Encouraging breastfeeding: financial incentives

SUMMARY: The NOSH (Nourishing Start for Health) three-phase research study is testing whether offering financial incentives for breastfeeding improves six-eight-week breastfeeding rates in low-rate areas. This article describes phase one development work, which aimed to explore views about practical aspects of the design of the scheme. Interviews and focus groups were held with women (n=38) and healthcare providers (n=53). Overall both preferred shopping vouchers over cash payments, with a total amount of £200-250 being considered a reasonable amount. There was concern that seeking proof of breastfeeding might impact negatively on women and the relationship with their healthcare providers. The most acceptable method to all was that women sign a statement that their baby was receiving breast milk: this was co-signed by a healthcare professional to confirm that they had discussed breastfeeding. These findings have informed the design of the financial incentive scheme being tested in the feasibility phase of the NOSH study.

Keywords Breastfeeding, financial incentives, qualitative interviews

Authors Heather Whitford, lecturer in mother and infant research at the University of Dundee, Barbara Whelan, research associate in public health, Patrice van Cleemput, research fellow in public health, Katharine Thomas, honorary professor of health services research, all at the University of Sheffield, Mary Renfrew, professor of mother and infant health at the University of Dundee, Mark Strong, clinical senior lecturer in public health, Elaine Scott, Nourishing Start for Health (NOSH) study manager and Clare Relton, senior research fellow in public health, all at the University of Sheffield

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Introduction
The three-phase Nourishing Start for Health (NOSH) study is the first study in the UK to offer women financial incentives for breastfeeding. This article outlines the background to the study and describes the findings of the first phase: development work to inform the design of the NOSH scheme. The second pre-trial feasibility phase of this controversial new scheme was tested in neighbourhoods in Sheffield, Rotherham and Chesterfield (Nov 2013-March 2014) and generated much interest and comment.

Exclusive breastfeeding is recommended until six months (Department of Health (DH) 2003), with breastfeeding continuing after the introduction of solid foods; however in the UK, although 81 per cent of babies are breastfed at birth, the rate of any breastfeeding drops to 55 per cent at six weeks and 34 per cent at six months. By six months only around 1 per cent of babies are still exclusively breastfed (McAndrew et al 2012). The challenge is to encourage more women to start breastfeeding...
and keep women breastfeeding – partially or exclusively – for longer.

Financial incentives have been used to encourage a range of health behaviours such as smoking cessation (Sigmon and Patrick 2012; Radley et al 2013), weight loss (Jeffrey 2012; Paul-Ebholhimhen and Avenell 2008) and attendance at health screening (Zenner et al 2012). Providing gifts (in the form of treats, presents or activity vouchers for the mother, baby and family) to encourage women to engage with a peer supporter breastfeeding programme has had some success (Thomson et al 2012) and extra financial payments are made by the government to women in receipt of benefits who breastfeed in Quebec, Canada. Linking breastfeeding to monetary reward may increase the perceived value of breastfeeding and change individual and societal attitudes, particularly in areas of low breastfeeding. However, monetary financial incentives for health-related behaviour change (rather than in the form of gifts) can provoke strong public reactions and need to be tested, developed and implemented with care.

In order to optimise the practical acceptability of the scheme, key stakeholders (women and healthcare providers (HCPs)) were involved in the first development phase of the NOSH scheme. Financial incentives for breastfeeding were found in principle to be acceptable and might have the potential to change attitudes to breastfeeding although some reservations about the ethics of this type of intervention and the possibility of negative effects were also expressed (Whelan et al 2013). This paper reports additional findings from this development phase, which aimed to explore views and reach consensus about the key components of a financial incentive scheme (whether cash or vouchers, the amount and timing and method of verification).

**Methods**

Individual interviews and focus groups were held with women of childbearing age (n=17 interviews; n=21 in three focus groups) and HCPs with infant feeding roles (n=37 interviews; n=16 in five focus groups) (see Table 1 for participant characteristics). Participants were recruited from North Derbyshire and from Sheffield where Stage 3 UNICEF Baby Friendly Initiative status had recently been achieved. Women were recruited from children's centres, breastfeeding support groups, parent and toddler groups and community and hospital maternity services. Participants were selected using purposive sampling to obtain maximum variation in a range of infant feeding preferences and experiences, across different age groups and socio-demographic backgrounds. Healthcare providers included midwives, health visitors, breastfeeding peer support workers, general practitioners, nursery nurses, children's centre managers, charity and voluntary sector workers, public health leads and commissioners.

Interviews were analysed by thematic analysis, drawing on the principles of framework analysis (Ritchie and Lewis 2003). A thematic framework was identified a priori and further developed through coding of data and emergence of themes. As analysis progressed, rigour and trustworthiness was enhanced by discussion among authors about the developing themes.

**Ethics**

Ethical approval for the study was obtained from the School of Health and Related Research, University of Sheffield Research Ethics Committee (0591), by NHS Research and...
Development (SCH/12/078 and STH17193) and by the Sheffield Local Authority Research Governance Committee. Each participant gave signed consent immediately before the interview or focus group.

**Findings**

Findings are organised around themes that represent the different practical aspects of designing the incentive scheme.

**Form of the incentive provision**

Women preferred vouchers to money because in general they thought vouchers allowed for more control over how the incentive could be spent. A range of suggestions was made, such as vouchers for breastfeeding items, baby-and-mother products or vouchers for more generic items. Some women thought that vouchers for breastfeeding would be equitable with the Healthy start vouchers, which can be used to buy infant formula as well as fruit and vegetables. This would prevent them from ‘fiddling the system’.

Many HCPs expressed concern that if given as money, the incentive would be spent on ‘unhealthy’ products like cigarettes, drugs or alcohol, or would be used by other family members and not to the benefit of the woman. Vouchers were the preferred payment option as they were viewed as being safer and more likely to be spent on healthy items or products for the family. Some HCPs were cautious about making the type of voucher too restrictive (for example only for the baby or breastfeeding products) as this could be seen as making a value judgement. A preference was evident for more generic store vouchers or local shopping vouchers to allow greater choice for participants.

**Amount and timing of the incentives**

Women thought the incentive should be paid regularly (such as weekly or monthly) or that women should be given a choice about when they should receive the incentive. In contrast HCPs favoured payments coinciding with challenging times (such as growth spurts) with loading towards the start to recognise the initial effort made to establish breastfeeding.

All participants found the ‘How much?’ question difficult. They struggled to conceptualise an equivalent comparison. Some women used the amount given in previous government grant schemes as a benchmark, such as the Child Trust Fund (run between 2002 and 2010) where every baby born received at least £250 from the government. Others used the equivalent cost of formula over six months. Some HCPs felt a balance was needed between making the reward attractive but not so large that people might manipulate the system. After discussion, amounts in the region of £40-£50 per month were thought to be reasonable.

**Method of verification**

Incentives for other behaviours such as weight loss or smoking cessation can be verified by objective measures but breastfeeding relies on self-report of the mother. It was anticipated that this could be problematic so views about acceptable additional methods of verification were sought.

Women made suggestions for verification of a feed being observed by a HCP, taking a photo, asking women to express milk or requiring attendance at a breastfeeding support group. However overall women concluded that many of these options were unacceptable and would be difficult to ‘prove’ with certainty. They felt that verification should be based on honesty and trust.

Verification was an important issue for HCPs. As with women, they recognised the need to confirm breastfeeding but had concerns about how it would work in practice. In addition they worried about the need for them to ‘police’ the scheme. They had concerns about the implications for their professional integrity and relationship with the woman if they were asked to verify the woman’s statement that she was breastfeeding, but doubted her report.

Most felt that it was impractical or unethical to require a feed to be witnessed or even to require attendance at a breastfeeding support group. One HCP suggested that the onus should be on the woman to seek verification: she could sign a verification claim form to state she was breastfeeding and ask a HCP to co-sign the form. This suggestion was put to other HCPs in later interviews and it was generally agreed to be the most practical option.

**Other concerns**

Both women and HCPs acknowledged the importance of breastfeeding support. It was suggested that if additional women decided to try breastfeeding because of the incentives, then they needed to be given an appropriate level of support so they were not left frustrated and isolated.
The authors would like to thank the Medical Research Council for funding this research, via the National Prevention Research Initiative Phase 4 Awards

References


