new stressor experienced during the pandemic, 61% mentioned “Feeling socially isolated”, in comparison with 40% of the total surveyed sample. 59% mentioned “Poor mental health" (compared with 34% of the total sample), and 32% mentioned ‘Relationship tension or stain’ (compared with 23% of the total sample).

→ 39% mentioned needing “Mental health support”, in comparison with 21% of the total surveyed sample. 25% mentioned “Social support” (compare with 15% of the total sample), and 21% mentioned “Furlough or Self-Employment Income Support” (compared with 13% of the total sample).

→ Respondents were more likely to mention “Friends” (50%), “My support bubble” (28%) or “A mental health professional” (20%) as sources of support.

→ When asked to describe their worries about the future, these respondents were more likely to mention general concerns about the future (e.g. “jobs”, “[worrying about] those who have lost their jobs”, “mental health of young people”) than specific events or people, though several mentioned “family” or parents.

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[32] Coronavirus Report: Impact on Young People with Mental Health Needs https://youngminds.org.uk/about-us/reports/coronavirus-impact-on-young-people-with-mental-health-needs/

[33] Jeffrey, C. & J. Dyson 2020. Geographies of the future: Prefigurative politics. *Progress in Human Geography* 030913252092656.

Spotlight: Leaders Unlocked Young Researchers

Milena Wuerth

In Spring 2021, the LSE Covid and Care research group formed a partnership with Leaders Unlocked, a social enterprise that enables young people to have a stronger voice on the issues that affect their lives. 14 young people, between the ages of 14 and 23, were recruited from across London, Leicestershire, and Derbyshire to participate in a series of virtual workshops and discussions on the local effects of the pandemic. They were instructed in the methods of anthropological data collection and interviewing and were encouraged to produce their own research questions and plans. In structured conversations with their fellow student researchers, they articulated valuable insights into the nuances of the pandemic on young people, especially in the context of interrupted schooling and uncertain futures.

The young participants shared reflections on losses caused by the pandemic, including the rupture of a reliable daily routine, but also brought to light certain positive outcomes. These included growing awareness of the impacts of human behaviour on the environment and new possibilities for social connection through virtual channels. In the processes of interviewing and presenting their findings, the researchers integrated their own experiences with those of family and friends in their local communities. The participants found that many were coping with stress, anxiety, and isolation in the wake of the lockdowns, which had kept them apart from their classmates and caused rifts between students and teachers where emotional support was lacking. A report of findings from their research will be published in the Autumn.

LEADERS
UNLOCKED

Children and Disrupted Development

Mothers have also reported concern regarding their children's mental health at all stages of development. A number of mothers reported surprise at the "clinginess" of their infant children, and others were noticing signs of fear of the outdoors or engaging with new people, particularly from their primary school-aged children. Mothers saw their children turning inward to the domestic family; with the reopening of schools, however, they hoped their children would be reminded of their wider networks of care and support. There has been growing concern from parents of young adults about the increase in eating disorders during the period of school closures. Many parents perceived this to stem from children's increasing use of social media platforms with little face-to-face social engagement to provide validation and support.

Concerns with child "development" were also a core concern cited by teachers, support workers and members of local government. As the pandemic progressed and schooling was interrupted, such workers increasingly noted "disrupted" child development, such as wearing nappies and lack of speech formation at relatively advanced ages (5-6 years). They were concerned that this was, in part, resultant from lack of engagement at home during lockdown, particularly if parents were struggling with financial, emotional, and relational burdens intensified by the pandemic. Education was itself cited as a core concern by many that the government had overlooked. Participants suggested that Covid-19 had exacerbated "the educational gap" in both "engagement and literacy". "*How many kids actually will come back?",* one asked. "*How do we address that many haven't touched a book in months?"*

Relationships between children, teachers and schools, and the trust and support that this generates, have been compromised. "Massive disappointment" was expressed in the way that the government had dealt with education; *"education has been a disaster*", a member of a school board reflected. For example, interlocutors in North East England ranging from members of school boards, to counsellors and support workers noted the lack of emphasis on educational policy and planning during the pandemic, and the failure to deal effectively with issues in schooling. It was anticipated that "learning loss" will have long-term consequences, contributing to unequal job prospects in the future. The erosion of higher educational opportunities was also a *"timebomb that's going to explode",* in the words of one interlocutor. Many felt that the government had been neglecting children, particularly in comparison to other areas of the response, and the uncertainty of the vaccine rollout for children and young people has remained a source of frustration. This was part of a broader generational politics that many articulated regarding the pandemic, where they were concerned that the lives, concerns, and futures of "young people" had been overlooked.

Systematic action is needed to address educational issues at the national and local level. Involving young adults in community organising and response is being trialed in some areas, such as Kirklees in West Yorkshire, where it is being combined with skills training. Local (community or school-based) initiatives are needed to uplift isolated young people, who have borne so much during the pandemic, to become researchers and advocates *within* and *for* their neighbourhoods. Investment in education to overcome attainment gaps is crucially important alongside such projects.

Case Study: South Asian Kinship Networks

Anishka Gheewala, Nikita Simpson and Laura Bear

South Asian networks of kinship in the UK are long-established, yet through the pandemic these were disrupted both inside the UK, as people live far away from each other, and globally, through large diaspora kin networks in India, the US, and East Africa. Families became separated through lockdown, but also through various travel restrictions and the "Red list", which has left some families unable to see each other for over a year. First generation South Asians immigrants have been left without informal networks of care, even during easing of lockdowns. Friendship and community groups among other South Asians had the potential to provide care; yet these opportunities were not always actualised, especially by the elderly, as these networks were formed through the internet or during the easing before vaccines were widely available.

South Asian women have been crucial to the maintenance of social support networks and the labour of care during the pandemic. They have the most intense and regular contact with all points in the social network; they are seen as the "glue", of kinship networks. Families developed their own detailed risk-reduction protocols and care in interactions including hygiene, cleaning, and masking. However, womens' tendency not to prioritise their own health meant they underplayed the risk that their caring labour made them subject too.

Care-work among older mothers and grandmothers was experienced as essential to their age and gender roles. Respondents mentioned that women had a "guilt complex", meaning that, if they didn't fulfil their caring obligations, they would both breach their ethical responsibilities of motherhood and compromise their social standing in the community. This was seen by many as an obligation to their children and grandchildren, and not fulfilling this obligation could mean their families would not be there for them in their times of need. For example, one Muslim Gujarati woman suggested "*People ask why you are still doing so much. I say that while I have the ability I will do for [my family]. When I am old, I don't want them to say I didn't do anything for them. They are my blood*." Men acknowledge that they unthinkingly expect women to carry these caring responsibilities, placing women at a heightened risk of social transmission and infection. In many families, except the most traditional, these female figures were also seen as the "opinion generators", as they were in intense contact with many across the community, gathering and checking new information.

The high rates of mortality were felt intimately in South Asian communities, where knowledge of 'blood relatives' and close kin (abroad and in the UK) contracting the virus and dying overshadowed decisions to comply or not comply with social restrictions. The extremely high rates of mortality in South Asian communities were felt intensely because these communities are highly networked. Announcements of those who had passed away were made on community social media groups, and the daily doses of distressing information was too much for many to bear. There was a sense of confusion as to why mortality rates are so high, as communities saw themselves as having taken utmost care. For instance, one Gujarati Muslim woman reported that her cousin brother, a taxi driver, was "*very careful and changed his clothes between shifts, and again before coming home*." However, he contracted Covid-19 while on duty and "brought it home to his family", transmitting it to his mother who later passed away.

Vaccine uptake in the South Asian community changed at the intersection of informational flows and national trends in transmission and mortality. Initially between November and February, many South Asian interlocutors were reluctant to take any vaccine or had decided against ever having it, trusting advice from medical kinship networks, including globally. However, as mortality rates increased both in the UK and in India, and Local Authorities engaged in open communication and engagement on vaccines, community opinion changed. In addition, the possibility of the vaccine offering a return to normal life, including eventually travel for pilgrimage and visiting relatives, made it more palatable.

The decision to offer vaccinations in temples and mosques was a crucial use of social infrastructures for this community, that made the vaccination feel safer and made it more practical for people to access. This change in approach and understanding in relation to the vaccine is a sign of the effectiveness of faith-based and social infrastructure focused investment. Local public health teams and voluntary sector organisations such as Near Neighbours and Strengthening Faith Institutions across the country used community champion funding to deepen relationships with all groups, including

South Asian British groups. The setting up of pop-up vaccine centres in temples and mosques contributed to uptake, growing trust and overall social cohesion. People from the British South Asian Community reported that community groups worked together to publicise and set these up. Seeing a diversity of people coming into places of worship that they would not usually enter had a huge symbolic power of inclusion and acceptance.

"The Indian variant" (now known as "Delta") and the diaspora

Diasporic links with India and other countries on the "Red travel list" embroiled families in high level political negotiations. The closure of borders was seen to have been done without attention to the huge impact on families, kin networks and businesses relying on Indian-UK connectivity. The cost of quarantining in hotels was (and continues to be) prohibitive in many cases and is discriminatory against disadvantaged and minority groups.

Yet diasporic links beyond the boundaries of nations have comprised vital social infrastructures of support. Organisations that initially were formed to help with humanitarian emergencies in South Asia among the diaspora in the UK were repurposed to help with the devastating second wave impacts on the Pakistani and Bangladeshi community in the UK. During the tragic situation in India from April 2021, diaspora links have been deployed to provide oxygen cylinders and food parcels for those in need. This has been organised through global diaspora networks on social media, within India through NGOs and aid organisations reaching out to other countries and within communities.

The devastation in specific communities in the UK and in India, Pakistan and Bangladesh has affected the diaspora through loss of relatives and other kin, the sense of helplessness for fellow Indians and instilled new forms of fear and distrust of governments in dealing with the pandemic; yet it has also led to a recognition of the power of social infrastructures to provision communities in the UK and abroad.

Inside the De Beauvoir Estate Community Food Hub, volunteer Tash Paul packs up a shopping trolley for someone waiting outside while Michelle Dornelly packs a bag alongside her, 7th December, 2020. Without a permanent space or any proper in-house storage, supplies are piled up inside the food hub. Michelle started a Go Fund Me page to raise the money herself for a permanent space.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

Case Study: Kinship Networks in the North East of England

Alice Pearson

Precarity

Lockdown had intensified financial, relational, and emotional burdens on families, particularly those who have precarious employment.[34] When the Covid pandemic arrived in the North East, the region was already coping with the aftermath of 10 years of reductions in government funding and resulting cuts to services, amidst increasingly precarious livelihoods. This had eroded services for family support, addiction, and mental health, and undermined ecologies of care in which formal support services were enmeshed. There are stages of support that services and networks seek to provide, and these were being disrupted. In particular, formal support services had been interrupted, including for mental health, domestic violence, drug and alcohol, and women's and children's support groups. Food bank use during the pandemic was widespread and increasing, with many people already depending on foodbanks in the region and even more during Covid. This included many people with incomes, whose work was often precarious or poorly paid, or self-employed.

Categorisation of "Workers"

The ambiguity of categories of "key worker", "essential worker", and "critical worker" meant that many of those who were relied upon as essential workers, but were not explicitly health workers, felt their contributions were eclipsed. Exposure to Covid-19 was endured by those who are relied upon to maintain "social contact", for example both the informalised labour relations of cleaners and nannies, and the relatively formal support roles of social workers entering homes, transport workers, charities delivering frontline services, teachers, legal aid lawyers continuing in courts, and foster carers maintaining "contact" between children and parents. There were high rates of infection across such demographics. In some cases, workers' families had tried to sustain "social distance', cutting off workers from their usual households. These workers, who were not explicitly healthcare workers but who were subjected to risks of exposure without Personal Protective Equipment (PPP), were often not celebrated and their sacrifices remained invisible. For example, an interlocutor who talked of widespread cases of Covid-19 among social workers, some developing serious illnesses, stressed "'*when we clap for the NHS, I am clapping for everyone really*." Her concern was with the relative invisibility of groups of both informal and formal workers who are not explicitly captured by the "healthcare worker" category.

There was also ambiguity about whether schools should take children who only had one of two parents who was a key worker, and whether they should take in children whose parents had been categorised as "critical workers", as opposed to "key workers". There was a lack of clarity on policy, with some schools saying that if a child had two parents, then both had to be key workers, while others emphasised the government was saying only one had to be. This generated tensions, including for parents who were being required to work while not being designated "key workers", and for teachers who themselves were in comparable situations to parents of having to work and put themselves at risk. The common experiences of risk and endurance at times produced tensions between teachers and other essential workers, rather than solidarity.

Relationality and New Social Infrastructures

People found new ways to communicate and create relationships of mutual support. "*We need that social interaction as human beings do, and we adapt*", one interlocutor emphasised. Work and friendship groups had taken on duties of support for each other, often through technological modes of communication such as group chats across various platforms. Yet, other forms of friendship had been eroded. Thus, new constellations of relationality were emerging through "willed"

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[34] This case study is based on interviews with interlocutors in northeast England in February - March 2021, with a focus on Tyneside and Sunderland. These interlocutors were involved in the relatively formal provision of support, including members of Local Authorities, local counsellors, legal aid lawyers, charities, and others involved with local businesses. This case study describes the concerns these interlocutors articulated.

practices enshrined in technological modes of communication, while those that did not have such sense of duty for one another became estranged.

Kinship networks were considered particularly close and crucial for daily support in the region, generating complex webs of care. These constellations were all compromised by Covid-19 regulations, as well as being stigmatised. For example, there were concerns that neighbours were calling the police when members of the family, normally crucial to childcare but residing outside of the same house, came around. There was also a strong regional identity of being particularly “sociable”, which had been compromised by the lockdown rules. People who understood themselves to be particularly “sociable” also felt they had become insular, and people were apprehensive as to how they would “go back to normal” in interacting with friends in the future. This generated anxiety about their understanding of their orientation to the world, as many had valued care and sociality, but were unsure how they would enact this.

Distrust of local statutory provision, stigmatisation of efforts to “get by”’through sharing the labour of care and the struggles of the pandemic have led to the informal organisation of new social infrastructures of support. The intersection of a strong regional identity as a positive basis for collective mobilisation with largely white working-class experiences has forged this. This has been inclusive, however, crossing different communities in workplaces and neighbourhoods. Nevertheless “the death of the social”, economic and emotional strains on families and absence of government funding for these activities is likely to produce negative effects as we move out from national restrictions. It is most likely that the trifecta of strained families, broken communities, and mental health issues could be overcome by concerted investment in social infrastructures and community-centred initiatives.

Overall, the loss of social infrastructures and relationships of support, as we can see from this section, has carried a great emotional and practical cost. Across all groups in our study there has been a “death of the social” and a lack of concerted provisioning to rebuild what was eroded. This has created an impact that goes far beyond the individual and neighbourhood. On the one hand, people have rallied to revitalise social support and connections in forms of mutuality and community work, but on the other hand, uncertainty about Covid-19 has generated divides in some settings, and intensified forms of stigma. It is these issues that the next section explores.

II | New Forms of Mutuality and Stigma

Introduction: Connection and Disconnection

The disruption of relations has resounding effects. On one hand, people have built their own new connections and forms of mutuality in order to meet their needs. This has occurred both at the familial level, where people have shifted their lives to provide financial, social, emotional and practical support for one another in their immediate kinship networks, often turning inwards. Our survey showed that one in four respondents were caring for children or elderly relatives/friends *and* experienced new difficulties related to these caring roles during the pandemic. 40% of respondents had formed support bubbles that allowed them to both give and receive care. Many people had moved regions, or moved in, with dependent relatives in order to provide care. These new forms of connection are both seen as an opportunity to be together, but also seen as a source of strain and burden.

But new connections have also been built at the community level within and between groups, where new and radical forms of community support have grown through volunteering, mutual aid, neighbourhood care and activism. However, these sources of support are not open to all, and there are significant barriers to accessing them for many. Indeed, government policies in some cases have not always worked to build connection, but produced new forms of disconnection, exclusion and inequality. Some individuals don't have the resources to seek help, and some communities do not have the spaces to build new forms of community. Further, this moment of uncertainty, where the risk of Covid-19 transmission compounds with other risks such as financial loss and mental distress, causes people to build new boundaries and thus generates new relations of stigma and distrust in communities, or in government actors.

Insights from the survey: Accessing Support

→ Respondents needed 2.22 forms of support on average. The most needed were information on the government rules (39%), information on Covid-19 (39%), medication or healthcare (22%), mental health support (22%), medical advice (18%), and social support (15%).

→ On average, respondents identifying as 'Long-term sick or disabled' mentioned 41% more new needs than the average within the total surveyed sample.

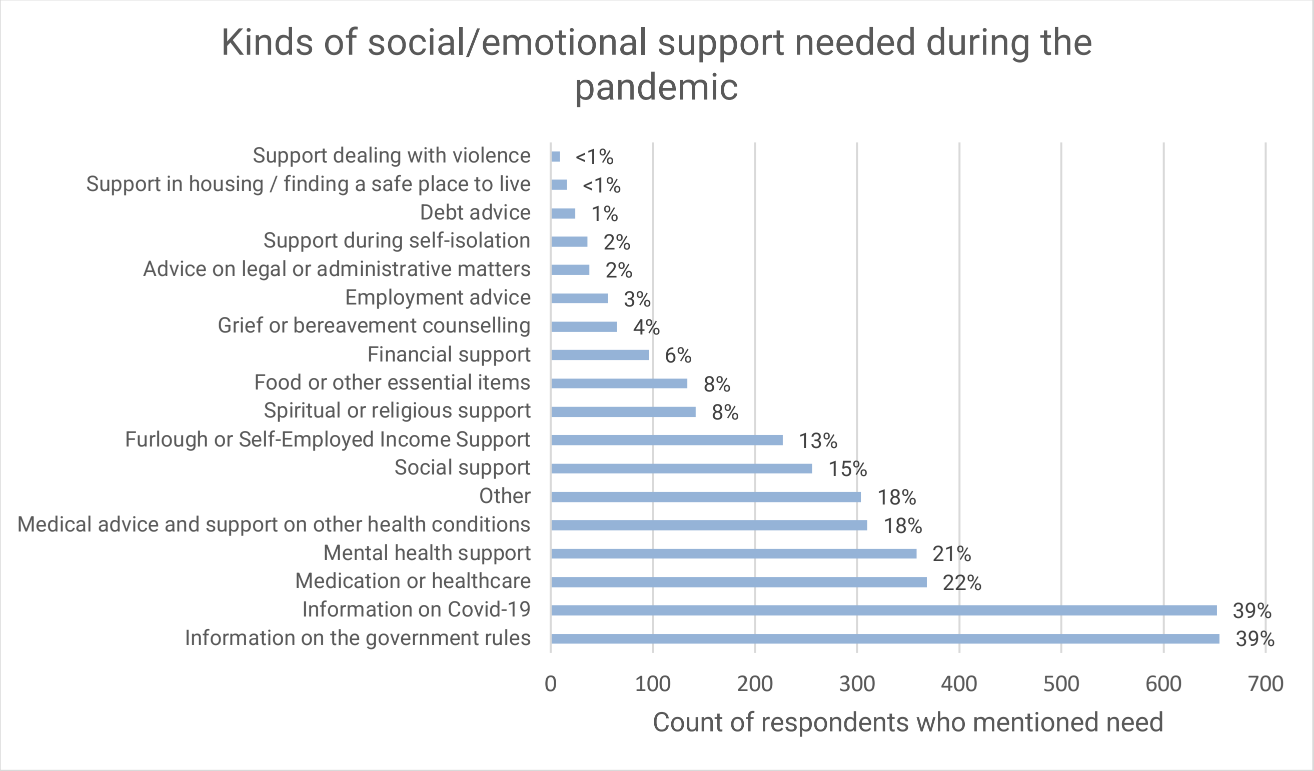

Figure 3

Our research showed that there was a sense for many that the central government did not provide any support during the pandemic to meet the basic needs of life. Indeed, 48% of survey respondents indicated that they received no support from the central government. Some respondents indicated that central government policies were actively problematic and caused fractures in their relationships. For example, one respondent expressed "*being compelled to send my children to school during a pandemic put strain on the family as due to pre-existing medical conditions we had to isolate ourselves from our children in the home in an attempt to keep safe, which has impacted on our relationships*".

There was also a sense of dissatisfaction with the local authority, where 60% reported that they got no support from this source. Indeed, there was a sense of abandonment by the government in this moment of crisis, that was the greatest for historically excluded groups such as ethnic minorities. Those who ranked satisfaction with Local Authority very low, cast local government as complicit in the incompetence and/or secrecy of central government. Those with more specific complaints about their local council condemned disproportionately harsh local lockdowns (especially Liverpool, Leicester) and claimed councils were driven by greed, implementing flimsy and ineffective measures with little effect (e.g. using pandemic as "*excuse to cut services*"). Several respondents expressed dissatisfaction in partisan terms (e.g. "*Tory council...*", "*Not happy with my Labour council*").

Instead, respondents tended to seek support from informal sources of support - their family, friends, and support bubble - but also accessed forms of online support and formal provision beyond the government, for instance, through faith institutions, voluntary sector organisations or mutual aid groups (see Figure 4).

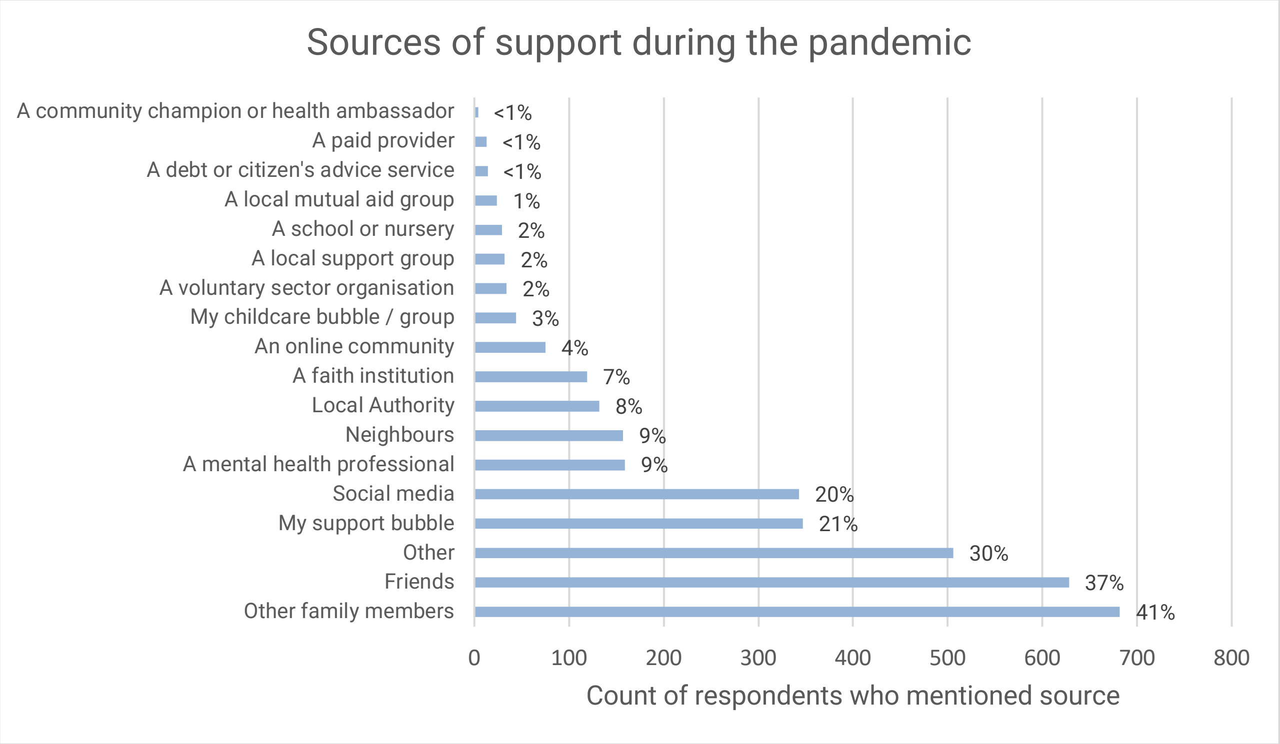

Figure 4

People also expressed some barriers to accessing support (32% of respondents). Some of these included the fact that they were not properly listened to, the support service was slow in provision, or didn't understand their needs. Accessing GP services and financial support, especially Universal Credit, was particularly frustrating for many. 60% of respondents who mentioned "Difficulty meeting basic needs" also mentioned experiencing some kind of barrier to accessing support, compared with only 32% of the total surveyed sample. Commonly mentioned barriers included long wait times and inaccessibility of medical services, difficulties related to disabilities, and lack of mental health support.

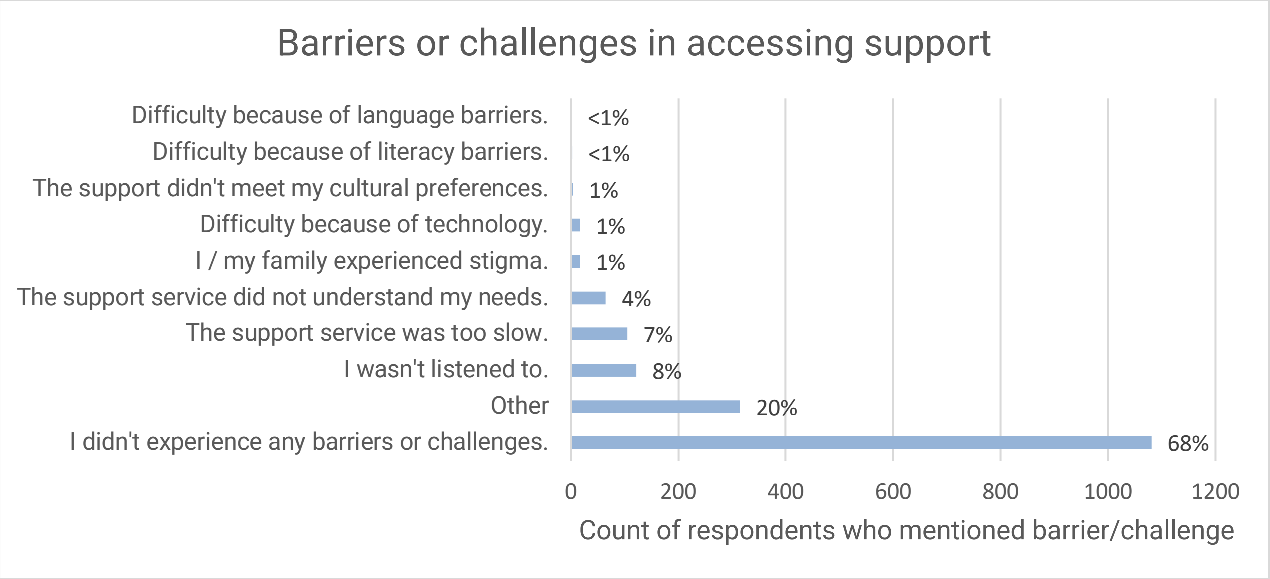

Figure 5

New forms of mutuality

Importantly, the ways in which people supported one another, and provided support for their communities, generated new forms of mutuality. In anthropological thinking, mutuality is the state of being present with another, often generated by the networked relationships in which people are embedded in their home and in their communities. Forms of mutuality are sustained by the ethics, values, and expectations that people have of each other. As these networks were remade in the pandemic moment, such values, ethics, and expectations also shifted. In some cases, this generated innovative and exciting opportunities for inclusion, redistribution, and care. We have seen how some local and central government responses and policies have worked to facilitate, support, and sustain such innovative forms of mutuality. Here we present three forms that arose from our research within communities, but we extend this analysis in the following section to understand how these forms have been sustained at civil society level.

Support Bubbles

The notion of a "support bubble" or expanded network of households allowed to provide care for one another to meet the needs of vulnerable or dependent individuals, has been a significant innovation in policy and practice during the pandemic.[35] Over the course of the pandemic, the national government has actively promoted the support bubble as a legitimate and legal way of negotiating care relations while under restrictions. The reasons for being able to join a support bubble expanded during the second and third lockdowns, and many informally used the notion of bubbling to negotiate risk during the easing of lockdown. Our research revealed that being part of a support bubble improved pandemic experiences, worked to ease care burdens and was an important source of public health information and advice. This was particularly the case for women, and those who lived in a one person or multigenerational households. However, a lack of clarity around the limits of a support bubble – who was allowed in, when, and where – was confusing for some.

For example, one female respondent from Ealing who experienced mental health issues suggested that "*the first lockdown when people like me were denied any sort of bubble was terrible*." During the second lockdown, she formed a support bubble with her mother – "*We both cried when we could finally have a support bubble and hugged for ages as we had had zero human contact. It was needed much earlier on. However, there was a lot of confusion around whether or not we could bubble as she lives in a different part of the country, and of course we weren't allowed to travel, but what were we meant to do? She drove to pick me up so we weren't in public transport or anything or interacting with anyone*." She was concerned though that her sister, who lived alone, was not able to also join the bubble: "*Another issue is that it could only be the two of us - my sister also lives alone and hasn't been able to interact with anyone - she lives further away so said my mum and I should bubble so at least we have each other - but we all were not interacting with anyone else and all lived alone so why couldn't the bubble have included all of us?.*"

The idea of the bubble was promoted by respondents as a crucial part of the recovery plan, and a means by which relationships could be revitalised: "*I think we should all try to form more groups, more get togethers and gatherings where people who are lonely can just be with others.*"

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[35] Long, Nicholas J., Aikman, Pounamu Jade, Appleton, Nayantara Sheoran, Graham Davies, Sharyn, Deckert, Antje, Holroyd, Eleanor, Jivraj, Naseem, Laws, Megan, Simpson, Nikita, Sterling, Rogena, Trnka, Susanna and Tunufa'i, Laumua. 2020. *Living in bubbles during the coronavirus pandemic: insights from New Zealand.* Rapid Research Report. London School of Economics and Political Science, London, UK.
SAGE SPI-B/EMG. 2020. *Covid-19 housing impacts* https://www.gov.uk/Government/publications/spi-bemg-Covid-19-housing- impacts-10-september-2020

Insights from the survey: Support Bubbles

51% of respondents reported that they had joined a support bubble at some point during the pandemic (876 out of 1729 respondents).

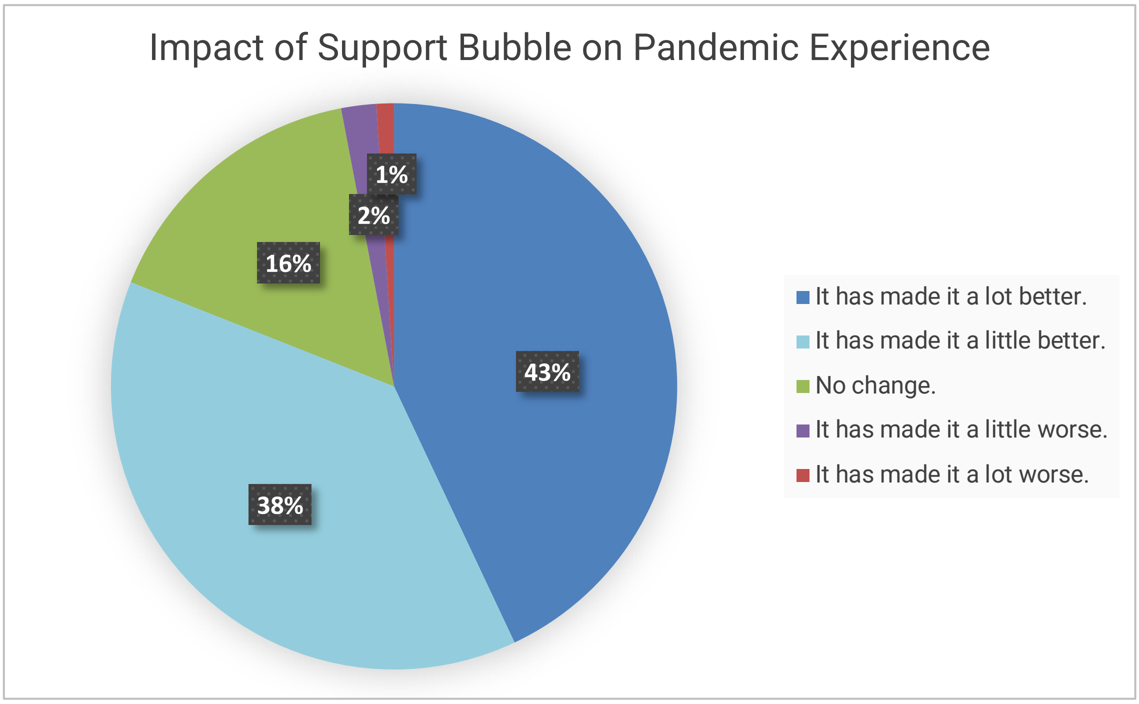

Figure 6

- → 32% of those who reported that they had formed a support bubble lived in a “one person household”. 36% of those who reported that the support bubble made their experience of the pandemic “a lot better” lived in a “one person household”.
- → 56% of women who answered the question said they had formed a support bubble at some point during the pandemic, compared with only 41% of men.
- → 63% of those who identified themselves as living in a “multigenerational household” said they formed or joined a support bubble at some point during the pandemic, compared with 51% of the total surveyed sample.
- → 16% of respondents who said they had formed a support bubble at some point during the pandemic also mentioned “Family and friends in the same household/support bubble” as a helpful or reliable source of public health advice.

Volunteering and Mutual Aid

During the first wave of the pandemic, the shape of the voluntary sector and the kinds of people volunteering shifted dramatically. Prior to the pandemic, many volunteers were elderly or retired people who were active in the provision of face-to-face services. As restrictions were announced, they often withdrew from their roles in order to shield or support family. However, there was a simultaneous outpouring of support and volunteering from younger groups within their local communities as employment was suspended and furlough was extended. As the pandemic has evolved, engagement has dropped off with the termination of furlough, as well as exhaustion and disillusionment produced by inconsistent or offensive government actions, including the publication of the Sewell report.[36] However, crucial efforts remain, sustaining important services such as food banks, mutual aid groups and vaccination support.

Important forms of provisioning have included the delivery of practical support such as medications, food, and other essential items, but also the provision of emotional support. One volunteer for Samaritans, for instance, expressed; "*[There was an] overwhelming need for emotional support ... high levels from across all society groups and generations .. [I was] doing 3x more weekly shifts*." Another mentioned that the provision of support was not only individual but enacted at community level: "*I was part of my local mutual aid group… All I ended up being involved with were events to boost moral e.g. window displays for people taking daily walks nearby."* There was a sense that those who were recipients of care also attempted to give back. For instance, one local mutual aid volunteer indicated "'[*I participated] Mostly as a recipient, especially buying food early in lockdown. I donate regularly to local food bank*." Volunteers also expressed a deep sense of wellbeing from having volunteered. An NHS volunteer indicated "'*I helped via the Responder app and also my local support group - this helped pull things into perspective and gave me something meaningful to do to help."*

Crucial infrastructures have also been set up by local authorities in the voluntary provision of support with vaccination, distribution of information, and consultation for the tailoring of services. However, these infrastructures were at first often seen as "slow off the mark" - one volunteer, for instance, indicated, *"It took local authority a long time to get organised during which time I helped to establish a voluntary community aid group."* Their efforts have been often successful at integrating and acknowledging the needs of marginalised groups.

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[36] Commission on Race and Ethnic Disparities: The Report 2021. Commission on Race and Ethnic Disparities (available on-line: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf, accessed 4 July 2021).

Inside Woodberry Down Community Club members of Woodberry Aid in Hackney package up fresh food which will be distributed to families in need in their area, 23rd October 2020. Food banks in Hackney have seen demand double since lockdown started.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

Spotlight: Voluntary Sector Action and Rapid Policy Responses: Community Champions

Laura Bear and Atiya Kamal

Many local voluntary sector organisations repurposed their activities for the pandemic when they had to close community centres or end support groups meeting face-to-face. Initially, many of their activities from March 2020, given the intense need, were focused on delivering food parcels or fulfilling other basic requirements such as nappies and toiletries. Through the relationships that they already had, they were able to notice need and connect with highly isolated groups such as the elderly, recent migrants or lone and young mothers. Through agile applications for funding from local authorities and the lottery fund they then began to expand their activities to online support groups, handing out devices to those digitally excluded and providing online support for applications for Universal Credit or EU settled status. They also began to collaborate with each other locally in an unprecedented fashion. Organisations associated with African, Afro-Caribbean, and Black British groups started to join together in part motivated by the “Black Lives Matter” movement, but also by the high mortality rates and general difficulties faced in their networks. In deprived areas in the North of England, Midlands, and London, groups began to collaborate across community boundaries between councils that served White working-class neighbourhoods and those supporting South Asian British groups.

Community Champions initiatives connected to these social provisioning efforts. These began as a local public health team or NHS Clinical Commissioning Group (CCG) response to the pandemic and repurposed existing health champions schemes designed to deal with issues such as obesity and community-led health for Covid-19. The first and most innovative scheme began in Newham in Summer 2020. Here the local community champion coordinator and public health team not only set up a scheme, but also provided regular webinars to advise other local authorities on how to develop their own. Online platforms became important forums for sharing practices and experiments between local authorities. This initiative soon attracted the attention of SPI-B and SAGE, which wrote a report on the potentials of the scheme and drew on research by the LSE Covid and Care group in Hackney and East London to make recommendations.[37] The Ministry of Housing, Communities and Local Government (MHCLG), already working on social cohesion for many years and interested in the growing Community Champion initiatives, drew on the SPI-B report and formulated the policy accordingly. This policy focused on decentralised local initiatives to deal with the specific regional issues faced and was informed by ongoing policy advice by SPI-B members Atiya Kamal and Laura Bear, who drew on research with 15 local public health teams and local authority initiatives. The scheme, with funding released in February 2021, was designed to empower local organisations and to generate solutions from local knowledge. This is an important example of a ministry, in this case the MHCLG, learning fast from local efforts led by public health teams, National Health Trusts and communities at a fast pace to make policy.

From January 2021 – as they received funding from local authorities and, in some cases, from the central Community Champions scheme – local voluntary groups expanded their activities, taking on new volunteers and training them, sometimes with pay. Typically, this drew in more young adults, men, and minority groups to volunteer and activist work. The Community Champions scheme landed in these networks and helped to amplify them, connecting them in new ways to local authorities.

In addition, national level organisations funded by MHCLG including Near Neighbours and Strengthening Faith Institutions turned their long-term experience of working with non-traditional volunteer groups among fragile and minoritised faith communities to powerful ends, connecting online activities with face-to-face outreach. In particular, Near Neighbours, through its local hubs in London, Peterborough, Leicester, Luton, West Yorkshire, Birmingham and the Black Country, directed funds to micro-groups who assisted with both social cohesion and the vaccine roll-out.

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[37] Gov UK, *Role of Community Champions networks to increase engagement in context of COVID-19: evidence and best practice, 22 October 2020.* https://www.gov.uk/government/publications/role-of-community-champions-networks-to-increase-engagement-in-context-of-covid-19-evidence-and-best-practice-22-october-2020

During the pandemic, voluntary and third sector organisations that held deep skills in consultation and community connection turned creatively towards dealing with the impact of the "social death" and economic strains of the pandemic. They did this at high speed, with much hidden, unpaid work driven by a desire to support their neighborhoods and often specific individuals or families within them, using micro-knowledge to refer to services and provide Covid-19 advice. Central funding has enabled local authorities to develop skills in consultation and build community connections. These are at very early stages in comparison to voluntary and third sector organisations, but represent positive steps in building and amplifying connections between Local Authorities, NHS, CCGs, and local community groups. National level funding has been at the core of sustaining and expanding these efforts.

Insights from the survey: Volunteering

27% of survey respondents indicated that they had volunteered during the pandemic.

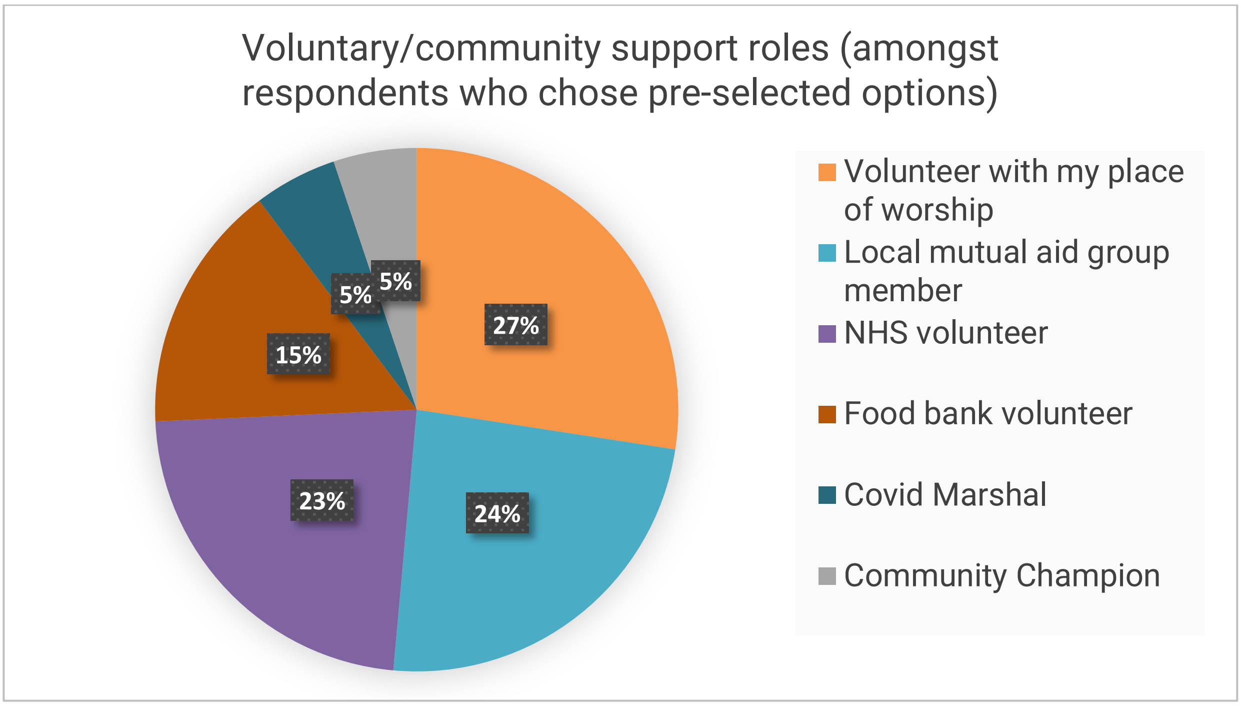
Voluntary/community support roles (amongst respondents who chose pre-selected options)

Figure 7

- → 71% of those who said they volunteered during the pandemic were women, higher than the percentage of women in the total surveyed sample (64%).
- → Two-thirds (12 out of 18) of those who mentioned "Mutual aid group" and half of those who listed "Voluntary sector organization" as a source of public health advice had volunteered themselves at some point during the pandemic.
- → Amongst those who went to a "A voluntary sector organization" or "a local support group" for support, several expressed frustrations around inaccessibility of individualised healthcare and the inadequacy of substitutes (e.g. counselling via text, telephonic/online GP appointments, failures of communication with care homes).
- → Other forms of volunteering included "Charity shop volunteer", "making masks", "litter picking", "delivering food to housebound", and forms of virtual volunteering (e.g. "online home education support group", "stroke association telephone support"). Others mentioned forms of activism and political engagement, for example "environmental advocacy" and "local political party action". Several mentioned "protests" and "activism" in the context of anti-vaccination organising.

Insights from the survey: Online Communities

Online communities provided an important source of connection for people during the pandemic. Interestingly, where personal interactions with friends, family, and local community (including council/health services) were referred to as "support", social media was described as space to "connect" with "like-minded people" (not necessarily *provide support*); this provides an interesting distinction between virtual networks and actionable community infrastructure.

22% of respondents mentioned "Social media" and/or "An online community" as sources of support. Several mentioned online communities and Facebook groups in their descriptions of positive experiences in accessing support, for example: *"I have made lots of new positive contacts with likeminded people, mostly through Facebook*". Two respondents mentioned Facebook support groups for "shielders", and others mentioned virtual mutual aid groups, new or sustained communication via Zoom and WhatsApp, and community forums like online church services.

Spotlight: A Study of Community Champion Online Communities - Southwark Ambassadors

Milena Wuerth

Like many other local authorities, in November 2020 Community Southwark and Southwark Council launched a pilot initiative, the Community Health Ambassadors Network, intended to facilitate the spread of reliable information relating to the Covid-19 pandemic and lockdown.[38]

Community Southwark advertised the program through local volunteer hubs and council mailing lists and encouraged voluntary sector workers, volunteers, and Southwark residents to be the "voice" of their local communities. I joined the first wave of "Ambassadors", inducted through a two-hour-long training hosted by Community Southwark in November. A Google folder with resources relating to public health and government advice was shared with all attendees and a WhatsApp group launched, to which subsequent waves of Ambassadors were added over the following months.

Like many of the new community initiatives started during the pandemic this was primarily an online community but was anchored in existing networks of face-to-face connection associated with specific community champions. It had a particular form because of its virtual immediacy. At times, it enabled the reversal of hierarchies as community residents cross-questioned experts and registered their concerns. Ambassadors fed in the concerns and questions of their local networks, and organisers provided factually sound and accessible information to share widely. They took feedback on how to make their resource drive more user-friendly and tailored resources to meet Ambassador's specific requests (e.g. resources in Mandarin). This generated an unusually responsive community of conversation that could react in "real time" to immediate local concerns, a powerful innovation to deal with the pandemic. People who would not usually meet in person, due to siloed lives of work and worship, found themselves sharing the same virtual spaces.

At other times, Zoom meetings and WhatsApp groups seemed comparably unrewarding and problematic forums. New connections of mutuality were somewhat limited by the virtual platforms; Zoom meetings and webinars placed firm time limits on discussions and gave organisers control, not just over the agenda, but also over the aesthetics and etiquette of sharing and Q&A. Tensions arose most noticeably when organisers had to "mute" participants (often because of disruptive background noise) or paused to "admit" participants who had been shut out of the online meeting room. The organisers supplied relevant links in the WhatsApp chat, but when asked in a Zoom call to provide free community spaces for health and wellbeing workshops in the post-pandemic transition, they were unable to offer satisfactory solutions. Virtual "space"

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[38] For more information, see https://www.communitysouthwark.org/news/we-are-launching-our-community-health-champions-programme

so far has not translated into physical buildings, rooms, and resources to support the new connections made, due to the limits of funding and continued closure of many community spaces (though spaces of worship have since been allowed to open).

Socialising Risk with Local Knowledge

Through analysis of the group chat and the virtual Ambassador "check-ins", it became clear that risk in Southwark was perceived socially, through the lens of local knowledge, rather than as a "fight" or "battle" against the contagion, as implied by political rhetoric and in the media.[39] Ambassadors' actions reflected this social knowledge and approach rather than the more abstract "behavioural" and individualised models of risk used in government. Ambassadors identified "risk givers" through lack of compliance with government guidance in delineated spaces (e,g. not wearing a mask in public spaces), not through any broader (stigmatising) identifiers like ethnicity or age. Taking this case-by-case approach, everyone was seen as a potential "risk-giver" if they failed to comply with government guidance or acted recklessly in local spaces. Recruiting the Ambassadors as both members and guardians of their local communities emphasised the value of community solidarity, but also raised questions about Ambassadors' authority.

Ambiguous Roles in an Online Contested Space

The Ambassadors, carrying out much of their advocacy and communication online, held ambiguous positions at the intersection of local "authority", health advocate, and neighbour. This ambiguity was reinforced by government media reports about their Community Champions scheme, which made Ambassadors seem potentially affiliated with the central government (much to some Ambassadors' dislike). During December and January, with Covid cases spiking and the vaccine rollout in its early stages, the issue of masking became the focal point around which the group came to articulate its place in wider constellations of authority and enforcement. One Ambassador commented that *"it seems the power of enforcement only rests on the police or designated enforcement officers, not Ambassadors"* and suggested harsher measures to ensure local shops were upholding mask mandates. Responding to a group member's anger towards unmasked crowds, another Ambassador advised, *"please don't let it get to you… our duty is to pass on the info in a simplified form to people in your community with the hope that they would comply. That's all*." The organisers reinforced this message by reminding Ambassadors that their roles were to *inform* rather than *enforce.* These negotiations of the limits of the "Ambassador" role have continued throughout the vaccine rollout – with many sharing videos of themselves receiving the jab – and phases of reopening. Most recently Ambassadors and organisers have discussed adapting the group to address ongoing and emergent health crises, especially related to mental health.

Ambassadors and Expertise

WhatsApp groups were lively forums for exploring the limits of permissible speech about vaccines and Covid-19 and for "fact-checking"; they were experimental spaces where the public often became experts. Requests to "please verify" were often answered by other group members (often quicker to reply than the organisers), and discussions could continue un-moderated for days (often over the weekend) before the organisers stepped in with the final word. Though their answers were thorough and clearly appreciated, the Council-affiliated organisers' positions as the arbiters of "fact vs. fiction" often cut off less formal conversations.

Latent tension relating to unequal power dynamics was often addressed through strategies of "listening". While the crisis response of the early pandemic was characterised by rallying cries of "we're all in this together", the vaccine rollout has prompted a more careful and deliberate rhetorical strategy. In the last weeks of February and into March, continued hesitancy to get vaccinated in minority communities suggested the need for an alternative timescale to panic-driven "crisis mode". Especially in forums for ethnic minority groups (e.g. Westminster Council's January briefing, the NHS Muslim Network, etc.) listening to and validating the fears of those who were hesitant was an encouraged alternative to making "pressurizing" demands. This was well-received by my informants and produced much more positive responses among neighbourhood and community networks.

Structural challenges

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[39] For examples, see: https://www.bbc.co.uk/news/health-53694982;https://www.theguardian.com/world/2020/dec/06/the-vaccine-miracle-how-scientists-waged-the-battle-against-covid-19; https://www.theguardian.com/politics/2020/sep/22/boris-johnsons-speech-in-full-the-fight-against-covid-is-by-no-means-over

In my interviews with Council employees and Voluntary and Community Sector (VCS) workers, the metaphor of an incomplete map emerged as a way of visualising gaps in communication, and, therefore, in service provision. This drive for "completeness" was a motivating factor in creating the Southwark Ambassadors group; one Council employee told his job was "strategic": to identify "holes" in the local authority's outreach strategy and pass this information on to his colleague in charge of recruitment. An employee of a local statutory organisation felt they were *"lacking that really strong community connection"* necessary for effective engagement of vulnerable communities, prompting plans to develop inclusive workshops. "Trust" was treated as a valuable but elusive commodity that could be fixed with greater online reach; VCS workers and Council outreach officers felt a "push from up above" to open new channels of communication along which this trust could potentially flow. Still, as brought into sharp relief by discussions around vaccine hesitancy, the complex social relationship of "trust" cannot be measured, or achieved, by the reach of information alone.

Mutuality was critically limited by discussions of funding or the exchange of money. Funding was clearly on the mind of the organisers, one of whom told me that the Ambassadors project was only guaranteed funding through the end of 2021 and that he anticipated impending cuts. Another VCS employee reflected that grassroots organising through "email and digital" had brought in unprecedented numbers of eager volunteers (mostly older, white, middle-class women) but that the virtual volunteer platforms quickly became overburdened. He hoped that there would be funding for a text alert platform targeted by postcode to effectively channel these volunteers and reach wider demographics.

Ambassadors rarely made direct requests (beyond requesting printed materials), but several times asked for advice in accessing financial support services, such as self-employment compensation and isolation support. A woman who had started her own food bank to address neighbourhood food insecurity, described the challenges of lacking stable funding or a dedicated space from which to operate her pantry; she located this insecurity in wider processes of gentrification and redevelopment arising from alliances between Southwark Council and developers. Funding streams were as elusive to most Ambassadors as 'underrepresented communities' seemed to VCS and Council employees. Without addressing financial impediments to community-based initiatives in pandemic recovery policies, these tensions will not be resolved; nor can they be overcome by simply bridging gaps in the flow of information online.

Future

Imaginations of the future were anchored on the organisers' side by logistical questions of funding, impact assessments, and sustained partnerships with government and local organisations. Worry about the reorientation from "crisis mode" to more "normal" functioning was often the dominant sentiment. For the Ambassadors, the future was often circumscribed by financial concerns, continuing government interventions (e.g. "red lists" for travel and "vaccine passports"), and emerging health issues (e.g. "long Covid", PTSD in frontline workers).

A time of complete achievement was never reached because of uncertainty about the future of the pandemic and the looming challenges of finding funding as the focus of national policy shifted towards (economic) reopening. The vaccine rollout was celebrated through self-recorded videos of Ambassadors receiving the jab; this celebration, however, was short-lived as new challenges (e.g. mass testing in schools) loomed large. Meetings via online platforms created evanescent fleeting emotions of connection, celebration, and then further anxiety about what needed to be done, feeding into larger concerns about mental health in local communities. Though its focus continues to shift, there is no sign that the Ambassadors project will become obsolete in the coming months.

The Southwark Ambassadors is emblematic of the online networked communities that have generated new kinds of social infrastructures during the pandemic. It was driven by mutuality and even activism but lived according to the potentials and limits of online interactions. It was associated with a great deal of social hope, dynamism, and egalitarian collaboration; still, the initiative was impacted by divides of expertise and power relations, framed by an uncertain future reliant on the willingness of the local authority and central government to continue funding such initiatives. It is important that future policymaking considers the centrality of face-to-face activities and socially sustaining support to local organising. Trust cannot be measured or built online only.

New forms of Stigma and Uncaring

In spite of the outpouring of mutuality and volunteering, disruptions in networks of kinship and care – and the withdrawal of important sources of formal care – have also produced disconnection across communities. As people attempt to stabilise the radically uncertain present, avoid transmission, and protect their loved ones, they are forced to make constant evaluations of what, where and who is considered safe or unsafe. Such evaluations, mitigating and managing risk, force people to build boundaries against certain external people, places, or groups they consider risky based on stereotypes and assumptions. Any community of care is likely to have exclusions and social figures who are seen as 'other' or, in the situation of a pandemic, *dangerous* to include in infrastructures of provisioning and support. Similarly, institutions often define particular groups as inherently problematic, turning the effects of disadvantage into a judgement on the essential identities of communities.

Without acknowledging this exclusionary side of community, any policies that engage with or amplify social infrastructures are likely to fail by reinforcing divides. Communities and governments need engage in open dialogue about the potential dangers of providing community-led care and how to overcome these. An acknowledgement of the ways in which national interventions and political debates during the pandemic have intensified stereotypes and stigmas is also important, and a prevention of these in the future. Education among health professionals of the direct effects of stigmatising experiences on health outcomes is important. At the heart of this dialogue needs to be an acceptance of the deep, long-term health inequalities related to minority and disadvantaged statuses. These have been starkly revealed by the mortality figures in the first and second waves in which minority groups have been at greater risk of death from Covid-19 than white groups; Black British Groups were hardest hit in the first wave and Bangladeshi and Pakistani groups in the second wave.[40] Stigma and uncaring have contributed to unnecessary deaths during the pandemic in the UK.

Importantly, our anthropological understanding of stigma differs from the way in which it is defined by some behavioural scientists, who often define stigma as a product of a lack of knowledge or awareness held by certain demographics.[41] An anthropological approach deepens this definition, seeing stigma as a set of moral relations of avoidance, pollution, or risk that are cast in local symbolic idioms such as safety, compliance, and hygiene.[42] These relations of stigma exist within public institutions, in policy, and in society. The language of stigma in this new pandemic moment is related to complex symbols such as masks and takes on specific forms of social avoidance and exclusion between groups based on axes of class, race, ethnicity, and occupation. Our research has revealed that the language and relational patterning related to Covid-19 stigma is different to that described in the HIV epidemic or in other stigmatising health conditions such as Leprosy, where models of stigma are applied to certain defined group identities.[43] Instead, in the instance of Covid-19, the labelling of dangerous groups is replaced by a constant speculative management of risk.[44]

It is striking that the question of Covid-19-related stigma has not been of public concern and has not been the subject of media investigation or even government communications. Indeed, some government messaging and the way in which data on transmission rates and "hot-spots" has worked to intensify or produce new relations of stigma. Stigma might be seen as an open secret; the reason it remains obscured is that it has been pushed back on the individual and their households, a space invisible to policymakers. The effects of stigma are significant, both for the individual who internalises stigma and across communities as they negotiate new forms of exclusion and social divides. Though there are a number of other groups who have experienced and managed stigma during the pandemic, we present here some of the most salient experiences that emerged from our research.

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[40] Gov UK, *COVID-19 Ethnicity subgroup: Interpreting differential health outcomes among minority ethnic groups in wave 1 and 2, 24 March 2021*. https://www.gov.uk/government/publications/covid-19-ethnicity-subgroup-interpreting-differential-health-outcomes-among-minority-ethnic-groups-in-wave-1-and-2-24-march-2021

[41] Bish, A. & S. Michie 2010. Demographic and attitudinal determinants of protective behaviours during a pandemic: A review. *British Journal of Health Psychology* 15, 797-824.
Sotgiu, G. & C. Dobler 2020. Social stigma in the time of coronavirus disease 2019. *European Respiratory Journal* 56, 2002461.

[42] Yang, L., A. Kleinman & B. Link et al. 2007. Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine* 64, 1524-1535.

[43] Campbell, C., C. Foulis, S. Maimane & Z. Sibiya 2005. "I Have an Evil Child at My House": Stigma and HIV/AIDS Management in a South African Community. *American Journal of Public Health* 95, 808-815.
Goffman, E. 2014[1963]. *Stigma: Notes on the Management of Spoiled Identity*. New York: Touchstone.

[44] Bear, L. 2020. Speculation: a political economy of technologies of imagination. *Economy and Society* 49, 1-15.

Insights from the survey: Stigma and Avoidance

Stigma is often expressed through the ways in which people try to avoid people, groups and places that are considered unsafe, or in this case sources of Covid-19 transmission. Indeed, 32% of respondents indicated that they avoided certain parts of their local area, 20% indicated that they have changed where they go shopping and 24% indicated that they avoid meeting certain groups of people like “crowds” and “tourists”. One survey respondent shared that they “don't visit 'suspect' shops/outlets/fast food”, and several others said they would only interact with people they ‘trust’ or with those who they know have been vaccinated. Media coverage of Covid “hotspots” produced regional stigmas that served to further interrupt social relationships. One key worker living in Leicester City recounted that her elderly mother, with whom she had formed a support bubble, *“was reluctant to come and visit us as Leicester had consistently high rates of Covid-19 and she lives in an area that had relatively low rates.”*

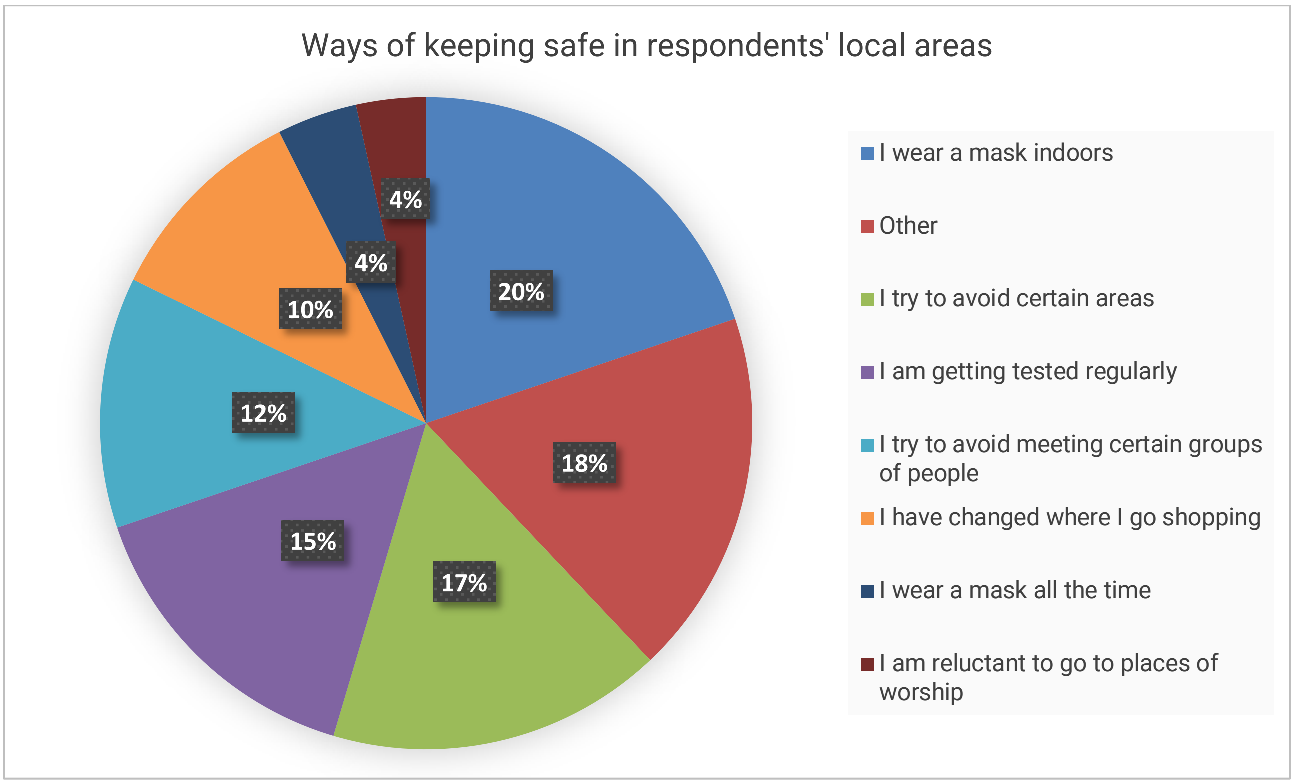

Figure 8

Spotlight: Stop Asian Hate

Anishka Gheewala Lohiya

Experiences of stigma and blame during the Covid-19 pandemic have led to greater exclusion, and sometimes violent interactions, but they also have offered opportunities for new forms of community creation, through online, mutual aid and other healing actions against the odds.

#StopAsianHate

Throughout the Covid-19 pandemic, there has been a rising social media movement among South-East Asian people across the globe against expressions of racism, stigma and blame towards the community. Historically seen as a model minority in the UK, the diverse group were seen as unified in assimilating to British life, through ideals of working hard and not causing any “trouble”. This sustained image continues despite the diverse communities subsumed in this type of categorisation, and the different generational migration experiences and understandings of the global community. The lack of visible representation either through the physical landscape of not having a ‘place’ (such as religious institutions or community centres) or through political/economic representation is felt keenly by the younger generations. Social media has become a platform for voicing opinions, creating space for diversity, and finding community.

Homogenising diverse communities

A gay couple, one Chinese and one from Singapore, were vocal about the lack of understanding of the diverse regions of South East/East Asia, which they suggested has led to a homogenising concept of the “Chinese”. An example they acknowledged was when Boris Johnson sent out a tweet for “Chinese” New Year and people were outraged by the outpouring of Asian hatred in the comments. While people noted these comments and acknowledged that much of it was Covid-related, the major concern was that the leader of the country had stated it was Chinese New Year, a faux pas amongst communities that celebrate the Lunar New Year. Interlocutors felt they had a very different sense of their migration to the UK than older generations of Chinese. Particularly outside of London, people were concerned about not having diversity in their surroundings, suggesting that incidents (and crimes) were more obvious outside of the capital. Within London, the established places of Chinatown and other “hubs” of South-East Asian culture, mainly through food, allowed for a sense of belonging and acceptance.

Silence and the model minority narrative

“My parents would stay silent. They don’t like me to post too much about my life and opinions on social media, but I think we should,” said one British-born Chinese mother, social media influencer, and medic. She has two young children and has concerns about the lack of diversity represented in schools. In reflecting on her upbringing, the emphasis, she says, was on fitting in and not standing out.

However, the more worrying phenomenon is the increase in discriminatory “incidents” or “encounters” many people faced. Throughout the pandemic, hashtags such as #wearenotavirus and #standforasians highlighted the discrimination faced by a homogenised understanding of Asians. The social media hashtag #stopasianhate started after the Lunar New Year, when an increase in violence and abuse towards people with (potential) Chinese heritage was being discussed over social media. Racially motivated attacks occurred in both the US and UK. Despite a UK Parliamentary debate, seen as the first ever of its kind on ESEA racism experience, racism continues to rise against the ESEA community.[45] The week of the 3rd of March 2021 saw Dr Peng Wang, a University of Southampton lecturer attacked and verbally abused.[46] A 23-year-old Singaporean-Chinese student Jonathan Mok was attacked in Oxford Street.[47] Boycotts, or avoidance, of Chinatown and South-East Asian-owned businesses, had huge financial impacts on families, as well as deepening the sense of stigma and “othering”. Many other people reported microaggressions and verbal abuse concerning Covid-19, rather than physical violence, yet the worry is that it could escalate.

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[45] https://news.sky.com/story/coronavirus-given-the-face-of-an-east-asian-person-parliament-debates-racism-during-pandemic-12102897

For example, see https://news.sky.com/story/coronavirus-hate-crimes-against-chinese-people-soar-in-uk-during-covid-19-crisis-11979388

[46] https://www.bbc.co.uk/news/uk-england-hampshire-56229747

[47] https://www.bbc.co.uk/news/uk-england-london-54048546

Such racism and abuse not only effects people's everyday lives, but their futures in the UK and the representation of the UK from the global perspective. A Chinese female teacher in a private school said that children were asking her about “bat soup” and visibly put masks on whenever she came into a room. Her school was mostly supportive and raised it as a school-wide issue. She said that combined with the UK’s handling of the pandemic and these microaggressions, she was considering moving back to China to raise potential future children. However, a Chinese colleague outside of London suffered blatant racism, where people asked why he brought Covid-19 into the country and refused to come to class if he was there. Without support from the school, he has decided to leave the country. Another Chinese born mother has two children who are half-Scottish. She said that her children “don’t look too Chinese” and speak English “perfectly” so she was hoping they wouldn’t get much bullying. She went on to say that had she known how bad the UK government would handle the pandemic and, subsequently, the poor economic status of the country, she may not have had children at all.

The general post-Covid uncertainty, and the perceived instability of the future, was compounded further by the increase in stigma towards anyone who may or may not look Chinese. This has a huge impact on the diversity, the economy and global attraction of the UK for migration, students, and work. The prevalence of the “model minority” category did continue, as shown by the Chinese-Scottish family, and is furthered by government policy, media outputs, and education on the UK’s diversity.

#StopAsianHate acts as a protest to the model minority model promoted by the government, continued by the silence of older generations and the frustration with the stigma against South-East Asian communities through the false sense of blame they face for the spread Covid-19. In addition, it has allowed for new forms of place-making through online communities and institutions, a search for social identity, and a growing interest and pride in heritage. This protest highlights three points: first, the lack of public acknowledgement and support on the diversity within the enforced ‘unified’ community; second, the turning inwards of community support as groups form to support each other, lacking confidence in the government or councils; and third, the wide scale changes created through the resurgence of stigma against the ‘Other’ community and lack of response from educational facilities and government, council, and public messaging. Such social infrastructures forged from experiences of social exclusion are a valuable resource for recovery from the inequalities caused by Covid-19. They make visible hidden experiences and work on a national and local scale to forge positive change. They need to be better supported and brought into closer dialogue with local and national policy moves.

Key Workers, Invisible Care-Work and Stigma

The perception of high rates of transmission for key worker groups also caused them to experience, anticipate and internalise stigma. Greater acknowledgement and support for key workers, and their inclusion in dialogues about stigma is important to gain acceptance for government policies and build more equal communities.

Insights from the survey: Key Workers

28% of survey respondents identified themselves as “key” or “essential workers”.

→ 26% of respondents who identified themselves as “essential” or “key workers” mentioned ‘Relationship tension or strain’; 11% mentioned “Difficulty caring for children”.

→ 17% of “essential” or “key workers” had contracted Covid themselves or lived with someone who had Covid.

→ Being a key worker was cited by some as an advantage, financially *and* in terms of overall well-being, over others in their local area; different respondents shared that *“As a key worker [they] had a purpose every day”* and “*had more freedom”*, as well as the opportunity to work overtime. Key workers *“got to go to work and see others and be out of the house”* and appreciated the continuity of income and social interaction.

→ Commuting, however, caused anxieties around transmission, and several experienced separation from friends and family who were shielding or vulnerable. “Key worker schools” were mentioned in open responses as critical forms of support for parents continuing to work full-time. NHS and medical staff as a subgroup (sometimes called “frontline workers”), as well as respondents who had themselves contracted Covid, were much more likely to describe their relative experience of the pandemic as “slightly” or “significantly worse”.

→ The decision to form a support bubble was more fraught for those in occupations with high levels of social contact; as one respondent recounted “*I was happy helping my grandmother but because of my job in a supermarket I was very worried about passing on the virus inadvertently*.” Many expressed concerns about working conditions, especially in schools and healthcare. Teachers were consistently concerned about overcrowding in classrooms and high levels of extended social contact that made social distancing impossible and personal protection measures arbitrary.

Minoritised Groups

For minoritised groups, stigma has been experienced in different ways. First, stigma has been experienced and anticipated as high rates of transmission have affected their communities.[48] Further, existing experiences of stigma and racism caused by histories of exclusion, discrimination, and colonialism have intensified with fear of transmission as such groups have been blamed for non-compliance with Covid-19 restrictions. For these groups, stigma can act as a barrier to accessing healthcare or formal support.

Our research found, for instance, that there is a reluctance on the part of some communities (especially Black African, Black British and Afro-Caribbean) to access hospital service as they fear *“people go in, but they don’t come out”*. There is a perception that unconscious racism is part of healthcare workers decisions to provide care in situations of crisis, with people from Black communities being overlooked or minimized. This perception is refuted by ethnic minority healthcare professionals themselves, who see care provision as equal especially in the second wave where strong protocols and better resourcing has mitigated the initial crisis. However, some ethnic minority practitioners, particularly at the start of the pandemic, felt they were being given roles in parts of the hospital where there was a greater likelihood of contracting the virus. A South Asian woman reported that, despite her attempts to avoid Covid-19 wards to keep her extended family at home safe *and* voicing these concerns to hospital staff, she was still expected to continually work with patients infected

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[48] Gov UK, *COVID-19 Ethnicity subgroup: Interpreting differential health outcomes among minority ethnic groups in wave 1 and 2, 24 March 2021.* https://www.gov.uk/government/publications/covid-19-ethnicity-subgroup-interpreting-differential-health-outcomes-among-minority-ethnic-groups-in-wave-1-and-2-24-march-2021

with Covid-19. There are fears of miscommunication and misrepresentation for people who don't speak English or who are perceived to come from an immigrant background. There is a perception that such people will not be provided with adequate or even standard care, especially in the provision of pain medication and follow up. This fear is not unfounded, particularly in light of emerging insights into black maternity care (see above section on *Mothers*).

Repeatedly in our research, Muslim groups spoke of the stigmatising effects of government communications around the interventions in Eid and Ramadan celebrations in 2020, alongside inconsistency in local authority regulations around Eid in 2021. The forbidding of interactions during Eid in 2020 with two hours' notice announced on ministers' twitter feeds was perceived as both stigmatising and disrespectful, working to label Muslim communities as a site of transmission. People indicated that, at least, it could have been announced with dignity at a national level press conference highlighting the sacrifice for the national good that was being asked. This, and restrictions around Ramadan, were reported to have led to long term effects on positive engagement with government Covid-19 policy. It made it very difficult to attract volunteers or generate community consultations in November-December 2020, which were so essential to the success of all public health initiatives. In 2021, Muslim faith groups have been restricted in their public gathering around Eid, and have found it problematic that, on the other hand, concerts, fairs, and elite sporting events were permitted shortly afterwards by national and local government. Experiences of exclusion have been intensified by these inconsistencies and heavy-handed actions.

In addition, community organisations that work with Afro-Caribbean and Black British groups have reported longer term negative effects from the publication of the Sewell report. Its refusal to accept structural racism and to acknowledge experiences of exclusion and trauma preceding and during Covid-19 meant that some people were unwilling to trust or engage with vaccination and NHS Test Track and Trace (TTT). Interlocutors logically doubted the truthfulness of government ministers' claims given their denial of lived experiences of stigma, discrimination, and disproportionate mortality. In both of these cases, national government policies made the work of generating mutuality and supporting public health by voluntary and third sector organisations much harder.

Insights from the survey: Ethnic Minority Groups

As anthropologists, we seek to analyse how the categories used by people to describe themselves and their communities impact social life, and to use this knowledge to inform more inclusive and less stigmatizing government policies. Our research values the voices and perspectives of everyday people, who complicate any simple definitions through the lens of their own experiences. Accordingly, we made the decision to allow the respondents of our most recent nationwide survey to self-report their ethnic identifications.

34% of survey respondents described themselves as "White British" and 21% as "White" or "Caucasian". 8% described themselves as "British" and 4% as "English", without indicating race or ethnicity. Beyond these most common answers, many described themselves as some other nationality (e.g. Indian, Irish, Somali) or regional-historical or language-based group identifiers (e.g. Bengali, Turkish-Cypriot, Celt, Cornish). Several identified themselves by their religion, even if not generally recognised as an ethnicity (e.g. Hindu, Christian, as well as Jewish). Some identified themselves as "mixed" while others specified "White and Asian", "Indian and British", "black African and white British", etc. This range of responses perfectly represents the variance in modes of self-identifying when categories are not pre-determined by data collection technologies.

Although this decision prevented us from obtaining data that could easily be compared with ONS databases, it was consistent with our previous research findings and ethical principles. In June 2020, we analysed survey data collected from 3,600 British residents; the responses demonstrated the significance of "BAME" as a unifying political force in the context of the Black Lives Matter movement, but also attested to experiences of exclusion and homogenisation under such a broad label. In the months since, we have conducted ethnographic interviews throughout the UK, picking apart processes of stigmatisation impacted by the pandemic and lockdown policy.

There are dangers in arguing, as did the Sewell report, for the separation of "BAME" into smaller subgroups; one of these is pitting groups against one another in competition for "model minority" status, as the Commission does by comparing "new African groups" performing well academically with their 'underperforming' Caribbean 'peers'. Rather, we argue for flexibility and diligence in person-centred policy making with the 'person' in question recognized as socially complex and connected. This premise has guided our work on “social bubbles” and our call for extended Community Champions funding.

Consequently, we argue for a productive disaggregation of the category “BAME”, but on the terms of those who demand accountability from the government in addressing the inequalities showcased by the pandemic. Interlocutors from minority communities have articulated particular kinds of trauma and grief that are produced by both personal experience and the representation of ethnically skewed death and infection rates. Categorising our survey respondents on their own terms – according to their own nested, complex forms of identification – is a small step towards a fundamentally inclusive process of social research.

A team of Hatzola volunteers in full PPE clean the ambulances, dispose of dirty linen, and restock anything thats been used that day, 12th May, 2020. Hatzola is a 24/7 emergency medical response organisation serving the Jewish community. Started in New York in the 1960s, it is the largest voluntary ambulance organisation in the world. The Stamford Hill branch has almost 50 volunteers and on a normal day might field 20 calls, but at the peak of the crisis it was receiving 80 calls a day.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

Case Study: Stigma and Social Support in Leicester

Nikita Simpson

The previous report conducted by the Covid and Care Research Group paid particular attention to Leicester as the first site of national intervention.[49] Leicester is an important case study as it illustrates the impact of localised social restrictions on the perception of a place in the national imagination, on the self-perception of local residents impacted by the lockdown, and on their way of life.

Legacies of Stigma

Across Leicester as of early 2021, acute local tensions between different residential, religious and ethnic groups have calmed down; in the words of our interlocutors, *“the argument has moved on*”. In 2020, there was a sense that Leicester was the *“plague city”,* but this has ebbed away; especially when Covid rates increased in “leafy suburbs” and in the counties. There is a perception that relations of stigma, however, will move on to how people think about vaccine uptake.

The centre of Leicester City was perceived by the public and in the media to be a ‘hotspot’ of transmission during both the first and second waves. The legacy of this stigma is acute, with those living in the counties, peri-urban areas and even Leicester’s suburbs continuing to avoid these areas, and friends and relatives who live within them for fear of transmission. In these areas, people are perceived to be ‘not wearing masks and congregating’. People call this area the “hotzone” or “dangerzone”.

People who live in densely populated neighbourhoods in the city centre (especially St Matthews, Spinney Hills, and Highfields) are concerned about ongoing narratives of transmission related to housing conditions, intergenerational living arrangements and urban environments. Indeed, people who live in suburban or semi-rural areas actively avoid the city centre for this reason, and avoid forming relationships, visiting, or allowing into their homes those who live there. This has opened new class divides within ethnic minority groups, where older links of care provision between family or friends who live in the city, vis-a-vis those who live beyond its limits have been truncated because of fear of transmission. The communities who live in these places are primarily from lower class South Asian and Black African backgrounds. They have relied on existing networks to support each other, rather than looking outwardly for support from formal care providers. This bolsters the perception of spread as located within these closed communities. Formal care services are finding it difficult to reach out to communities who are not digitally connected, have poor English skills or literacy barriers. This contributes to the idea that such communities are bounded and “hard to reach”, a term that communities themselves strongly resist.

There are new relations of stigma generated by financial strain along ethnic divides; where South Asian migrant groups who are otherwise financially secure are suffering but unable to access financial support from the government (e.g. Universal Credit). Some perceive new migrants as taking advantage of welfare provision while maintaining wealth in their home countries. There is a perception that there are higher levels of domestic violence and gendered abuse in such isolated communities. There is a persistent stigma against young people, who are perceived to be non-compliant with regulations, especially toward young men.

Racism and Blame

When research was conducted in 2020, there were a range of intensifying social and political divides between communities in Leicester. Though there was a perception, mainly from White-British respondents, that interfaith and inter-community relations are respectful and peaceful, this is contrasted to an alternative perception, mainly from South Asian respondents, that such relations were breaking down between groups. This breakdown, it was suggested, preceded the Covid-19

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[49] Bear, L., Long, N. & Simpson, N. 2020. ‘Case Study: Leicester Local Lockdown’. In *A Right to Care: The Social Foundations of Recovery from Covid-19* by L. Bear, D. James, N. Simpson et al, pp 93-99. London: The London School of Economics.

pandemic and Leicester local lockdown but had been intensified by it. There were deepening social divides on religious, ethnic and class lines, between the Muslim, and Hindu and Sikh communities.

In 2021, the social divides that opened and intensified during the summer of 2020 have shifted in alignment with new geopolitical events. For example, the rise of the farmer's protests has caused new rifts between the Sikh and Hindu communities. Some Sikhs perceive their Hindu neighbours as betraying them in the belittling of the movement. Covid-19 related stigma against and between South Asian communities has diminished as all communities have been affected by the virus. However, there is a stigmatising perception from non-Asian interlocutors that particular areas are populated by Asian communities who *"have not behaved themselves"*. Such non-compliance though is perceived to be associated with occupation, where such groups are seen as impoverished, badly paid and forced to work. Though respondents were quick to suggest that *"white people have also broken the rules"*.

The original decision to close all places of worship was perceived badly by many faith communities. The inability to go to places of worship, to pray and serve or seek help is seen as a breach of human rights. In the Leicester community, some mosques felt like they were being "picked on", though this was not a general sentiment and most sought advice on how to keep their populations safe. When this decision was reversed, and places of worship were allowed to stay open, the choice to stay open was seen as a "*hidden litmus test of religiosity*". Decisions were made on social media – in WhatsApp groups of community leaders – though some guidance was taken from federated civil society organisations.

Class divides

The pandemic has opened new class divides in minortised communities in Leicester. For instance, in the Sikh community there is a perceived existing divide between wealthy established migrants who are professionals or landowners and working-class Sikhs who work in factories or call centres in Leicester. It is perceived that this pandemic will exacerbate this divide. There is a perception that some communities have dealt with the strain better than others as a result of moral or particular cultural behaviours. For instance, a Hindu man cited that his Gujarati community has a strong ethos for people to "save for a rainy day" and "not live hand to mouth". Therefore, they are not dependent on the state in times of need. The community is committed to education and integrated early into "western ways" meaning they are "ready to adapt, studious, and hardworking" because they have a "way of life rather than a religion". The furlough policy for business owners is seen as a "smart investment" that people paid into over the course of their lives and are now getting back from the benevolent treasurer. However, the policy is seen as morally superior to Universal Credit, the latter of which is stigmatising and perceived to "encourage dependency" on the state.

Garment Factories

There was a sense across all communities that national media coverage of the local lockdown, and particular issues surrounding it, such as the precarious working conditions of garment factories, was stigmatising for Leicester as a city. As of 2021, the stigma against garment workers in "illegal" factories has lessened in intensity as local groups (unions, employment rights services, local authority) have mobilised to provide new support services and regulation for these groups (though such efforts are 10 years in the making). However, there is a perception that such business has gone on as usual despite the second wave lockdown. The willingness of the government to deal with these issues now is seen as a means of protecting brand reputations as opposed to a commitment to real reform. There is a need to "raise the bar across the piece" in the standards of migrant labour in order to really deal with the problem.

From within the community, there is a sense that the will for more "rights" is at odds with the will to "work for cash in hand". This tension has grown historically, where in the past the flexible structure of employment and contracting worked for small garment businesses as they were able to build piece work that they could sell to brands. However, as brands have gotten bigger and been better backed by laws that favour corporations, the negotiation of power for small businesses has diminished and their need to provide competitive prices has grown to compete with outsourced industries. This has meant that those within families who have the least voice are further exploited in these industries, for instance new brides who are brought out from India and must do both housework and work in these factories for cash in hand.

The financial cuts to health and safety enforcement and inspection during the past decade of austerity have caused a situation where workplaces are not managed well, causing Covid-19 to spread. The lack of legal support for employees leaves people in a position of weakness, meaning they can't claim their right to safe working conditions. There is a need for strengthening the union voice in order to deal with this new layer of concerns. This is particularly important where employers are making it difficult for employees to report breeches. For instance, there was one factory in Leicester where the employer replaced the name of the Health and Safety helpline with his own personal phone.

Supporting Minoritised Groups

It is perceived by some groups that their self-sufficiency in relation to care provision has put them at a disadvantage in terms of the receipt of government funds related to Covid-19. There is a sense that as communities struggle to care for themselves they are becoming increasingly isolated and "siloed". For example, one Sikh interlocutor mentioned that their "*seva* mentality"; the willingness of his community to contribute small amounts of money to setting up food banks and other support systems means they are overlooked by the Local Authority for funding. The Midlands Langar Seva Society has, for instance, taken on significant responsibility that should be provided by the state. There is, however, a sense of pride from minoritised communities as to how they have been able to build and sustain food provision to thousands right throughout the pandemic. For instance, one Leicester Hindu restaurant owner cited that he had turned his restaurant into a food distribution centre and served over 52,000 meals over the last 9 months. Now, however, he is thinking innovatively about returning to the business and is passing on provision to other organisations.

Community leaders

Many community leaders cited that they had lost significant social capital by not being able to go to people's events such as funerals. This was problematic for both faith and interfaith cohesion. For instance, one Christain pastor cited his inability to go to events from the Hindu Gujarati community as detrimental to his ability to build supportive relationships and engage. The fact that they have also had to manage and break up important gatherings has seen them lose respect in the eyes of some. Community leaders have also become important points of contact across communities where usual practices of congregation are not possible. For example, one Sikh hospital chaplain said he is the source of information and assurance for many, and their only link to the outside world. He felt privileged by this position but unable to keep up with all the referrals.

Community Champions

The Community Champions scheme in Leicester were distributed through Near Neighbours partners, who then redistributed funds to grassroots community organisations from different ethnic and religious groups. This redistribution was seen as the "best use of money"; communities were able to be innovative in the use of funds and choice of channels through which they should get the message across to their communities. This has included, for instance, the sponsorship of a community radio program. There was a perception that if this money was not provided there would be no incentive for the groups to be mobilised, but "money talks" in the work of engagement.

Local authority funding

There is a big problem with local authority funding not reaching the grassroots, and especially not reaching Black and Asian groups; yet it is also difficult to access information on these processes or provide processes of audit and governance that encourage inclusion. Within organisations, there is a lack of data generated around the ethnic groups that are served, making it difficult to hold organisations accountable to promises made. The lack of Black leadership on boards meaning inability to participate in decision making processes, particularly around funding, further exacerbates the situation. The use of the term "co-production" is seen as "a play on words", a means of glossing over inherently unequal processes. The fact that community organisations are informally structured means they are further discounted from funding pots on grounds of insufficient governance. When funds are distributed, "divide and rule" mechanisms are used to pit ethnic groups against each other as they squabble for scarce funds. When there are organisations run and embedded within minority communities, they act as redistributive networks aiming to employ and redirect funds to the communities they hope to serve. They can act as a lead applicant on grants or seek funds from sources inaccessible to grassroots groups. Relational work in managing cohesion between groups and celebrating wins collectively is essential. The loss of rental income for many community spaces such as churches and halls is causing a swathe of closures of community groups dependent on them for their viability. There is a sense that such closures will come at exactly the time when need is greatest when the suspended rents and evictions are resumed. This will be a 'time of reckoning' for the local authority.

The Leicester case study demonstrates the barriers and opportunities for the formation of social infrastructures. Enduring transmission in the urban areas, and in particular postcodes, associated with minoritised and occupational groups provides an important example of the way in which relations of stigma are generated over time. Most importantly, this case study shows how such relations of stigma are exacerbated by government policy. Addressing such relations of stigma requires not only a more careful and nuanced approach to communications locally and nationally, but the deeper investment in minority communities to improve indicators of self-determination, decision-making, and deprivation.

In sum, this section of our report has shown that new relations of mutuality and stigma have emerged during the Covid-19 pandemic in the UK. Government and local authority efforts to support mutuality and social infrastructures are undermined by power differentials and their management of the Covid-19 pandemic. Some policies have been actively stigmatising. Short-term approaches to funding also risk undermining the social mobilisation that has occurred and potentially producing greater disengagement even among people who have been key social animators. South East Asian communities, key workers and minority groups have experienced stigma. Long-term social restrictions in places such as Leicester have also left a legacy of valuable efforts at community mobilisation and self-help, but also divisions within and between communities. However, at the community level, people have reached out to each other in new ways as they have experienced stigma or just try to help each other in a time of need. Stop Asian Hate and Community Champions provide important examples of the potential of this moment in community activism, but also are limited if deeper relations of co-production and cooperation are not generated and funding remains too time limited. Only by building in more processes of difficult, radical and honest dialogue about inequality and stigma alongside a holistic policy to fund social infrastructures that recovery from the pandemic can be achieved. This must include an acknowledgement of mistakes made by the government and the acceptance of deep structural inequalities that have been entrenched by Covid-19. This will not be an easy dialogue, but it is one that is necessary before community led social infrastructures can thrive. It is part of a process that will develop over time and form the steppingstones required to (re)build trust in the government.

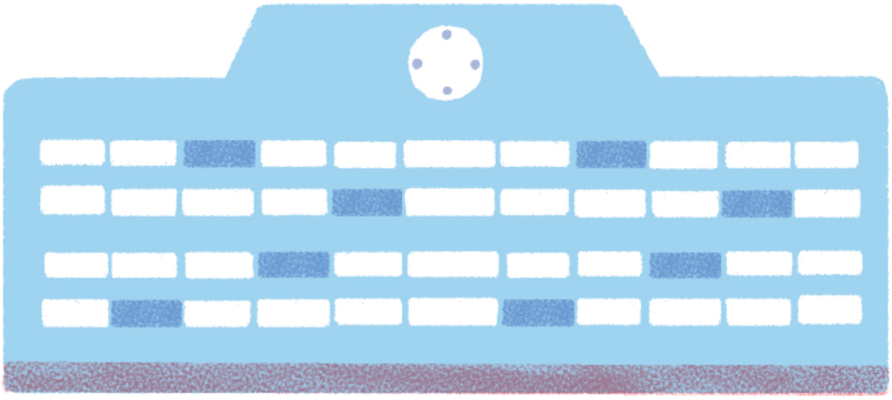
Insights from the survey: Leicester

Survey responses from participants who reside in Leicester city and counties captured the scale of suffering that has been experienced as a result of unceasing lockdown restrictions. Respondents expressed that their experience of the pandemic was significantly worse than others. One respondent indicated, “‘*The eternal [L]eicester lockdown meant that we didn’t really benefit when lockdown restrictions eased*.” However, for some the “eternal” lockdown generated resilience: “‘*Leicester was in lock down for such a long time, we all just pulled together*.”

Residents of Leicester particularly felt that they had been abandoned by the central government; respondents commented that “‘*Leicester was a forgotten city throughout”* and the government *“Seemed to forget about Leicester being in lockdown much longer than other areas”*. Some respondents indicated that Leicester was being “picked on” by the central government and treated differently to the rest of the country. There was a mixed response to the question of satisfaction with local government. Some indicated low satisfaction, where “*Leicester council have been absolutely useless at getting us free from constant restriction*s.” Others indicated that the local council had been supportive especially in surge testing, the provision of information, contact tracing and vaccination; “*Leicester City Council worked really hard to give support, information and guidance to local people”* in contrast with central government, whose *“guidance was confusing, contradictory, last minute and disingenuous to the point of being insulting*”.

However, such suffering was unevenly distributed. Respondents from the least deprived areas of Leicester including postcode LE2 South Knighton and Clarendon Park expressed that their local area was passed over by the worst of the pandemic. One respondent indicated, “*we didn’t directly suffer any illness, everyone had their lives on hold and my area is reasonably comfortable and has a large number who complied with what was asked of them*.” Another reflected, “*I retain my employment and am not in financial difficulty at this stage; I live in a caring community and have a private garden which has at times felt like a lifeline; I haven’t had to juggle working from home at the same time as home-schooling (I don’t have kids), I’ve been able to work from home without too much difficulty, I have good informal support networks*.” By contrast, respondents who live in more deprived postcodes such as Spinney Hills indicated that their experience has been more stressful. “*We've had access to rapid home tests for longer than most and have been very lucky to avoid contracting covid despite being in an area with high rates and both being teachers. We have however had the stress of working as teachers and of having repeated hospital admissions with our child*.” Some ethnic minority respondents also indicated that there was *“no support for people of [their] economic class*”.

III | Supporting Social Infrastructures



Introduction: Social Infrastructures and Policymaking

This final section turns to the question of how social infrastructures might be supported by government policies in order that communities recover from Covid-19. Government pandemic policies have often not addressed social inequality or have been designed by using behavioural models of individual decision making about risk. Government communications too have over-emphasized issues of blame and compliance, rather than forging concepts of collective mutuality and interdependence.

To recover from Covid-19 policymakers need to understand individuals as part of networks of social relationships, which shape their behaviour but which also contain inequalities that can be exacerbated by government interventions. These are important in determining health outcomes and pandemic response and preparedness. Importantly, these social infrastructures are not "out there" for governments to tap into or offload responsibility onto. If policies don't take social infrastructures into account this can have a number of negative consequences. These include the fact that policies might work to contravene peoples' values, appear immoral or not make sense; they might undermine existing coping mechanisms or intensify inequalities; and they might create new burdens for communities who take on responsibilities for provisioning that should be provided by the state. The way in which we might take social infrastructures into account in policy making is through deep and sensitive co-production and adoption of policies with communities themselves. Such approaches improve the legitimacy and appropriateness of policies, ultimately improving compliance and resulting in better distributive outcomes.

Key concerns

This section presents two in-depth case studies from London where our research team has worked to map out the ways in which communities, the voluntary sector and the state have come together during the pandemic. These case studies have been chosen as they represent microcosms of intersecting disadvantage and have presented key concern areas in relation to Covid-19 transmission. Through these case studies we reveal a number of important concerns that might be taken into account when taking a social infrastructures approach to policy making.

The impact of austerity

These case studies reveal that the pandemic policies entered, at local level, into a set of fragile and often broken relationships between communities, local authorities, and voluntary sector organisations. Frequent changes to central government policy and bureaucratic organisation, especially around public health, has been disruptive to local social infrastructures in the past decades. These relations were rendered even more fragile as a result of more than a decade of austerity policy that has starved local public health, social care and housing infrastructures of funding, induced new and often discriminatory protocols of reporting, impact assessment and procurement. The varying constellations of NHS, local authority and VCS provision of public health care has seen people cycle through different roles without being able to institute lasting change.

Recognising existing work

The pandemic moment has generated a “state of exception” where the usual protocols for procurement, funding and reporting have been suspended. This state of exception, as indicated in the previous section, has generated both opportunities for mutuality and relations of stigma. However, it has also indicated a new reliance on the voluntary sector and community groups. Such groups were able to mobilise quickly in order to meet the needs of those in their local communities by drawing on their nuanced local knowledge and existing relationships. However, our research revealed that much of this work remains invisible to both the government and public, where recognition has been directed instead to new mutual aid groups or central government efforts. The lack of recognition is experienced particularly acutely at the grassroots level, and for black and ethnic minority organisations who are generally smaller, more informally organised and hence have less access to decision making spaces and funding.

Inequality in Provision

There is a perception that nepotism in local authority funding panels results in inequality in provisioning, where decision makers tend to support larger and more established voluntary sector organisations with whom they have previous relationships. Some voluntary sector organisations have such deep and long-lasting relations to the state that they are seen as an extension of the local authority or arm of the council. Tensions often exist between the more established organisations and the smaller and newer organisations that can better reach people who are reluctant to actively seek support. This environment can create unhealthy competition and decreased cooperation as the pandemic continues, as groups vie for the same limited funding pools. The question of “who is in the room” when funding decisions are made, both in the past and during the pandemic, was of critical importance in addressing these biases. Often the same people who work for the local authority move on to working in these large voluntary sector organisations – referred to as a “revolving door” – resulting in decision making power being concentrated in certain individuals.

Structural Bias in Data and Impact

Our research revealed that structural bias in provisioning for voluntary sector and community groups, and hence the support for local social infrastructures, is marred by structural biases in the specific requirements for application, monitoring and evaluation of funding bodies. A “data-gap” exists for many minority groups, meaning large-scale data sources do not disaggregate to evidence their needs; and specific studies don’t exist to support their claims to local and central government. Moreover, many groups have expressed their view that local authority and funding body Key Performance Indicators (KPIs) and associated Monitoring and Evaluation (M&E) frameworks fail to address the needs of many groups and fail to capture the affective and social value that VCS organisations provide over private provision. Often the needs of many minority groups are only prioritised for short periods of time, before they are silenced or rendered invisible by a lack of engagement. Efforts to design more appropriate KPIs and M&E frameworks, as well as map the range of voluntary sector and community groups in any given place are critical to redistributive efforts.

Sustaining energies

As aforementioned, an upsurge of energy surrounding community provisioning and volunteering has been largely well received and reinvigorated relations between communities, voluntary sector organisations and the local authority. This has led to innovative and layered efforts, new partnerships, and imaginations of what the voluntary sector could and should be. However, there is a risk that such new energies and partnerships dissolve as the pandemic continues, and new austerity policies are introduced post-pandemic. The key questions being asked at the time of research were - how to entrench positive relationships, sustain new sources of funding and harness the energy and working relationships that emerged from the initial response in the hope of maintaining them. Interlocutors indicated that an overhaul of existing processes of consultation, engagement and co-production was required; as well as a profoundly greater commitment to funding local social infrastructures, especially for historically excluded and under-represented groups.

Case Study: Ealing

Nikita Simpson and Laura Bear

A borough cut by inequalities

Ealing is a borough in West London that comprises seven areas: Acton, Ealing, Greenford, Perivale, Southall, Northolt and Hanwell. The borough is ethnically diverse, with a majority white population (58.8%), with a long-standing Irish community and a large Polish community concentrated in Acton, Perivale and Greenford. Ealing has a large South Asian/British Asian community (24.5%), primarily Panjabi Sikhs, who live primarily in Southall. Ealing has smaller Black British representation (8.7%); in Northolt and Acton resides a large Afro-Caribbean community and a smaller African community, primarily with Somali heritage. Ealing is a largely affluent borough, but has pockets of high relative deprivation, especially in Acton and Southall, indicating deep inequality that primarily runs along the lines of ethnicity. For example, the ward of South Acton has two areas (LSOAs) in the worst deprived 10% of England[50]. Across Ealing, 18% of children live in low-income households[51], while this figure was as low as 7% in the ward of Northfield and as high as 25% in East Acton.

Local Authorities, GPs and CCGs are aware that such inequality has deep implications for health and wellbeing. There is an overarching perception that Covid-19 has exacerbated existing health inequalities within the borough, and that this year will see the full scale of a year of neglect made visible. There is a sense that a lot of the important work around health promotion for Non-Communicable Diseases and social prescribing will have to be "repeated" or will be "lost". The increase in poverty and deprivation in some communities is seen to have adverse lifestyle impacts – for instance the lack of good food and exercise is seen to have resulted in a general health decline. There is dismay that mental health has not been seen as a priority for all, and no substantial efforts have been made to deal with a burgeoning mental health crisis. However, there are fears for those who have severe mental disorders, in the sense that they were never provided for.

The Legacy of Austerity

Frequent changes to central government funding and bureaucratic organisation, especially around public health, has been extremely disruptive to local social infrastructures in the past decades. The varying constellations of NHS, Local Authority (LA) and VCS provision of public health care have seen people cycle through different roles, without being able to institute lasting change. The starvation of this infrastructure of funds since 2010 has damaged relationships and partnerships, leaving organisations feeling antipathy toward each other and particularly toward the LA, and hollowing out service provision. The increased oversight of procurement processes and complex tendering meant only organisations with the governance capacity and existing networks were able to access funds from the LA. The result is a very fragile network of relationships that entered into the Covid-19 response.

In Ealing, as noted in the Build Back Better report,[52] the lockdown caused an immediate suspension or significant reduction to voluntary sector organisations' ability to deliver services (51.5% of survey respondents). Vulnerable groups have been made more vulnerable and new groups have been vulnerable in this period. The loss of volunteers has been a significant blow to many community-based organisations; losing up to 20% of their workforce. Some organisations spoke of staff, all of whom know someone who has either died or has been seriously ill from Covid-19.

However, the LA response to the pandemic in "Ealing Together" was an important source of support. The provision of unrestricted funds and the suspension of procurement processes left organisations feeling "liberated", able to "get the job done" to "form new collaborations and partnerships" and to successfully layer care. The alignment around a common set of objectives and strong communication networks such as CACHE and other forums have been instrumental. A multitude

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[50] Index of Multiple Deprivation 2019

[51] Ealing Data, Deprivation Report 2019
https://data.ealing.gov.uk/deprivation/report/view/1e779db28bdb4b5995f9081ab6bacf61/E09000009/

[52] Young Ealing Foundation and Ealing Community Network. 2020. *Build Back Better: How organisations can improve practice in light of learning during the Covid-19 pandemic* September 2020.

of such partnerships emerged in this moment that would not have been possible before – for instance, between Age UK and Ealing Community Transport (ECT) or between the Met Police and Cape Project Mental Health Care. There were also a range of innovations that emerged in this moment as a result of such partnerships – for instance getting the runners clubs to drop in information pamphlets, providing information and advice numbers in food parcels, and providing barbers with vaccination information.

The closure of key touch points of community provision such as day centres, GPs and drop-in centres was difficult. Most services were able to transition to some form of digital or telephonic outreach and adapt their services. The lack of face-to-face care hence made other kinds of figures – such as outreach workers, telephone providers and delivery drivers – important sources of referrals and information about who needed what kind of support. For example, at ECT, many out of work drivers volunteered their time to deliver food parcels and provide community transport. They acted as important sources of information to other service providers like Age UK. It is critical that these key spaces and figures remain funded and provided for into the next phase of the pandemic and beyond.

Excluded groups

Respondents from the voluntary sector indicated that there are three "super-excluded" groups who they are most concerned about as we emerge from a year of lockdown.

1. Those who are 'housebound' – including the elderly, disabled, severely mentally ill and their families and/or carers.

Respondents indicated that for many elderly people, the need to shield has left them entirely cut off from networks of social support, resulting in a "crisis of loneliness and isolation". It is perceived that the lens through which the government has dealt with elderly care is the care home, leaving those who are still in their own accommodation underserved. The closure of day centres and other drop in and social services mean many of such people are invisible to social services. The vaccination drive has been important for reassessing the situations of many. However, the contracting out of food delivery and other social care services to private providers raises fears that they will not go the extra mile to use such opportunities to check in and provide important social contact, but instead just "leave boxes of food in the driveway". There is encouragement to provide such contracts to the voluntary sector as they will layer them with 'social value' that is crucial in this time.

There are further particular fears for those for whom social exclusion was the norm, even prior to the pandemic. For those living with severe mental health conditions, for instance, there is a sense that "nothing has changed". There is a further perception that opening up will result in parallel lives – where some are able to return to participating in society, and others – as a result of cognitive decline, mobility issues and lack of confidence or support – will never emerge. There should be a drive for opening social and day centres, and provision of bespoke support, or a helping hand, for those who have barriers to accessing them.

2. "Frequent Flyers" or people with no fixed abode.

There are concerns for those who are not visible to social services because they have no fixed abode, no recourse to public funds or only access service informally. The closure of drop-in centres such as the Ealing Advice Centre has been catastrophic for such groups, and many have been pushed into homelessness or further poverty as they are unable to navigate the systems alone. Food banks and other services that have stayed open are a key touch point for such people.

There is a "paradox" of digital exclusion that has afflicted these groups, where lack of hardware, knowledge or confidence means they can't get online to access support, but also makes them invisible to the service providers who could help them. Poverty compounds with these problems meaning people don't have the regular income necessary to pay for broadband or technology maintenance. There is a fear that further inequalities will deepen along the lines of digital exclusion.

3. Some minoritised groups, refugees and people with No Recourse to Public Funds (NRPF)

There are some minoritized groups, especially people seeking asylum, with refugee status or NRPF status, who are not on the radar of social services as a result of poverty and poor social infrastructures set up to meet their needs. Lack of funding has resulted in the last decade of an erosion of the 'last mile' of service provision – meaning steps taken to translate materials into less spoken languages, delivery services, broadband and transportation are overlooked as essential parts of service provision, meaning some miss out. Fear of the state is a big barrier to accessing services for new migrants and existing migrants with ambivalent migration status, of which there are many more after Brexit.

Unequal social infrastructures

A recent report authored by six black and ethnic minority led groups reported that their organisations had been denied access to funding to deliver vital services, evicted from LA owned workspaces without risk or impact assessments being conducted, had their ideas plagiarised without consent or attribution by bigger, better resourced organisations, been unfairly excluded from local decision-making processes, and had witnessed tokenistic employment of BAME personnel, amongst other issues.[53]

There is a sense that some communities are underserved because they don't have sufficient social infrastructure already in place. For example, there is a perception that some, more established, minority communities have a plethora of services that are already formally working and known to authorities. However, other often newer migrant groups such as the Somali community have lesser formalised infrastructure. Even when they do have organisations for their own communities, they are often perceived as "informalised" and lacking in the "knowledge" to be able to access funds and support from key VCS and LA organisations. There is a sense that if they were given the support and know how – for instance in setting up websites, setting up governance structures and audited accounts – they would be able to access funding. There is also a sense that some of these organisations for minoritised groups are being overburdened with the demands of mainstream figures to do things like distribute information, encourage vaccination uptake, and even mobilise around the census, but without being adequately compensated. They "have their own agendas" and so have "no incentive" to work with LA and the mainstream VCS to engage their communities. This logic is seemingly sometimes used to make demands for these groups; and in order times to chastise them for inadequate "values" or integration along idioms of model minorities.

Funding

51% of voluntary sector organisations have described their funding as having been greatly affected by the pandemic; where one in ten VCS organisations had no reserves at all prior to the pandemic.[54] In order to deal with funding issues, there is a sense that funders need to "know their organisations". At present, funding is being concentrated in a series of the 'usual suspects' because others – particularly grassroots and organisations from minoritized and underserved groups – don't have the governance or network to access the pots of money. There is a sense that they are "not looking for people to do the work". Money is hence seen to "evaporate into thin air" with questioning "where does the money go". There is also a sense that the LA is willing to pay themselves good salaries but unwilling to support VCS organisations with sufficient funds so they can't even pay their own staff the living wage. This has been mitigated in instances where mediator organisations that are deeply embedded in communities and know the ecosystems of smaller organisations act to support such networks. For instance, the Southall Community Alliance has been instrumental at channeling funds to small grassroots organisations. However, this is also because they are able to do the "relational work" to advocate for these ecosystems and ensure even provision across groups. Another important example is the Young Ealing Foundation that provides a series of networks and support for local youth charities in order to get and spread meagre funds across the borough. There is a need to develop new funding mechanisms and provide unrestricted and core funding to organisations as opposed to grant funding.

Monitoring, Data and Impact

Communities are vocal and clued up about the need to collect their own data and evidence of need and the need to question evidence sources provided by others – in order to best advocate for their interests. There is a sense that there has been a wealth of existing research done into inequality in the borough, and significant research done in the last year on the Covid-19 response. However, communities have not seen or been able to use this data or insights to be able to make sense of their own situations and they are not seeing the results or impacts of such research. Organisations are making strong efforts to set up synced and managed data systems to improve their coverage and reduce repetition of service provision – stimulated by the austerity measures. For instance, the Ealing Advice Service is a partnership of nine different service providers with a central drop-in centre and database. This model provides an important example of how response was quick and collaborative in the first moments of the pandemic due to strong infrastructure and synergy across services; backed up by a strong database.

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[53] Diriye, S. 2020. *The impact of covid-19 on Ealing's BAME communities: A survey by six BAME-led organisations* September 2020.

[54] Build Back Better *ibid.*

The use of monitoring and evaluation data in the voluntary sector is being questioned, where, after Black Lives Matter, organisations like Healthwatch are revising their KPIs to ensure that they are serving communities who are in the most need and not setting arbitrary targets. There is also a sense that funders and authorities need to set up more manageable M & E frameworks that are not laborious and account for the soft outcomes of relational work that are less measurable, especially for grassroots organisations who can provide important support but find it difficult to capture their impact. These frameworks should be flexible and allow organisations to innovate, especially within the rapidly evolving situation. There is a sense that such M & E frameworks fail to capture the affective and social value that voluntary sector organisations provide over private provision.

Trust, Engagement and Co-Production

There are extremely fractious relationships between minoritised groups, particularly from the Somali, Afro-Caribbean and Black African communities, and local authorities or mainstream service providers. These groups feel the experience of structural racism to be pervasive, and the experience of daily racism in accessing services to be ubiquitous. There is a sense that efforts to engage these communities around vaccine uptake is, in the words of one white public health expert, a “trojan horse” for other forms of social control. There is a sense that efforts at engagement of such communities are hollow and inauthentic, where “the facilitators will perform, and the community will perform back”. Where efforts at consultation are a “tick box” exercise and co-production is just another language. The use of certain terms works to hinder such processes of engagement. For instance, the “BAME” category is seen as both discriminatory of black and brown communities and excludes the needs of other precarious minority groups such as the Polish community who also experience historical exclusion. Ethnic minority communities are imagined as closed and bounded blocs who must be penetrated, meaning interested are seen to be collapsed and not nuanced along other axes of identity. The language is also lacking for conceptualising long term health inequities that are bound up with deprivation, poverty, housing issues, mental distress and other factors. Communities strongly resist the language of their being “hard to reach”.

However, there is a growing awareness on the part of many parties for the need to have more diverse faces in their organisations. This means both recruitment of people who are embedded in communities and taking the time to get to know and immerse oneself in communities in order to best provide services. It also means building alliances with diverse organisations as one’s face is “not always the right one to deliver the message”. Though on the other hand, some indicate that some communities ‘want it all on a plate’ and feel entitled to services without working for them, running again on logics of the model minority.

There is a sentiment that the health system needs to be “relational rather than transactional” and that currently there is “not enough space” to do important relational work and give space for people’s persuasion. This can be achieved by empowering the voluntary sector and embedding it in the communities themselves. There is also a need to empower this sector to make more specific and direct demands of government and LA provisioning, as well as to hold stakeholders accountable.

Sabir Bham, the founder of charity Salaam Peace and SP United FC, encourages his team to fight back after going 1-0 down at half time to Inter Lucia on the Hackney Marshes, 1st November, 2020. Hackney Marshes is home to the largest concentration of football pitches in Europe, and the Sunday League can get very competitive. Salaam Peace uses sports to help tackle sociocultural issues such as gang violence, mental health, and religious hatred within communities across North East London.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

Case Study: East London - Hackney and Tower Hamlets

Connor Watt and Jordan Vieira

Pre-pandemic context and aggravating factors

Pre-existing networks

At the onset of the Covid-19 pandemic, East London was already well served by a dense network of voluntary and community groups that had grown in response to need arising from significant cutbacks to statutory services since 2010. Ranking high on several indices of deprivation including high levels of child poverty,[55] high poverty and isolation among older people,[56] and a high proportion of out-of-work benefit claimants,[57] East London had also been severely impacted by the austerity policies introduced in 2010. Many community organisations had sprung up in an effort to provide for those most impacted by these measures – independent food banks, community hubs providing professional advice services, voluntary organisations targeting various "at-risk" groups, etc. In this sense, East London was already well served by a dense network of community and voluntary organisations who were able to redirect efforts as the Covid-19 situation and lockdown progressed.[58]

The starvation of this infrastructure of funds since 2010 has severely strained relationships and partnerships, leaving many organisations feeling antipathy toward each other and particularly toward the local authorities in the face of a systemic hollowing out of statutory service provision. The result of the above is a very fragile network of relationships that entered into the Covid-19 response. So, although the potential existed for these networks to morph into more sustainable and comprehensive means of providing "care", the fragilities and tensions present in these networks of support meant that much work was needed to iron out inconsistencies, inequalities, and damaging power dynamics.

Funding

In immediate response to the onset of the pandemic, organisations providing certain immediate services - mainly those focused on food distribution – were able to apply for community grants from local authorities due to vastly increased demand.[59] Many organisations reorientated their operations in order to focus on food delivery, which were aided in some cases by small grants from the LA or other charitable organisations that provide funding. However, a number of already-existing and newly emerging issues have become apparent around how various VCS organisations access funding.

There is substantial demand from VCS organisations to receive "core funding" for the long-term sustainability of operations, rather than "project funding" which is intended to be used for specific and limited operations. Core funding can also help address issues of structural bias (of which more below) by minimising the conditions of financial support for organisations that would otherwise find it difficult to meet extensive KPIs and M&E expectations.

Organisations have had to diversify their funding streams beyond LA grant schemes to seek funding from a variety of sources: corporations with Corporate Social Responsibility (CSR) components, wealthy individuals, solicitations for community support through residential leaflet distribution, London Community Response, East London Foundation, and the Thames North Trust.

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[55] Child poverty rates of 53.4% in Tower Hamlets, and 41.3% in Hackney -1st and 3rd highest in London respectively, https://cpag.org.uk/child-poverty-london-facts

[56] See 'Connect Hackney Report' https://hcvs.org.uk/wp-content/uploads/2018/10/CH-Appendix-2-Profile-of-social-isolation.pdf

[57] https://www.trustforlondon.org.uk/data/out-work-benefits-borough/

[58] Watt, C. & J. Vieira. 2020. 'Case Study: Stacked Care and Social Foundations for Recovery in Hackney'. In *A Right to Care: The Social Foundations of Recovery from Covid-19* by L. Bear, D. James, N. Simpson et al, pp 49-52. London: The London School of Economics. https://blogs.lse.ac.uk/covid19/2020/10/29/covid-and-care-how-a-stacked-care-system-could-help-places-like-hackney

[59] See here for details on Hackney's community grants scheme - https://hackney.gov.uk/community-grants
And here for details on Tower Hamlets funding for community organisaitons - https://www.towerhamlets.gov.uk/lgnl/community_and_living/community_grants/Funding_for_voluntary_and_community_organisations.aspx

Interlocutors in East London described a "chicken-and-egg" pattern with regard to funding whereby the older, more established, and larger organisations are more likely to receive more funding and sustain themselves at the expense of newer small to medium organisations. It was generally understood that some of the smaller, more recently established organisations, many of whom emerged during the first wave of the pandemic in 2020, were able to interact with people who may not have previously sought out support services. Thus, the value of these smaller groups lay in being able to support those reluctant to seek assistance through other, more established pathways. Many of these groups, however, lack the experience and capacity of the more established groups when it comes to funding applications, and so tend to receive insufficient funds to sustain their operations.

The majority of small and medium operations tend to be managed and operated by people from Black and Asian minority groups. These groups in particular struggle to receive funds, as the larger organisations generally have more direct relationships with funding bodies and local authorities. Even in instances when a relationship with a LA officer has been established and modest funding has been received, issues around building capacity and infrastructure in order to meet demand and sustain operations remain prevalent.

Furthermore, particular vocabularies and knowledge are missing from some small organisations around how to engage better with the funding process and write grant bids according to funder specifications. The skill and efficiency which comes through repeated experience of making funding bids is usually lacking in newly established small groups. One organisation we spoke within Hackney noted that they had hired a white person specifically to procure funds, due to the perception that communication barriers along racial lines would prevent them from winning funding applications. This particular organisation's director felt that this white employee was able to attract an increased perception of legitimacy and trustworthiness. This is part of wider structural bias that surrounds funding. Again, these biases tend to play out along racial lines, in that larger organisations often employ members of staff whose sole focus is on funding procurement and bid application making, while smaller organisations tend to have small teams of core volunteers who carry out a wide range of operational tasks, administrative roles, on top of efforts to secure funding.

Gentrification: Two Hackneys (and Tower Hamlets)

Gentrification and development inform the experiences of various community groups in East London beyond just VCS organisations. Gentrification impacts how people construct, navigate, and perceive senses of "community" beyond immediate care services, although the development and use of public space certainly affect local (social) infrastructures. We have argued that there are in effect "two Hackneys" – one more vulnerable, precarious, and subject to the high rates of deprivation in the Borough, and the other more economically mobile/affluent.[60]

While various community care organisations have vocalised general approval of the Council in terms of their collaboration and support of such organisations during the pandemic, other groups are far more critical of the Council's broader support of private development – an issue that certainly pre-dates the pandemic – and decry the social/community divisions of "different Hackneys" that it reproduces.

We suggest that this wider context of gentrification should not necessarily be excluded from the conversation about various forms of care and the public good, despite its ostensibly tangential relationship to immediate care provision. After all, community groups have noted that it would be of significant help if the Council would intervene in issues around land use and allow community care groups to operate from vacant office spaces. Local Authority officers, however, were keen to stress that the root causes of this dynamic are often unrecognised – that Central Government cuts to LA budgets in recent years have created significant shortfalls in council budgets. In order to lessen the impact of these cuts on services provided directly by the LA, councils have had to look elsewhere to balance budgets, and often this has meant a much greater reliance on new building developments aimed at attracting groups with high incomes into the Borough. While this is often perceived as the LA catering to the interests of high-income portions of the population, LA officers were keen to stress that this dynamic masked the core problem of severe underfunding by the Central Government.

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[60] For further details on this dynamic see - Watt, C. & J. Vieira (2020). 'Case Study: Stacked Care and Social Foundations for Recovery in Hackney'. In *A Right to Care: The Social Foundations of Recovery from Covid-19* by L. Bear, D. James, N. Simpson et al, pp 49-52. London: The London School of Economics.

Pandemic Response - Interaction between VCS groups and the state

Initial responses

The onset of the pandemic magnified the social fault lines outlined above, even though volunteer work and mutual aid responses might have temporarily alleviated and obscured some of them. Stress points were tested amid (1) attempts ensure that basic needs were met, (2) concerns over the scope and reach of organisations and LAs struggling to contend with surges in demand, and (3) increased public scrutiny of local activities and the work of LAs. LAs heavily relied upon the VCS in the immediate reaction to the pandemic, leading to a realisation of the potential benefits of providing services in this form. As noted above, many organisations redirected their operations to address food provision; a host of mutual aid groups formed as community projects to provide a range of assistance; and Hackney Council coordinated their own volunteer-led food and supplies service while depending on the VCS to supplement care provision. A bridge formed between the "two Hackneys" in this moment, as affluent volunteers engaged in mutual aid activities. This initial blurring of social fault lines was ultimately ephemeral and now, one year later, underscores the socio-economic tectonics in East London. Indeed, the very realisation of the need for VCS groups has generated many questions about the structural fault lines and inequalities in these relationships of care provision, discussed further below. Still, interlocutors from both the VCS and LA acknowledge that dependence on the VCS will likely be integral to short- and long-term recovery.

Language of exclusion/abandonment/visibility

A Tower Hamlets councillor echoed our concerns about the language that should be used when discussing relationships between vulnerable people and communities, VCS groups, and the state. There is a widespread sense among policymakers that some communities are "hard to reach" because they lack sufficient social infrastructure. The language of "hard to reach", however, removes responsibility from the state to provide resources and care. While the term "excluded" might better capture the reality of these relations than "hard to reach", this language ignores the agency of vulnerable individuals/communities and the groups that aim to support them. The councillor suggested that "seldom heard/seldom seen" might be more appropriate and useful to illustrate that these individuals and groups are neither silent nor fully excluded, but they come in and out of focus and priority of the state.

Indeed, VCS workers argue that there is a more general issue around the visibility of these networks, which are understood as always present but moving in and out of public awareness. This dynamic – of constant presence, but intermittent and unequal recognition–creates tensions between different VCS groups. This was most prevalent in the initial lockdown last year when a sense of irritation, several interlocutors noted, developed in reaction to the widespread recognition of the work of the mutual aid groups despite the fact that similar networks of care – often organised and maintained by Black and Asian minority groups – had existed for many years but had never received such public exposure and praise.

Contesting (funding) priorities and recognition

Another prominent issue in East London was the prioritisation of emergency provision activity, namely food provision programmes, at the expense of support which targeted longer-term and structural issues – e.g. mental health support charities, or programmes aimed at alleviating exclusion of young Black and Minority Ethic people. Although there was an appreciation that greater support for those organisations providing basic provisions was necessary at the onset of the pandemic, the emergence of various additional crises becomes a major risk without ongoing support for a much wider range of community services. Currently, common stipulations that funding be used for quantifiable "high-impact" short-term projects creates sporadic income flows that result in severe precarity and potential closures of those organisations which provide less tangible, but nonetheless vital, support services. Moreover, there is substantial frustration among the newer, smaller organisations that although they operate on "fresher" models that include diverse forms of reaching "seldom seen/heard" people (e.g. face-to-face contact, WhatsApp messaging), they nevertheless experience the brunt of funding shortfalls. This reality is due in part to the increased oversight of procurement processes and complex tendering, creating a scenario in which organisations with the governance capacity and existing networks are able to access funds from the LA.

Given this environment, embedded umbrella groups such as the Hackney Council for Voluntary Service (HCVS) and Tower Hamlets CVS have been instrumental in channeling funds to small grassroots organisations. Such organisations possess the capital and infrastructure to execute the relational work of advocating for these ecosystems of support and ensuring balanced provision and fairer distribution of resources across groups. In the early stages of the pandemic, Hackney Council, in collaboration with various umbrella organisations, repurposed a borough-wide programme called

“Neighbourhood Conversations” to foster connectivity between these VCS groups and statutory service providers. Their aim was to increase assessment and general provision capabilities. However, in their role as mediators between the Local Authority and VCS, these umbrella organisations are often perceived as extensions of the state. In order to counter this impression, it is crucial that extensive sustained dialogue and substantial co-production with a wide range of community and voluntary groups become central to these relationships.

Lessons for the long term - New forms of alliance, innovation, mutuality

Preserving new relationships

A major worry expressed by many of our interlocutors is that the relationship between voluntary and community groups and local authorities will “return to business as usual” rather than maintain the new collaborative and integrated model of mutuality to address particular issues, such as food poverty. Some organisations were able to ride the wave of crisis response support and funding schemes, yet they are apprehensive that the transition to a long-term recovery will see a new era of austerity, even if this will be “dressed up in different language”, as one interlocutor phrased it. These concerns are compounded by an awareness that it will again fall to the VCS to ensure that the most vulnerable are provided for in the likely upcoming era of both continued and intensified austerity.

Some organisations want to engage in discussions about the long-term, arguing that the broader context beyond the “Covid moment” will continue to need work. They hope that VCS groups and LA officials do not become complacent once the stress points caused by the pandemic lessen in severity. An acute frustration exists that more long-term conversations about addressing social issues, austerity, and care are not being had to the extent necessary to secure meaningful change. This relates to the below comment on the need to inspire more philosophical discussions on “community”.

One of the more positive developments since last autumn has been the flexibility around referrals between statutory and informal care providers that address food poverty in Hackney. This was spearheaded by the newly created Food Network, which consists of a range of frontline community anchors from across Hackney who run essential services centred on food provision, as well as senior Council officers. At the point of the Network’s creation, the Council had, according to one director of a community organisation, established a system that supported the most critically vulnerable and those self-isolating. However, the Council wanted to work with frontline organisations around referrals. This endeavour has created a more concerted effort between informal providers and the Council to narrow gaps in provision through increased communication/collaboration and strategic referrals within particular geographical boundaries. In the previous report, for instance, various groups were unable to manage demand for food provision from people beyond their immediate areas, and the LA would not make referrals to VS organisations. With time and what some feel is a working partnership with the LA, people have been directed to resources that make more geographical/logistical sense and are better able to manage demand.

The aforementioned tensions between well-established organisations and smaller groups in relation to funding bids is prevalent in East London. In order to address this, Hackney Council trialed a “consortia funding” approach with the Food Network (an alliance of food provision bodies). A number of organisations were encouraged to collaborate on funding applications, thereby sharing the capacity and expertise of the larger groups with the smaller and allowing the larger organisations to achieve greater reach through the more fine-scale networks of the smaller organisations. Although beneficial in terms of allowing the smaller organisations access to administrative infrastructures and extensive knowledge that in turn increased the likelihood of winning funding bids, there was little incentive for the larger organisations. Such groups have in several cases found the process a drain on resources and were also reluctant to share best practices. Note that these larger organisations often have a dedicated member of staff engaged solely in fundraising efforts, an example of what “infrastructure” might consist of, and what the consortia sharing process would aim to redistribute.

One interlocutor felt these efforts made by LA and the Food Network have, beyond just temporarily “filling gaps” in food provision, effectively “reset the relationship between the voluntary community sector and the Council”, in terms of “a more equitable and strategic partnership” and a focus on a “collaborative response”. In Tower Hamlets, a number of different forums with similar aims of integrated thematic collaboration amongst different community organisations have been revitalised. They include the Health and Wellbeing Forum and the Training, Employment & Enterprise Forum. The working partnerships have, at least in Hackney, been of particular importance, not least because general mutual aid activity has declined sharply since our Covid and Care Research Group’s previous report, as volunteers have exhausted their energy, time, and money. Aside from mutual aid groups, the mental health and exhaustion of small- to medium-sized VCS groups and burnout have also created stress points.

Some interlocutors have expressed a need and personal desire to have broad philosophical discussions about 'community' – i.e., what that means and what people want and need from their 'community'. However, such discussions are not being held – "people are not there yet", as one interlocutor put it, but are rather addressing individual thematic needs through ad hoc and some collaborative action. Yet another interlocutor suggested that people can be "turned off" if those conversations are not being held. In other words, there is perhaps increasing demand to address such big questions as how to define the public good and implement policies that provide for it.

Trust - Generating and sustaining collaborative reliance

All of the aforementioned points underscore broader issues of trust and ideas of the public good, which include thorny issues about whether the Council is able to navigate the often opposed interests of different groups in the LA. Driven by the perpetual property development that LAs argue is necessary in order to supplement their budgets, gentrification intensifies social fault lines along divergent interest in the short- and long-term, creating further tangential issues around trust between vulnerable groups and LA. These feelings of mistrust may be very difficult to change. Even when new relationships are being formed, or new processes are instigated, the historical experiences of interacting with the Council (especially as it is often the most prominent or only point of interaction with the state) will persist. Consequently, a certain ongoing level of mistrust has to be expected. Additionally, independent groups who work closely with the LA (volunteer centres and other VCS groups) will often be imagined as extensions of the LA. The large/small organisation dichotomy mentioned above often influences the perception of where the boundaries of state and community lie. Those who are employed by larger community organisations are often portrayed as working for the state and, accordingly, perceived to exist 'outside' the communities they aim to serve. Moreover, several interlocutors from both LA and the VCS described those who participate in providing care programmes and services as "the usual suspects", emphasising the need to generate new alliances and expand engagement through building trust. Interlocutors suggested that old structures and methods of "community engagement" reproduce these unequal relationships, and so new, more substantial relationships of reliance and co-production are needed to break these patterns.

In order to help foster trust relations, the provision of "core funding" aimed at supporting the general operations of an organisation should be privileged over project-based grants which can only be put to specific uses. Such funding would greatly increase the capacity and durability of many voluntary and community organisations. However, such funding is contingent on flexible M&Ps and KPIs that trust innovative modes of evaluation. An interlocutor commented, for example, that the National Lottery Fund had been incredibly helpful during the pandemic. This was not only because their organisation had received funding from the National Lottery Fund, but also since the Fund is "*much more flexible than other funders in terms of how you want to deliver something and what you call your outputs - your outcomes - [and] they're very flexible to listen to what it is you think is going to work*". Moreover, "*the application process doesn't feel as cumbersome as some of the others"*.

In our previous report on the impacts of the pandemic on various disadvantaged groups around the UK we proposed a system of "stacked care" as one potential policy response.[61] By this we envisaged a system of service provision which combined statutory and VCS organisations, working together to assess and respond to need in a demarcated geographical location. Regular communications between as large a range of groups as possible would, we argued, increase the ability of all groups to assess complex and hidden needs, and would also lead to the development of inventive ways of responding to a wide range of issues.

Several interlocutors have noted that the voluntary sector is a broad spectrum of complex and often competing agendas. For this reason, a "stacked care" system would need to be sensitive to potential points of tension, namely around issues of funding and trust. Some interlocutors feel this would become too complex within an integrated system unless the funding mechanisms were much more inclusive and changed drastically. Such an endeavour would require substantially increased amounts of funding to ensure that all member organisations within a stacked care system were sustainable and not competing against each other. For these reasons, thematic approaches, such as that of the aforementioned Food

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[61] Watt, C. & J. Vieira (2020). 'Case Study: Stacked Care and Social Foundations for Recovery in Hackney'. In *A Right to Care: The Social Foundations of Recovery from Covid-19* by L. Bear, D. James, N. Simpson et al, pp 49-52. London: The London School of Economics.

Network case, might work better than a broader structure of stacked care. Nevertheless, the potential benefits of collaborative working practices are clear, and whether more comprehensive or more thematic structures for cooperation are appropriate would need to be assessed on a case-by-case basis.

These case studies from Ealing, Hackney and Tower Hamlets alert us to significant opportunities that exist for investing in local social infrastructures; but also, to the significant challenges in overcoming and managing tensions, social divides and mitigating long-lasting and historical forms of exclusion and inequality. The first step toward investing in social infrastructures is to systematically map local carescapes and intersections of formal and informal care - voluntary sector organisations, grassroots groups, activist groups, faith institutions, community spaces, networks of kinship and neighbourliness.[62] Further, to investigate the intersecting forms of disadvantage, misrepresentation and mistrust that cut across such ecologies; and the ways in which KPIs, M&E frameworks, strategies agendas, co-production processes and decision making processes must be adapted to promote equality, diversity and deliberation. Ethnographic methods are uniquely suited to such efforts of mapping and contrasting perspectives and can be integrated into local efforts to build and revitalise equitable social infrastructures.

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[62] Bowlby, S. & L. McKie 2018. Care and caring: An ecological framework. *Area* 51, 532-539.Bowlby, S. & L. McKie 2018. Care and caring: An ecological framework. *Area* 51, 532-539.
McKie, L., S. Bowlby & S. Gregory 2004. *Caringscapes: experiences of caring and working*. Edinburgh: Centre for Research on Families and Relationships.
McKie, L., S. Bowlby & S. Gregory 2001. Gender, Caring and Employment in Britain. *Journal of Social Policy* 30, 233-258.

Michelle Dornelly, founder of charity Children With Voices, smiles outside her Community Food Hub on the Wilton Estate, 6th April, 2020. Michelle Dornelly started Children With Voices 25 years ago, but since lockdown the demand for her food hub has grown exponentially. She distributes food donated to her organisation to some of the most underserved estates in Hackney, a lifeline to many low-income families or vulnerable residents who are shielding.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

Conclusion: Taking Social Infrastructures into Account

This report reveals how important social infrastructures have been to sustaining UK society during the Covid-19 pandemic and how significant they are for recovery from it. There is no "trade-off" between investing in these or "the economy". Without central and local government support these innovative networks of social provisioning will collapse. You wouldn't build a bridge or an internet network and then immediately destroy it. Why, when so much individual and collective constructive effort has been made with so many important effects would a government not value this?

The extensive ethnographic and survey research of this report has shown how essential these provisioning services are at this moment. The disruption of relationships of care within and between families, friends and communities has had significant impacts on our society – including most notably a psychological cost and increased burdens on unpaid carers, young adults and middle-aged women. This has impacted us all but has hit the already disadvantaged and minority groups the most. The disruption of relationships has also had impacts within and between communities, where new inequalities and relations of stigma have been generated as a result of unequal exposure, mortality, and government policies.

The ways in which families and communities have mitigated these disruptions has been through the mobilisation of new connections. At family level, this has involved changes in the way we live and provide care to one another. At community level, this has been in new collaborations and initiatives like mutual aid groups. These forms of support have included the provision of practical and physical care, emotional support and even connection and activism through online communities and social media. These innovations in our social infrastructures have seen us through the pandemic. Where they have been supported by government policy – such as through Community Champions policies, local grant investments, and income support, these innovations have been sustained. Where they have not been supported by government policy – such as in the lack of sufficient social isolation payments or for voluntary sector organisations – new inequalities and relations of stigma have been generated, threatening social cohesion and increasing existing forms of disadvantage. Key concerns in supporting social infrastructures include acknowledging and reversing the impact of a decade of austerity; structural biases in provisioning and decision making; collecting and representing data on a wider range of groups; adding nuance to the way in which we measure and evaluate impact; and promoting innovative and sustainable partnerships.

Hence, we call for the systematic and equitable investment in social infrastructures in the post-covid period. We need a national consultation with voluntary and third sector groups on how to take this forward or a Royal Commission on Social Infrastructures, that could draw on the wealth of expertise across the country. This should lead to the foundation of a permanent body similar to the National Infrastructure Commission or a National Social Infrastructure Commission. This would provide strategic advice on how to plan for social infrastructures, how to fund them and the best way to assess and anticipate needs at the national and local level.

Alongside this, as the Women's Budget Group have been arguing for many years, we need a National Care Service that includes not just "carers" or "social care" issues but that provides funding for social infrastructures at the local level.[63] Alongside this, government at the national and the local level will need to decentralise consultations and policy funding in the way that the Community Champions initiative has. This is often seen as a high-risk strategy, but the Community Champions initiative is the beginning of a new confidence in the potentials of national level funding for micro-locally designed provisioning. National third sector organisations such as Near Neighbours and local ones can help with the

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[63] Social Care Is In Crisis: We Need A National Care Service 2019. *Womens Budget Group* (available on-line: *https://wbg.org.uk/blog/social-care-is-in-crisis-we-need-a-national-care-service/*, accessed 5 July 2021).

design of this consultation and provisioning from their deep experiences of the realities of working with fragile communities. Ethnographic approaches, data and methods would be crucial to these new strategic initiatives as only these can capture the intersecting factors that contribute to success and failure of policy from the ground up. Anthropologists too can act as mediators of various vistas on the major issues faced by various participants in social infrastructures. They, along with third sector organisations, can engage deeply and carry challenging realities into the formulation of policy in government. That this can be done at speed and in a time of crisis is evident from our research here. So much more could be achieved with a concerted long-term focus.

These ambitious schemes will take a long time to realise, so in the short-term we need more immediate, emergency measures for recovery. These could include:

- Reopening of **community centres** and central government grants for Community Hubs in areas disadvantaged during the Covid-19 pandemic (areas of enduring transmission and/or local interventions).
- National level funding targeted to national and **local voluntary sector** and third sector organisations, especially those run by minority and disadvantaged groups.
- Systematic and frequent **mapping of the forms of informal and formal care** at community level in order to make targeted investments in local social infrastructures, especially to serve disadvantaged groups.
- Expansion of the **Community Champions** programme with funding to support coordination efforts between groups at the local level.
- **National and local recognition,** through awards and honours, of the hidden work carried out by the voluntary and community organisation sector during the pandemic.
- Prioritised funding for locally-provided **mental health, childcare and eldercare services,** particularly through community organisations.

These policies may seem far removed from the usual pandemic concerns of vaccination rates, enduring transmission or economic recovery. However, issues of trust, compliance, innovation and enterprise cannot be addressed without first provisioning our vital social infrastructures.

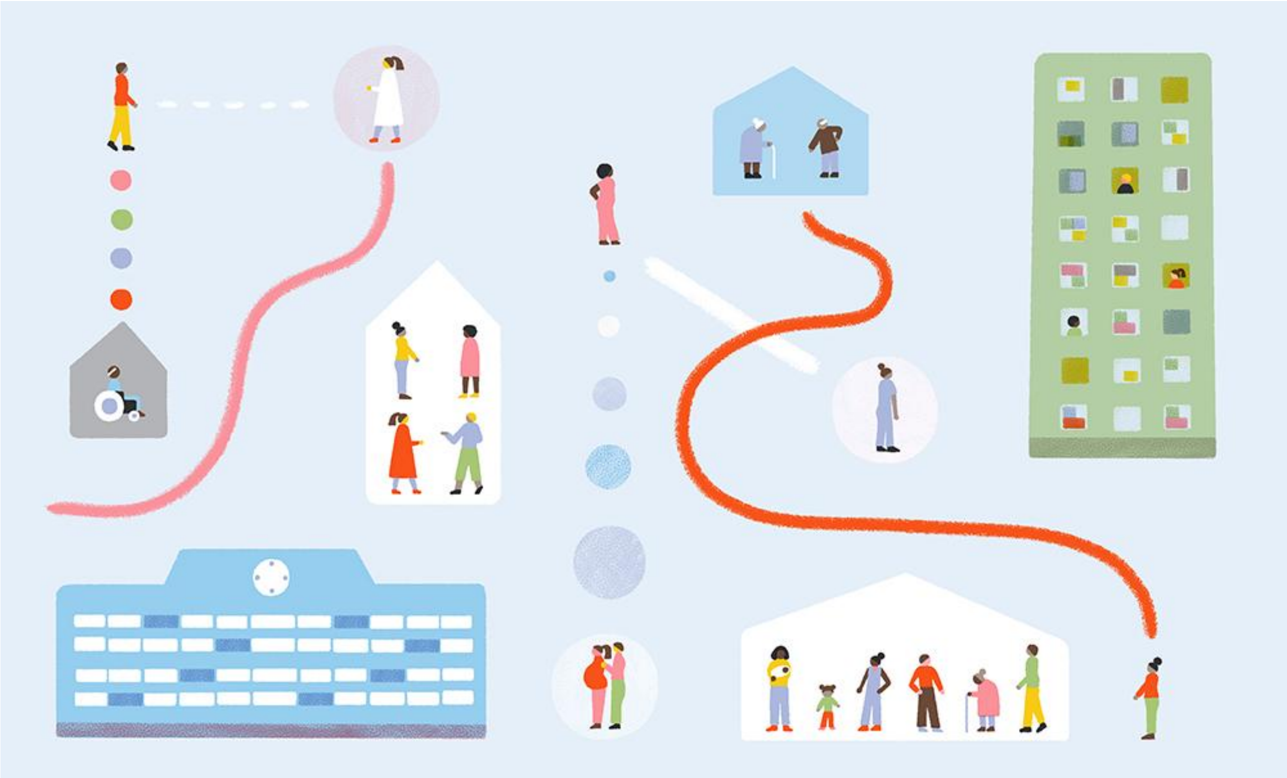

Illustration by Maggie L

Appendix 1: Methodological Reflections and Sampling

Anishka Gheewala Lohiya

To contribute to spotlights on motherhood and schooling, I conducted 7 phone interviews with mothers, followed by a couple of video calls initially then chatting over WhatsApp. The majority of these mothers were first time parents with newborns born just before the pandemic in their 30s-40s. Two had older children from the ages of 3-5. One mother was going through fertility treatment. Some of the information on mothers and motherhood came from websites such as Mumsnet, pregnant then screwed, FlexAppeal campaigns, The Gynae Geek surveys and social media, TUC conference in 2021 and mum influencers on social media. I contacted mothers I knew through my network, and they introduced me to their networks.School information came from three teachers, one primary school, one language teacher and one was a music teacher who taught at 4 schools. All in their late 20s and 30s. Nursery came from my own nursery T&C's in Jan 2021 and two others who sent me their covid rules from May 2020.

To contribute to spotlights on South Asian groups, I conducted 16 formal interviews with South Asian participants, over Zoom. I drew on my fieldwork contacts who I messaged over WhatsApp and voicenotes. I am in constant touch with about 4 of these discussing motherhood though the majority were parents. Age ranged between early 20s to 70s. I receive updates from the temple organisations I interviewed in the first report as well. Again, all my interviews came from my networks and introductions through them. I only contacted two temple organisations that were not formally introduced to me.

To contribute to the Stop Asian Hate spotlight, I conducted 10 formal interviews, and some digital ethnography through social media. Two of these were mothers with two or more children. Three were thinking of starting families, one was a gay couple and all three were from China and Singapore and moved here for education before being residents. Age varied from late 20s -40s. The interviews were all video calls over an hour long and we chatted through WhatsApp after.

Caroline Bazambanza

My research for the Covid and Care project was based on a number of methodologies seeking to investigate motherhood, pregnancy, race and early years provisions in Britain during the pandemic. I conducted eight interviews lasting an hour or more with mothers across Britain. These interviews were conducted over the phone and through longer-form narrative collection via online platforms. I made calls for evidence through online platforms and closely followed the work of advocacy and informational groups online. Informally, I have spoken to a number of black residents in Tower Hamlets and Hackney about their experiences of Covid-19 policy. Additionally, I have been working with Birthrights on the inquiry into racial injustice in maternity care where I have learnt about experiences of pregnancy and labour during Covid-19. This research has offered insights into the perspective of pregnant and labouring women as well as medical professionals, including midwives and obstetricians and non-medically trained birthing professionals such as doulas. I have collaborated with The Motherhood Group founded by Sandra Igwe to support black mothers where I have been able to assess my in-depth interviews alongside a larger sample of narrative reports concerning pregnancy, labour, mothering, race and household composition and relations.

I also interviewed nursery staff and asked mothers about their experiences of early years provisions during the pandemic. Some of my research in this capacity was conducted via online forums. This was coupled with reading emerging news and following groups dedicated to mothering and parenting in Britain, particularly those engaging black mothers. I attended online events about black birthing and mothering during the pandemic.

Outside of this project, my PhD research seeks to investigate black women's perceptions and experiences of pregnancy, labour and mothering in London at the intersection of race, welfare and reproduction. Focussing on forms of knowledge and modes of care and recognition I turn attention to women's creative strategies and negotiations of racism, health-seeking and care in the context of stark health, social and economic inequalities in Britain today.

Nikita Simpson

In Leicester, I conducted 23 semi-structured qualitative interviews with people located in Highfields, Evington Valley, Belgrave, Central Leicester, Oadby & Charnwood; in two rounds - first between July 15th and August 7th 2020; and again between February 3rd and March 3rd 2021. The interviews described here were with members of Hindu, Christian, Sikh and Muslim faith groups, and with people of White-British, Indian, East-African Indian and Sri Lankan ethnic backgrounds. Respondents included local counsellors, trade union representatives, faith leaders, third sector workers, small business owners, university lecturers and carers' representatives.

Together with Laura Bear, in Ealing I worked systematically with the local public health team to collect relevant ethnographic insights on health inequality. I conducted 11 interviews in February and March of 2021 with community sector organisations. Research participants included CVS members, leaders of the Ealing Together partnership, members of the CCG, local public health teams, faith groups, local activists, mental health organisations, aged care, community transport and advice. I also attended a number of specific and general community forums on vaccination, testing uptake and health inequality.

Across both of these sites, I also focused on interviewing key figures from South Asian communities, and engaged with people of Muslim, Sikh and Hindu backgrounds; and from the Panjabi, East African Gujarati, Bangladeshi and Pakistani communities. In addition to the above interviews, I engaged with an additional two interviewees both based in North London.

Milena Wuerth

Throughout February and March 2021, I conducted eight interviews with contacts made through the Ambassadors network. Most of these contacts worked for the Council or in the voluntary community sector and represented the interconnectedness of the local authority and established voluntary bodies. I also attended eight group feedback sessions and about twenty public health briefings which were advertised by the group's organisers through a weekly newsletter. I monitored the WhatsApp group, which has stayed highly active from November to the present, on a daily basis.

Many of the Ambassadors work or have worked in health and social services, and most are middle-aged or older. Membership seems to generally reflect the demographic diversity of the area (54% White, 25% Black, 10% Asian, 11% other), with an overrepresentation of BAME individuals (over half of those regularly attending the feedback session and using the group chat).[64] Amongst the Ambassadors interviewed and communicated with are representatives from a local Sierra Leonean mutual aid network, a voluntary childcare provider, a Council employee and foster carer, several members of tenants' organisations, a carer for the deaf, and the education officer of a local mosque. Two of the network's organisers and the founder of a local food bank were also interviewed.

Connor Watt and Jordan Vieira

We formally interviewed twelve contacts between February and April 2021 via online platforms for an average of over one hour each. These interlocutors include both individual and umbrella community organisation directors, housing activists, a local councillor/deputy mayor, and Local Authority officers whose work ranges from Community Champions projects to strategic planning and volunteer sector relations management to addressing issues of food poverty. Several interviews were conducted jointly, and those that were not were transcribed with an online transcription service and made available to the absent party for analysis. These contacts were made by Connor's 'on the ground' networking in Hackney, made possible by living in Hackney and participating informally in the work and meetings of various community organisations. We were able to contextualise our interview analysis with this more traditional participant-observation material, in addition to Jordan's previous fieldwork conducted in the Isle of Dogs area of Tower Hamlets that explored issues of gentrification and class. Further contextualisation and analysis were aided by consulting ONS data and reports from Local Authorities, the National Council for Voluntary Organisations (NCVO), and the Institute for Fiscal Studies.

Alice Pearson

For this period of research, I have carried out eleven interviews with interlocutors involved in formal and informal provision of care. These were conducted over the phone or via online platforms. These included Local Authority officers and local councillors, members of charities and a member of a school board, social workers and legal aid workers. The focus of their formal roles ranged from housing, communities, families, mental health and education. Interviews focused on

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[64] JSNA Factsheet 2018-19, https://www.southwark.gov.uk/health-and-wellbeing/public-health/health-and-wellbeing-in-southwark-jsna/southwark-profile

concerns both emanating from formal roles that interlocutors inhabited and their informal networks of care.

Laura Bear

From October to June 2021 I have carried out research on the Community Champions scheme across the UK. I had 8 interviews with public health teams and one community champion network in October-November 2020. I also attended several online community engagement events around public health issues such as vaccination and NHS TTT in Oct-December 2020 and March 2021. These included briefing sessions by Clinical Commissioning Groups, local authorities discussing collectively Community Champion schemes and events designed for Community Champions. Two national level voluntary sector organisations and their local hub leaders were also interviewed at two time points in March and June 2021. In addition, I carried out focus groups with local authority leads, community organisations, and community champions engaged in one region's roll out of Community Champions. I was also involved in policy formulation activities related to SPI-B, the Ethnicity subgroups of SAGE and MHCLG.

Atiya Kamal

In October and November 2020, I conducted nine one-to-one interviews with public health teams and a community organisation lead to discuss community engagement efforts during the pandemic. I carried out four one-to-one interviews with public health teams involved in the Community Champions scheme and two focus group discussions with Community Champions. The same participants were interviewed in March and again in June 2021. I was also involved in policy formulation activities related to SPI-B and the Ethnicity subgroups of SAGE and MHCLG.

Survey Sample

2,170 responses were gathered in total, via online dissemination strategies including personal invitations by email, organisational list-serves, and social media ad campaigns. 64% of our sample self-identified as 'Woman' (1334 respondents) and 34% (714) as 'Man'. Fewer than 1% selected 'Prefer not to say' (20) or 'Non-binary' (13). The following tables offer further demographic breakdowns of the survey sample:

Age	Count	Percent of total
55-65	690	33%
65-75	432	21%
45-55	400	19%
35-45	307	15%
25-35	142	7%
75+	75	4%
18-25	52	2%
Total	**2098**	

Type of Household	Count	Percent of total
Couple	712	35%
One person household	454	22%
Couple with dependent children (1 or more)	358	17%
Couple with non-dependent children	227	11%
Other, please explain.	70	3%
Multigenerational household (more than 2 generations)	65	3%
Flatshare / houseshare	65	3%
Lone parent family with dependent children (1 or more)	61	3%
Lone parent family with non-dependent children	41	2%
Total	**2053**	

Employment status	Count	Percent of total
Employed and working	899	43%
Retired	658	31%
Self-employed and working	169	8%
Looking after the family / home as a full-time job	68	3%
Long-term sick or disabled	66	3%
Unemployed	62	3%
Owner of small / family business	52	2%
Unpaid carer	33	2%
Prefer not to say	30	1%
Furloughed / unable to work due to COVID-19-related restrictions	29	1%
In full-time education	28	1%
Total	**2094**	

Author Contributions

This study was designed by Laura Bear and Nikita Simpson. All authors contributed to ethnographic and qualitative data collection and analysis for this study, and conceptualisation of key arguments. The survey was designed by Laura Bear and Nikita Simpson, and analysis was conducted by Milena Wuerth. Authors wrote their independent spotlights or case studies, and overall report writing and framing was done by Nikita Simpson and Laura Bear. All authors edited and reviewed the final draft. The wider Covid and Care Research Group supported in the conceptualisation of the research.

Media

Illustrations are by Maggie Li. Photographs are by Grey Hutton with support from the National Geographic Covid-19 Emergency Fund. They are from the 'Ties that Bind – Community Lifelines in Hackney' series.

Declarations

Laura Bear is a member of the SAGE SPI-B committee, the Independent SAGE committee and the BAME SAGE sub-group. Nikita Simpson has also worked as a freelance social researcher for the UK Government's Policy Lab. Atiya Kamal is a participant of the Scientific Advisory Group for Emergencies sub-groups: SPI-B and the Ethnicity sub-group.

Ethics and Funding

Approval for this study was given by the London School of Economics Research Ethics Committee [REC ref. 1137]. This research was funded by the London School of Economics Research Office, with contributions from SAGE and Professor Laura Bear.

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