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## Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England

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# Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England

## Full Report

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## Executive Summary

The Healthy Start scheme provides a nutritional safety net for pregnant mothers, new mothers and young children (under 4 years) living on low incomes across the UK and aims to improve access to a healthy diet for these vulnerable families. It does this by giving families food vouchers and access to Healthy Start-branded vitamins. Food vouchers can be used in neighbourhood shops to buy fresh cow's milk, infant formula milk, and plain fruit and vegetables (fresh or frozen). Each voucher is worth £3.10, and families receive two vouchers each week for babies less than 1 year old, and one voucher each week for pregnant women and 1-4 year olds. Vitamin coupons entitle families to free vitamins for children and new mothers, usually accessed from health or Children's Centres. A health professional (GP, midwife, health visitor, or other nurse) must sign application forms, confirming that applicants are pregnant or have young children and have received health advice. The Department of Health is legally responsible for the Healthy Start scheme in Great Britain, and it is the statutory responsibility of the local trust or board to make Healthy Start vitamins available.

This study was carried out in 13 Primary Care Trusts (PCTs) across all regions of England only. With a focus on understanding roll-out in disadvantaged communities, this study aims to understand the views and experiences of women, professionals and independent retailers on Healthy Start voucher and vitamin use. We interviewed 107 families living in a range of circumstances including current, past and non-beneficiaries. We spoke to 65 professionals who have day to day contact with Healthy Start families including health visitors, midwives and staff from Children's Centres. We also interviewed 20 staff in a range of different types of small retailers. Our findings are grouped into four areas: local management and coordination, the views of frontline professionals, the views and experiences of families, and the views of small and independent retailers.

### Local Management and Coordination

Most PCTs had someone acting as a Healthy Start Coordinator, and most had set up or tasked an existing group to oversee the implementation of Healthy Start. Professions represented in these groups included: Directors of Public Health, midwives, health visiting, Local Authorities (usually representatives of Children's Centres), Medicines Management, Dietetics and Nutrition. Communicating across organisational boundaries was problematic for Healthy Start Coordinators.

Local management seemed to work best when different groups of professionals were involved and where there was a group or an individual who could act as a champion for Healthy Start. The involvement of senior staff (such as midwifery leads) was found to be helpful because their agreement was needed to achieve changes in practice in their teams.

In all the research sites, local teams had focussed their energy on resolving problems with the distribution of Healthy Start vitamins to families. Four PCTs had also put in place schemes to increase provision of free vitamins (e.g. to all pregnant women). Despite these efforts, few women and children were taking Healthy Start vitamins and problems with access to vitamins remained.

Healthy Start Coordinators and local management teams knew little about the implementation of the food vouchers element of the scheme.

### The Views of Frontline Professionals

Frontline professionals associated with the implementation of the Healthy Start scheme were: **Midwives** who provided first contact with expectant mothers, signposted eligible women to the scheme, signed application forms, and in some cases handed out Healthy Start vitamins. **Health visitors** also promoted the scheme, ensured that eligible families were in receipt, and signed application forms. Occasionally they also handed out Healthy Start vitamins. **Nursery nurses** working as part of health visiting teams often replaced health visitors in child health clinics and could signpost the scheme, but were not able to sign applications. **Children's Centre Staff** had a variety of roles,

often in relation to vitamin distribution but in some sites promoting the scheme more widely. Respondents reported that **General Practitioners** were rarely involved at any level, despite their contact with eligible families.

The majority of midwives and health visitors reported that Healthy Start fitted with their remit to promote maternal and child health. They regularly encouraged application and countersigned forms. Additional strategies to encourage applications, for example including a Healthy Start tick box on records, and distribution of materials (application forms, leaflets, posters) to health and Children's Centres, were working well.

Professionals had good knowledge of the aims of the scheme, and viewed it as a financial and nutritional safety net; ensuring low income families always had access to healthy food.

While both midwives and health visitors offered nutrition advice as part of their usual role, most were not connecting this to the potential of Healthy Start vouchers to increase the amount of fruit and vegetables families buy. In most of the sites there were limited other nutrition services (such as cookery classes, or diet advice) available, and links were not made to the Healthy Start scheme.

Health professionals were pleased that the move from welfare foods to HS meant that breast-feeding mothers now receive the same level of financial support as bottle-feeding mothers, and believed this removed a disincentive to breastfeed.

There was some evidence that families who are disengaged from health services are brought to the attention of health teams when they seek out a counter-signature for Healthy Start applications.

Most frontline professionals said they would benefit from training or regular updates on Healthy Start, including: eligibility criteria, recommended vitamin intake for all groups, the benefits of the scheme to beneficiaries, local vitamin collection points and participating retailers. These latter two are available on the Healthy Start website, but the professionals we spoke to were not regularly using this resource.

## **The Views and Experiences of Parents**

Uptake of the Healthy Start scheme amongst eligible families was generally high (in our research sites an estimated 72- 86% of eligible families were signed up). Data provided by DH showed that estimated take-up rates tended to be lower in less-deprived PCTs; the five least deprived PCTs had take-up in the range of 72-77%, while the more deprived were in the range 78-86%..

Most families found accessing the Healthy Start scheme easy. We can't be certain which families are not signing up, but our research suggests some groups may find it more difficult: those with chaotic lives particularly with unplanned disruptions in housing; who speak English as a second language; and whose income fluctuates. Additionally, some parents (especially under 18s) did not understand the process for notifying Healthy Start after their baby's birth and dropped out of the scheme at this point. The diet of children in some of the most vulnerable families may not be protected.

The Healthy Start phone line, used for administrative contact with the scheme, worked well for most parents, but was reported to be expensive to call especially for families who only had mobile phones.

Most parents reported receiving minimal information from health professionals about how they could use their food vouchers to improve their family's health. Some parents found the Healthy Start website and leaflet information useful for recipes and nutritional advice.

Most families found using the Healthy Start food vouchers easy. Nearly all had good access to a choice of places to spend their vouchers, and were able to buy food their family needed and used. Most breastfeeding mothers were successfully using the scheme, although a very few breastfeeding mothers didn't claim vouchers because they didn't perceive a need.

The fixed value of vouchers created some annoyance for families. The unspent portion of the voucher is usually lost to parents, and many would like smaller denominations, but this was not a barrier to using the scheme.

Parents were seldom using Healthy Start vitamins. Where they wanted to, most had been hampered by lack of access. There was a greater perceived need for vitamins during pregnancy, and more women had tried to locate Healthy Start vitamins during pregnancy than afterwards. Parents expected the Healthy Start vitamins to be available in high street pharmacies, were confused about where vitamins could be accessed, and reported that health professionals were also unsure.

Parents valued the Healthy Start scheme highly. It made a significant contribution to their weekly shopping budget. Infant formula and fresh cow's milk were the most commonly bought items, but many parents also reported an increase in the purchase of fruit and vegetables. Only a few parents perceived that taking part in the scheme had considerably improved their diet, but more parents said that it had broadened food experiences for their children.

Some parents felt they received good advice about diet and nutrition, but many parents were not in receipt of health and nutrition advice from a health professional or any other source.

### **The Views of Small and Independent Retailers Using Healthy Start**

Most areas had a large number of registered retailers of different sizes, confirming parents' reports that most were able to reach a registered retailer. Small retailers found the scheme easy to use.

Many small retailers viewed their registration with the scheme as a way to serve their community. The financial contribution to their turnover was small, but their local families needed the scheme. Small retailers were largely providing fresh milk in exchange for vouchers, probably because they were often more expensive than supermarkets for infant formula and fresh fruit and vegetables. We found no solid evidence of widespread fraudulent use of vouchers (for example all vouchers used for adult items), but some evidence of minor inappropriate use where unspent proportions of vouchers are sometimes put toward non-eligible products they perceived as healthy items for children.

### **Implications and Recommendations**

Local management teams in England have concentrated on arrangements for Healthy Start Vitamins to be available to families, but not enough families are accessing these vitamins. Families themselves felt the best solution would be to be able to collect vitamins from supermarkets and high street pharmacies. Resolving these challenges will probably need national action supported by good promotion by frontline staff, and would likely have budget implications.

Vitamins should be promoted consistently by frontline staff and at the earliest possible contact with families. Universal vitamin provision for pregnant women was implemented in some case by requiring midwives to offer vitamins directly to women at the first booking appointment. Expansion of this approach may help ensure that families are able to access vitamins from the earliest possible opportunity in pregnancy. Existing pilots of universal vitamin provision for pregnant women should be evaluated for their potential to increase take-up of vitamins in the short and longer term.

Strategies are needed to ensure that those who struggle to access the scheme are known about, and supported to apply.

The place of Healthy Start in relation to Universal Credit is not yet certain, but its particular value as a nutritional safety net available to the most vulnerable families should be considered in any changes. Furthermore, our findings would suggest that the place of Healthy Start as a public health intervention should be maintained and strengthened, and any changes should take account of this.

Good local management of Healthy Start should involve promoting take-up, and maximising the health benefits of the scheme. The devolution of health commissioning, and the movement of public

health to local authorities may create new opportunities for groups who could take responsibility for Healthy Start, but it is not yet clear what these might be nor how they will operate where funds are centrally dispersed. Learning from mechanisms already employed to improve vitamin availability, a successful team is likely to: be accountable for delivering against success criteria; be able to monitor local take-up, use and impact of the scheme; and to include or engage representatives of Public Health, health visiting, midwifery teams, and Children's Centre management. GPs may be an as yet seldom used addition to this professional group.

Frontline staff are successfully signing up families to the scheme, but they should strengthen links between the support and advice they provide on health and nutrition and Healthy Start.

The existing Healthy Start datasets hold data about families and retailer use that could provide data to assist with local planning and management, such as identifying locales with high or low use.

# 1. Introduction: Purpose and Scope of the Research

## 1.1 Policy Context for Healthy Start

The Healthy Start (HS) Scheme provides vouchers which can be exchanged for infant formula, liquid cow's milk, and fresh or frozen fruit and vegetables to low-income families which include a pregnant woman or children under the age of four years. HS-branded vitamins are also available free of charge to those within the scheme. The Department of Health is legally responsible for the Healthy Start scheme in Great Britain, but it is the statutory responsibility of the local trust or board to make Healthy Start vitamins available. The scheme is accessed via an application form that must be countersigned by a health professional (nurse, midwife, health visitor or doctor) who should also ensure that applicants are offered advice and information on healthy eating and breastfeeding<sup>1</sup>. The scheme is targeted towards families in receipt of Income Support, Income-based Jobseeker's Allowance, Income-related Employment and Support Allowance or Child Tax Credit and an annual family income of £16,190 or less (but those receiving Working Tax Credit, except during the Working Tax Credit run-on period only, are not eligible)<sup>a</sup>. Women under the age of 18 qualify during pregnancy regardless of income or benefit status. Food vouchers have a fixed value (£3.10 at the time of writing) and eligible families receive one voucher per week for each pregnant woman or child aged between 12 and 48 months, and two vouchers per week for families with babies under the age of 12 months. These food vouchers are sent directly to beneficiary families by post every four weeks and can be used at participating retailers. Beneficiaries also receive coupons which can be exchanged for HS vitamins for expectant or nursing mothers and children over 6 months old. HS vitamin coupons are sent to women during pregnancy and until their child is 1 year old, and for children from birth (although parents are advised not to use them for infants less than 6 months old unless recommended to do so by health professionals). HS tablets for women provide a daily dose of 70 milligrams of vitamin C, 10 micrograms of vitamin D and 400 micrograms of folic acid. HS vitamin drops for children provide a daily dose of 233 micrograms of vitamin A, 20 milligrams of vitamin C, and 7.5 micrograms of vitamin D3. The vitamin coupons are sent every other month and can be exchanged at local collection points, usually a health or Children's Centre. Ongoing nutrition and health information relevant to the age of the oldest eligible child is sent out with the vouchers and coupons.

The HS scheme replaced the Welfare Food Scheme (WFS) which provided free milk or infant formula to pregnant women and young children living on a low-income<sup>1</sup>. It was rolled out across the UK from November 2006 following its introduction in Devon and Cornwall in November 2005. The new scheme responded to evidence that WFS provided little incentive to breastfeed, and that providing a choice of food items other than milk would improve the scheme at no additional cost<sup>2,3</sup>. Although there was concern that the new requirement to register with a health professional to access the scheme might act as a disincentive and further alienate some low-income families<sup>4</sup>, the scheme aimed to emphasise early contact with a health professional as an opportunity to signpost families to other health advice.

HS has been linked to a wider range of initiatives aimed at reducing health inequalities amongst children in the UK. Improving diet and increasing benefits to pregnant women and families with young children is identified as a key route to tackling inequalities in health<sup>5</sup>. Sure Start Children's Centres remain key providers of services to improve health<sup>6</sup>. The 3600 Children's Centres in England<sup>7</sup> provide childcare, family support services, child and family health services, links with Jobcentre plus, and access to wider services. One role of these Centres is to encourage healthy eating patterns and equip parents and carers with information needed to give children the healthiest possible start<sup>8</sup>.

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<sup>a</sup> For full details, see DH (2010a). Delivering a Healthy Start for pregnant women, new mums, babies and young children: A guide for health professionals.

The future of HS is also affected by two other important policy initiatives: the move to Universal Credit and reform of the NHS. Universal Credit will replace a number of in and out of work benefits (Income Support, income-based Jobseeker's Allowance, income-related Employment and Support Allowance, Housing Benefit, Child Tax Credit and Working Tax Credit) with a single payment. It is calculated to take account of income and family circumstances, and has a single taper for withdrawal of benefit as income rises<sup>9</sup>. The impact of Universal Credit on the operation of Healthy Start is not yet determined<sup>10</sup> but planned changes to eligibility thresholds and the link with other benefits are part of the future of HS. At an organisational level, HS will also be affected by past and future changes to the NHS<sup>11 12</sup>. These reforms provide a backdrop of change for the frontline health professionals involved in the delivery of the HS scheme including changes to the way community services are provided, the new and evolving role of GP commissioning groups and the new role for local authorities in public health commissioning.

## 1.2 Nutrition and Health in the Early Years

Public health in England falls under the Healthy Lives, Healthy People Strategy<sup>13</sup>. "Starting well" by promoting the health and wellbeing of women before, during and after pregnancy, alongside "living well" and promoting improvements in diet and nutrition for children and adults are key components of this strategy. Additionally, it makes explicit links with Change4Life, a public health programme tackling obesity, including plans to link with retailers to provide vouchers to support healthy choices and increase access to healthy foods<sup>13</sup>. The Healthy Child Programme (pregnancy and the first five years of life) aims to increase the proportion of mothers who breastfeed for six months or longer, with a focus on vulnerable children and families<sup>14</sup>. Interventions in pregnancy and those that improve access to good nutrition, are identified as key to a strategy to reduce health inequalities and improve the health of the nation<sup>15</sup>.

Nutritional insufficiencies during pregnancy are known to be associated with birth defects and diet-related disease patterns in later life<sup>16</sup>. Mothers from the lowest income households are also less likely to breastfeed their babies, losing the attendant benefits for the child in infections and long term health<sup>17</sup>. Research suggests that both nutrient intake and eating patterns affect children's behaviour<sup>18</sup>. The early years (from conception to age five) constitute a key developmental period characterised by critical periods during which fundamental developmental change takes place<sup>19</sup>. Disadvantage during this period has particular importance. During pregnancy maternal poverty predicts low birth weight, preterm birth, infant mortality and the likelihood of a range of serious health conditions in their babies<sup>15</sup>. Food insecurity probably contributes to these effects; the UK Families and Children Study shows that 35% of families in the lowest income quintile report being unable to afford at least one food or meal item per week<sup>20</sup> and single adult households with children are particularly at risk<sup>21</sup>. Disadvantage is concentrated among particular groups of people, in the UK in the period 2001-2004 16% of families with a child aged under 4 were living in persistent poverty<sup>22</sup>. While awareness of healthy eating is high<sup>21 23-25</sup>, it is difficult to change food consumption patterns<sup>26</sup>. The evidence base for healthy eating behavioural change interventions lacks data from the UK regarding pregnant women<sup>16</sup>, and in studies which have the potential to decrease inequalities<sup>27</sup>. Healthy Start could instigate behavioural change in the most disadvantaged groups and decrease these inequalities.

Poor diet also contributes to obesity. Current figures suggest 16% of boys and 15% of girls in England aged 2-15 are obese<sup>28</sup>. The health consequences of childhood obesity are severe and occur across pulmonary, psychosocial, neurological, endocrine, cardiovascular, gastrointestinal, renal and musculoskeletal systems<sup>29</sup>. Genetic causes probably play some part in childhood obesity, but poor diet is identified as playing a major causal role through prenatal and early life nutrition<sup>29</sup>. Children from disadvantaged backgrounds are known to be more likely to be exposed to all of these obesogenic factors and, indeed, rates of obesity are higher in the lowest income quintiles and in Spearhead Primary Care Trusts (the 70 Trusts with the worst health and deprivation indicators in England)<sup>28</sup>. Research with low income mothers suggests that mothers of young children don't interpret overweight to be a simple function of overeating<sup>30</sup>.

Diet itself is socially patterned<sup>17</sup>. Families with children and households with lower incomes spend a greater proportion of their income on food than the better off<sup>31 32</sup>, but consume less fresh fruit and vegetables, skimmed milk, fish, fruit juices and breakfast cereals than average<sup>21 31</sup>. The diets of young British children have been shown to be low in fruit and vegetables, low intakes of some vitamins and minerals, and to include too many soft drinks (such as fruit squash)<sup>33</sup>. A review of 98 studies of fruit and vegetable consumption in 6-18 year olds consistently found an association between lower socioeconomic status and lower intake of fruit and vegetables<sup>34</sup>. The UK's low income diet and nutrition survey (LIDNS)<sup>35</sup> confirms that low income adults and children were consuming well below the recommended 5 portions-a-day (adult men 2.4 portions a day; adult women 2.5, boys 1.6 and girls 2).

Currently NICE guidelines state that all women who are or plan to become pregnant take folic acid, and consideration should be given to Vitamin D supplements during pregnancy and breastfeeding<sup>16</sup>. In 2010 69% of women in England took folic acid during early pregnancy, 6% taking supplements which included Vitamin D, and 64% take some kind of supplement (including iron)<sup>36</sup>. However, these high rates are not sustained after birth with just 23% of mothers and 7% of babies taking supplements at 8-10 months<sup>17</sup>. Current UK government recommendations are that babies children over 6 months of age should be given supplements containing vitamins A, C and D (unless they are being fed more than 500ml a day of formula milk which will already be fortified with these)<sup>37-39</sup>. However, only 15% of 8-10 month old babies in England are currently given vitamin drops, and this figure was lower among those who had bottle fed and among white british families<sup>36</sup>.

### 1.3 Impact of Other Food Voucher Schemes in High Income Countries

Healthy Start forms part of a tradition of providing benefits in-kind rather than in cash. Benefits in-kind are preferred, particularly for children, because they allow policy makers greater control over resources<sup>43</sup> and it has been argued that in-kind transfers are more likely to benefit children<sup>44</sup>. However, a search of the international literature and contact with experts in the field has established just three programmes with a similar structure to HS; namely the provision of vouchers to low income families with children which can be exchanged for healthy foods. The best known of these is the Special Supplemental Program for Women, Infants, and Children (WIC) in the USA<sup>45</sup>. In Wales, there has been a trial of provision of vouchers to pregnant women exchangeable for fruit juice<sup>47</sup>, and in Australia a pilot programme giving fruit and vegetable vouchers to new mothers from indigenous groups<sup>48</sup>.

The WIC scheme is a longstanding US federal scheme to support pregnant, postpartum and breastfeeding women, infants, and children up to age 5 living on a low income and judged to be at "nutritional risk" by a health professional. WIC vouchers can be used in exchange for a far wider range of healthy foods than HS vouchers (infant cereal, iron-fortified adult cereal, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, peanut butter, dried and canned beans/peas, canned fish, and more recently soy-based beverages, tofu, fruits and vegetables, baby foods, whole-wheat bread, and other whole-grain options along with iron-fortified infant formula for women who do not fully breastfeed)<sup>49</sup>. Numerous studies have reported on outcomes for those participating in the WIC scheme, and it has been shown to have a positive effect on birth outcomes<sup>50</sup>, birth weight<sup>51 52</sup>, breastfeeding and attendance at well-baby checks<sup>50</sup>. It may have particularly positive effects among some groups; vouchers for baby milk have also increased appointment keeping among US low-income teenage mothers<sup>53</sup>, and better maternal and infant health outcomes have been observed for homeless and African American women<sup>54 55</sup>. The recent addition of fruit and vegetables has resulted in increased consumption and access to fruit and vegetables among recipients<sup>56 57</sup>.

Since 1992, in some areas WIC vouchers can be used in farmers markets to buy locally grown fruit and vegetables<sup>49 58</sup>. These have also been shown to have positive impacts on purchasing of fruit and vegetables, with early data suggesting that these vouchers are used to buy fruit and vegetables<sup>59-61</sup>. A further pilot programme (Health Incentives Pilot) provides a financial incentive for vouchers spent on the purchase of fruit and vegetables (30c for every dollar spent). This pilot began in late 2011 and will

report in late 2013<sup>62 63</sup>. In preparation for this pilot, a US Government review of incentives to improve diet concluded that short-term positive effects had been achieved by use of targeted financial incentives and may be more effective than unrestricted cash or food benefits, but that little is known about long term change nor about different approaches to improving access<sup>64</sup>.

Studies of WIC have also highlighted potential problems with the scheme, which may be useful to consider in the context of HS. Some have highlighted procedural barriers to collecting WIC vouchers<sup>65</sup>. An electronic system (changing from paper vouchers to debit cards) may have had a negative impact on healthy foods available through the scheme because it excludes small stores and markets<sup>66 67</sup>. Electronic systems are perceived to benefit programme integrity and ease for voucher users, but drawbacks include the cost and complexity of administration and increased risk of fraud<sup>64</sup>.

In Wales a randomised controlled trial was conducted<sup>47</sup> in a deprived area, comparing pregnant women receiving a voucher for 100% orange juice, exchangeable through a local milk delivery firm, equivalent to 2 litres per week for ~30 weeks (n=63); women receiving enhanced nutrition advice from midwives about the benefits of eating fruit and suggesting cheap ways to increase intake of fruit and fruit juice (n=63); and women assigned to usual care (n=64). Diet was assessed at 16 weeks (baseline), 20 weeks and 32 weeks of pregnancy, and blood samples were taken at baseline and 32 weeks of pregnancy and tested for  $\beta$ -carotene concentrations. Modest, but important, changes were achieved in this short time. Although all groups decreased fruit consumption over the period of the trial, this was not statistically significant in the voucher group, and was accompanied by a significant increase in consumption of fruit juice by those in the voucher group and a significant increase in serum  $\beta$ -carotene (from 106.2 to 141.8mmol).

The Australian pilot has not been subject to a formal evaluation of impact. Under this scheme, pregnant indigenous women (Aborigines and Torres Strait Islanders) living in a remote area are provided with health education materials, three baby baskets (containing items such as nappies, soap, sanitary pads, baby clothes and folate supplements), and, at each of five ante-natal appointments, vouchers worth \$40 (approx £25) exchangeable locally for fruit and vegetables<sup>48</sup>. The aim of the scheme is to improve maternal and child health outcomes in a very deprived community. The scheme has covered approximately 150 births per year since late 2008<sup>68 69</sup>. It has been evaluated using feedback forms included with the baskets which will, in future, ask about food voucher use and breastfeeding practice. To date, 40% of evaluations forms have been returned and almost all of the women responding report they found the basket useful. In addition, first antenatal contacts have moved from 15 to 10 weeks gestation since the implementation of the baby baskets<sup>48</sup>.

#### **1.4 Previous Evaluations of Healthy Start**

The introduction of the Healthy Start scheme in Devon and Cornwall (in 2005) prior to national rollout provided an opportunity to conduct an early evaluation<sup>40</sup>, with the aim of informing the national roll-out of the scheme. The study included qualitative interviews with key stakeholders (service managers, health professionals, beneficiaries, retailers etc.) in five case study areas, and two small surveys of beneficiaries (N=38) and retailers (N=20). Although some aspects of HS were modified before national roll-out, some of the findings remain of relevance to beneficiaries and health professionals. Beneficiaries in the study reported that in general, communication about the scheme from health professionals and benefits officers was good, although the authors acknowledge that their sample did not include 'hard to reach' groups. Over half of their sample of beneficiaries reported buying more fruit and vegetables since receiving the HS vouchers. Some problems spending vouchers were reported including check-out staff not recognising the vouchers, and some embarrassment if staff checked purchases against voucher value. The study found that most health professionals were aware of the scheme, although there was confusion over eligibility in some areas. The healthy eating messages provided by health professionals were not always considered significantly different to that provided prior to the scheme, and links to wider public health initiatives in the PCT (for example on obesity, health inequalities, nutrition, physical activity) were often poor. The authors noted an absence of leadership or a coherent strategy for HS in the areas visited, recommended that links between HS



and wider health policy objectives were made more explicit, and that joined-up working between services at the local level be encouraged.

In Sheffield, an independent group of academics have conducted a 'before and after' Healthy Start comparison of the nutritional intake of pregnant and postpartum white women<sup>41 42</sup>. The study compared 163 women benefiting or eligible for the Welfare Food Scheme (in 2006) with 149 benefiting or eligible for HS (in 2007). Participants' dietary intake was estimated using a Food Frequency Questionnaire (FFQ) that recorded frequency of consumption of a range of foods including meat, poultry, fish, fruit and vegetables, bread, alcohol and milk. The results indicate that both pregnant and postpartum women in the HS group had significantly higher energy and nutrient intakes than pregnant and postpartum WFS beneficiaries. The difference was significant for energy intake, calcium (due to increased consumption of milk, milk-based drinks and breakfast cereals), folate (fruit and vegetables, fruit juice and breakfast cereals), iron (meat, fish, poultry and breakfast cereals) and vitamin C (fruit, vegetables and fruit juice). Pregnant women in the HS group consumed significantly more portions of fruit and vegetables per day (3.3 portions per day compared with 2.5 in the WFS group). A similar result was found for postpartum women (3.3 portions per day compared with 2.7 for the WFS group). The authors report that the main effect appeared to be that women in the HS group were simply eating more of all food types (including less healthy foods)<sup>41 42</sup>.

## **1.5 Background and Purpose of this Research**

### 1.5.1 Commissioning Background

The Department of Health commissioned a scoping study of Healthy Start that included in its remit the identification of criteria for evaluating success<sup>26</sup>. The study considered health and social outcomes relating to effectiveness, as well as process outcomes to monitor delivery of the scheme. A list of priority outcomes was developed that were considered 'plausible'; that is, could plausibly be changed by the intervention. In making this judgement Dyson and colleagues considered outcomes that could be influenced by a) HS compared to the absence of any intervention; b) HS compared with the Welfare Food Scheme; and c) any local best practice intended to support HS (for example, nutrition education and support). The result was a list of outcomes relating to programme effectiveness, impact on the target population, change in health service activity and the impact on the health and commercial sectors.

Outcomes to measure effectiveness included dietary intake, food purchasing behaviour, nutrition, health and education status, and infant feeding behaviour (in particular, breastfeeding and introduction and type of weaning foods). Outcomes to measure the impact on the target population included the use of foods purchased using HS vouchers, the acceptability of the programme to beneficiaries, recruitment, level of take-up by eligible families, and ease of use of the vouchers. Health service outcomes included timing of first contact with maternity services, the ability of health professionals to identify and refer eligible recipients, and the impact on their workload. Finally, the study identified plausible outcomes for the health and commercial sectors including cost effectiveness when compared to the Welfare Food Scheme and changes in retailer behaviour relating to the supply of fresh fruit and vegetable<sup>26</sup>.

The scoping study recommended that the Department give 'serious consideration' to determining which of these outcomes should be used to evaluate HS before commissioning any such evaluation. The Equality Impact Assessment of HS issued by the Department of Health<sup>1</sup>, states the main aim of the scheme is to use existing limited resources more effectively to ensure that children in poverty have access to a healthy diet and to give increased support for parenting and breastfeeding. The Department's success criteria for the intervention, outlined in the 2010 Equality Impact Assessment, are that:

- estimated take-up of the scheme is 80% or more
- 90% of all HS vouchers issued are used by beneficiaries and returned by retailers

- women and families supported by HS understand that milk, fruit and vegetables make an important contribution to a healthy diet
- all women and families supported by HS are aware that they can claim free vitamin supplements through the scheme
- 50% or more of eligible children and 50% or more of women entitled to the vitamin supplements regularly claim them
- all frontline NHS staff working with pregnant women and young children are aware of HS and know the local arrangements for supplying the free vitamin supplements
- all health professionals signing HS application forms are giving appropriate advice on breastfeeding and healthy eating when doing so, or ensuring that this information is offered by another appropriate person - such as an infant feeding advisor or health care assistant
- 85% of midwives and health visitors are aware of the importance of the application signing process as an opportunity to signpost other services and make positive contact with vulnerable families
- Retailer participation levels continue at around 30,000+ outlets across the UK, with all geographical areas having an appropriate level of coverage of outlets taking into account demographic and geographical considerations

These assess process outcomes; take-up of vouchers and vitamins by eligible families and the behaviour of health professionals and retailers in promoting the scheme. Measures of programme *effectiveness*, notably impacts on beneficiaries including dietary intake (energy, vitamins and minerals), health outcomes for both mother and child in pregnancy and birth, infant feeding, including breastfeeding and weaning, are outside their scope. One of the difficulties of evaluating the impact of schemes such as HS is distinguishing the benefits to children from the benefits derived to the whole family<sup>70 71</sup>. Even where spending can be shown to go on goods for adults, this may offset rather than replace spending on children<sup>71</sup>. While policies aimed at parents will impact on their children, child impacts are often unevaluated<sup>72</sup>. Moreover, such evaluations often focus on mothers only. The context for children's development is not confined to their interactions with their mother but encompasses all immediate family members, their community and broader society<sup>73</sup>. Considering this background, the UK Department of Health commissioned a process evaluation of HS, which this report describes.

### 1.5.2 Purpose of this Research

This research was commissioned by the UK Department of Health to gain a real life view of the operation of the HS scheme within disadvantaged communities. The purpose was to suggest operational improvements, provide contextual information which may be used to interpret existing data sets, and explore the feasibility of a future evaluation of the economic or health impacts of the HS scheme. With a focus on understanding roll-out in disadvantaged communities, this study aims to understand the views and experiences of women, professionals and independent retailers on Healthy Start voucher and vitamin use. In particular, we set out to explore:

- Perceived successes and failures of the HS application system
- HS food voucher use, including misuse
- Perceived impact of fixed value vouchers, in particular on purchasing of fixed volume items such as formula
- Reasons for low take-up of HS vitamins
- Implications of mediation of the scheme through health professionals for parents and all professional groups
- Local implementation, adaptations and responses to the scheme
- The decisions of HS families about child and infant feeding, and the place of HS vouchers in these decisions
- The possibilities for future research regarding family food behaviours (purchasing or consumption)

In 2010 around half a million women across the UK were supported by Healthy Start<sup>74</sup>, and around one in four children under five lived in an eligible family, so the potential reach of this policy initiative is

wide. Research understanding the take-up and use of the Healthy Start scheme will assist policy makers to identify successful elements of this programme, and to understand which groups of mothers are not accessing this scheme and why.

We were also asked to consider the potential of new, innovative methods of recording family food purchasing and consumption habits to inform any future impact evaluation (including economic impact) of the scheme. These are discussed in Appendix 4.

### 1.5.3 Scope of Research

This research examines the experiences of those using the HS Scheme in England. Its focus is primarily on qualitative data collected from parents, professionals and independent retailers about their interactions with the HS scheme. Thirteen Primary Care Trusts (PCTs) were purposively sampled to achieve a range of geographical and socio-economic contexts across England, including at least one PCT from each Strategic Health Authority (see Appendix 1). In each area the HS coordinator and up to six health professionals and 17 parents were interviewed. Twenty small retailers from across the 13 areas were also interviewed. These interviews are supplemented with descriptive data derived from data routinely collected as part of the HS scheme. Taken together, these data cannot assess the impact of the scheme on families because there is no non-HS comparison data; instead the research intends to explore a range of points of views (including those of minority groups) with the purpose of describing the breadth of experience within the scheme. They provide a holistic view of local implementation and processes alongside the views and experiences of scheme users. Brief methodological details are provided in the opening to each chapter, supplemented by a full description of method and sample in Appendix 1.

The study was submitted to the Social Care Institute for Excellence (SCIE) Social Care research Ethics Committee and received a favourable review in January 2011 (REC number 10/IEC08/360). Fieldwork was undertaken between May 2011 and February 2012.

## 2. Results: Management Overview of Healthy Start

### 2.1 Key Findings

- In England, local management of Healthy Start through named HS Coordinators and Steering groups was varied. Some areas had coordinators in name only because of a lack of staff or funding.
- Effective management involved a number of key groups (particularly midwifery and health visiting teams) along with a 'champion' for HS.
- Communicating across organisational boundaries was problematic for HS coordinators. This was due to reorganisation of local trusts and to working across trusts where health visitors and midwives were located in separate trusts.
- There were concerns among some coordinators that the public health messages of HS were undermined by 1) moving vitamin distribution to Children's Centres and 2) overstretched midwifery and health visiting teams struggling to take on additional roles.
- HS vitamin take-up remains low across all sites. One key factor is ensuring a reliable local supply and distribution mechanism, and all HS coordinators had focussed all management efforts on resolving problems with vitamin distribution and increasing vitamin take-up. Four PCTs have also put in place schemes to increase provision of free vitamins (e.g. to all pregnant women).
- HS Coordinators had good knowledge about local vitamin take-up rates, and awareness of low take-up of vitamins drove local management to a great extent.
- Most HS coordinators reported poor or no data on take-up rates of the scheme as whole, that is including food vouchers, or on the demographics of non-applicants (which would facilitate targeted promotion of the scheme).

### 2.2 Background, Methods and Sample

We were interested in how HS was managed at the local level, and the challenges and successes that local coordinators had experienced in making HS 'work' in their area. In this section we report themes that relate to how the scheme is managed at each site. This includes how the scheme is organised at a strategic level, what professional groups and agencies are involved, the arrangements for the distribution of vitamins, how the scheme is monitored and the engagement of professionals at an operational level.

The Department of Health provided the research team with the named contact for HS in each of the 13 PCTs. We approached these contacts by email and telephone with information about the study and a request to interview. In all sites we identified and interviewed the local lead for HS implementation with a final sample of 15 HS coordinators (further details are provided in Appendix 1). Although they seldom used the name HS coordinator we use this terminology throughout this report.

### 2.3 Findings

#### 2.3.1 Healthy Start Coordinators

The coordination of HS varied across sites. However at most sites an individual professional had been given responsibility for leading or coordinating local implementation. These individuals usually had a background in nursing, public health or nutrition. Examples of roles and job descriptions for HS coordinators across the sites include: professional lead for public health nursing; Early Years Eating

manager; breast feeding specialist; integrated service manager; and Head of the Improving Health Partnership.

Although we were able to identify a HS coordinating role, it was apparent that some sites had only recently appointed a named coordinator, and in one the coordinator had only recently volunteered to 'plug the gap' when the last coordinator left. Additionally at one site we learnt that while there were named staff listed as Department of Health contacts for the scheme, in reality no one was overseeing or indeed promoting HS because there was no funding to support the role. The scheme relied on individual professionals leading different elements of work.

### 2.3.2 Steering Groups

No consistent pattern emerged with regards to how HS was managed across the sites. Several sites had established a specific steering group to manage implementation. However, these groups appeared to have been set up to oversee the introduction of HS vitamins rather than the wider aims of the HS scheme. Additionally several sites had established steering groups to oversee local pilots of universal provision of HS vitamins. Steering groups were normally chaired by the HS coordinators and usually met on a quarterly basis.

Occasionally steering groups had been formed to discuss and resolve specific problems. For example at one site the Director of Public Health set up a steering group when the monitoring information provided by the Department of Health revealed that vitamin take-up was low. Similarly falling take-up rates were the impetus for the relaunch of a steering group at another site after it had fallen into abeyance.

At several sites we were told that managerial overview of HS had been subsumed within existing organisational groups, once again these groups had a nutrition or vitamin focus. For example at one site the 'Vitamin Management group' oversaw HS, at another responsibility sat within the Infant Feeding Partnership, while at another the Maternal and Infant Nutrition group had delegated the HS portfolio to a sub-group that managed breast feeding and infant feeding.

Occasionally participants were not clear whether or not there was a local steering group. At one site the HS coordinator told us there was no steering group whilst other respondents told us the scheme was overseen by the Maternity Women's Information Group. Respondents at five sites reported that no steering group or sub group had been established to oversee HS.

#### *Steering Groups: Representation and Focus*

Most steering groups or sub groups were intended to have a multidisciplinary membership. Sometimes membership was drawn only from health professions, for example one steering group included community midwifery leads with additional involvement from the breastfeeding support manager and a consultant in child public health. At others the membership was broader, for example one steering group was attended by the professional leads for midwifery, health visiting, an obesity specialist and the local Children's Centre lead. Significantly a representative of medicine's management was also a member of the group; interviewees suggested this was because that department were paying for the vitamins. Occasionally steering groups were attended by senior staff such as the Director of Public Health but usually we were told that the HS coordinator reported back to the executive level.

Representatives from the local authority or local Children's Centres were members of steering groups at several sites. Often their involvement was integral to the local strategy for distribution of HS vitamins. The HS steering group at one site, for example, was established as a sub group of the Maternal and Infant Nutrition group and was attended by dieticians, midwives, health visitors and a representative of the local authority. Like most steering groups the focus of work had been on vitamins, in particularly setting up the logistical processes to distribute vitamins, including establishing invoicing and distribution processes. The involvement of the local authority had been central to this

process as their agreement was needed in order for vitamins to be distributed through local Children's Centres.

The involvement of midwives was integral to the strategic management and operation of the HS programme at most sites. However the engagement of local midwives was sometimes problematic. Where this had been a problem various strategies had been adopted to ensure their engagement. For example the involvement of a senior midwife had helped mobilise the participation of operational staff at several sites. At another the coordinator told us that the previous lead for the midwifery service had blocked the involvement of the service in HS, but her replacement supported the development of better links between the midwifery service and the programme and it was hoped that this would improve engagement.

### 2.3.3 Management Effectiveness

Some interviewees reflected on the effectiveness of the local management of HS, particularly the role of the steering group/ sub group. Whilst many sites had experienced initial difficulties implementing HS vitamins, usually to do with the logistics of ordering, distributing and invoicing the vitamins, these difficulties were reported to have been resolved through the steering group. At one site we were told that it was only when the monitoring data revealed that take-up of vitamins was poor and the director of public health had set up a steering group that they were able to resolve these issues. Importantly having senior people involved in the group meant that they could 'get things done'. The steering group provided a forum for discussion and was able to galvanise momentum behind the scheme which was necessary because:

*... even though we are all NHS employees, things, just don't click into place .... this is a long term complex piece of work that needs us to make those new connections.*

HS coordinator, Site 3

Similar views were expressed at two other sites.

Coordinators also reported the importance of involving staff at an operational level as advocates for the scheme. For example one site had identified HS local champions within the health visiting team who promoted the programme to colleagues. Similar strategies were being considered at other sites in an effort to raise awareness of the programme.

In some sites where a steering group had not been established interviewees bemoaned a lack of managerial support, suggesting that a steering group might have helped raise awareness of the scheme at a senior level, which in turn might have influenced practice at an operational level. At one site a participant reflected

*Perhaps it would have been better to have a local steering group that looks at and monitors uptake, fallen down on the job with that.*

HS coordinator, Site 11

In one site where no steering group had been set up, participants reported that having key people take a lead on specific issues was the only way that anything relating to HS was accomplished. For example the involvement of a member of the public health team had been key to establishing a one year pilot of universal distribution of HS vitamins in pregnancy:

*I don't think this programme would really be in existence without her pushing to get this funded. She's been really amazing and raising the flag on saying we need something because none of these women can get these vitamins.*

Dietician, Site 8

### 2.3.4 The Focus of Healthy Start Management

An interesting feature of the programme at all sites was the attention paid to vitamins, almost to the exclusion of the wider aims of the HS programme. Activity focused almost entirely on setting up a distribution process for the vitamins as well as on establishing a data collection system. Participants found the work of designing, setting up, and troubleshooting these systems was demanding. A participant at one site remarked:

*The Healthy Start vitamins have been stupidly complicated; a labyrinthine scheme.* HS Coordinator  
Site 8

She went on to comment on the difficulty of administering a scheme where only some people were eligible, where only NHS sites can order vitamins which means that Children's Centres can't be self sufficient, where coordination must be absorbed into existing staff tasks, and where she had no budget to order a supply of vitamins (albeit this would be reimbursed).

The focus on vitamins could not be explained by whether or not there was a steering group or an active lead coordinator. Nor could it be explained by where the steering group was located in the organisation or the professional background of the coordinator. No participants mentioned the duty on PCTs to provide Healthy Start vitamins, although this may have been implicit. Occasionally participants reported that their work had had a broader focus, for example one steering group, which initially had focused exclusively on vitamins, had, over time, begun promoting the wider healthy eating message of HS through events such as a picnic in a local park organised as part of world breast feeding week.

### 2.3.5 Monitoring Take Up

In order to understand more about how decisions effecting the operation of HS were made at strategic managerial level coordinators were asked how they monitored the take-up of the HS scheme in their areas. Most responded that they monitored use of HS vitamins closely and in detail, but not take-up of the scheme as a whole (ie proportion of those eligible who had applied and were in receipt), or use of the food vouchers by entitled families.

Coordinators in seven of thirteen sites were aware of getting quarterly data on the percentage of eligible families signed up to the HS scheme. Some received this from the Department for Health, others thought it came from their Strategic Health Authority. Of those who knew take-up rates, most were relaxed that these were reasonably high. Two coordinators had seen a league table of take-up rates for trusts in their SHA; in another site the coordinator mentioned this might be useful but had never seen it. Two coordinators had requested additional data from the Department of Health on eligible families in their area and had received it but did not get this information routinely. Many coordinators felt that more information would be useful, including on entitled families *not* signed up to the scheme allowing efforts to be targeted towards them. Two coordinators mentioned they would like to see more data on beneficiaries' views of the scheme and its impact on them.

All coordinators were aware of the top-line take-up figures for HS vitamins. Eight had implemented local monitoring systems for the distribution of vitamins, most often by asking Children's Centres to keep records but in some cases midwifery and health visiting teams were also involved. There were two drivers for monitoring vitamin take-up so closely: the need to request reimbursement from the Department for Health for vitamins distributed, and an awareness that vitamin take-up was very low, often less than 10% of eligible beneficiaries. The focus on monitoring vitamin take-up may also have been driven by the fact that this data was owned locally; distribution was locally controlled and monitored and local responses were possible where vitamin distribution was especially low. Access to and control over this data, compared to far less data on take-up of the entire scheme and use of food vouchers appeared to encourage coordinators and local steering groups to concentrate almost exclusively on HS vitamins.

*I am led a little bit by the data, and what we report on.*

*HS Coordinator, Site 1*

*There has been some discussion about the vouchers but the focus is on the vitamins. The wider scheme, there has been a couple of conversations about shops and the vouchers, and what you can buy with them. But the focus has been on the vitamins and what we can do something about, what we can measure easily. I think it's very difficult to measure, obviously we get the voucher scheme uptake monthly from DH, but it's quite difficult to break that down by area and work out which areas, where uptake is lower than usual. But this system with the vitamins, we can track that a bit better.*

*HS Coordinator, Site 5*

At the time of interview coordinators (and where applicable, steering groups) were much more focused on strategies to increase the take-up of vitamins by eligible families than on strategies to increase the proportion of entitled families signed up to HS as a whole. Again, this was probably driven by the knowledge that vitamin take-up was very low. Strategies to increase vitamin take-up included employing a part-time midwife with a remit to improve vitamin take-up; re-launching the HS scheme amongst professionals with a view to 're-energising' interest in vitamins; improving vitamin distribution through antenatal clinics, health and Children's Centres; feeding data back to health and Children's Centres to encourage them to promote vitamins; improving 'advertising' of free vitamins in Children's Centres and health clinics; and seeking additional funding for universal vitamin provision to improve take-up rates amongst all mothers. In contrast, few responses to improving take-up of the whole HS scheme were given. Where actions were taken, these included auditing midwifery teams to ensure HS was discussed during booking appointments, inserting a HS check box on assessment paperwork used by health professionals, and some promotion of HS amongst health and children's professionals. In general, however, frontline staff were unaware of any data related to the local rates of take-up of the HS scheme.

#### 2.3.6 The Engagement of Different Professional Groups in Healthy Start: The Significance of Vitamin Distribution

When asked about the level of engagement amongst different professional groups, HS coordinators concentrated on three main groupings; midwives, health visitors and Children's Centres. Vitamin distribution emerged as a key factor influencing attitude and commitment towards HS amongst these groups. Vitamin distribution methods varied across the research sites, with some trusts using Children's Centres as the main distribution points, some using both Children's Centres and health clinics, and some allowing midwives and health visitors to hand HS vitamins directly to families. In several sites, setting up a reliable vitamin distribution system was reported to be time consuming and difficult to resolve.

Where vitamin distribution remained problematic, the engagement of health professionals suffered as a result. Several coordinators reported that interruptions in the supply chain for vitamins due to a lack of availability nationally and/or locally meant that midwives and health visitors lost confidence in the programme which took time to recover. Health professionals also had mixed reactions to handing out vitamins directly to families. Some coordinators found that this increased professionals' engagement and promotion of the scheme; in one site where midwives were able to hand vitamins directly to pregnant women but health visitors were not distributing vitamin drops, the coordinator reported that the commitment of the midwifery team was greater because they had something 'tangible' to hand out. Other coordinators reported frontline professionals were reluctant to distribute vitamins directly, because of the complications of carrying extra items and taking responsibility for managing and monitoring their distribution. Coordinators also reported that health professional's reluctance to hand out vitamins may have stemmed from a lack of knowledge about recommended vitamin dosages for



infants and a concern that vitamin distribution to breastfeeding women undermined the 'breast is best' message. Finally, one coordinator reported that the engagement of Children's Centres in vitamin distribution and monitoring had led to frontline health professionals thinking that HS was no longer within their own remit.

Concern about the impact of the vitamin distribution system working well or otherwise was also reflected in the responses of midwives and health visitors. Many frontline professionals reported problems obtaining a secure supply of vitamins if they were responsible for handing them out and poor knowledge of where to signpost expectant mothers to collect them. Some perceived that the consistency of advice and vitamin distribution could be patchy, because not all professionals within the same team would follow the same practice or have the same knowledge about vitamins; some would forget due to high workloads and busy clinics, and gaps between pre- and post-natal appointments being longer for second and later pregnancies than for first-time mothers.

*[Vitamin distribution] was a real bug bear of mine because for a long time in this area they couldn't get them anywhere and now I know where they can get them from the estate where I work on but I wouldn't like to say that was across the board.*

Midwife, Site 13

*Also because if the ladies are second or third time round, there are changes in how often we see them so it can be some time between visits, can be 15-16 weeks, that's a long time if they haven't had their vitamins, .... Unfortunately we do have very busy clinics and with the best will in the world we do sometimes forget to give out vitamins.*

Midwife, Site 6

Coordinators also reported that the response of Children's Centre staff was also important particularly when centres were set up as vitamin distribution points:

*If you've got a children's centre that doesn't want to engage with it, because they don't see it as a priority then you can encourage, support and train and discuss it until the cows come home but as soon as you walk out of the door they are not going to do it, they won't.*

HS Coordinator, Site 2

Moving vitamin distribution into the domain of children's services within the local authority and away from health services resulted in some areas in a reduction in commitment to promoting HS from midwifery and health visiting teams as the scheme loses its prominence amongst senior management. However where Children's Centres have been supportive of vitamin distribution this was a key factor cited by coordinators in making HS vitamins 'work'.

### 2.3.7 The Engagement of Different Professional Groups in Healthy Start: General Issues

Other factors influencing the engagement of professional groups in HS included where the management of the scheme sat. Several coordinators reported that due to recent restructuring amongst Health Trusts, teams responsible for the implementation of HS, in particular health visiting and midwifery teams, were often 'part of a different organisation' and communicating with and managing across these organisational boundaries was difficult. Often these reorganisations had involved staff being made redundant, posts not being filled or changes to personnel in key roles. Changes in personnel resulted in delays in processes such as the ordering of vitamins, and a lack of clarity between one PCT and a local Acute Trust over who had responsibility for completing the financial returns.

Finally, coordinators noted that for midwives and health visitors, concerns about understaffing, workload, and the amount of information they were required to cover with families during each contact led to individual variability in their commitment to informing all families about HS and ensuring that

eligible families were signed up to and benefiting from the scheme. One coordinator reported that cuts to services meant that there were fewer professionals in post to carry out clinical work with the result that involvement in schemes that were seen as additional to core clinical work became more difficult:

*It's how you fit all that into the day as well as providing all your performance figures in a target driven environment.*

HS Coordinator, Site 11

A small number of coordinators report limited success in engaging GPs with HS but the main message was that GPs needed to be more aware of HS and promote it to families.

### 2.3.8 Working with Retailers

Coordinators did not involve retailers in the strategic or operational management of HS at any of the sites. Some sites had attempted to work with retailers in the past, with varying success. For example one coordinator wrote an article in a Trade magazine publicising the change in the scheme to include frozen food, whilst another wrote to all local retailers encouraging them to sign up to HS. In another site the steering group had plans at the time of the launch of HS to use the scheme to engage with retailers and had commissioned the design for a local HS promotional campaign, but this was never used. Finally one site had successfully arranged for a mobile shop selling fruit and vegetables to visit areas where access to shops selling healthy food was limited. The van also carried HS application forms and accepted the vouchers. None of the coordinators reported having any current capacity to work with local retailers, either to encourage them to sign up to the scheme or promote it to their customers.

Neither coordinators nor other professional respondents had much knowledge about which shops accepted the vouchers, although all who expressed an opinion thought it would be reasonably easy for beneficiaries to spend their vouchers locally. Some coordinators had concerns about anecdotal reports of fraudulent use, where shops would accept vouchers for non-HS items. Most coordinators would have liked to have more engagement with the retail sector. Additionally frontline professionals in particular often wanted to know where vouchers were accepted so they could advise parents.

## **2.4 Successes**

Having a named coordinator and the establishment of a HS steering group, or delegation of responsibility for the scheme to an existing group, provided a focus for management of the scheme.

The existence of pilot schemes for universal provision of HS vitamins to all pregnant women added impetus to the implementation of Healthy Start by raising the profile of the scheme amongst health professionals.

Ensuring that all of the professions and agencies involved in HS at an operational level were represented in steering groups appeared to improve 'buy in' to the scheme.

Where Children's Centres were supportive of vitamin distribution this has been a key factor cited by coordinators in making HS vitamins 'work' in their area.

## **2.5 Challenges and Opportunities**

Management of HS at the local level in England remains almost entirely focused on vitamin distribution and take-up. Wider aspects of the scheme, including monitoring and addressing gaps in signing up entitled families and engaging with local retailers remains a low priority for local coordinators. These priorities appear to be driven by the need to monitor vitamin take-up (in order to ensure that statutory obligations for providing vitamins were being met) alongside the paucity of data on the take-up and impact of the HS scheme as whole.

The most common challenge was solving the problems of vitamin distribution. This soaked up managerial energy and effort directed toward HS, and was also felt to impact on frontline professionals' trust in the scheme.

Moving vitamin distribution into the domain of local authority children's services and away from health services sometimes resulted in a reduction in commitment to promoting the HS scheme from midwifery and health visiting teams.

Engaging all professional groups was challenging for some. Coordinators noted concerns amongst frontline staff about understaffing, workload, and the amount of information they were required to cover with families during each contact this led to individual variability in their commitment to informing all families about HS.

Changes to the organisation of community health services and the wider cuts in public spending were reported to be impacting services, including HS.

Very little work has been carried out at a local level with retailers and no one we spoke to was currently promoting the scheme to local retailers.

## Results: Frontline professionals

### 3.1 Key Findings

- A number of different professionals were associated with the implementation of the HS scheme most commonly: midwives, health visitors, nursery nurses and Children Centre staff.
- Most frontline professionals said they would benefit from training or regular updates on HS, including on eligibility criteria, recommended vitamin intake for all groups, the benefits of HS to beneficiaries, and local vitamin collection points and participating retailers. These latter two are now available on the updated Healthy Start website and this might usefully be promoted amongst health professionals.
- The majority of midwives and health visitors reported that HS fitted well with their remit to promote maternal and child health. They regularly promoted the scheme and countersigned forms. Professionals had good knowledge of the aims of the scheme, and viewed it as a financial and nutritional safety net.
- Nutrition and diet advice from professionals to HS parents was somewhat limited. Both midwives and health visitors reported offering some advice as part of their usual role, but HS was not routinely embedded in the health and nutrition advice provided by front-line health and children's professionals.
- For professionals, the scheme has been successful in addressing the perceived inequality of the Welfare Food Scheme between the financial support provided to breast- or bottle-feeding mothers.
- There was some perception amongst professionals that families disengaged from health services were brought to the attention of health teams when they approached health centres for a counter-signature for HS applications.
- Uptake of HS vitamins is low. Frontline professionals perceive this is because of difficulties for families in accessing them.

### 3.2 Background, Methods and Sample

The experiences and perceptions of front-line health professionals, who promote the scheme and act as counter-signatories to applicants, were key to understanding the implementation of the scheme and its potential impact on both professionals and beneficiaries. Once the local research area was identified, the HS coordinator put us in contact with the team leader for local health visiting and midwifery teams. In some sites, non-health professionals were also approached for interview where these were known to have a key role in HS implementation, for example signposting families to the scheme and/or delivering aspects of the intervention or related interventions (such as the provision of nutritional advice). Across the 13 sites we interviewed 50 frontline professionals. Health professionals were comprised of two General Practitioners, 12 midwives, 21 health visitors, four community health nurses, one healthcare assistant, and one dietician. Other professionals included one children's centre manager, six children's centre project staff, one receptionist, a parent education coordinator and two early years' practitioners. Full details are provided in Appendix 1.

Our interviews with these frontline professionals covered their knowledge and views about the scheme, reaching HS eligible families (and barriers to doing so), use of HS resources, experience of HS training, the impact of the scheme on their other work, and their perceptions of the potential impact on beneficiaries.

## 3.3 Findings

### 3.3.1 Standard Patterns of Care

In order to understand the roles and responsibilities of key professional groups involved with Healthy Start, it is important to first understand how they operate and who has contact with families at which points.

In most circumstances among the teams we spoke to pregnant women had midwifery appointments ('booking') at 10 weeks, and regularly thereafter either at a clinic or a home visit (less common). First-time mothers in most areas attended appointments with the midwife more frequently throughout their pregnancy than women who had been pregnant before. In some areas targeted groups such as teenage mothers saw midwives more frequently. Mothers in the majority of sites tended to be offered appointments with the same midwife for the duration of the pregnancy, with typical caseloads reported by midwives as between 70-100 women. Midwifery clinics were held in GP practices, health centres, hospitals and Children's Centres. Some hospital-based midwifery teams were supported by health care assistants.

For health visitors, the picture was more complex, with more variability in the core offer to mothers (e.g. number and timing of home visits), type of baby clinic (drop-in or by appointment), staffing, and caseload (some areas operated a corporate caseload, others had individual caseloads). In interviews health visitors were more likely than midwives to report problems with understaffing. In all sites, health visitors carried out a primary visit to the home when the baby was newborn, but follow-up visits varied in frequency, number, and the type of staff undertaking them across the sites. For example in three areas health visitors reported that their involvement in follow up visits was restricted to families for whom additional needs had been identified (e.g. complex health or child protection cases). Follow up visits for other families in these areas would either be replaced by drop-in clinics or carried out by other members of the team such as community or nursery nurses. By contrast one site had developed an enhanced service with health visitors undertaking home visits with all mothers at 10 days (primary visit) and six weeks, and a further follow up at four months if required. Five sites had a policy of not using health visitors to staff drop-in baby clinics, instead these were run by nursery or staff nurses. This meant that for many families their regular postnatal contact was not with a health visitor, but with a nursery nurse who weighed babies and ran health and information sessions.

The other professional group that had regular contact with families in our study areas were Children's Centre staff. In some areas health clinics were situated in Children's Centres, so parents were seeing midwifery and health visiting teams there. Children's Centres were sometimes the main distribution and collection point for Healthy Start vitamins, and at these centres reception staff were involved in exchanging vitamins for coupons and monitoring vitamin take-up. Children's Centres have a remit for promoting healthy eating, and we observed health-linked initiatives based in them, for example groups supporting families with fussy eaters, and cooking classes for parents of young children.

Very few sites reported GP involvement in the scheme. Whilst many professional respondents felt it was unrealistic to expect GP engagement, others reported that GPs might play a useful role in promoting vitamin take-up amongst eligible families.

### 3.3.2 Training and Healthy Start

Provision of information and training for frontline health professionals around the HS scheme varied across study sites, but in general was not a high priority. Most coordinators reported that no training had taken place with health professionals, although some had been undertaken with children's centre staff involved in vitamin distribution. Some had aspirations to provide training in the future, particularly around vitamin distribution and guidance on vitamin intake for mothers and infant children. Some training or at least provision of basic information had taken place in six areas in the past including:

- A compulsory training session for health visiting teams and children's centre staff on vitamin distribution and benefits of taking vitamins for mothers and children. Some information about the HS food vouchers was also covered. This training was now online for new staff.
- Training on infant feeding, weaning, and the Healthy Start scheme for those in contact with children who may influence diet, including health visitors, community nursery nurses, and Children's Centres project workers. The HS coordinator had plans to invite midwifery teams to the next round of training.
- One site ran four training sessions on HS for health visitors, midwives, children centre and nursery staff which also included training on vitamins and impact of vitamins A, C and D. This site had plans for this training to recur annually but this was currently on hold until vitamin distribution has been achieved.
- One site trained midwives and the health visitors together on acting as signatories for HS and provided wider information around health and nutrition, including vitamin intake.
- Training for midwives and health visitors in Healthy Start, including support required by some families to complete the application form.
- Distributing a list of Healthy Start vitamin collection sites to all midwifery and health visiting teams.

The low priority afforded to training health professionals in Healthy Start was reflected in the responses of midwives and health visitors when asked about the training they had received.

*No training. Typical isn't it? Not as far as I remember, anyway. [Healthy Start is] just something you learn.*

Midwife, Site 6

Some could recall training sessions run locally some years ago. Newly qualified professionals were unlikely to have received any HS-specific training.

Some health professionals recalled receiving information, rather than formal training. This included basic information about Healthy Start, details of which local shops were participating, and vitamin collection sites. A very few respondents were aware of the DH-produced guidance materials for professionals and those that were found them useful. Some staff felt that this lack of training was 'normal', they were expected to pick up information independently. Some admitted they may have received information via email but were likely to have deleted or forgotten it. A number of respondents identified sources of information about the HS scheme that they had found themselves, including searching for information in the internet, reading articles in magazines, or informal advice from colleagues.

*In all honesty in the community practitioner magazine that we have there was an article in there and I learned a lot more reading that than I have ever had from the DH – it was very good. It was about health visitors being aware of Healthy Start, and telling you about people who should have them. It gave you like a box or something, things like people who are obese, that was something that I wouldn't have known about, but they should have vitamin D, so it highlighted more to me than what I knew.*

Health visitor Site 5

We were aware of some gaps in knowledge among the professionals we spoke to. For example, the health visitor quoted here is wrong that those who are obese are at particular risk of vitamin D deficiency, and at least one midwife believed that HS vitamins included iron.

A small number of respondents felt that no training was necessary, that they could pick up what they needed to know without formal training. Most health visitors and midwives interviewed however said that they would value training (in some cases refresher training) to cover the following issues:

- Updates in changes in the scheme, for example the monetary value of vouchers and what they can be used for
- Eligibility criteria and 'fit' with other benefits
- Recommended vitamin intake for pregnant women, breastfeeding mothers and infant children
- Benefits of the scheme, so this could be passed on to parents when promoting Healthy Start
- Lists of local vitamin collection points, and participating retailers
- General training to reinforce the importance of Healthy Start and make it a priority for frontline health professionals

We can say little about the experiences of GPs, since we were unable to recruit them to our study. The two GPs we did interview (from the same practice) for the study had received no training or information about Healthy Start that they could recall.

### 3.3.3 Introducing Healthy Start to families

There was a consensus among the health visitors and midwives interviewed for this study that promoting the HS scheme was part of their role which suited their wider responsibilities.

*It fits in well because we are always talking about children's diets whether it's about breast feeding, weaning, infant diet – it's a massive part of our role, so I think it fits in to that easily and nicely, it's appropriate.*

Health visitor, Site 5

*As a midwife you look after the health of that women, her unborn baby, and her children and the wider family because you have a remit into public health. And anything that you can do to assist this and to make it better you should do.*

Midwife, Site 8

All midwives interviewed said that they would mention Healthy Start at the first booking appointment, or at the referral meeting to set this appointment up. Some suggested that because of the local demographics, the majority of their clients would be eligible and would have heard of the scheme already either because they were a current or previous beneficiary with older children, or had been told about the scheme by friends and family. In some cases, families would raise HS and ask midwives to sign the application form without being prompted. More often, midwives introduced HS during the initial consultation with women, as part of a discussion about either health and nutrition in pregnancy, or income support and benefits. Practice varied with regard to how much time midwives would spend explaining the scheme and supporting mothers to complete the application form, with some relying on expectant mothers to find and read the application form provided with the information pack handed out:

*I can tell you that I myself pull out the leaflets that I consider to be the most important, which for your first booking appointment is the leaflet on your first blood tests and I also say that there is this form, if you are entitled fill it out and have it ready for when we book you, and then you'll get it as soon as possible. That's what I say and I don't tell them anything else. That's what I say because the referral appointment is very quick and there's no time, it's the first contact and there are other things you need to tell them, and you just end up swamping them with information otherwise. The form is there in the pack.*

Midwife, Site 4

Other midwives reported providing more information about the scheme, supporting mums to complete the form and checking at later appointments whether or not they were in receipt of vouchers. In those areas where midwives were able to distribute HS vitamins to mothers, the scheme would be introduced along with an explanation of the free vitamin provision.

*Right from the very beginning, at our booking sessions once we identify a new lady that would benefit from it, we give them the information about their eligibility for free vitamins, and for fruit and vegetables, and we fill in the form with them, so right from between 8 and 10 weeks into the pregnancy we are giving them that information. We go through and make sure that they start off right from the beginning. And then throughout their pregnancy we make sure that they have had the vouchers and that they benefit from it, and then give out the vitamins as well, so we are constantly promoting it throughout their pregnancy.*

Midwife, Site 6

Health visitors did not all report mentioning HS routinely at the primary home visit. In at least four study sites, the scheme is included as part of the checklist of information health visitors should cover in their initial assessment with families and this 'tick box' approach encouraged health visitors to raise it with all families. Others reported raising it routinely at all primary visits even where no such tick-box checks were in place. In some areas professionals reported raising the scheme at first contact with families new to the area, follow up visits and all baby clinics:

*We do that [mention HS] at most of our universal visits – primary birth visit, four month check, one year and two years. And transfer-ins, we do it at all of those. Any family you think might be eligible, you raise it with them.*

Health visitor, Site 6

In some sites, health visitors were more selective about when and with whom they raised HS. In some cases this was because they assumed that eligible mothers would already have been signed up by their midwife. At the primary visit, income and benefits were usually discussed as part of the family needs assessment and many health visitors reported using this as a cue to raise HS, though some qualified this as only when they thought families were likely to be eligible.

*I wouldn't say I ask everybody because one of the first things we do, we have a front cover of the record and I go through the personal information and if both parents say that they work, and it's a reasonable income and it's their own house then I don't tend to ask. But obviously unemployed, single parents, if they are looking like they are anywhere near the criteria then I certainly ask.*

Health visitor, Site 6

There were a number of concerns raised by coordinators in relation to health professionals acting as counter-signatories, including some confusion over whether community nurses and nursery nurses could sign forms. Where nursery nurses were running drop-in baby clinics in place of health visitors they were seen as having a role in promoting the scheme and providing application forms to eligible families and in some cases, returning completed forms for health visitors to sign. Since nursery nurses are unable to sign application forms some of the professionals we interviewed thought this was a barrier to efficient recruitment onto the scheme, as this created a delay in the system. Others were of the view that only a registered nurse or midwife should be able to sign despite this barrier.

Where Children's Centres were the main distribution and collection point for vitamins, reception staff were involved in exchanging vitamins for coupons and monitoring vitamin take-up. In some sites Children's Centres were seen as having a role in promoting Healthy Start more widely, using promotional material, having application forms available, providing translation/advocacy services to help parents complete the form, and ensuring that all staff were aware of the scheme and checking that eligible families were signed up. Project and outreach workers associated with Children's Centres sometimes described their role in HS as promoting and educating families and ensuring all eligible families were benefiting from the scheme. The early years professionals interviewed for this study all indicated that the scheme was promoted in their work, including through the use of posters and displays, mentioning the scheme in relevant baby groups and classes, and targeted work with vulnerable groups, in particular teenage mothers. The community food project worker also reported handing out information about HS and supporting applicants with completing the form.



GP's involvement in the implementation of HS was very limited in all sites, and HS coordinators reported difficulties in engaging GPs. The two GPs interviewed for the study both reported not knowing much about the scheme and seeing its implementation as the responsibility of midwives and health visitors. Some GP surgeries did display HS posters and had application forms available.

Other groups identified by respondents as having a role in the promotion of HS included:

- Consultant paediatrician and dietician involved in the promotion of Vitamin D supplementation and professional training
- Community food workers promoting HS to eligible families
- Breast feeding peer supporters sharing information about the scheme
- Dieticians talking about HS with patients
- Volunteer 'community health champions' promoting HS
- Benefits advisers working in Children's Centres and job centres ensuring eligible families were signed up.

#### 3.3.4 Countersigning Healthy Start Application Forms

Regardless of how families become aware of HS, they must obtain the signature of a health professional on their application form. Most health visitors and midwives reported no concerns in signing forms during contact with families. Most were clear that they were signing to say that the applicant was pregnant and/or had young children, and was in receipt of health-related advice, and that eligibility with regard to financial status would be checked by someone else.

*If they fit the criteria and I have seen them on that day for a consultation for health then that's what I'm signing, I've given them health-related advice and they are entitled to that. What I use as a failsafe is if they are not entitled financially it goes higher than me and is monitored somewhere else, so obviously they are not going to get something they are not entitled to.*

Health visitor, Site 5

Some reported more concerns about signing when families approached health professionals to sign forms outside routine contact points. For example, families would leave forms with health centre receptionists or approach professionals during drop-in well child clinics. In these circumstances, health professionals sometimes withheld their signature until they had checked that the parent and child were known to the team and had been in recent contact. If this was not the case, applicants would be asked to attend for a consultation before health visitors or midwives would sign the form.

Neither of the GPs interviewed for the study reported ever being approached to sign forms. They were confident that midwives would ensure that all eligible families would be signed up to the scheme.

#### 3.3.5 HS Take-up by Eligible Families

Measures put in place raise to awareness of the HS scheme among entitled families have been largely successful. Across the 13 sites a range of measures were employed for this purpose:

- Training frontline health and children's professionals
- The use of a HS 'tick box' on antenatal notes, family health assessment form, Personal Child Health Record (PCHR), or other paperwork used by health professionals, to remind them to cover the topic during their assessment of families.

- Including the HS application form with the information pack provided to pregnant women at initial booking appointments
- Auditing health professionals, in particular midwives, to ensure that they were mentioning HS to all families
- Undertaking promotional work targeted towards Black and Minority Ethnic (BME) groups, particularly around the importance of Vitamin D
- Promotional material, including posters, staff badges and stickers, in Children's Centres and other Early Years settings, and health clinics/centres.
- Encouraging Children Centre staff to mention HS during groups and classes related to breastfeeding, weaning and infant feeding/nutrition.

In some areas these efforts were hampered by organisational boundaries between groups, and by restricted availability of health professionals. One coordinator reported that where health professionals are not easily available to families, checks and delays may deter eligible families applying for the scheme.

Finally, most coordinators reported having no access to data about which entitled families may *not* be signed up to HS. Aside from top line take-up figures for each Trust (which some coordinators were unaware of), there is no easily available data on the demographics of eligible non-applicants enabling coordinators and frontline professionals to take a more targeted approach to promoting the scheme.

*If the DH could provide that information for us then we would be able to do something about that but we don't know where the people that aren't getting the vouchers are.*

Healthy Start Coordinator, Site 2

Frontline professionals were confident that they were reaching most eligible families, but some believed some eligible families may be missed, or late in signing up because of:

- Financial circumstances may change after regular contact with health professionals has stopped meaning those who become newly eligible are not signed up to the scheme
- Some families may be experiencing challenges resulting from domestic chaos, housing difficulties, drug and alcohol abuse, and other stress factors and will not prioritise completing application forms and/or posting them
- Poor literacy levels, and/or having English as a second language may deter potential applicants from completing the form, and mistakes completing it will delay acceptance onto the scheme
- Looked-after children, particularly those in temporary or less secure placements or newly returned to parents, may miss out because their vouchers are stopped and parents do not re-apply
- Lack of publicity about the scheme
- Lack of clarity over eligibility of non-UK nationals
- Some women will not seek health advice until very late in pregnancy
- Health professionals may not routinely mention HS in some geographical areas, meaning that low income families living in affluent areas may be missed

*Because of the area I work in I'm probably much more aware of them than my colleagues, I mean this lady that came to see me today [to ask about HS], she'd actually had her booking done by a midwife who doesn't usually work in an area where people are on low incomes whereas for me it's almost*

*routine and automatic to mention HS whereas it probably isn't for some of my colleagues, they're more likely to slip through the net there.*

Midwife, Site 13

- Families who move home regularly and do not register with a GP or see health professionals regularly may not be informed about HS
- Expectant mothers are 'bombed' with written information and HS application forms get lost within this
- Families may not understand the eligibility criteria, in particular the income threshold, and some perceiving that the scheme was for formula milk and breast-feeding mothers were ineligible
- Where health professionals were unable to pass application forms directly to parents because local supplies have run out, it was harder for parents to complete a form and get a counter-signatory
- Families with more than one child will often have less frequent contact with health professionals and seek less advice than first-time parents so may be less likely to be informed about HS
- Difficulties in reaching families that do not engage with health or children's services, for instance gypsy and travelling communities

### 3.3.6 Views of Professionals About Eligibility Criteria

The professionals we interviewed had some concerns about the eligibility criteria for HS, in particular that the income threshold may be too low and low-income families just above this would miss out but still be in need of the support that HS could offer. In addition, there was some confusion over the eligibility of non-UK nationals and a number of front-line professionals were particularly concerned that asylum seekers were ineligible. Young mothers living in care are ineligible and professionals carrying out targeted work with these groups were unhappy about this.

A number of respondents stated a preference for universal provision of HS, particularly of vitamins during pregnancy, to increase take-up rates and awareness of the need for vitamin supplementation in pregnancy and the early years. Some sites were already supplying universal vitamins and one had commissioned a report looking at the costs and benefits of universal vitamin provision because of the PCT's concerns over the rising costs of Vitamin D prescriptions. One respondent was concerned at the targeting of low income families when '*the whole nation's diet to be looked at*'.

### 3.3.7 Advice to Beneficiaries About Health and Nutrition

Health professionals were asked about the advice they routinely provided on healthy eating and nutrition to pregnant women and parents, and how this was linked (or not) with HS. All midwives said that they would discuss healthy eating in pregnancy; always including foods to avoid but mostly also covering general health and nutrition and the importance of a balanced diet. Healthy eating and nutrition would be discussed at first booking and throughout the pregnancy. Most midwives included information on nutrition within the information pack for pregnant women, for example a 'nutrition in pregnancy' guide produced by their Trust, and/or leaflets about vitamins. Some reported additional provision put in place for targeted groups, including cookery lessons for teenage mothers-to-be or mothers with high BMIs. Pregnant mothers would be referred to a dietician usually only where obesity and/or diabetes were risk factors. While many midwives said that HS complemented their role in promoting a healthy diet, very few reported making explicit the link between the HS food vouchers and healthy eating.

Access to support for diet and nutrition beyond that provided by the midwife varied across sites, with some midwives unaware of what provision was available at local Children's Centres and not

signposting women to other services. Others reported recommending Children's Centre provision, including lunch clubs, cooking and nutrition courses.

Health visitors also reported providing advice on healthy eating and nutrition for mothers and young children at all contacts, whether this was a home visit, or seeing a parent at a drop-in clinic or appointments at clinics. Some teams provided home visits timed to coincide with weaning so that they could provide additional support at this time. Health visitors were more likely than midwives to identify additional sources of support if diet and nutrition were an identified concern for a family. These included targeted home visits from nursery nurses within the health visiting team; referral to family support workers at the local Children's Centre; referral to cooking, healthy eating, breast feeding and or weaning support groups and classes at Children's Centres. Health visitors, nursery nurses and family support workers in their teams were often involved in running weaning classes in Children's Centres, family health drop in sessions and 'taste for life' sessions. Some teams reported not running as many weaning classes as they would like because of staff shortages. Some health visitors also mentioned that families might also have access to additional support through Home Start or the Family Nurse Partnership scheme.

Some midwives and health visitors were concerned that there was not enough support for families struggling with diet and nutrition because of cuts to children's services. Provision within the Children's Centres had either been cut completely or reduced so much that the waiting lists would deter families from accessing them. However Children's Centre staff interviewed for the study did mention a range of provision available for families, including; providing leaflets with healthy recipes; Healthy Exercise and Nutrition for the Really Young (HENRY) classes for mothers, as well as training all staff in HENRY so they could provide advice when asked; weaning parties and classes; 'cook and eat' sessions and cooking courses. Again, it is not clear from Children's Centre staff accounts whether the links between this sort of provision and the HS scheme were made, although one early years practitioner did report making clear how the vouchers might be used to support teenage mothers in providing a healthy diet for their children.

*We have a lot of young parents who are very much under the influence of their parents and changing that cycle can be really difficult...Some of the young parents as well just don't know how to cook. Well they know what they should be giving but it's about 'how do I cook that?'. One of the things I use with teenagers a lot is I say that you can use your vouchers to get a bag of frozen veg and actually take a handful of frozen veg out and puree that – only takes a tiny amount of commitment.*

Early years practitioner, Site 11

### 3.3.8 Views of Professionals About the Aims of Healthy Start

Professionals identified a range of outcomes that they perceived the scheme aimed to achieve. These included reducing income-related health inequalities (in particular obesity), promoting the intake of fresh fruit and vegetables amongst low income families, and ensuring pregnant and new mothers and small children received their recommended intake of vitamins. Professionals identified two main mechanisms through which HS was intended to impact on these outcomes; educating beneficiaries about healthy diet and nutrition, and providing a financial and nutritional 'safety net' to ensure that families on very low incomes could afford nutritious food.

Professionals were often positive about the value of HS, both for their own practice and for the impact it could have on vulnerable families. Frontline health professionals in particular valued the scheme for its links with their own role in promoting health, for example in advising pregnant women about nutrition in pregnancy or mothers of young children about weaning, diet and nutrition for infants. HS was seen to provide practical support to help put such advice into practice and 'normalise' healthy habits and choices from the earliest opportunity. This was especially important when working with very low income families who may struggle to prioritise health:

*I do believe it's really good for women. Women are often in a dilemma about whether they should or shouldn't eat healthy foods because something else is needed more. Their own health and maybe the health of their younger children are on the back burner because something else is more pressing.*

Midwife, Site 8

The aims of the HS scheme were often described as linked with and supporting a range of health initiatives within the local area. Professionals listed a range of local priorities and initiatives that HS contributed to, including:

- Early years health and nutrition strategy
- Maternal health strategy
- Obesity strategy for both children and adults
- Targeting vitamin deficiencies in the local population, where Vitamin D was the most commonly cited vitamin
- Breast feeding promotion schemes
- Family Nurse Partnership schemes, where many of the beneficiaries would also be eligible for HS
- Food access initiatives– working with local retailers to ensure access to healthy food in local neighbourhoods.

While frontline professionals were positive about the 'fit' with other initiatives, it is less clear how these were operationalised at a strategic level given the focus of most HS coordinators on vitamin distribution.

### 3.3.9 Views of Professionals About the Potential Impact of Healthy Start

Frontline professionals and HS coordinators were asked their views on the potential impact of HS on beneficiaries. None of the coordinators had access to data on the impact of HS on beneficiaries, and did not get any direct feedback from families. Some believed that this was a problem and would like to be able to commission work in this area but did not have the resource.

*None of it feeds back to me, that is gap, but to be perfectly honest I don't know where I'd find any time at the moment.*

Healthy Start Coordinator, Site 2

Frontline health professionals were more likely to have some feedback on the impact on families, but again this was very limited. Many were unable to comment on the benefits for families as they didn't talk to families about how the food vouchers were used. Families were more likely to talk about HS to health professionals when there was a problem with their application or their vouchers stopped arriving in the post. In these circumstances health professionals commonly advised calling the HS helpline, though some were concerned that this was expensive for families with no access to a landline and would offer the use of their staff mobiles. Nevertheless some respondents did have views on the impact of HS on beneficiaries. In all cases health professionals reported only anecdotal accounts or their perception of the benefits (or lack of) rather than any evidence of how the scheme was impacting on families, but these impacts were perceived in finances, health, and engagement with professionals.

#### *Financial Impact*

Most health professionals were of the view that the vouchers were a much-needed financial benefit for families. For those beneficiaries in receipt of vouchers for two or more children, professionals

noted that the vouchers could add up to a substantial contribution to the weekly food shop. In particular, the vouchers would alleviate the expense of formula milk, although some mothers had commented to them that the vouchers did not cover the full cost of baby formula. Where families moved in and out of eligibility because of changes in their employment status, professionals noted that families were keen to sign up to HS as soon as possible if they became eligible again and concluded that it was a much-appreciated financial help.

Not all professionals thought that the extra financial help would provide much incentive to purchase healthy food, but were of the view that it would cut the cost of the family food shop. While most suggested that the vouchers would be used for milk, fruit or vegetables, they did not think that this would impact on the family diet but instead 'free up' money to be spent on 'the usual groceries'. Some noted that parents they worked with were struggling too much to make ends meet to prioritise the long-term health needs of themselves or their children. Some noted that for young mothers who may still be living with their parents, the vouchers would allow them to purchase at least some of their 'own' food and be less reliant on what their parents provided for them. Finally, some felt that the HS scheme might encourage families to seek out advice on other benefits and make sure they were receiving all the benefits they were entitled to.

Health professionals were usually aware that the HS scheme addressed the perceived inequalities between breastfeeding and formula feeding mothers in the old Welfare Food Scheme and liked the fact that breastfeeding mothers could spend the same amount of money on healthy food as bottle-feeders used for formula milk. Few thought that HS actually helped promote breastfeeding, but were glad that the scheme no longer acted as a financial disincentive and was a 'fairer scheme for breastfeeding mothers'.

### *Health Impact*

While most respondents thought the scheme had the *potential* to impact on the health of families, many perceived that the entrenched poor health habits in the local population, including high rates of smoking, alcohol use, poor diet, and low breastfeeding rates, would not be changed by HS.

Many of the frontline health professionals reported that the scheme was still referred to by mothers as 'milk tokens' and in fact that was what the majority would be spending the vouchers on, not fruit and vegetables. This was attributed to the fact that in some areas workless and low income households were so prevalent that the majority of families living in the area would have used the Welfare Food Scheme, with its focus on milk, and the transition to HS had not been successful in broadening the remit of the scheme in the minds of the local population. Furthermore, health professionals working in areas with low rates of breastfeeding perceived that the vouchers would still be used to supplement the cost of baby formula, and not encourage the purchase of fruit and vegetables. Formula and cow's milk were still perceived to be higher value products for which the vouchers would mostly be used:

*I don't think you can buy a lot of fruit and veg for three pounds, so they probably go for the best value. One of the local shops where I live sells 8 pints of milk for two pounds, and that's a lot of milk for a family.*

Midwife, Site 5

Despite this, some respondents did believe that HS would promote to parents the importance of eating well and providing a healthy diet for their children. The provision of vouchers during pregnancy was perceived to promote good nutrition from the earliest opportunity and encourage a healthy diet through pregnancy and the early years. Setting these habits in the early years would, it was hoped, promote the provision of a healthy diet throughout the child's later years as well.

Where vouchers were used for fruit and vegetables, professionals perceived that this would encourage parents to buy a wider *variety* of fresh produce as well as a greater volume. Less familiar fruit and vegetables were often reported to be perceived as expensive and risky to buy in case they

were not liked and professionals thought the provision of vouchers might help alleviate this. The move to include frozen fruit and vegetables was welcomed by most as a means of encouraging parents to buy more without the risk of it spoiling before they had the chance to use it. In particular, they thought HS would have an impact on the health and nutrition of families where parents actively wanted to improve the family diet but struggled to afford to. Some professionals expressed the hope that the scheme would result in lower levels of obesity and dental decay in the local child population. However, some also commented that for a significant impact on diet and nutrition the scheme would need to be supported by a greater level of education and support for families.

### *Engagement with health professionals*

Some professionals were happy to be able to give 'something tangible' to their clients, either by signing an application form or providing free vitamins, and felt that this was a helpful tool in encouraging families to engage with the health messages they were trying to deliver. Some noted that a conversation about HS could easily link with a range of other support available to families, including other available benefits, nutrition and diet advice, and other health concerns.

Not many felt that HS encouraged families to actively engage with health professionals where they were previously reluctant to. However, some noted that where families approached health clinics simply to get an application signed, this could provide an opportunity to engage with a previously unknown family and ensure at least that all the basic pregnancy and child development checks were carried out.

### 3.3.10 Use and Impact of Healthy Start Vitamins

Some professionals were of the view that the provision of free vitamins was more likely to have a health impact than the provision of food vouchers. Particularly in areas where the provision of vitamins was universal, some believed that the scheme had already impacted in the rates of vitamin D deficiency in the local population (although we cannot substantiate this). Respondents believed that low income families were less likely to purchase vitamins than those on higher incomes, and that without the free provision would not have access to them. Some health professionals found the provision of vitamins 'reassuring', in that they were helpful in making sure pregnant and new mothers and young infants in particular were getting the minimum recommended intake of vitamins even when family diet was demonstrably poor. One health professional noted that the provision of free vitamins for pregnant and breastfeeding mums was one of the few health initiatives directed at the mother rather than the child, which was welcomed.

*The women are very grateful because it's as if someone is looking after 'me', not just my baby or other children but 'me'. They're very grateful that someone has thought about her health.*

Midwife, Site 8

HS vitamin take-up, even in those sites where provision was universal for pregnant women and/or infant children, was very low, often below 10%, and this was reflected in the number of sites where efforts were concentrated on the promotion of vitamins and resolving the problems with supply. For health professionals, by far the greatest identified barrier in vitamin take-up was a lack of access, either because frontline health professionals were unable to hand out HS vitamins directly, were unaware of where to signpost families to collect them, or families themselves had tried and failed to find a local collection point.

*We had quite a lot of confusion when we started this about the vitamins and about where they were available and we were told that they were available in pharmacies so some of the midwives went in to check and the pharmacies didn't have them. I think if the midwives are having trouble accessing them then the women are definitely going to have trouble and they often tend to give up, if it's not easy then they won't pursue it. So I don't think it's terribly easy.*

Parent Education Coordinator, Site 13

This problem was exacerbated in rural areas where families may live some distance from distribution points, usually health or Children's Centres. Some professionals reported that parents would often try and collect them from high street pharmacies and supermarkets but none were involved in the distribution chain for HS vitamins. Many sites had addressed this by making HS vitamins available in Children's Centres but take-up was still low, often because families were still unaware of the collection points. In addition, professionals suggested that families who do not engage with Children's Centres were unlikely to collect their vitamins from them either, and some health visitors felt that being able to deliver vitamins directly during home visits would have been more successful:

*It's the majority of our white families that don't go [to the Children's Centre], and it's literally across the road from them. It's like there's a barrier, they won't go. But they will accept you into their home, they are accepting our service and we are seeing them, so it feels like it would be easier for us to have them and give them out.*

Health visitor, Site 5

Strategies to increase HS vitamin take-up were reliant on the engagement of frontline health professionals, in particular health visitors and midwives. However respondents identified reasons why this approach was problematic; some professionals were sceptical of the need for vitamins if mothers and infant children were eating a healthy diet, professionals were under confident in their knowledge about the recommended vitamin intake for infant children; and some were unaware of the collection points for vitamins and/or lacked confidence that the supplies were in place (this has been replicated in other studies<sup>75</sup>). In sites where health professionals were handing HS vitamins directly to beneficiaries, problems with the logistics of this could cause lengthy delays in getting vitamins to potential beneficiaries and discrepancies in their availability. In some sites, some groups of health professionals could hand out vitamins (e.g. only health visitors or midwives) while others could not:

*it should be in pregnancy but for various logistical reasons which are outside the health visitors' control and really with the person running the scheme, for some reason it hasn't gone ahead with the midwives yet, which is very disappointing because it's a bit like shutting the stable door, not getting vitamin levels up in pregnancy. It was about having a place to store them and actually there was an offer to store them in this building, but.... Something that needs highlighted, as this project has been going for nearly two years now. Sad to say, only a few pregnant women are getting vitamins now, even through the national scheme. What we find is that some eastern European women are having them sent from home, which is a bit humbling, isn't it?*

Health visitor, Site 4

*This was the big argument with health visitors – they have an abundance of vitamins in their cupboard in that clinic. Shelves of them, but they can only give them post-natal. And they've said what's the point. So we said can we not get vitamins from you for ante-natal and they said no, that's not what they are for...In reality they can't get any free vitamins in this area because they are physically not here. That's been the problem. We know they are available because the HVs have them, but we can't access them.*

Midwife, Site 4

In several sites respondents were concerned that mothers were unable to access the vitamins early enough in their pregnancy, because in some areas the midwifery team had no supplies or did not know where to signpost mothers to collect them. In addition application forms cannot be signed by health professionals until the tenth week of pregnancy and some coordinators were concerned that this would delay the provision of free vitamins until too late in the pregnancy.

Professionals also identified reasons why beneficiaries would not collect the vitamins, including not noticing the vitamin coupon included with their HS letter or not knowing whether or not vitamins were



necessary. Some worried that families might feel stigmatised by asking for free vitamins and this was one of the drivers for universal provision. The HS vitamin coupon does not have a monetary value like the food voucher does, and this was also felt to undermine the importance of vitamin provision. Some health professionals felt that BME populations needed particular persuasion of the need for vitamin supplementation; conversely however a small number of professionals noted that these groups and other non-UK nationals may be more likely to collect vitamins because of vitamin schemes in their country of origin.

### **3.4 Successes**

The percentage of eligible families that take-up HS is high suggesting strategies are working to ensure eligible families are signed up. The majority of midwives and health visitors interviewed agreed that HS fits well with their wider responsibilities and regularly promote the scheme and countersign forms. Additional strategies, for example including a HS tick box on family assessment forms, and distribution of application forms and promotional materials to health and Children's Centres are working well.

HS is recognised by local professionals as a useful contributor to a range of health initiatives and priorities, including addressing income-related health inequalities. The scheme is considered to provide an opportunity to promote a healthy diet as well as a financial safety net for low income families. This is valued by frontline health professionals.

For professionals, the scheme has been successful in addressing the perceived inequality of the Welfare Food Scheme between the financial support provided to breast- or bottle-feeding mothers.

Health Trusts in some research sites have good working relationships with local authority children's services, harnessing their contacts with eligible families to promote the scheme and, in many cases, act as vitamin distribution points.

There is some evidence that families disengaged from health services are brought to the attention of health teams when they approach health centres for a counter-signature for HS applications.

### **3.5 Challenges and Opportunities**

Healthy Start is not routinely linked to the health and nutrition advice provided by front-line health and children's professionals. This misses the opportunity to promote the scheme as a health promotion initiative as well as a financial benefit to families.

HS coordinators and frontline health and children's professionals have limited or no data on the impact of the scheme on families. Many perceive that the scheme has a limited impact on the food purchasing and intake habits of low income families amongst whom poor health habits are entrenched. In turn, this may be responsible for the limited health education advice provided alongside HS as some professionals perceive the scheme as 'a drop in the ocean'.

Healthy Start vitamin take-up remains low across all sites. One key factor remains ensuring a reliable supply and distribution mechanism, and HS coordinators have been focused on this. Supply remains problematic for many areas, both because of interruptions in the national supply chain and the difficulties associated with getting vitamins available at points where parents would expect to collect them (in particular supermarkets and pharmacies). This might better be addressed centrally by DH than at the local level. In addition, some frontline professionals are reluctant to promote vitamins, either because of a lack of confidence in the supply chain and/or lack of knowledge about the recommended intake for pregnant women and young children.

Most frontline professionals said they would benefit from training or regular updates on HS, including on eligibility criteria, recommended vitamin intake for all groups, the benefits of HS to beneficiaries, and local vitamin collection points and participating retailers. These latter two are available on the

updated HS website and this might usefully be promoted amongst health professionals.  
Misunderstandings by some we spoke to support the need for ongoing professional training.

Difficulties communicating across organisational boundaries, staff shortages and workload pressures for midwifery and health visiting teams can result in HS not being prioritised by frontline professionals.

Very few sites are successfully engaging with GPs.

## 4: Results: Experiences of Parents

### 4.1 Key Findings

- Sign up to the HS scheme among entitled beneficiaries was high, with 72-86% estimated take-up across our research sites. Uptake was slightly lower in less deprived areas (estimated as 72-77% in the five least deprived PCTs compared to 78-86% in the most deprived in our sample). For most parents the application process runs smoothly and swiftly. The majority of parents had been told about the scheme by health professionals (most often midwives during pregnancy or health visitors) who explained how to apply.
- A very few breastfeeding mothers didn't claim vouchers because they don't perceive a need, but most breastfeeding mothers were successfully using the scheme.
- Our research suggests those most likely to be missing out on the scheme include a number of key groups: those with more chaotic lives particularly with unplanned disruptions in housing, those whose income fluctuates because of employment insecurity, teenage parents after the birth of their child, and those who struggle to communicate in English. This means that the diet of children in some of the most vulnerable families may not currently be protected by HS.
- Resolution of problems seemed to be working reasonably well, and we received reports of prompt and helpful responses from the HS helpline to changes in circumstances for some. However parents find the HS helpline expensive to call.
- A number of parents misunderstood the need to call and register the birth of their child, resulting in interruptions to the receipt of HS vouchers.
- Parents highly valued the HS scheme. For many it made a significant contribution to their weekly shopping budget. For those using infant formula, the entirety of their vouchers were spent on formula. Cow's milk was very commonly bought with food vouchers, but fruit and vegetables were also often bought and many parents reported an increase in the amount and variety of fruit that they bought for their families.
- Health professionals were not explicitly linking HS applications to healthy eating advice, although parents made this link themselves.
- Nearly all parents had good access to a choice of locations to spend their vouchers, and were able to buy food their family needed and used. A few younger parents in areas with fewer shops and poor public transport struggled to access suitable retailers. Several parents commented that it was embarrassing to be seen using the food vouchers, and valued the greater anonymity afforded them when using vouchers in supermarkets. Supermarkets were also perceived to be cheaper and parents chose them for most of their shopping, but used a range of different retailers according to price and convenience.
- The fixed value of vouchers meant that parents chose between spending over the value and 'topping up' with cash or losing the unspent value of their voucher. Most families monitored their spending to match the vouchers, but the loss of money when vouchers are under-spent annoyed parents.
- Parents were seldom using HS vitamins. Where they wanted to, most had been hampered by lack of access or interruptions in supply. There was a greater perceived need for vitamins during pregnancy, and more women had taken, or tried to locate, HS vitamins during pregnancy than afterwards. Parents expected vitamins to be available in high street pharmacies, were confused about where vitamins could be accessed, and reported that

health professionals often didn't know either. Where HS vitamins could not be accessed, it was very rare for mothers to seek out vitamins through other routes.

## 4.2 Background, Methods and Sample

HS beneficiaries have been studied in the past<sup>40, 41 42</sup>, and the Department of Health commissions an annual telephone survey of key performance indications for benefiting parents<sup>76</sup>. However to date, the perceptions of HS beneficiaries have not been examined in a qualitative study. Parents can provide insight into the ease of application and ongoing use of the scheme, its implications for their family, and whether or not HS is having the intended impact on beneficiaries.

Take-up of benefit schemes varies considerably; 96% of household likely to be entitled to child benefit claimants are signed up to receive this benefit, compared to 81% of Child Tax Credit and 61% of Working Tax Credit<sup>77</sup>. The Department of Health set 80% take-up of the HS scheme as a criteria for success<sup>1</sup>. To achieve this high level of take-up it is necessary to understand why some families are missing out, which families find it difficult to apply, and how they might best be reached. Take-up is estimated by comparing HMRC records of likely entitlement<sup>b</sup> to HS records of current beneficiaries and in England as a whole, take-up of the scheme was 78.4% in Jan 2011. Data provided by DH showed that average take-up in our PCTs was slightly lower than the national average (77.4%, range 72-86%). Take-up rates tended to be lower in less-deprived PCTs; the five least deprived PCTs (with Indices of Multiple Deprivation below the midpoint) had take-up in the range of 72-77%, while the more deprived were in the range 78-86%. Moreover, there was also within-PCT variation in take-up rates. Examining estimated take-up by small postcode areas (eg AB1 2), there were as many as 107 'missing' beneficiaries in a single post code area, and 47 postcode areas with more than 50 'missing' beneficiaries suggesting that in some areas, many entitled families were not signed up. Across our research sites there were a total of 60,000 individuals benefitting from the HS scheme in mid 2011, (1,300-9,700 per PCT).

In total we interviewed 107 parents across the 13 sites. Full details of the recruitment and sampling strategy, and the achieved sample, are included in Appendix 1. We recruited 81 parents face to face in health or children's services, and 26 parents using contact details obtained from the national HS database. Most interviews were conducted in respondents' homes or in Children's Centres.

We categorised our sample according to their likely experience of HS use. We hypothesised that vouchers may be used differently during pregnancy, infancy (babies <12), and childhood (12+ months). We also believed mothers under 18 at the time of pregnancy (who are eligible for HS regardless of income), BME parents, and larger families may have different experiences. Finally, we were interested in a range of 'success' in using HS: current users, those no longer eligible, and non-users (failed applicants and non applicants). Table 1 below reports our achieved sample in each of these groups (groups are not mutually exclusive). In most cases the parent interviewed was the mother, however we also had two interviews with fathers only, four with fathers also present, and one where a grandmother was also present. Respondents were aged between 16 and 48 years (mean 27); 17 were from BME groups. Almost half of our sample were single parents. In our analysis we focussed on describing common experiences and exploring what we could learn from the variant cases: which families under what circumstances found HS more difficult to use and access?

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<sup>b</sup> These records are also used to write to potential beneficiaries, inviting them to apply

Table 1: Breakdown of Parent Recruitment by Sampling Criteria

	<18 years (n=8)	BME (n=17)	White, non British (n=4)	Eligible users (n=70)	Eligible non applicants (n=11)	Applicants not in receipt (n=8)	Previous users (n=18)	2+ children including pregnancy (n=56)
Pregnant (n=14)	0	5	0	10	2	0	1	10
Parents of ≤12 months (n=50)	7	5	2	29	4	7	10	24
Parents of 12+ months (n=43)	1	7	2	30	5	1	7	22

### 4.3 Findings: The Experiences of HS Beneficiaries

#### 4.3.1 Finding Out and Applying for Healthy Start

For most parents receiving HS vouchers the steps involved in applying for HS went smoothly and worked well. Most (over three quarters) of the parents we interviewed who had gone through the application process had found out about HS from a health professional. Most of this group were told about it by their midwife, with the rest finding out through a health visitor. The remainder were informed about HS by friends, family, or via advertisements/leaflets that they picked up at their GP surgery, health clinics, the Job Centre, or at Children’s Centres.

Several parents described how helpful they had found health professionals and reported that their midwives and health visitors had explained the scheme to them in detail. Health professionals were perceived to be the most appropriate people to promote the scheme.

*It’s good that midwives are the ones that raise Healthy Start because they know what keeps you and the baby healthy, so them telling you makes you think you should use them.*

Ex-recipient, mother, two children aged 7 and 30 months, Site 1

On the whole there were few concerns about the information health professionals had given parents about HS. There were less positive experiences: a couple of parents were frustrated that they only found out about HS from a health professional quite some time after they became eligible as opportunities to mention the scheme earlier had been missed. There were also complaints from some parents that the information given to them was limited and that, although they received booklets about HS among other written information, it was never discussed with them.

Most parents were given an application form at the same time as they were informed about the scheme, most often by midwives. A very few parents reported getting forms through the HS Helpline, the Job Centre or over the Internet. A small number of parents reported that none of the health professionals had mentioned HS to them and some others said they had to ask their midwife or health visitor about HS before they were given any information.

A small number of parents felt inconvenienced at having to fill out the form as they assumed that benefits agencies already had the information required. One mother found the application form rather difficult and the amount of information ‘overwhelming’, some had concerns about providing financial and benefit information. However most of the parents who filled out the application form found the process easy and had no concerns or issues with the information requested. Several were given help by a health professional, including for literacy difficulties.

On the whole, respondents had no difficulties getting their forms signed by a health professional. Most commonly it was midwives who signed parents’ application forms. Other parents had their forms

signed by health visitors, a very few parents had the form signed by a GP and one by a family nurse (part of the family nurse partnership). Forms were typically signed at routine appointments and some were signed at the same time as applications were distributed, ready to send off.

Not having regular access to health professionals was associated with greater difficulties with applications. A small number of parents who were not given the form at routine appointments reported having to wait to get an appointment with a health professional. For these parents the process of getting forms signed was also more inconvenient. One mother described how frustrating she found it that she had to have an appointment:

*Midwives, oh, when I've been up there they're like 'No you have to have an appointment in order to come in for us to sign it', that's what they were saying to me and I was like 'Well but I'm here now, all you've got to do is sign it' and they're like 'oh you have to come at this time'. They are a bit like...fob you off.*

Mother, Site 13, current recipient, child 22 months

We note that in this example the midwives appear to be showing the appropriate caution; ensuring families are in contact and engaging with health professionals prior to signing the application form. A couple of parents reported that their form was lost or filled out incorrectly by a health professional causing inconvenience and delaying their receipt of vouchers.

Of the respondents who discussed how long it took between filling out the application and receipt of vouchers, a few started getting them less than two weeks after applying and the majority 2-4 weeks after application. Several parents described the period between application and receipt as quick. One mother explained how swiftly the process seemed to go; she felt:

*That's quick because everything else [other benefits] was all taking forever and then that it was ok, it was oh good they're here already!*

Mother, Site 3, current recipient, child 8 months

However, some parents had to wait longer and felt that the process took a very long time. One mother said that having to wait for her vouchers and chase up her application left her feeling 'frazzled'. Where receipt was held up for several months because of errors or late application, all felt that they should receive back payments, but we found different experiences; three parents reported receiving a back payment and three reported that they hadn't and were annoyed at this. We could not get enough information from the parents to understand why they had been treated differently.

In contrast to the good experience of applying, the processes for reporting the birth of babies was problematic for many. Parents reported that vouchers stopped soon after their baby was born and were confused about why. The HS scheme provides parents with one voucher a week for up to 16 weeks after the estimated delivery date on their application form. A second voucher (provided for all children under 12 months) is added when parents contact the helpline to confirm the birth, and eligibility is confirmed by HMRC (as a result of the mother claiming Child Tax Credit). HS materials sent to parents advise parents that they need to contact the Healthy Start Issuing Unit, however not all parents were aware of this; some parents were clear they had been advised to contact the scheme to confirm their baby's birth while others were not aware and often stopped receiving vouchers for a lengthy period.

Where parents reported difficulties in receiving vouchers many contacted the HS helpline to find out why. While this service was found to be useful, the helpline was expensive to call for many mothers who only own mobile phones and when several benefits claims were contested. Parents who used the HS website avoided this cost, but many users have little or no access to the internet.

#### 4.3.2 Parent Understandings of the Aims of Healthy Start

Parents were asked what they knew about the aims of HS, that is, who the scheme was targeted towards and what it was trying to achieve. Around one third of respondents made the link between the provision of food vouchers and healthy eating; stating clearly that the scheme was intended to encourage healthier eating habits.

*Healthy Start [was] set up to keep people healthy during pregnancy and to help people take care of their children.*

Mother Site 11, previous recipient no longer eligible, two children aged 3 years and 18 months

*Healthy Start was to get people to give their children healthy food.*

Pregnant mother Site 7, current recipient, two children aged 11 and 13 years

There was some variation by site regarding the responses about the aims of the scheme – two sites in particular had a high proportion of parents reporting that Healthy Start's primary aim was to improve healthy eating. Parents in both of these two sites were recruited from Children's Centres where healthy eating was promoted strongly; one ran a range of cooking classes and all staff in the centre promoted HS, the other had organised for a van selling fresh fruit and vegetables to call regularly to improve access to fresh produce for mothers living locally. This promotion of healthy eating may well have influenced mothers' responses about the aims of HS.

The most common alternative perception of the scheme's aims was that it was to provide financial support to families. Again, around one third of respondents mentioned this.

*To try and help make it easier for parents who don't work and things like that. To help them out with cutting the costs.*

Site 11, mother in receipt, two children aged 6 years and 6 weeks

Those who had an impression of the target group generally said it was for 'low income families' or specified it was for those who received benefits or child tax credits. Some teenage mothers were aware that pregnant women and mothers under 18 years were eligible.

There was some overlap between those who perceived the scheme to be aimed at improving health and financial support. Of the group making the link between HS and healthy eating, about half also knew that the scheme was specifically targeted at improving the diets of low income families.

*It's aimed at people with kids on benefits to get them to eat more healthily.*

Pregnant mother in receipt, one child aged 5 years, Site 11

These parents were generally positive about the scheme aims and welcomed help with the costs of food purchasing and encouragement to buy healthy food for their family.

*The idea is to encourage people to get at least some fresh fruit and veg into their diet because it can be very expensive and when you're on a limited income your money has to go on bills first and whilst it's never gonna provide your whole shopping budget it can make sure you get money towards those essential things that you might otherwise struggle to find the money for.*

Previous recipient, Site 13, mother of four children aged 18, 16, 11 and 2 years

Therefore, most parents who were asked about the about the aims of the scheme had some understanding that matched the actual aims of the HS, though the focus on financial support or health

promotion varied. No respondents had views about the aims of HS that were entirely wrong, although some misperceptions were apparent (for example, that the scheme was for 'single mothers' only, or that the vouchers were to cover the costs of milk only). More likely was that respondents reported having no knowledge at all about the aims of the scheme; 16 said they had never been told and would not be able to speculate about why the scheme had been set up or who it was targeted towards.

#### 4.3.3 Spending Healthy Start Vouchers

Most parents across all sites reported that the vouchers helped them with the cost of food items that their family needed and liked to eat. The type of food bought with the vouchers was associated with the age of the child(ren) in the household. Pregnant mothers and those with older children reported using the vouchers for cow's milk and additional fruit and vegetables; parents of formula-fed infants tended to use the voucher to offset the cost of formula milk; parents of breast-fed infants for fruit and cow's milk. A number of parents reported difficulties in using the vouchers for 'follow on' formula, with some retailers allowing this and others refusing to exchange vouchers for this type of formula.

The majority of parents receiving HS vouchers across the 13 sites used them at supermarkets only. The reasons they gave for this choice were: convenience (where they tended to shop anyway, preference for doing one big shop); greater food range; lower prices, ease of use of the vouchers (see section below); and a greater ability to use the vouchers 'anonymously' at the supermarket. There were a smaller group of parents who tended to predominantly use local small retailers for their HS shopping. This group was comprised almost exclusively of younger parents (<25 years). They gave the following reasons for using these shops: easier accessibility; for milk only purchases; lower prices; and the perceptions that vouchers could be used more flexibly in these shops. Some of these younger parents were living a great distance from larger shops, with limited transport options. As such using the local shop was a necessity, rather than a choice.

A small number of parents also used large national chemist stores for the purchase of formula milk. In a couple of the sites, parents mentioned using their HS vouchers at market stalls and, in one site, at a mobile fruit and vegetable van. Those who used these always said that the produce was cheaper here. The mobile van made stops at Children's Centres and this made it a very convenient option for the parents we interviewed in this site.

Most of the parents we talked to indicated that it was straightforward to find local shops that accepted the vouchers. They found out which shops took them by word of mouth, looking on the HS website, and asking at shops. Some indicated that they had referred to the information on the website about which retailers would accept them, only to discover that this was out of date. Few mentioned advertising for HS in shops as a means of identifying whether they took the vouchers. A common theme was for parents to say that they went to shops that they knew took the vouchers, rather than ask a shop whether they accepted them as this was considered too embarrassing.

Although we planned comparisons between the experiences of those living in rural/urban and more/less deprived locations, we didn't find any locations where families as a whole reported concerns or difficulties finding a shop where they could use vouchers including in the three areas with fewest registered outlets. Nonetheless, there remained difficulties for individual families and the range of shops available did vary considerably between our research sites. In some areas it was common knowledge amongst parents that nearly all the local shops took vouchers, whereas in others only the supermarkets were perceived to accept them. This latter situation was predominantly found in areas of lower HS eligibility and in some of the more rural sites.

*I don't think a lot of the local ones take them, back when I was in London quite a lot take them but up here I found it really, really hard to get anywhere to take them, you have to go and use the big stores.*

Mother in receipt of vouchers, Site 13, two children 4 years and 11 months



On the whole, HS vouchers are accepted in enough places that families like to shop, although several mentioned their frustration that some of the cheaper, bigger, stores (like Lidl and Aldi) did not accept the vouchers.

Parent's experiences of using the vouchers in shops varied, predominantly by the type of shop used, and sometimes by different staff on the till. For most the use of the vouchers was unproblematic at the till, where the cashiers would simply accept the vouchers prior to payment and deduct them from the bill. There was some variation between shops (including across different branches of the same store) with regard to how carefully the cashiers would check that parents had sufficient HS-eligible items to match the value of vouchers being used. Occasionally families were asked to separate out the HS and non-HS items into different baskets of shopping. When cashiers exercised a lot of caution over voucher use, parents often reported feeling exposed and embarrassed:

*Sometimes the people in the shops, I don't think they're educated enough about them and there's a little bit of a blag they do, like 'Oh I don't know if you can use it for this' or they've got to go right through your receipt and there's a big long queue and it makes you feel really self conscious, it's like 'Oh you're on the welfare!'*

Site 13 Mother in receipt, four children aged 16, 4 and, 2 years and 7 month old son

Where parents had under-spent (that is, did not have enough fruit, vegetables or milk to match the value of their vouchers) some cashiers would refuse to accept vouchers, others would advise that the parent bought more HS-eligible items, some would deduct the full amount of the vouchers off the total bill, and some would only deduct the value of the items bought and not the full value of the voucher. The risk of 'losing' the unspent part of vouchers was perceived by parents as the main problem with the fixed value of the food vouchers. Most parents who talked about this problem reported deliberately spending just over the voucher value, and making up the difference with cash. This wasn't always possible however, and parents resented this waste when it happened:

*In some places, they were a bit particular...they would put them through, and then they would add it all up and then they would cross through the voucher. So they would waste one voucher, before you had time to say 'oh no I'll take that back and use it next time'. So like sometimes there might be £1.25 still left on it, and I could have used that... I would rather have like grabbed a bunch of apples or something to top it up.*

Formula feeding mother in receipt, Site 2, 2 children 3 months and 30 months

Most parents said that shops were strict about what they could use their vouchers to buy. There was a general perception that smaller shops were more likely to allow small variations – they occasionally gave change when vouchers were under spent, or allowed any under spend to be put towards other food purchases. In four of the thirteen sites, some parents mentioned that they were sometimes aware, or had been in the past, of retailers allowing non-food purchases with the vouchers. In just one of our sites, the majority of respondents reported that they had heard of local shops where retailers allowed HS vouchers to be used for the purchase of cigarettes and alcohol either by not checking carefully or deliberately sanctioning misuse. One mentioned that the retailer would usually treat the vouchers as less than the £3.10 face value so that the shop could make a profit. However fraudulent practice by retailers or parents was seldom raised or reported by our respondents.

#### 4.3.4 Accessing and Using Healthy Start Vitamins

Healthy Start vitamins are provided free with the scheme for pregnant women, women with a child under one year of age, and children between 6 months and four years old. Parents in receipt of HS vouchers get a vitamin coupon sent every eight weeks (i.e. with the food vouchers every other month), attached at the bottom of the letter sent with the HS food vouchers.

Healthy start vitamins for women (in tablet form) contain folic acid and vitamins D and C. Current government guidance is that folic acid should be taken pre-conception and up to the 12<sup>th</sup> week of

pregnancy. Where folic acid has not been taken prior to conception intake in early pregnancy can still be beneficial in protecting against neural tube defects such as spina bifida<sup>78</sup>. Vitamin C is provided to maintain healthy cells and ensure pregnant and breastfeeding females get enough as it is not stored by the body<sup>78</sup>. Vitamin D is the only vitamin for which there is good clinical evidence of deficiency amongst UK children, resulting in rickets or symptomatic hypocalcaemia<sup>79</sup>. The main source is skin synthesis when exposed to sunlight, and Vitamin D deficiency is more common in women and children with darker skin or who cover up for cultural reasons and hence is disproportionately seen in BME groups<sup>79 80</sup>.

Healthy Start Vitamins for children (in liquid form) contain vitamins A, C and D (Vitamin A is not included in vitamins for women as high levels can be damaging to the unborn baby)<sup>78</sup>. Current UK government recommendations are that babies be breastfed up until 6 months. After 6 months, it is recommended that children are given supplements containing vitamins A, C and D (unless they are being fed 500ml or more formula milk which will already be fortified with these)<sup>38 78</sup>. Vitamins are provided for children over 6 months; health professionals can provide vitamin supplements to infants under six months old if they consider that their vitamin stores are likely to be low.

Parents were asked during interviews about their knowledge of and use of HS vitamins and the reasons behind this. In our sample, take-up of vitamins was low for all groups; pregnant mothers, mothers of infant children likely to be breast or formula feeding, and mothers of older children between one and four years of age. This concurs with the views of both HS coordinators and health professionals that vitamin take-up was low, even in areas which are piloting universal provision of vitamins for pregnant or new mothers and/or infant children regardless of HS eligibility status.

### *Pregnant Women*

Of the 14 pregnant women in our sample, six were currently taking, or had taken, vitamins during their pregnancy. Four of these women were interviewed in areas where there was a pilot of universal supply of HS vitamins to all pregnant mothers and they had received the vitamins directly from their midwife. A fifth woman had received her first bottle of vitamins directly from her midwife, but after they had run out was unsure where to take her HS vitamin coupon to collect more and had stopped taking them. Only one pregnant woman in an area where vitamins were not universal was using her HS vitamin coupon to collect vitamins regularly. Of those women taking vitamins, most had been advised to by their midwife or their GP (this GP had recommended taking the HS vitamins rather than writing a prescription for folic acid). A further 11 women no longer pregnant reported taking HS vitamins in pregnancy.

Pregnant women *not* taking vitamins gave a range of reasons for not doing so. These include not knowing about vitamins or not being advised about them by a health professional; because they had been prescribed other vitamins by their GP; trying and failing to exchange the voucher for vitamins at the local chemist; not knowing where to collect vitamins from; local supply (distributed through midwives) had run out; knowing about the vitamins but believing that they were unnecessary.

### *Parents Whose Youngest Child was 12 Months or Younger*

Of the mothers we spoke to with a youngest child under one year old, only a very few were taking vitamins for themselves (five) or were giving vitamins to their child (six). Of these children, three were younger than 6-months. None of the mothers using vitamins were reported being advised about vitamins by a health professional. One was living in an area which was piloting universal vitamin provision to all mothers and young children regardless of HS eligibility. Despite this she had not been advised about vitamins by a health professional and instead had enquired about vitamins after speaking with her sister. Another had been told by her midwife in pregnancy that vitamins were unnecessary if she was eating a healthy diet; despite this she collected HS vitamins and continued to do so for herself and her daughter.

### *Parents Whose Youngest Child was Over 12 Months Old*

Only three parents in this group were giving HS vitamins to their child and only one was taking vitamins for herself. None of the mothers mentioned being advised by a health professional; two read the information on HS materials sent with the food vouchers or had found information online.

#### 4.3.5 Barriers to Using Healthy Start vitamins

Parents who were not using HS vitamins were asked what they knew about vitamin supplementation, both in general and as part of the HS offer. A small number of parents were taking folic acid or vitamins prescribed by their doctor, or buying their own vitamins from the supermarket. Very often, parents reported that no health professional had mentioned vitamins, either during pregnancy or after childbirth. Whilst health professionals, in particular midwives and health visitors, were successfully introducing the HS voucher scheme very few mothers could recall them mentioning the vitamin coupons or advising them on supplementation during pregnancy or in infancy. Many of the mothers we spoke to in the study were unaware of the vitamin coupon.

Beyond an absence of knowledge or advice, parents gave a range of other reasons why they were not using HS vitamins. Several parents reported noticing the vitamin coupon and raising the need for vitamin supplementation directly with a midwife or health visitor, who responded that if they or the child were eating a healthy diet vitamin supplementation was unnecessary. Some had received advice to use vitamins, and this appears to have been more likely to be followed when the professional handed vitamins directly to the parent. A number of respondents could recall being advised about HS vitamins but had not known where to collect them.

*That was the problem. We had the vitamin coupons and for ages and ages I was trying to find out where to get them from, I'd go to my doctors they'd say you have to ask your health visitor or, um the midwife. I went to Boots cos they was telling me they'd do them at pharmacies, and they were saying they'd never seen them before didn't know what I was on about....I think one of the midwives said no its the pharmacist you go to, so I went to the pharmacist and they said they'd never seen this before I think it's your GP. So I went back to the GP and then I think one of them says it was Sure Start.*

Mother in receipt, one child aged 10 months, Site 3

*When I rang up my health visitor to ask them about it they sort of like, one of them didn't even know what I was talking about and the other one, I couldn't even understand what she was saying about where I needed to go to get them. It's not well known about here.*

Mother in receipt, Site 13, one child aged 22 months

This was a common story amongst respondents trying to exchange the vitamin voucher in pharmacies and supermarkets. A number of parents reported finding it embarrassing asking in retail stores for vitamins and staff not knowing anything about them; others got tired of trying and gave up after several attempts. A number of parents had tried health centres with no success. Some knew that their local children's centre would accept the coupons but had often found they had no stock and had stopped trying to collect them. Finally, some mothers knew their local distribution point, either a health centre or Children's Centre, but it was too far away or inconvenient for them to go and collect the vitamins. Other reasons for not taking the vitamins include believing that vitamins were unnecessary, a dislike of taking tablets or drops, concern that the vitamins were causing ill health in children, and concern about measuring the correct dosage with liquid drops.

#### 4.3.6 Parents' Perception of the Impact of Healthy Start Food Vouchers

Seventy parents in the sample were current beneficiaries of HS. They were asked what impact, if any, receiving the food vouchers currently made to their lives. Answers were grouped around two main areas; diet and nutrition, and financial benefits.

## *Diet and Food Purchasing Habits*

Around one third of current beneficiaries reported that having HS vouchers impacted on their food purchasing habits in a positive and healthy way, encouraging them to buy greater amounts and variety of fruit and vegetables than they would otherwise do without the vouchers. For a small number of parents, HS had encouraged them to buy fruit and vegetables when previously they were buying none at all. Parents on a very tight budget admitted categorising fruit and vegetables as non-essential and these would often 'fall off the list' without the vouchers.

*If I couldn't have the vouchers I couldn't get fruit - do you understand? Because it's expensive, so they wouldn't get fruit.*

Mother in receipt, three children aged 6 weeks, 2 and 5 years, Site 3.

Some parents were aware that encouraging their children to eat fruit and vegetables soon after weaning might have a lasting impact on their food choices and were keen to encourage embedding healthy habits in their children from an early age. One parent reported seeing a difference between her two children, one of whom had benefitted from HS vouchers, the other who had not. She attributed not buying fruit and vegetables for her elder son from an early age as the reason he would not eat them now, aged seven.

*I did try my best to get fruit and veg for my son but I just couldn't afford it. I think it would have been a big help if I'd have had that (HS) back then to start off, I think he would now be a bit more open to it [fruit/veg], because I just didn't have the money for it.*

Mother in receipt, two children 7 years and 15 months, Site 11

More parents reported buying fresh produce even before they received the vouchers, but that the scheme increased the amount they were able to buy. They knew that these were popular choices with their children, but had previously found these unaffordable. Many said this was for financial reasons; the vouchers enabled them to buy produce they otherwise would not be able to afford. A few others also felt that receiving the vouchers acted as a 'reminder' to purchase fruit and vegetables, as well as financial support.

*I have them at Asda when I do my shop, and I think how many vouchers I've got and I buy the veg that I have the vouchers for. I suppose if I didn't have the vouchers, I would just pick out the little things. I don't think if I didn't have the vouchers I'd buy half as much, no. I think it's to encourage people to eat well and help mothers buy healthy stuff because obviously a lot of kids things like pizza and stuff, they are always cheaper and a lot of mothers find that buying lots of vegetables makes it more expensive.*

Mother in receipt, one child 4 months, Site 2

Many parents also reported that the vouchers not only encouraged them to buy more fruit and vegetables, but also a greater variety. One common theme was that parents said that they were more able to justify the expense of purchasing more exotic soft fruits (raspberries, grapes, blueberry, etc) for their children than they had previously. Families on a restricted budget also found it difficult to risk buying new and untried products. Parents were concerned about buying new foods that might go to waste if their children did not like them. HS vouchers gave some families the flexibility to experiment with new foods.

*Before if she [mother] bought it you'd be like 'do you know what, we'll waste that'. We don't feel like we've wasted it to be fair she likes everything she tries!*

Father in receipt, Site 10, one child 10 months

*I was able to get him on different types of veg and fruit and not think about the cost.*

Mother in receipt, one child aged 15 months, Site 4

Finally, a small number of parents reported that the vouchers allowed them to buy more cows' milk for their (weaned) children than they would otherwise be able to do without the vouchers.

Not all parents reported that HS impacted on their food purchasing habits or family diet. Many said that the vouchers made no difference. This could be for one of several reasons; some parents preferred to save money on food costs rather than change what they bought. Some were spending all their food vouchers on formula milk and hence their own diet, and that of any older children, remained unaffected. Some parents were happy with their diet and did not think that HS would change it. In some instances this was because they did not prioritise fruit and vegetables and were unaffected by any support to buy more.

*Because we prefer McDonalds! I don't see many people eating fruit and veg really. If I have any veg then it's usually frozen as part of dinner but that's it.*

Mother in receipt, one child aged 22 months, Site 13

Other parents felt that they were already buying a lot of healthy products and would do this regardless of the receipt of HS food vouchers because they placed a high priority on a healthy diet for themselves, and their children. Some parents reported spending a lot of time planning, shopping and preparing meals that meant their children got a wide variety of fruit and vegetables and that HS had not influenced this. Their limited budget meant that this was more time consuming, but they would not compromise on diet and often preferred to save money in other ways.

*We can get clothes from the charity shop, and we do that, but food is important to me.*

Mother in receipt, one child aged 2 years, Site 5

There was no indication from parents that vouchers were used to buy food that mothers and children didn't eat, and indeed families avoided food wastage and made efforts to ensure that all food bought was consumed.

### *Financial Support*

Most of the parents interviewed had something to say about the financial impact HS had on their budget. This was more likely to be mentioned by parents than any other kind of impact. The food vouchers clearly made a difference to the food budget of low income families, although the value placed on this contribution varied quite a lot in our sample.

We found a very small number of parents (three of our sample) who reported that receiving the vouchers was a crucial financial safety net that ensured they were able to feed themselves and their children. For these families, HS meant that:

*You can get a meal even when you've got no money.*

Mother in receipt, Site 1, two children aged 7 weeks and 6 years

Often, families in these circumstances mentioned the use of potatoes as the most basic and affordable of foodstuffs that would prevent them and their children going hungry.

*Mother: You're sort of relying on the vouchers just to get you a little meal ...when we was on a short patch when the money was crossing over we didn't have a lot. So we've say, like, a jacket potato so we'd go in the shop and get a jacket potato and think then, well we can't even get any cheese to go with to have with our jacket potato...Father: and when you're feeling sort of stuck, when you had the voucher there was always something.*

One parent with a newborn baby admitted to the researcher that she only had one pound in the house which would be used for a potato for her evening meal. Another reported a strategy of deliberately not spending the vouchers during her weekly food shop but saving them for the middle or end of the week when this would have run out, and was able to use them for milk and potatoes to 'see the family through' until the end of the week.

For other families in less challenging circumstances HS was often perceived as a help towards the cost of the family's food budget. Over half the parents in our sample of current beneficiaries described the food vouchers as a 'big relief', a 'big help' or 'making a big difference'. We asked parents how much they typically budgeted for food, and the majority who planned in this way said that they typically spent in the range of £30-50 per week on food, depending on the number of children. The provision of £3.10 (or more) per week in vouchers represented a considerable additional allowance for food expenditure. A number of parents mentioned that this had been especially important to them where the cost of many essential goods had increased. Fruit and formula milk were both identified by parents as particularly expensive items. Parents were not always able to quantify what they spent each week on the family's food, as this often depended on the money available to them. However, most described the food budget as 'tight' and appreciated the difference that HS vouchers could make.

*I was really pleased [to get the vouchers], it was like 'Thank God, I can actually get some baby formula without being totally crippled for the rest of the week', so yeah, I was really pleased.*

Mother in receipt, three children aged 16, 10 and 3 years, Site 13

This was especially true for families receiving more than the minimum £3.10 per week:

*We don't really have a fixed budget. It varies, because one week we get just the baby's money, and then one week we get our money as well, so one week it's like £30, the next it's like £50 a week that we spend. . So the vouchers do make a big difference.*

Mother in receipt, two children aged 3 years and 9 weeks, Site 2

We have already discussed how some families used the vouchers to buy additional or a different variety of food. The majority of families who reported that the vouchers were a big financial help also reported buying more fruit and vegetables because they had the vouchers. Others used the vouchers to cut the cost of the weekly or monthly food shop so that the money saved by using the vouchers could be spent on other things.

*£3.10 a week when you're working doesn't feel like much but when you're not working and are on benefits it does make a difference, it's £3.10 a week you have of your money to spend on other things aside from milk, fruit and veg.*

Mother in receipt, one child aged 2 years, Site 13

Not all families thought that the vouchers made a big difference to their budgets, and while they appreciated being able to save a little money they felt that £3.10 a week was not enough to have a noticeable impact. Some noted that it definitely would not be enough to influence what they purchased. Families buying formula were especially likely to comment that the vouchers made little impact on family diet, because HS did not provide enough even to cover the cost of formula milk.

*It's sometimes frustrating that they don't cover the cost of formula, if we're a bit skint that week it's trying to find a bit of money in a tub somewhere...*

Pregnant mother in receipt, one child aged 13 months, Site 11

*I thought that the scheme was great and would be a help, especially as I had just lost my job. It did help in pregnancy but now the baby is born and she needs formula, the vouchers do nothing, really.*

Pregnant mother in receipt, 1 child aged 4 months, Site 4

#### 4.3.7 Parents Suggestions for Improving Healthy Start

While many parents had no suggestion for changes to HS, those who did proposed that improvements could be made to a variety of aspects of the scheme.

##### *Broadening Eligibility*

In line with the fact that parents were generally very happy to be recipients of HS, some made suggestions that the scheme should be extended to reach those whose income was above the current threshold of eligibility. Only one wanted universal coverage of the scheme to all parents. Additionally, some parents suggested that an extension of the scheme until the child was older (e.g. five years) would be beneficial. Ex-recipients were vocal in suggesting both of these possible ways of widening eligibility of the scheme: they felt the absence of HS and were suggesting ways that would allow themselves (and people like them) a way to be part of the scheme for a longer period.

*Parents are told that they should be buying healthy food for their children but you just can't afford it, it is particularly hard for people on low incomes who don't qualify for Healthy Start.*

Ex-recipient mother, one child aged 2 year, Site 11

##### *Increased Voucher Value*

Some recipients would like their weekly allocation of HS vouchers to increase. Specifically there were suggestions to raise the amount of the vouchers to cover the full cost of formula milk. The perception for some was that the predecessor 'milk token' scheme had provided this level of coverage for families and that HS should do as well. Some who were using formula milk for their baby said that the entire voucher went towards this cost, leaving nothing for healthy food purchasing.

##### *Modifications to the Voucher Mode*

As discussed previously, the use of vouchers was sometimes problematic for recipients because of issues related to the exact amount of vouchers and change not being given for purchases below that amount. Some parents suggested possible solutions to these problems: issuing the vouchers in smaller denominations to allow greater flexibility; and provision of a chargeable card instead of paper vouchers.

##### *Wider Range of Eligible Products*

There was a desire amongst recipients for a wider range of items to be eligible for purchase with the vouchers. Some children in this study had special dietary needs, most often intolerance to dairy milk or wheat/gluten, and parents wanted to be able to buy soya or goat's milk with HS vouchers. Other food items suggested were: yogurt, fruit juice, tinned fruit, jars of prepared baby food, follow-on formula milk and bread. A small number of parents suggested that the scheme should be extended to include other non-food basics for babies, such as nappies.

##### *Increased Promotion*

Some recipients felt the scheme needed improved promotion by health professionals so that parents and pregnant women learned earlier about HS. This was a view expressed especially by those who had not learned about the scheme when they were pregnant, and therefore felt that they had missed out on the perceived benefits to their health and finances. There were some parents who also thought that the scheme could be better advertised by retailers – both in terms of signage in windows of shops so it was clear that they accepted vouchers, but also in the form of a HS icon being placed on/next to products alerting that these were part of the scheme.

### *Additional Healthy Eating Advice*

Some parents suggested that more advice was needed about weaning and getting children to eat healthily. This could be offered with their vouchers, via the website, and from health professionals.

#### 4.3.8 Exploring Different Experiences of Healthy Start

As well as common experiences of HS described above, the study design adopted allowed for further analysis to consider the particular experiences of groups whose experiences of using HS might be likely to be different. These were: parents not currently in receipt of HS vouchers; teenage mothers (below 18 years when pregnant); Black and Ethnic Minority parents; larger families; first time parents; differences between those who breast feed and bottle feed their infant children. This section comments on the experiences of these groups where they appear to differ from the description provided above.

Few differences were apparent according to size of family or age of children. Age of youngest child did not seem to change experiences of applying for or using HS, nor on their perceptions of the impact of HS on their diet. Those families with a baby aged 0-12 months were more likely to report not buying any fruit and vegetables with their vouchers, and this is likely to be because of spending on infant formula.

There may be some association between family size and financial impact; families with two or more children were more likely to report that the vouchers had a helpful financial impact than smaller families, perhaps because larger families received more vouchers. Parents with larger families, (that is two or more children) were also more likely to state that the vouchers had no impact on fruit and vegetable consumption.

We were also interested to look for differences between family experiences related to contextual factors such as neighbourhood characteristics and availability of local services. For instance, we have already commented on the impact of universal provision of HS vitamins in some areas. From these planned comparisons we found no patterns of difference between rural and urban areas, and few between more and less deprived areas. One important difference between families that emerged was quite differing availability of dietary advice, and the nature and importance of these differences are described next.

#### 4.3.9 Diet and Nutrition Advice Available with Healthy Start

Healthy Start is mediated through health professionals, a deliberate reform to the Welfare Foods Scheme that was designed to reinforce the public health role of the scheme. While most parents were introduced to the scheme by a health professional and will have required one as a counter signatory, we could not find examples of parents who recalled the scheme being introduced explicitly as a health intervention. We therefore looked in more detail at current HS recipients' (n=70) experiences of diet and nutrition advice and support from a range of sources, reasoning that even where this advice and support was not explicitly linked with HS, receipt of it might influence how beneficiaries used their HS vouchers and could suggest routes for promotion of HS health messaging.

#### *Diet and Nutrition Advice Received From Midwives Only*

The first group of parents described here are those who recounted receipt of advice and support around family diet and nutrition from their midwives only (19 of the parents in our sample). This group were primarily comprised of pregnant women or women with children <3 months of age, who may have had limited contact with other services (although some also had older children). Two mothers were seeing health visitors regularly at child health clinics but thought that the clinics were for baby weighing only. Most of the group recall receiving advice from their midwife about diet during pregnancy, including foods to avoid but also in some cases information about healthy diets. While most women spoke with their midwife about this, some received the information in written format



through leaflets or books. In addition, many women recall being advised and encouraged to breastfeed. Only three women recalled being advised to take HS vitamins in pregnancy.

Some women were keen to emphasise the importance placed on the advice received from their midwife, and were clear that they followed the dietary guidance carefully, in particular avoiding certain foods. Encouragement to breastfeed was more likely to be discounted. One respondent noted that the midwife's encouragement to take vitamins meant that she would have bought them, if they hadn't been available for free. While midwives were not explicit about the health role of HS, some mothers made the link between the scheme and health because of their role in introducing it.

Of the current beneficiaries who recalled receiving diet and nutrition advice from midwives, almost all also reported that one impact of receiving HS vouchers was that they were buying more fresh fruit and vegetables.

#### *Diet and Nutrition Advice Received From Health Visitors Only*

Eighteen parents recalled advice about diet and nutrition primarily from their health visitor. The youngest children in most of these families were over one year old and this may have influenced their recall of any advice received from midwives whilst in pregnancy, although a small number had children under six months of age. Most of the support received had been directed towards the child, in particular support for breastfeeding, weaning, and child diet. No parents recalled being advised on their own diet. Parents received this support either at home visits, or at well child clinics. Most parents' advice was in response to feeding and diet questions, and occasionally for more serious concerns such as child food intolerances or low weight. In all cases, parents reported getting helpful and valued advice from their health visitor, which they followed. A smaller number recalled the health visitor raising food and diet without prompting, and others were aware that the health visiting team ran regular weaning sessions.

Similarly to the midwife-only group above, almost all of the current beneficiaries who recalled receiving diet and nutrition advice from health visitors reported that one impact of receiving HS vouchers was that they were buying more fresh fruit and vegetables.

#### *Diet and Nutrition Advice Received From Midwives and Health Visitors*

Twenty respondents recalled receiving advice on diet and nutrition from both a midwife and a health visitor. Three were pregnant as well as having older children, the remainder were evenly split between those with infants under 12 months and those with older children. There were no reported differences in the types of advice and support provided by midwives and health visitors to parents in this group.

Very few of the current beneficiaries in this group reported using HS vouchers to buy more fruit and vegetables when compared with those who could recall receiving diet and nutrition advice from either one of a midwife or health visitor (not both). Several of the parents in this category had children who had health problems (e.g. underweight or food intolerance) and it may be that much of the advice recalled was concerned with these issues rather than more generic healthy eating support.

#### *Other Sources of Support For Diet and Nutrition*

Some parents identified additional sources of advice beyond that available from health visitors or midwives. The first of these groups were those accessing specialist services through the Family Nurse Partnership or teenage mothers groups. In both cases, these were reported as their primary source of advice including on infant feeding and diet. We noted that many parents we spoke to in teenage parent groups were no longer in their teens.

Children's Centres were another key source of information. Parents identified making use of the written information available there, usually recipes or healthy eating advice. Others mentioned attending classes, including on weaning and child nutrition. Some also mentioned the general support available from children's centre staff, who would help mothers with a range of queries and concerns

they may have with their children's diet. One mother was attending cooking classes aimed at mothers of young children at a local food cooperative.

A small number of respondents were in the care of dieticians and nutritionists. The advice they received was not always perceived as helpful – one mother reported being advised about adding extra calories to meals without understanding what a calorie was.

A number of respondents mentioned asking family (in particular their mothers) and friends for advice on breastfeed, weaning, and child diet.

The information provided with HS vouchers wasn't recalled by many respondents. When prompted a few valued the advice, for example one first time mother told us it was useful to know what children can eat and how healthy choices benefitted their child. But many parents didn't recall additional information ever coming with their vouchers, and some of those who did felt it was not helpful.

*I just wish with Healthy Start there was a bit more advice about what to cook and how to cook it and recipes cos that would help but it's got to be down to earth like I say, not chickpea pie! That might work for middle class people and things like that but they're not middle class people getting the tokens.*

Mother in receipt of vouchers, Site 13, four children aged 16, 4 and 2 years and 7 month old son.

### *Parents Who Received Poor or No Support*

A sizeable number of respondents (26) reported receiving no advice/ support on diet and nutrition from any source. Many of these were parents with children over 12 months old who may have stopped regular contact with health professionals. However some in this group were pregnant or had babies. As one mother told us when we asked if she felt she knew enough and whether there was anyone who provided advice:

*Not really. It would be good to know what's got what in it, what has broccoli got in it, vitamins? I don't know.*

Mother receiving vouchers, two sons 2 and 4 years, baby of 7 weeks, Site 1

Not all in this group were able to say why they felt they hadn't had any support and advice, though some reasons were identified. These included:

- Not seeking support from health professionals but relying instead on information from baby books, the internet, and own instinct/knowledge or that of their family
- Seeking support, but finding health professionals dismissive. In some cases parents approached a GP after health visitors or midwives did not provide sufficient support or reassurance
- Finding health professionals too busy to approach
- Not developing a trusted relationship with health professionals because they never saw the same one more than once
- Concern that health professionals 'looked down on them' because they were overweight, or a very young parent
- Limited access to child health clinics because of cuts in local services or lack of transport (especially in rural areas)

Of the current beneficiaries who recalled receiving poor or no support for diet and nutrition advice from health professionals, approximately half reported that one impact of receiving HS vouchers was that they were buying more fresh fruit and vegetables. Eight of our PCTs were above the mid-rank for deprivation, so more of our parent sample lived in PCTs ranked high for deprivation. There is a pattern in our data that indicates some association between receiving little or no support for diet and nutrition, and living within a PCT which ranks more highly on the indices of deprivation. In addition,

respondents living in a less deprived PCT more commonly recalled using some other resource beyond a health professional for support. Whilst caution should be observed in a small, qualitative sample, it appears that those parents living within PCTs ranking more highly on the indices of deprivation may be doubly disadvantaged – more likely to miss out on advice about diet and nutrition in pregnancy and the early years from a midwife or health visitor, and less likely to have identified alternative sources of support.

#### 4.3.10 The Healthy Start Experience of Those Who Choose to Breast or Bottle Feed

Given the importance of the changes from the Welfare Foods Scheme to better suit the needs of breastfeeding mothers, we felt it was important to consider whether there existed any observable differences between those who had breastfed and those who had exclusively bottle fed. We compared the views and experiences of respondents with a child under one year old (where breast or formula milk would still be a substantial component of their diet), comparing those 16 mothers who breastfed for at least 2 weeks including those who used mixed feeding (5 of whom were not currently receiving HS vouchers) and the 32 mothers who had exclusively fed their babies using infant formula (all but one of whom was currently receiving HS vouchers). We predicted that they would be using their vouchers differently (given the high cost of infant formula), but were keen to know whether HS was perceived as supporting a healthy diet for breastfeeding mothers.

Few families in this study reported exclusively breastfeeding their babies for 6 months. This is in line with national trends<sup>81</sup>. Those that did breastfeed didn't report any problems with the scheme. We found some evidence that those who bottle-feed are less likely to buy fruit and vegetables reflecting the fact that vouchers cover less than the cost of infant formula. Those with young children seemed tuned in to healthy eating messages, and most felt they had a healthy diet regardless of their feeding decisions. Although some of those who exclusively bottle fed had briefly tried to breastfeed, most had never considered it and weren't to be persuaded otherwise:

*I've got a good relationship with my midwife, she delivered the baby!...When I said to her I need to go and buy baby milk because I was panicking in case she comes early she went 'ok well you've got breasts'. And I went 'no chance!' I've got 6 children and I've never done it with any of them.*

Mother in receipt, 6 children aged age 16, 14, 13, 12, 6 years, and 4 weeks, Site 10

For those exclusively using infant formula the entirety of their vouchers are used to buy this. Of the 32 families who had exclusively bottle fed their babies only around half (15) mentioned ever using any of their vouchers on fruit or vegetables. This compared to 12 of the 16 who had partly breastfed, even though several were no longer breastfeeding. This difference was apparent when considering the attitudes of the two groups to the receipt of fixed value vouchers. Five of those who had only formula-fed complained that the vouchers were not sufficient to buy all the formula they needed, but this was only mentioned by one parent who had breastfed for some time. Only one parent (a breastfeeding mother) mentioned the difficulty of having to buy in bulk to use the vouchers, and found the short shelf life of fresh milk and fruit meant food was sometimes thrown away.

Most parents in both groups (those who never breastfed, and those who breastfed for at least 2 weeks) felt they had a healthy diet. There were many parents who were proud to be good cooks, and felt well able to give their families good food and some parents in both groups report making efforts to increase the amount of fruit and vegetables in their diet:

*I try and give her the best like, I don't want her to eat loads of junk food.*

Site 8, mother of 8 month old, exclusively breastfed till 5 ½ months

*I also just make sure I get at least one bunch of bananas for my son.*

Site 11, mother of 6 year old and 6week old, never breastfed

Only one of the breastfeeding parents said she felt their family diet was not healthy enough, and she attributed this to lack of funds since she stopped getting the vouchers:

*The food has gone down and they're [the children] very upset because I can only buy things like onions and potatoes and not what I used to buy.*

Site 7, previous user, Mother of three children aged 3 years, 2 years and 5 months

Whereas a couple of parents in the bottle feeding group felt they didn't have enough time:

*I wouldn't say my diet is very healthy...it's just time, I can't leave him on his own to get my food, and if he sees me he wants my food.*

Mother of 10 month old exclusively bottle fed, and given solids at 2 months, Site 1

And one reported a very unhealthy diet for her 10 month old daughter:

*She likes KFC and stuff that. If I'm out and about I'll get her KFC or McDonalds...She'll eat the popcorn chicken, or at McDonalds I'll get her a burger...My daughter eats more than I do.*

Mother in receipt, one child aged 10 months, Site 12

There were no differences between groups in willingness to take vitamins; some took vitamins but equally some felt they were unnecessary because their diet was sufficient.

#### 4.3.11 The Experience of Those Not Currently In Receipt of Healthy Start Vouchers

Although the majority of our sample had successfully applied for HS, we did speak to a minority who were not signed up to the scheme. The first group of interest is those who we believed, given circumstances they described in their interview, would likely be entitled but had not applied for the scheme. There were five women in our sample who fitted these criteria, four of these had had recent chaotic periods in their lives, including three with recent periods of homelessness. Two of these respondents remembered receiving the application, and one had completed it and obtained a health professional's signature, but had never submitted her application. Although a couple said they weren't sure about eligibility (one had been working so felt this might make her ineligible, and another thought that those who were breastfeeding didn't need to apply), but the main reason given was that it was simply too much take on when other parts of life were challenging:

*There has been that much going on, with the split, that I just haven't thought about it.*

Mother not in receipt, 6 children, aged 10, 9, 7, 4, 3 and 2 years, Site 5

Another mother reported that she thought about applying, but

*I couldn't take another refusal.*

Mother not in receipt, 2 adult children in their 20s, one aged 12 months, Site 2

The second group of non-recipients were a group of six who had been receiving vouchers, but they stopped without explanation. Of these three were teenage parents (see section 4.3.12). The other three had been receiving vouchers since their baby was born, but they had stopped. Two had moved house, and there was some confusion as to whether their address change had been communicated to HS, or if changing address for one benefit would result in an automatic address change for all. One of these had spent a period in a crisis shelter and (like the non-applicant group) had had a chaotic period in her life and the vouchers were particularly important at this time:

*When I was living in a shared house I was only getting £32 a week off a crisis loan because my money all got messed up, so when my vouchers came through they did really, really help.*

Site 1, Mother not in receipt, baby aged 5 days

Finally, there were a number whose applications had been rejected, but who were at the margins of eligibility (n=12). Often these respondents had a pattern of reapplying as circumstances (employment or relationship status) changed. Prominent among these were those with less secure employment; where they or their partners were employed part time, self-employed or moved in and out of employment. Given that belonging to this group often related to employment, it may not be surprising to note that families in this group tended to have a higher level of education than average among HS recipients. All of these 12 had some post secondary education, while in the whole sample around one quarter of respondents had no qualifications.

Most of those we spoke to at the margins of eligibility seemed surprised that they weren't eligible, and were unsure why they weren't. For example, one mother told us she was receiving income support at the time of applying but was told her income was too high, and she was unsure whether her previous year's tax return (when she had been working) had been used to calculate her eligibility. They also found the 'cliff edge' of eligibility, where a small increase in hours or income meant the loss of eligibility, difficult to understand and this put a financial strain on families. One family told us they were "living penny by penny" and that the vouchers had made a much bigger difference than they thought they would when they applied. Another was struggling to get by:

*I explained that my husband was only working 17 hours and asked if they could give me extra help ... All my money goes on the rent, the bills, clothes, shoes... Our income is a lot less than when we had the vouchers and were able to be in good health.*

Previous recipient, Site 7, mother of 3 children aged 3 years, 2 years and 5 months

There were some among this group who told us they were receiving additional services, suggesting that the family was struggling in other parts of their lives. However, there were also some who were quite sanguine; for example one young mother with a 9 month old baby had not heard back after applying but hadn't chased this non-response because she had moved back in with her parents and her mother told us:

*I think it's just because we've supported her now see, so I just think [she needs it].*

Grandmother, Site 3

And these families, unlike non-applicants, seemed on top of their family administration. One mother told us that she knew her husband's hours were going to be cut back so she would check the calculator on the HS website to see if a recent change in circumstances will put her family back into eligibility.

Among both those whose vouchers stopped, and those who were never eligible, most didn't know why. They felt the letters they received didn't explain why they were not eligible and, though they made assumptions about why this might have been the case, they would have liked more information.

#### 4.3.12 The Experience of Teenage Mothers

Eight teenage mothers aged 18 or under were interviewed for the study. The youngest respondent was 16 years old. All had one child, aged between five weeks and 15 months. One respondent described herself as mixed black/white British, the remainder as white British. Most respondents were recruited from Children's Centres, usually from groups targeted towards teenage parents. Two of the respondents were recruited by telephone. Five were currently in receipt of HS vouchers at the time of interview, the remaining three were previous recipients no longer in receipt of vouchers. These three

were unclear why their vouchers had stopped and did not recall having received any information telling them why. Pregnant women under 18 years are eligible for HS regardless of benefit status, however once the baby is born, or they turn 18, only those also claiming qualifying benefits will continue to receive HS vouchers. In one case, the cessation of vouchers coincided with the birth of her baby and the mother turning 18 years of age. In a second instance, the vouchers also stopped just after the baby was born, although this mother was still 17. We know from other respondents that there was often an interruption in the receipt of vouchers soon after the expected birth date. Three other mothers in this group experienced a gap in the receipt of vouchers just after their babies were born which they had queried via the helpline or website. One previous recipient had received a letter inviting her to reapply but hadn't yet responded; the other had sent a query via the HS website including her national insurance number but had not received a reply. The third previous recipient was 16 and had recently moved into foster care, making her ineligible for the scheme (although she herself was unaware of this). None of the teenage mothers were clear about their eligibility for the scheme and the high number who had experienced interruptions or unexplained cessation of vouchers suggests that the administration of the scheme may not be working well for this group.

Most of the teenage mothers found out about the scheme from their midwife. One mother could not recall being told about the scheme in pregnancy but also reported that her life was 'chaotic' at the time and she was frequently moving home so may have missed this information. Most reported no problems with the application form, but three felt that the vouchers took an overly long time to arrive after their application. One previous recipient had been invited to reapply but found the process too laborious with a small baby, both completing information about benefits and making an appointment with a health professional to get the application signed.

Only one of the teenage mothers was currently breastfeeding, the remainder were either feeding their child with formula milk or the child was weaned. None reported significant problems spending the vouchers and they were usually exchanged in larger supermarkets for formula, milk, fruit and vegetables.

Teenage mothers were more likely to mention parents, partners and carers as a source of information and advice around diet and nutrition and infant feeding. Three were living with parents or foster carers who did the bulk of the food shopping for the household and prepared most of the meals. Four of our respondents were recruited from teenage pregnancy support groups, where they had ready access to support from Children's Centre staff and, in some cases, midwives who helped to run the group. They rarely mentioned other midwives or health visitors as a source of support. Only one reported receiving and following dietary advice from a health visitor, who encouraged her to change her diet whilst she was breastfeeding.

Three of the mothers had taken vitamins throughout their pregnancy, on the advice of their midwife. None of these had carried on once the baby was born, one because the vouchers had stopped and the remaining two because they were unsure whether or not they or their child should take them.

*I know there are vitamins for babies but since she's doing so well I didn't want to mess up a good thing.*

Mother in receipt, baby aged 9 months, Site 6

The remainder had very little knowledge about vitamins and had never received any advice about them from a health professional.

The most important impact of receiving HS vouchers for this group was financial. Most of the respondents reported that the vouchers made a significant improvement to their food budget. Two reported that the vouchers helped them afford formula milk, three that they could buy extra fruit and vegetables, and a further respondent recalled being able to buy extra milk for herself in pregnancy. The three previous recipients all noted that not receiving the vouchers made a difference to what they were now able to buy.

### 4.3.13 The Healthy Start Experience of Black and Ethnic Minority Parents

For the most part, no differences were apparent between the experiences of families from white British or other ethnic groups. We could find no differences in use of vouchers by shop type or food purchased, nor on the perceived impact of HS. A couple of mothers for whom English was an additional language noted that even though the form was in English, it was simple enough to complete. However, most of the BME parents we spoke to were UK born, and we considered that the experiences of those born outside the UK may differ, since they themselves grew up outside the UK context and may be more likely to experience language barriers. The rest of this section focuses on the experiences of such first generation migrants.

We spoke to eight mothers who told us that they had migrated to the UK as adults, and who had English as an additional language, although their fluency in spoken English varied. Of these, three were Polish, two from South Asia and three from Africa. Two were lone parents. We note that interviews took place in English, though we did offer those who were less fluent to use a friend or interpreter, but none took this offer up.

These respondents didn't report problems applying, although only two remembered being told about the scheme by a health professional. Most had found out about HS through other routes (friends, benefits advice, and government websites) and sought out an application form. Four of these women had a child who was not fully weaned and all exclusively breastfed and bought no infant formula. Of the four with older children, two had exclusively breastfed, and two didn't discuss past feeding choices. First generation migrants appeared to be more likely to initiate breast feeding and to breastfeed exclusively and/or longer – one mother told us she was still breastfeeding her daughter at 18 months, confirming findings from other studies of greater initiation and duration of breastfeeding among women from ethnic minority groups<sup>81</sup>. Nonetheless, none of these mothers reported having any difficulties using all of their vouchers, and only one black-African mother reported any problems using vouchers. This was because she liked to use the smaller local shops because they were cheaper, but many of these weren't registered with the scheme.<sup>c</sup>

## **4.4 Successes**

Most parents found the application process straightforward, including getting a counter signature from a health professional. Vouchers often arrive quickly for eligible applicants, and the application system appears to be working well.

Many parents get their information about how to use the food vouchers from the written materials sent with HS vouchers. This is working well.

Parents find the vouchers easy to spend in their local area. Almost all report easy access to major supermarkets and smaller retailers who accept them, and very few report having to visit retailers they would not normally shop in. Some reported using the HS website to find a local retailer; recent updates to the retailer information on the site will benefit users.

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<sup>c</sup> In addition to the interviews we conducted, a Master's student at Bristol University conducted interviews with 9 Chinese women who had come to the UK as adults<sup>82</sup>. Leung WY. A qualitative study of Healthy Start - perceptions of Chinese beneficiaries and Chinese store supervisors [Masters Dissertation]. University of Bristol, 2011. These interviews took place in their first language (Mandarin or Cantonese)<sup>82</sup>. Ibid. All reported language barriers to accessing the HS scheme; they had great difficulty completing the application forms. These parents also experienced problems using both the food and vitamin vouchers. They experienced significant difficulties trying to use food vouchers because they couldn't communicate with supermarket staff if there was a query. This was even more acute when they tried to seek out vitamins. The participants in this study also found their shopping choices were more restricted, as their preferred Chinese supermarkets didn't take HS vouchers or sell any cow's milk products. This study also suggests that the lack of involvement of GP practices is a lost opportunity. Access to translators was often a barrier to health care, so two of these women had sought out a Chinese speaking GP, but since the GP didn't know about HS they were unable to provide advice.

Parents are generally positive about the range of foods that can be bought with HS vouchers, and appreciate the inclusion of frozen fruit and vegetables.

Healthy Start may be having an impact on diet and nutrition for some parents. Some parents reported purchasing a wider range of fresh produce for their children (which would otherwise be unaffordable), and increased quantities of fruit and vegetables.

For most parents, HS vouchers contribute significantly to their weekly food budget. A smaller group report that the vouchers ensure they can buy the bare essentials for their family, or act as a 'safety net' allowing the family to buy enough to eat.

#### **4.5 Challenges and Opportunities**

Some parents reported that vouchers stopped soon after their baby was born and were confused about why. Beneficiaries are sent instructions and reminders to notify the Healthy Start Issuing Unit after their baby is born, but some parents still did not know about this requirement.

Some parents were aware that they needed to contact the Healthy Start Issuing Unit to confirm their baby's birth and ensure continuation of vouchers; others were not. Consideration should be given to how the process for confirming birth could be clarified as this is a busy and chaotic time for many parents. This lack of awareness seemed to be a particularly common problem among mothers under 18.

Parents who have applied but not been successful, or whose vouchers stop suddenly, are often unsure why. Healthy Start might better communicate the reasons for refusal or non-continuation of vouchers to applicants.

The HS helpline has been useful to parents, but expensive to call especially since many only have access to mobile phones.

Some eligible families are probably missing out at the moment. Parents in crisis, including disrupted housing and financial problems, are often most vulnerable but also more likely to stop receiving HS because of changes in address and/or changes in benefit status. Some neighbourhoods have lower take-up rates, and so do less deprived PCTs.

Ex-recipients and unsuccessful applicants report that the income level for eligibility is very low, and often struggle to make ends meet without the support of the scheme. This also makes them ineligible for vitamins. This is especially problematic for families whose income fluctuates just above and below the eligibility level.

Few parents are aware of, and access, the HS website.

Access to retailers accepting HS vouchers is good, but some parents expressed disappointment that some cheaper multiple retailers do not accept them.

The impact of HS food vouchers on parents' purchasing habits varied. Some parents reported that having HS vouchers encouraged them to buy greater amounts and variety of fruit and vegetables than they would otherwise have done, and a small number of parents reported that the vouchers allowed them to buy more cows' milk. Many also reported no difference in purchasing habits; they were used for food items they would have bought anyway, rather than contributing to a change in what they bought.

We can find no examples of parents who recall information about the food vouchers provided by health professionals explicitly linked to health and nutrition advice. Some parents make the health connection precisely because the scheme is introduced by a health professional but for others, the health promotion message may be getting lost.



A sizeable proportion of parents in our sample did not recall receiving any advice about diet and nutrition. Some of these parents had not sought out advice, but they may also have found health professionals unhelpful and/or inaccessible. There is also some evidence to suggest that parents living in more deprived PCTs are less likely to receive diet and nutrition advice from a health professional or any other source.

For parents with a very limited budget, fixed-value vouchers can be problematic. The unspent portion of the voucher is usually lost to parents, and many would like smaller denominations or a 'charge-card' approach to increase the flexibility of the scheme. However, it may be challenging to include vitamins in a paperless scheme, and the WIC example suggests moving from paper vouchers to debit cards excludes small stores and markets<sup>66 67</sup>.

Some children in this study have special dietary needs, most often intolerance to dairy milk or wheat/gluten. Healthy Start vouchers cannot be used for non-cow's milk such as soya and for parents on a low income forced to buy expensive alternatives, this seemed unfair.

Uptake of vitamins amongst parents is very low. The main causes appear to be lack of advice to take them (both in pregnancy and infancy) and difficulties accessing them locally. Vitamins are not available in the places parents expect to find them (high street pharmacies and supermarkets).

Even if take-up could be improved, there would remain a time lag in accessing vitamins from the earliest opportunity in pregnancy. Parents cannot apply for HS till ten weeks gestation and must then wait for the voucher and find a place to collect the vitamins. Where universal provision is being piloted professionals reported that parents were able to access vitamins much earlier in pregnancy, often they were given by the midwife at first appointments. This seems to be a more efficacious way of distributing vitamins.

## 5. Results: Small and Independent Retailers Using Healthy Start

### 5.1 Key Findings

- Most research areas had a large number of registered retailers of different sizes, confirming the reports from parents that most were able to reach a registered retailer with ease.
- Small retailers found the scheme easy to use; they recalled no problems with joining the scheme; and after submission of vouchers, reimbursement was speedy.
- Many small retailers viewed their registration as a way to serve their community. The contribution of HS to their turnover was small but they felt that local families needed the scheme.
- Small retailers report largely providing fresh milk in exchange for vouchers, probably because they are often more expensive than supermarkets for infant formula, or fresh fruit and vegetables.
- There is a perception amongst small retailers that some shops exist who allow beneficiaries to misuse the HS scheme by buying cigarettes and sweets, although none were identified by name and none of the retailers we spoke to admitted to this practice. Some of the retailers we spoke to reported allowing part of the value of HS voucher to be put toward non-HS items they believed to be healthy and/or essential for children, and some errors may be made when retailers misunderstand which items are allowed.
- Retailers' belief in their community service and longstanding relationships with customers means they may be receptive to approaches which aim to improve the health of their community.

### 5.2 Background, Methods and Sample

Neighbourhood food availability plays some part in explaining unhealthy diets in poor areas<sup>83</sup>. For instance, the major supermarkets, often the cheapest sources of high quality food, may be less present in the most deprived neighbourhoods<sup>83</sup>. Price, choice, and availability are likely to differ for different groups. In a recent study, researchers found that in an area with a largely white British population healthy food was both more expensive and harder to find than in a neighbouring area whose population largely came from South Asia<sup>84</sup>. Since HS food vouchers have a fixed value, differing prices mean the absolute quantity of goods that can be purchased will vary between shops. The equality impact review of HS<sup>1</sup> suggests that ethnic minority women and those who live in the most disadvantaged areas are more likely to shop with independent and franchised retailers above multiple outlet grocers.

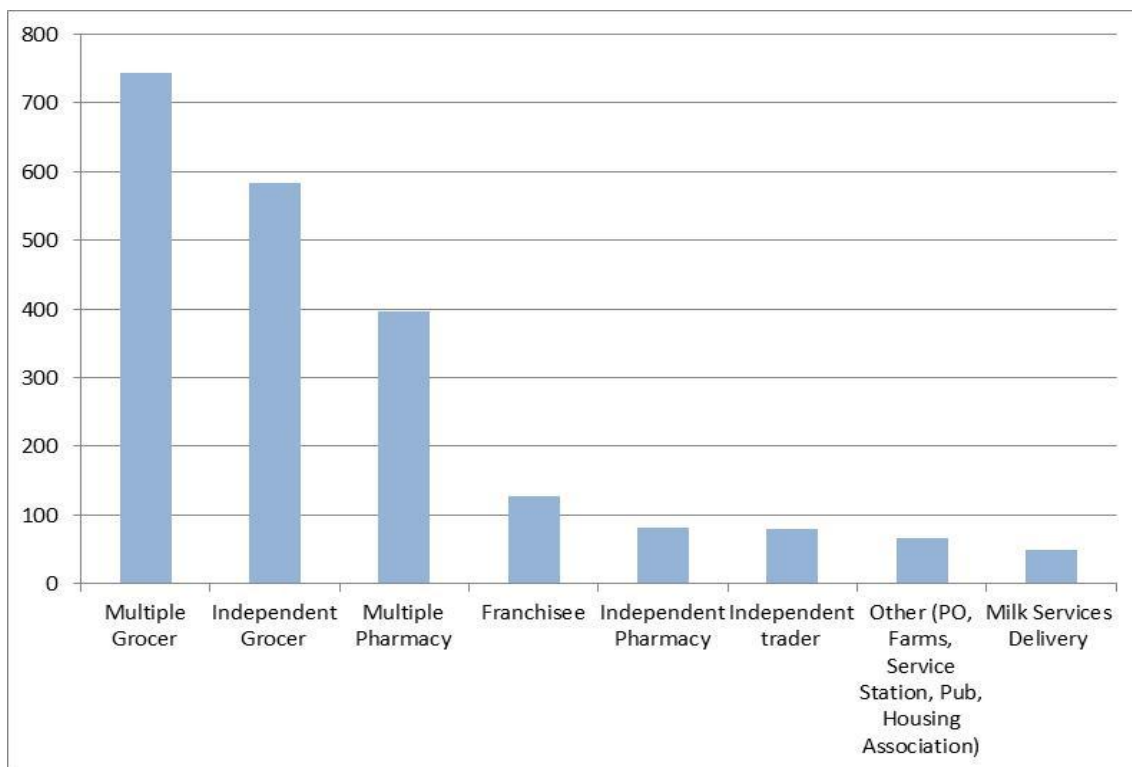
The experience of small retailers may be particularly important in understanding the use of vouchers within the most disadvantaged neighbourhoods, and among ethnic minority groups who may be less likely to shop in large multiples. We therefore planned to use HS data to examine retailers in our study areas, and to carry out interviews with independent retailers and their trade associations.

Data was provided to the study team by the HS reimbursement unit which summarised retailer activity across England. In addition, further detailed reports for all registered retailers in our 13 selected for study were provided. These data included date and value of retailer's first and last claim, total claim value, and items retailers were registered to supply and were analysed to provide contextual data to supplement interviews (See Table 5, Appendix 1 for full details). These data confirm that HS recipients' shopping habits do vary from average patterns of grocery shopping. Nationally, 79.5% of

instore grocery spend goes to multiples (including their convenience store branches) with independents and franchisees holding the remaining 20.5% (£30 billion) share of the market (derived from IGD 2010). In contrast, a lower proportion of HS vouchers are spent in multiple grocers (73%, see Appendix 5) This may, in part, reflect the larger proportion of independent retailers in the convenience sector (that is, small stores with long opening hours (IGD 2010), but HS recipients do appear to have particular shopping habits that means they, as a group, use multiple grocers a little less often than average. Independent grocers together account for 13.5% of all HS vouchers used and are the third most common place for HS food vouchers to be used (Table 9, Appendix 5). A large proportion of vouchers are spent with milk roundsmen (5.8% of all vouchers) while milk delivery services are contracting in the wider marketplace. Furthermore, HS recipients use Asda and Morrisons more often than Sainsbury's (who hold second largest market share nationally, (Reuters 2012, citing Kantar) (Table 10, Appendix 5).

As well as spending patterns, we were interested in access to retailers. Across the 13 research areas, a total of 2,234 outlets were registered to accept HS vouchers. The biggest single group were multiple outlet grocers (e.g. Tesco) with 779 outlets (see Figure 1), but the second largest group were independent grocers and convenience stores with some 598 outlets.

**Figure 1: Number of Retailers Registered to accept HS Food Vouchers in Research Sites**



Twenty retailers were interviewed including at least one retailer in 12 of our 13 sites. Full details of the recruited sample and recruitment approach used are shown in Table 6, Appendix 1. Our achieved sample reflected the mix of registered retailers in both type and trading patterns (Tables 11 and 12, Appendix 5), most of those interviewed were independently owned and run general or convenience stores (n=9), but also included an independent dairy, 6 franchisees, a pharmacy and two food co-ops. Two of the 20 retailers were registered as selling all HS items, 6 all except frozen fruit and vegetables, the pharmacy sold only infant formula, and the dairy only fresh milk. One newly registered retailer was purposively sampled, the remainder had been part of the scheme for at least 2 ½ years.

Most of the retailers we interviewed were turning over £10-15,000 per week, although this ranged between £200-£250 and £85-90,000. The smallest of these, a food co-op, accepted vouchers from families despite not being formally registered with the scheme. The 17 retailers for whom we had

reimbursement data in our sample were returning 52 vouchers for reimbursement on average per month (range 8-182). This level is higher than the average for small retailers of 1.6 per month in research sites (Table 12, Appendix 5). We made contact with 5 trade groups, but only one responded and this group had not heard of the HS scheme.

## 5.3 Findings

### 5.3.1 Local Context

Most of the areas in which our study took place had a large number of retailers where HS food vouchers could be spent, but this varied between 50 and more than 300 registered retailers. Similarly, although the large multiple grocers were present in all, the number varied between 15 and 171 branches per area. There were both urban and rural areas with low supermarket presence, but in urban areas this tended to be offset by a very large number of independents, whilst more rural PCTs simply had fewer retailers registered on the scheme (see Table 12 for numbers of registered retailers). Levels of Healthy Start activity among small retailer also varied<sup>d</sup>, ranging from 1 per month to over 600 per month (for larger milk delivery services). Across the 1035 small retailers for whom we have data, 39 (3.8%) had no recorded claims and a further 30 (2.9%) had not returned any claims within the preceding year so could be viewed as inactive. 'Inactive' retailers are removed from the HS register (and thus the website) on an ongoing basis, but inevitably this centrally maintained list will lag behind changes, particularly where retailers become inactive (stop accepting/submitting vouchers) but do not actively ask to be removed. The proportion of 'inactive' retailers was not evenly distributed and in some study areas this was a significant problem. In PCT 2 (a rural area) although a large number of small retailers were registered (n=150), 20 had no recorded claims (13.3%) and a further 7 had not claimed within the last year. In another rural PCT (PCT 12) only 12 small retailers were registered, of whom 4 had no claim recorded. Taken together these data suggest that most beneficiaries will have access to a good choice of active retailers of different types, but that in a small number of rural areas access may be more problematic.

The local context was described by the retailers we interviewed. All but one of the businesses were located in residential areas (one was located on an army base), and many of the owners/managers we spoke to characterised the neighbourhoods as mostly poor:

*This is a poor area, we are surrounded by betting shops and the Weatherspoons ....a poor area with lots of families with young kids, so nearly everyone will use [Healthy Start].*

Retailer 16

These shops were stable parts of the local community; most used sites that had been occupied by similar shops for decades and two family businesses had been in the family for more than 20 years. They served a regular clientele often going back over generations:

*Most have them have come in here since they were kids when I came here. I know their granddads and know everybody.*

Retailer 20

### 5.3.2 Knowledge of Healthy Start Scheme and Signing Up

Few of the retailers we spoke to were able to recall why or when they joined the HS scheme. Certainly, none recalled any difficulties signing up for the scheme. Most of those we spoke to had been registered for more than three years and this was representative of other small retailers in the 13 areas, where the average time registered was a little over three years. Most therefore couldn't

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<sup>d</sup> Retailers with multiple branches claim reimbursement through head or regional offices, so it isn't possible to comment on branch activity.

comment on the ease of signing up (or necessarily remember who had been responsible for this), but said that if it had been difficult this would have been remembered.

For those few that recalled the impetus to join, this seemed mostly customer driven:

*They [the owners] had a lot of customers coming in and asking ...bringing in the vouchers and, you know, asking would we change them.*

Retailer 1

There was a recurrent theme through these interviews among some that being part of HS was part of their service to the community:

*[We] wanted to help local community...and provide a service.*

Retailer 9

Although some of the retailers knew very little about the HS scheme, most explicitly said its purpose was to help families on low incomes to buy milk, fruit and vegetables. Some were very well informed:

*I think the HS scheme started because the government regards nutrition as a high priority, especially young children. Hence the re-launch of the scheme, to help young families, in inner-city areas and poor areas, exchange the vouchers for fruit and vegetables as these are especially important.*

Retailer 15

*Especially in a poor area it's to help people get their way through, to provide more healthy food for their children, more fruit and veg. And because it's free it encourages them more to do that. It's to help children learn to eat better than what they would usually eat from a corner shop.*

Retailer 8

The retailers we interviewed were not completely secure in their knowledge about what could be purchased with the vouchers. In answer to an open question about what HS vouchers could be used to buy, retailers mentioned HS approved items, but also bread, eggs and baby food, and one general store till operator took a voucher out of their till to confirm. Four retailers who sold frozen food were surprised and pleased to learn from interviewers that frozen fruit and vegetables were now part of the HS scheme:

*That's fantastic. I might even put a little sign on our freezer.*

Retailer 6

The only retailer we interviewed who had any knowledge of HS vitamins was a pharmacy (Retailer 1). This pharmacy had had families come and try to exchange their vitamins voucher, and had tried to contact the PCT to find out how to stock HS vitamins but no one had responded to their call.

### 5.3.3 Voucher Use: Exchanging Vouchers

For the most part, the practical steps in using the vouchers were straightforward for the retailers we spoke to. All the retailers were checking expiry dates and making sure that vouchers weren't defaced in any way (e.g. bar code torn off) but only one reported that customers had ever tried to use expired vouchers. Where there were any difficulties these were among those who received fewer vouchers. A typical store within our sample received one or two vouchers each day, and most of these retailers felt this was a regular, but small, part of their business.

*7/8 per week at the moment, so not loads but regular. People are using it.*

Retailer 8

We were particularly interested to know about the process of exchanging vouchers at the till, and whether this caused any difficulties for retailers or families, including potential misuse of vouchers. Busier shops had different solutions to handling vouchers at the till, the largest recorded voucher use at the tills and could use their till screens to scroll through purchases and check what items had been bought. The low tech solution was to ask customers to separate the items they wanted to purchase with their vouchers. In the smallest shops, retailers reported that staff just looked at the items and worked out for themselves if there was the right amount:

*Just bill what they got, take the voucher amount off. It's not rocket science. If you can't do your maths don't go to work in a place like this. It's easy.*

Retailer 20

Only one of the interviewed retailers reported ever giving customers change; shops either kept the difference or encouraged customers to add another HS approved item. Although the HS website states that small retailers can 'hold over' the unspent portion of a voucher until a later shop none of those we spoke to reported doing so.

Retailers report that most families are using their HS vouchers in their shops to buy fresh milk only (not infant formula). Retailers attributed this to cost and perceived need:

*To be honest most people buy milk with it here, our fruit and veg is expensive.*

Retailer 16

*Mostly the vouchers are exchanged for milk...that's what people need to buy when they have small children.*

Retailer 11

Since families with young children report buying infant formula often, the absence of infant formula in retailers' reports probably reflects how price sensitive parents are. Infant formula is a high cost item, and is usually a planned purchase so it appears that families are particularly reluctant to buy infant formula in local shops.

Fruit and vegetables were being bought by families, but rarely so according to the retailers we interviewed. One retailer mentioned making sure his regular customers knew they could also buy fruit and vegetables but they didn't seem interested (Retailer 8).

*Because it's regular customers we've told them but I don't think they're interested in fruit and veg.*

Retailer 8

#### 5.3.4 Voucher Use: Potential for Misuse

Voucher misuse can occur through a misunderstanding of the scheme (eg wrongly believing a food item is legitimate) or when shopping is not carefully checked to ensure the full value has been spent on HS items. Alongside such accidental misuse we were also interested in deliberate misuse, when retailers knowingly allow vouchers to be spent on non-HS items.

When asked about use of vouchers to buy non-HS approved items, one group of retailers were adamant that they never knowingly allowed any items other than those approved by HS under any circumstances, and this was part of their role as a responsible trader:

*No, no, no. I'm a really thick skinned person. They're for kid's food... They know not to ask me.*

Retailer 3

*They're vouchers I'm paying for because I'm a tax payer as far as I'm concerned, so they get what they're entitled to: fruit, milk, vegetables....They don't even bother. I don't even get asked to sell underage kids cigarettes; they know it's a waste of time.*

Retailer 12

Although it was sometimes difficult to stick to these rules both personally, and for business:

*Sometimes you know they do argue over 'I can't buy this' or 'why can't I buy that?...I don't want to give them something which is against the law but it's difficult because you see their faces... they say 'I'll go across the road, they can do this, they can do that' and then we say 'ok, sorry'.*

Retailer 13

One retailer reported a problem with people using vouchers that he believed didn't belong to them, although the families may well have simply come from a different area:

*A little while ago they postcoded them to stop people trading them. Yeah, now I put their postcode in and we take the ones that are postcoded in our area. Because there was a little bit of a market and we used to get some from people who didn't live anywhere near us. People swapped them. I don't need my token this week, you have it.*

Retailer 20

The second group reported knowingly 'bending' the rules, but only for goods (usually food) which they can clearly see will benefit the children particularly for parents struggling to provide for their children. For small shop owners with a close relationship to their community, this is part of their role in the community:

*It depends if you think they are buying anything their children use or they can use in their family. If they want to get a drink for their children we understand.*

Retailer 14

*But you have to realise that I get people coming in here, they are buying £1 pound of electricity every day. £1. That must run out after an hour. How do they live? And in the winter, it really does get very cold and they come in and ask me if they can use the voucher for electricity. What can I do? I can't see them living in the flat with young children, with no heating, it's so cold. So I do let them do that. They come in and show me their empty wallet and I have to believe them and I do sell gas and electricity for the voucher. You can report that back. I don't care, what can I do?*

Retailer 15

Several discussed other shops where they believed families could exchange vouchers for cigarettes or other items not for children, but none named or seemed to know which shops these were. We note that some parents, professionals, and retailers themselves all report such shops existed. However, this does not provide evidence to help understand the extent of this problem. We would assume that retailers that were knowingly and frequently allowing misuse of vouchers in this way wouldn't agree to speak to researchers. But for those who did, framing the behaviour of others as immoral may support the framing of one's own behaviour as morally correct. By presenting the bad behaviour of others, the retailers are supporting their belief in the moral correctness of their own decisions<sup>85</sup>. The fact that often these aberrant shops were introduced by retailers as a contrast to their own behaviour might support this hypothesis; they report bent the rules at the margins to benefit children, while others were flagrantly fraudulent. Nonetheless, our data can't comment on whether, or how often, voucher misuse of this type may actually be occurring.

### 5.3.5 Voucher Reimbursement

As discussed above, one retailer was not attempting to be reimbursed for vouchers accepted. The remainder all reported no complaints about the time taken for reimbursement once vouchers had been submitted by them. However, all the retailers we spoke to waited until they have a batch of vouchers to return for reimbursement. For some small shops, then, the total time taken from accepting a voucher, waiting for sufficient vouchers to accumulate to justify posting, and reimbursement was problematic. This delay in requesting reimbursement was driven by the retailers' belief that the freepost provided weren't appropriate because vouchers lost in the post couldn't be compensated, and therefore they were paying for recorded delivery. Retailers are advised to obtain a proof of posting, but none we spoke to mentioned doing so. Auditing the process (counting and recording vouchers) was also an irritant for some:

*it's not easy like when we have to wait to collect them, count them, then send it over in the post and it's a long procedure to get money in our account, four or five weeks.*

Retailer 9

*I have to send the vouchers by special delivery, as that means I am compensated if they get lost in the post. That costs money, about £5...I see in the trade magazine people writing in saying they have lost their vouchers in the post but there is no compensation.*

Retailer 15

### 5.3.6 Perceived Benefits of the Healthy Start Scheme

The retailers we spoke to were universally positive about the HS scheme. A few thought that the scheme brought in a little more trade, and that there were benefits to the retailers:

*To bring the customers in because they know that this shop only takes it. Bring more business in...I don't think others on the street take them [the vouchers].*

Retailer 17

*It is good for us. If they buy 2 big milks that's £2.70 and we get £3.10 for it. We don't give change. If they spend over they can just pay the difference.*

Retailer 16

Others felt that it probably didn't increase trade. What was often more important was that this was a scheme that supported the poorest families in their area. The sense for small shop owners that they are part of their community, support local families, and help out those they know well was echoed in their overall impressions and feelings about the HS scheme:

*It isn't convenient for us to send the voucher back and get cash and this and that, but for the local community we are happy to do this favour. ...it's really good for the people.*

Retailer 14

*It's good for children to get food or something, for single parents at least they've got fruit and veg or food or milk.*

Retailer 9

*Think it is a good scheme, the families on benefits do need the help and anything that helps them feed their children, especially in the winter, is a good thing.*

Retailer 5



In fact, the community food co-op did not redeem any vouchers brought in (including HS vouchers), because their main purpose was to support the local community to eat more healthily. Since they only sell healthy food, the worker told us:

*I would accept money-off coupons for other things as well, knowing I wouldn't redeem them.*

Retailer 19

### 5.3.7 Suggestions for Improvements to the Scheme

Although the scheme was well received, when asked in interviews, retailers had some suggestions for improvements. There were a few requests for changes to administration: reimbursement for postal charges where they are using recorded delivery; more leeway on accepting expired vouchers; doing away with invoices; a handling fee from HS to retailers (since the goods have a low margin and it is perceived as a service provided). Additionally, a couple of retailers suggested moving to a card system instead of paper vouchers:

*Maybe they should have a card system or some kind of tracking, instead of sending them vouchers. Top up, you know like PayPoint, which is a big network now. And plus they can check what the customer is buying with the vouchers.*

Retailer 13

There was no consistency across the retailers we interviewed in suggested changes for what the vouchers should be exchangeable for. Individual retailers mentioned: expanding to any items for children; restricting to only milk; and encouraging purchasing of fruit and vegetables instead of milk.

Most retailers were not receptive to information provided by HS with their reimbursement; they simply didn't look at what was sent to them and, when asked didn't want to be sent more information. However, one retailer did suggest that a poster to keep next to the till stating clearly what can be exchanged and placed in view of both staff and customers would be useful<sup>e</sup>.

The greatest agreement for improvements were suggestions to increase the visibility of small retailers with the scheme: new marketing materials; promotion of doorstep milk delivery, and sending a list of the registered Retailers in their neighbourhood to recipients along with their HS vouchers.

## **5.4 Successes**

Most of our 13 areas had a large number of registered retailers of different sizes, confirming the reports from parents that most were able to reach registered retailers with ease. Recent changes to remove 'inactive' retailers from HS website had been a positive change and few inactive were identified in our areas.

Small retailers found the scheme easy to use, they recalled no problems with joining the scheme and, after submission of vouchers, and reimbursement was speedy.

Retailers are generally well informed about the aims of HS, and we were provided with little evidence of wide-spread voucher misuse.

## **5.5 Challenges and Opportunities**

For the smallest retailers, the total time taken between accepting the voucher and reimbursement can be a long time. This length of time is extended because they are not willing to risk sending vouchers unregistered, so wait until enough have been collected to warrant the cost of registered post.

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<sup>e</sup> Since interviews were conducted updated quick reference materials, including information to show to customers, have been distributed to retailers.

Small retailers could be a better utilised asset to the HS scheme. Those we spoke to were community minded, and were prepared to carry some small costs in order to support their community. None of the retailers we interviewed had been approached by anyone regarding their role in HS. There is an unexplored opportunity for promoting the scheme through these retailers, but this is probably best achieved through local staff who retailers would associate with their local focus.

Small retailers are often used by HS families, but most HS families are very price sensitive. Initiatives that promote cheap fruit and vegetables for HS recipients, such as making up mixed boxes of fruit and vegetables worth £3.10 as suggested on the HS retailers' website might benefit both parties if it were taken up.

The sense of community service among small retailers carries a risk; while we saw no evidence for widespread fraud, small retailers reported wanting to help their regular customers. This leads some to 'expand' the list of foodstuffs for which they will consider accepting HS vouchers to items they consider healthy (bread, eggs) or necessary (electricity in cold weather) for young families. While these may constitute a small portion of the value of the HS vouchers accepted by each shop, it may be happening quite often.

The suggestion from some retailers of switching to a charge card system mirrors suggestions made by some parents. However, we would note that the use of such a system would probably exclude many important retailers (particularly market traders and milk delivery services) from the scheme<sup>64</sup>.

Small retailers would benefit from additional information, but are resistant to reading additional material posted to them. The production of a poster to display near tills in addition to the quick reference guide already sent out would likely be welcomed by some, and may provide an opportunity to remind retailers and parents about eligible items at the point of sale.

## 6: Conclusions and Implications

### 6.1 Conclusions

The main aim of the current study was to describe the views and experiences of those groups using the Healthy Start scheme in order to inform improvements to the operation of the scheme and assist in the interpretation of established data sets. Healthy Start was introduced to provide a nutritional safety net for vulnerable low-income pregnant women, new mothers and children under four years old. It replaced the Welfare Food Scheme with reforms intended to encourage beneficiaries to eat a more nutritious diet, provide a better incentive for mothers to breastfeed, and reinforce the public health role of the scheme through closer links with the NHS. Our findings are based on qualitative interviews with a purposive sample of 107 parents, 65 health and children's professionals, and 20 retailers across 13 PCTs in England.

Our study benefits from being undertaken in a diverse sample of research areas across England. In addition, our sample strategy ensured that we recruited parents, retailers and health professionals drawn from a range of backgrounds and likely differing experiences of Healthy Start. This ensured that the broadest possible range of perceptions were included in this study. We used multiple recruitment strategies to ensure that 'hard-to-reach' parents, that is, those not engaging with health or children's services, were included in this study. HS beneficiaries have been researched before<sup>40 41 42</sup>, and the Department of Health commissioned an annual telephone survey of benefiting parents. However to date, the perceptions of HS beneficiaries have not been examined in a qualitative study. We also included the views of parents who are *not* currently benefiting from Healthy Start, and the views of professional groups.

This is not impact evaluation, and we were not commissioned to undertake a quantitative study nor recruit an appropriate comparison group. We can comment on observable behaviour changes that any future impact evaluation should consider, including the success criteria for Healthy Start outlined in the 2010 Equality Impact Assessment<sup>1</sup>. In addition, we would particularly recommend that outcome measures include the proportion of vouchers spent on non-milk and formula milk products, proportion of eligible pregnant women and children receiving Healthy Start vitamins, and proportion of health and children's professionals routinely and consistently linking Healthy Start to advice on health and nutrition.

However we can comment on the likely impact on benefiting families as perceived by those parents and health professionals interviewed for the study. In particular, we comment on the use of vouchers and their influence on family diet and nutrition including infant feeding practice, and parents' experience of advice and support provided by health professionals alongside the scheme. This includes the take-up and use of HS-branded vitamins.

Conclusions are structured around particular areas of implementation including local management, the application system and mediation of the scheme through health professionals, vitamin distribution and take-up.

### 6.2 Local Management of the Scheme

There was no consistent pattern across our 13 research sites with regard to how HS was managed, either in the wider role and remit of the person charged with overseeing local implementation, or in the establishment of a steering group with representation from the main professional groups involved in the scheme. Effective HS implementation demanded the cooperation of a range of professional groups identified by coordinators, not least midwives, health visitors, and Children's Centre staff, to consistently promote and support the scheme to eligible families. Where steering groups had been set up to oversee HS most had a multidisciplinary membership often involving midwifery and health visiting teams and, in some cases, representatives from local authority children's services. General

Practitioners were rarely involved either in management or in the implementation of HS, despite their likely regular contact with eligible families. HS coordinators reported challenges in working across organisational boundaries, particularly where midwifery and health visiting teams were located in separate trusts and in the wake of recent reorganisation.

While coordinators and frontline professionals were clear about the contribution HS might make to local health priorities and strategies, including maternal and early years' health and nutrition, concrete examples of operational links between HS and other initiatives were hard to find. We therefore note that, in common with the earlier evaluation of the HS pilot<sup>40</sup>, there was often a lack of coherent local leadership and strategy for HS, and recommend that links with wider health policy objectives should both be made more explicit, and put into practice. Despite looking closely at our data for differences between sites, we could find no discernable impact of local management decisions on the way the scheme was promoted by health professionals, the advice and support provided, or the experiences of parents. In our research sites, the scheme was mostly *not* managed or monitored by local trusts.

In those sites with clear and established management arrangements, these have been primarily developed to oversee the distribution and take-up of HS-branded vitamins. Wider aspects of the scheme, including monitoring rates of HS application, promoting the public health role of the scheme, supporting and training front-line professionals and working with retailers were not prioritised in any of our sites and in some, not addressed at all. There were some good examples of work done to promote the scheme amongst health professionals and parents including through the provision of training and inclusion of HS checks in family assessment forms and maternity records, and some promotion of the scheme to parents, but these were exceptions. We believe there are four related drivers for the focus on vitamins; 1) local teams are responsible for establishing access points for HS-branded vitamins in health and Children's Centres and maintaining a regular supply to these centres has been problematic; 2) local teams are required to monitor vitamin take-up and create accounting systems in order to claim monies back from the Department of Health; 3) in consequence local management teams are very aware that vitamin take-up remains low. Additionally, the focus remains on vitamins partly because 4) local teams are *not* required to monitor and report on take-up of the HS scheme more generally and often have little knowledge or access to take-up data beyond top-line take-up rates by eligible families living within the Trust boundaries. Aggregated data highlighting take-up in smaller geographical areas, or among particular groups (e.g. highlighting where women are signing up late in pregnancy) would help local staff to identify gaps in their provision.

### **6.3 Take-up of Healthy Start by Eligible Families**

In our sites the take-up of HS was generally high and awareness of the scheme was high among target families and health professionals. Estimated take-up rates in our sites ranged between 72.1% - 85.6% of eligible families, and thus most were approaching or exceeding the target rate of 80% take-up outlined in the Equality Impact Assessment<sup>1</sup>. All frontline health professionals interviewed for the study were aware of the scheme and were promoting it to parents. In particular, health visitors and midwives, the key groups responsible for signing-up families, perceived HS to fit well within their remit, including both promoting the scheme and acting as counter-signatories. A few Trusts had introduced measures to ensure families were signed-up effectively including adding HS to family health assessment forms or maternity records and ensuring wide availability of promotional materials and application forms. Delays in signing forms may be occurring as increasing numbers of child health clinics and home visits are carried out by professionals who are unable to countersign forms. There was some limited evidence that the scheme encouraged families previously unknown to health services to come forward in order to get their application forms signed. Professionals reported good practice in ensuring that these families were in contact with health professionals and therefore in receipt of some health advice before counter signing forms. Where local authority children's professionals had been encouraged to promote the scheme, they were another effective entry point for vulnerable families. We note however that GPs were disengaged from Healthy Start in most sites and this may result in a lost opportunity to sign up vulnerable families who do not access other services. Parents generally reported finding the application process straightforward, although less so

for parents with English as a second language. Interruptions in the receipt of vouchers around the time of birth remain a problem and the process for confirming birth is not well understood and needs further clarification or simplification for parents and professionals. It occurs at a busy time, and we know that the costs of calling from a mobile phone were reported as problematic when there was a problem to resolve.

There was some evidence from both professionals and parents that the approach of frontline professionals to HS was inconsistent within and across teams, both in regard to who they promoted the scheme to (universal or targeted), how they promoted the scheme and what supporting information was provided (simply mentioning the financial benefits of the scheme, or outlining its links with family health and nutrition). There were several reasons for this. Provision of information and training for frontline health and children's professionals was not currently a high priority, and they were not accessing resources available on the HS website. While local training had been provided in some of our research sites, it was rarely recurring or high profile. Some coordinators reported consistent problems working across organisational boundaries to promote, train and monitor practice. Cuts to services and workload pressures may have discouraged staff from prioritising HS, and interruptions in local vitamin supplies (when supplies had run out) may have de-motivated frontline staff further. Training on eligibility criteria and fit with other benefits, recommended vitamin intakes, vitamin distribution points and wider benefits of the voucher scheme and its contribution to health promotion would support frontline professionals to better promote and implement the scheme and crucially, link it to wider health promotion information for families in order to maximise the potential benefits. The Healthy Child Programme discusses the role of health professionals in promoting the use of Healthy Start<sup>86</sup>, and training associated with the Healthy Child Programme should provide an ideal platform for disseminating good practice.

The professionals and parents we spoke to expressed some concern that the current eligibility criteria are too stringent. Some health professionals were particularly concerned that those families just above the income threshold and perceived to be in need of additional financial support, asylum seekers, and young women living in care might miss out. Ex-recipients and unsuccessful applicants are often those whose income lies just above the eligibility criteria but who still struggle to make ends meet. Both groups felt there is a 'cliff edge' of access to food vouchers and vitamin coupons that means many low income families who might benefit from support fall outside of the HS scheme. In addition, some of the neediest families we spoke to whose lives had been disrupted by homelessness and domestic abuse had not applied. The place of Healthy Start following the introduction of Universal Credit is not yet clear<sup>10</sup>, but the impact on families living in these most difficult circumstances should be considered to ensure that HS continues to serve the most vulnerable groups<sup>6</sup>. This may provide an opportunity to improve access for some through avoiding the cliff-edge of eligibility, but may risk that loss of differentiation as a health benefit and reliance on a single assessment leaving families with no provision if there are errors<sup>87</sup>.

While the top-line take-up rates for the HS scheme were good, local trusts did not have access to data on the characteristics of those eligible families *not* signed up to the scheme. As far as we can determine, data is not disaggregated by beneficiary groups and therefore the opportunity to identify groups or neighbourhoods that might benefit from targeted promotional efforts is lost. We identified some likely gaps in coverage in our interviews, including families whose financial circumstances fluctuated, those leading chaotic lifestyles, parents for whom English is a second language, vulnerable and low income families living in affluent areas, and those disengaged from formal health and children's services.

## **6.4 Food Voucher Use**

Parents found the vouchers easy to spend locally, and did not have to change their shopping habits to use the vouchers. Reports from parents strongly suggest that the majority of food vouchers received by beneficiaries are spent. Furthermore, retailers report HS vouchers are spent on 'legitimate' items within the terms of the scheme. Pregnant women tended to use the vouchers for extra milk, fruit and

vegetables; formula-feeding mothers to offset the cost of infant formula; and breastfeeding mothers and those with older children for additional fruit and cow's milk. For all groups not buying infant formula, the fixed value of vouchers caused some minor difficulties (bulk buying, and retailers retaining 'change') but these were perceived as annoyances rather than major faults with the scheme. Healthy Start vouchers were most often used during larger shopping trips at supermarkets though many families use a range of shops and some families, most often young parents with limited transport access, were using most of their vouchers in smaller local retailers. A small number of parents, professionals, and retailers gave anecdotal accounts of deliberate fraudulent use to buy cigarettes, alcohol or sweets. Similar anecdotes have been reported by retailers in previous research<sup>88</sup>. In our sample, both retailers and parents report that keeping strictly to the rules of HS is common. However, some report allowing part of the HS voucher to be put toward non-HS items perceived as meeting children's needs sometimes deliberately but also sometimes due to misunderstanding of the scheme.

PCTs were not required to monitor the impact of HS vouchers on local beneficiaries, nor were they provided with any data from other sources on how families use the vouchers and the impact on parents and children. In our view this contributed to the lack of focus locally in encouraging and supporting health professionals to make explicit the links between the scheme and wider health promotion initiatives. Many frontline professionals perceived the scheme to be a 'drop in the ocean' and, at best, a financial safety net for families (albeit one that was needed). Professionals were positive about the inclusion fruit and vegetables since the change from Welfare Foods, but were sceptical that the scheme had moved beyond 'milk tokens' and judged that families struggling to cope with stringent budgets would usually buy cow's or formula milk. Many parents do report that the HS vouchers are an essential part of their food budget, particularly when buying infant formula. However, we also found a sizeable proportion spending the vouchers on fruit and vegetables that would otherwise be unaffordable. This suggests the scheme is moving further beyond 'milk tokens' than professionals realise, particularly for those families who breastfeed or have older children. Many parents in our sample prided themselves on providing a good and healthy diet for their children that included fresh fruit and vegetables. Many health professionals believed that to maximise the health benefits to families the scheme would need to be better supported by education and advice; we suggest that many families would be receptive to such support.

## 6.5 Mediation of the Scheme Through Health Professionals

Healthy Start was successfully mediated through health professionals. The impact of this would likely to be increased if professionals go beyond simply handing out and signing application forms, to also providing and linking the scheme with health and nutrition advice. Again, we observed that practice varied within and across teams. While all midwives and health visitors said they were providing health and nutritional advice regularly and repeatedly to parents, they were less likely to report linking this specifically to the HS scheme. We could find no concrete examples of parents recalling the food vouchers explicitly linked to health messages by professionals. In consequence, some parents were unaware of the aims of the scheme beyond financial support. We cannot say with confidence that all the families supported by HS understand that the vouchers could make an important contribution to a healthy diet.

Most women were in receipt of dietary advice from at least one health professional or a combination of midwives, health visitors, Children's Centres, or some other source. Our interviews with both health professionals and parents gives us confidence that most health professionals who were signing HS application forms were giving appropriate advice on breastfeeding and healthy eating, or were ensuring that this information was offered by another appropriate person - such as an infant feeding advisor or health care assistant. However, we are not confident that they did so *when discussing HS eligibility or signing the form*. We note recent research suggesting that those receiving regular support from health professionals were more informed about the HS scheme<sup>76</sup>. The planned increase in availability of health visitors in Sure Start Children's Centre<sup>6</sup> has the potential to support a stronger link between nutrition advice and Healthy Start, if this improves contact with families. Health visitors

were more likely than midwives to be aware of, and signpost parents to, additional sources of support for cooking, healthy eating, breastfeeding and weaning provided both by their own teams and by local Children's Centres. Children's Centre staff reported a range of support available, including cooking classes, breast feeding and weaning support, and staff trained in health and nutrition. However we found only one example where HS integrated or linked to these services. It seems to us that an opportunity was being missed, both by health and children's professionals, to link the provision of vouchers to healthy eating messages made elsewhere in their practice. It appears that the healthy eating messages provided by health professionals were not always significantly different to that provided prior to the scheme, and links to wider public health initiatives in the PCT (for example on obesity, health inequalities, nutrition, physical activity) were often poor. More worryingly, our sample indicates that a sizeable number of parents may be missing out on support for diet and nutrition altogether, either because they did not seek it out or, more commonly, because their access to health professionals was limited or they found them unapproachable. Families living in areas of higher deprivation may be especially vulnerable, being more likely to miss out on support from a health professional or identify an alternative resource.

## 6.6 Vitamin Use

Despite the focus on vitamins displayed by HS management in all of our research sites, take-up of HS vitamins remained very low amongst eligible families. This was true for pregnant and new mums, and for all children. The target of 50% or more of eligible children and women entitled to the vitamin supplements regularly claiming them remained out of reach in all our research sites.

Despite robust efforts by local trusts, the most significant barrier that remains is access to HS vitamins. The supply chain had been unreliable both locally and nationally, and both health professionals and families were too often unaware of local collection points. Parents expected to find HS vitamins in high street pharmacies and supermarkets and only highly motivated parents actually tracked them down. Local trusts had been working hard to resolve this and some progress had been made, in particular the engagement of local authorities to allow Children's Centres to act as collection points. In most cases this was a challenging and resource-demanding process. Details of local access points are now available via the HS website (a link is provided to NHS Choices) and this will be useful for both professionals and families if it is promoted, but is unlikely to be sufficient since many will not access this information.

Access was not the only barrier to take-up of vitamins, and knowledge and attitudes about the need to take vitamins in pregnancy and during infancy remained poor across both health professionals and families. Some health professionals remained sceptical about the need for vitamins, and there was some evidence that they were not confident in advising parents because of a lack of knowledge of the recommended intakes. The target that all women and families supported by HS are aware that they can claim free vitamin supplements through the scheme is some way off. Many parents reported not being informed about the HS vitamins by any health professional. Some simply did not notice the vitamin voucher when they originally received it, nor understood what it was for. Again, this might best be addressed through training for professionals, which has been implemented in some sites. Material is sent directly to parents, but parents do not attend to it and they lack knowledge of local exchange points.

We believe supporting health professionals to hand out vitamins directly to families, at least in the first instance, is likely to increase take-up. In the areas we visited this arrangement appeared to increase impetus amongst local health professionals to promoting vitamins. In particular, this would encourage vitamin take-up at the earliest opportunity in pregnancy, as the delay between first contact with a health professional and families receiving vitamin coupons and accessing collection points is of serious concern to many frontline professionals. In some areas, universal provision was being piloted in an effort to ensure all pregnant women received vitamins at the earliest opportunity and this was something valued by health professionals. It may also be the case that early introduction via health professionals would get mums in the vitamins 'habit', so a focus on pregnant and new mums may be

justified in this regard. These hypotheses are currently untested, however, and further evaluation of these pilots to determine their impact on vitamin take-up in the short and longer term is recommended.

## 6.7 Retailers

While the majority of vouchers are spent in large supermarkets, small retailers remain an important resource for some families with limited transport and/or living some distance from a supermarket. The number of small retailers accepting vouchers varied considerably by PCT and tended to be lower in sites with lower proportions of eligible families. Parents, and retailers, would welcome better promotion of which small retailers accept vouchers. The recent update to the HS website will help if it is promoted to parents, but few parents in our sample used this resource and this is confirmed by previous research<sup>76</sup>.

Accepting HS vouchers did not bring notable benefits to small retailers, either through increased footfall or profit, but retailers in disadvantaged neighbourhoods often felt they had a role in serving their community and supporting vulnerable families. Both parents and retailers reported that vouchers were most likely to be used for milk in smaller stores, because of the acknowledged expense of fresh produce. However, the fixed value of vouchers meant that some retailers were bending the rules of the scheme to offset the cost of other purchases with unspent portions of vouchers. Those that acknowledged doing this only did so for items they perceived as benefiting children (e.g. not adult items such as cigarettes or alcohol). Others were clear that they never allowed this. Where HS vouchers were used in this way, this resulted from a desire by small retailers to ensure that HS supported their local families. None had had any contact with local managers of HS and again, we believe an opportunity to promote the aims of HS by working more closely with this group of motivated retailers was being missed.

## 6.8 Achieving Healthy Start Objectives

For the families in our study, Healthy Start food vouchers successfully provided a nutritional safety net, by ensuring that all families always had money to spend on essential food for young children. It is not yet ensuring minimum nutrition through vitamin supplements.

For the families in our study, Healthy Start is encouraging a healthier diet for some, and is supporting those breastfeeding mothers who chose to use it. Changes in diet are difficult to achieve, but Healthy Start includes several components that should increase the chances of achieving this: clear messaging, repeated and regular reminders, reduced barriers to access, and the potential for links with professional groups.

The policy context for delivery of Healthy Start is complex, sitting at the intersection of reforms in both health and welfare. In the following section the implications of our findings for the different elements of the Healthy Start scheme are drawn.

### *Implications for National Coordination and Policy Units*

- Vitamin distribution is the priority at the local level, yet take-up remains low. Health professionals value handing vitamins to mothers in the first instance and this helps to increase vitamin take-up, but ongoing collection is problematic for parents who expect to collect vitamins from high street pharmacies and supermarkets. These outlets have national distribution arrangements and cannot be accessed by local trusts, who instead have set up complex and time consuming local distribution mechanisms. While making vitamins available at health and Children's Centres has been helpful, resolving distribution to retail outlets at a national level would be beneficial.
- There is a delay for pregnant women accessing HS-vitamins until their application is submitted, processed, the coupons dispatched, and finally exchanged at a local vitamin distribution point.



Universal vitamin provision, at least for pregnant women, would help ensure that low income families are able to access vitamins from the earliest possible opportunity in pregnancy.

- The take-up and impact of HS (beyond vitamin take-up) is currently not prioritised by Trusts at strategic or operational level. They do not monitor or report on either and in consequence the HS scheme is often not actively managed. Opportunities to improve the impact of the scheme through work with frontline health professionals, children's services and local retailers are therefore being lost.
- This study demonstrates the financial safety net the HS can provide for low income families struggling to make ends meet. However, some very needy families are probably missing out and others just above the eligibility criteria are likely to also benefit from food vouchers and access to vitamins. The immediate implication of this is consistent promotion of the scheme among frontline professionals and ongoing monitoring take-up among target at risk groups nationally. However, local management also has a role. Data that disaggregates take-up in particular neighbourhoods or amongst different types of beneficiary groups could usefully be disseminated to local managers (e.g. HS Coordinators).
- Frontline professionals may underestimate the potential impact of the scheme on family food purchasing habits. Addressing this perception might motivate staff and support them to better align HS with ongoing health promotion activity.
- While there are some difficulties associated with mediation through health professionals, principally gaining counter signatures, reduced contact after infancy, and a tendency for professionals to treat HS as a welfare benefit, we believe that this link to health services must be maintained. Health professionals currently fulfil three roles when they counter sign HS applications; confirmation of eligibility for HS Vitamins, confirmation of receipt of health advice, and signposting to other health interventions. The first two roles must fall to those with responsibility for the clinical care of families. There may be merit in exploring the possibility of allowing some local flexibility, for example by allowing multidisciplinary teams to provide these guarantees under supervision.
- We believe that good local management would support effective promotion of the scheme by frontline work with families and linking the scheme to other health initiatives. Achieving this depends on local responsibility for HS residing in the right team. Learning from mechanisms employed to resolve vitamin availability, a successful team is likely to: be accountable for delivering against success criteria; be able to monitor local take-up, use and impact of the scheme; and include or engage representatives of Public Health, health visiting, midwifery teams, and Children's Centre management.
- Identifying a management solution in the context of changes to commissioning of services is challenging. While central management of resources associated with this welfare-linked benefit remains necessary, this responsibility comes without local funds. From April 2013 NHS Commissioning Board, Clinical Commissioning Groups and/or local authorities will be responsible for commissioning or providing maternity services and/or child health clinics, and responsibility for providing or arranging the provision of HS vitamins will follow these services. There is still a role for managing local aspects of HS including promoting HS with professionals, parents or retailers and monitoring take-up. Clinical Commissioning Groups may be well placed to take responsibility for HS alongside commissioning of maternity services and may be particularly powerful in promoting vitamin take-up by increasing the involvement of GPs and catching pregnant women at the earliest opportunity. However, it is not clear to us how this could operate in practice as a commissioned service, nor whether these groups could support the broader health promotion activities needed. Local authorities may be better placed to lead on Healthy Start within their public health remit, through Sure Start Children's Centres, and perhaps linking to teams managing Early Intervention Grants may assist in reaching the most vulnerable families. This

approach may risk missing families during pregnancy when they are less likely to be in contact with these services and may weaken the link with frontline health professionals.

- There may be merit in considering whether any groups other than health professionals could take on a greater role in promoting the aims HS among families with children after the first year of life. Most women will see health professionals through pregnancy and early infancy, but they are less accessible as children age.

## **6.9 Implications for Local Coordination and Healthy Start Leads**

- In England, local management of HS needs to go beyond the current concentration on vitamin distribution and take-up in order to increase the benefits of HS to all eligible families. This should include, at least, better monitoring of take-up and better promotion of the potential health benefits of the scheme.
- Healthy Start Coordinators occupy a range of roles and in addition to national management a clear 'home' for local HS management needs to be identified. In addition, working across organisational boundaries remains problematic. At least the following services should have a named lead for the scheme: midwifery, health visiting, General Practitioners and Local Authority children's services.
- The HS website has recently been updated to identify distribution points for vitamins alongside local participating retailers – this should be promoted to frontline staff so they can support parents with this information.
- Staff need training on recommended vitamin intake for pregnant and new mothers and infant children.
- Front-line health and children's professionals would benefit from support, either through training or promotional material, to enhance information–giving about the health benefits of HS for beneficiaries. Currently the scheme is in danger of being perceived by both professionals and parents as a welfare benefit only.
- Children's Centres are a key resource for health and nutrition support to parents and embedding HS within the range of activities on offer, including weaning and cooking classes, might provide further opportunity to reinforce the public health aspect of the scheme.
- Local coordinators and/or management teams should make better links with local retailers who are registered with the scheme and exploit their role and motivation to maximise the benefits of HS to vulnerable families.

## **6.10 Implications for Frontline Staff**

- Health and children's professionals should better embed HS into their health and nutrition support and advice, to help promote the scheme as a health promotion initiative as well as a financial benefit to families.
- Professionals are successfully signing up families, though some gaps remain. HS should be routinely mentioned at least at all antenatal booking appointments, new-baby checks, and contacts with new families. Including HS on patient-held maternity records and family health assessment forms in all areas would encourage this.
- Professionals need to be especially careful to ensure families for whom English is a second language, and who have chaotic lives (including homelessness) have equal access to the scheme.

- Parents too often ignore or miss the vitamin coupon, and health and children's professionals should be more active in promoting vitamin take-up amongst HS beneficiaries during all contacts with families.

### **6.11 Implications for Established Data Sets and Future Research**

- The existing HS beneficiary datasets could provide data to assist with local planning and management. Estimates of scheme take-up should be regularly reported to health trusts, to enable local monitoring and targeting to groups or areas where take-up is low.
- HS retailer datasets are also a valuable resource. Patterns of reimbursement show spending patterns different to the grocery market as a whole. These data provide reports on retail activity of independent retailers not available through any other route. Unusual patterns of reimbursement may be the only independent source of data to indicate misuse of vouchers. Further, retailers with high rates of voucher reimbursement may be more receptive to connecting with local health initiatives.
- Closer study of HS family food purchases could contribute to an understanding of the contribution of HS vouchers to total food budgets for low income families, and could usefully confirm the findings from qualitative interviews that HS vouchers are largely spent on infant formula and fresh milk. Larger retailers will have access to some of these data through electronic till records. Since most families spend the bulk of their vouchers in supermarkets these data are likely to provide a reasonable estimate of spending if retailers were willing to share this information. In addition, flagging or including HS families in the Living Costs and Food Survey would provide detailed comparative data to compare against other low income groups.
- Parents too often ignore or miss the vitamin coupon, and it may be useful to conduct consumer testing to understand why. This should include careful consideration of whether combining vitamin coupons with food vouchers in a single letter is achievable.
- The scheme would benefit from increased emphasis by linking with other healthy eating initiatives, and increasing visibility as a health promoting scheme. Small scale pilots of such initiatives would be worth evaluating.
- Existing pilots of universal vitamin provision to pregnant women in some areas should be evaluated for potential to increase take-up of vitamins among all pregnant women.

## References

1. Department of Health. Healthy Start. Equality Impact Assessment. London: Department of Health, 2010.
2. Committee on Medical Aspects of F, Nutrition P, Panel on C, Maternal Nutrition of the Committee on Medical Aspects of F. Scientific review of the Welfare Food Scheme. Reports on Health & Social Subjects. (51):i-xxi.
3. Buttriss J. Healthy Start: proposals for reform to the Welfare Food Scheme. Nutrition Bulletin. 2003;28(1):35-6.
4. Royal Society for the Promotion of Health. Society statement on new Healthy Start Scheme. Journal of the Royal Society for the Promotion of Health. 2004;124(2):53-.
5. Acheson D. Independent Inquiry into Inequalities in Health. Norwich: The Stationary Office, 1998.
6. Department for Work and Pensions, Secretary of State for Education. A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives. Norwich: HM Stationary Office, 2011 Contract No.: ID: 2424064 04/11.
7. Directgov. Sure Start Childrens Centre's. 2012 [cited 2012 16 Aug 2012]; Available from: [http://www.direct.gov.uk/en/Parents/Preschooldevelopmentandlearning/NurseriesPlaygroupsReceptionClasses/DG\\_173054](http://www.direct.gov.uk/en/Parents/Preschooldevelopmentandlearning/NurseriesPlaygroupsReceptionClasses/DG_173054).
8. Department for Education. Diet and nutrition in Early Years. Department for Education; 2011 [updated 14 June 2011; cited 2012 13 April 2012]; Available from: <http://www.education.gov.uk/childrenandyoungpeople/earlylearningandchildcare/delivery/providers/a0074583/diet-and-nutrition-in-early-years>.
9. Department for Work and Pensions. Universal Credit: welfare that works. Norwich: The Stationary Office 2010 Contract No.: Cm 7 9 5 7.
10. Department for Work and Pensions. Universal Credit: the impact on passported benefits. Report by the Social Security Advisory Committee and response by the Secretary of State for Work and Pensions. Norwich: The Stationary Office, 2012.
11. Health and Social Care Act 2012, (2012).
12. Department of Health. Transforming Community Services: enabling new patterns of provision. London: Department of Health, 2009.
13. HM Government. Healthy Lives, Healthy People: Our strategy for public health in England. Norwich: The Stationary Office, 2010.
14. Department of Health. Healthy child programme. 2009.
15. Marmot M. Fair Society, Healthy Lives. Strategic review of health inequalities in England post-2010. London: The Marmot Review, 2010.
16. NICE. Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. London: National Institute for Health and Clinical Excellence, 2008.
17. Bolling K, Grant C, Hamlyn B, Thornton A. Infant Feeding Survey 2005. Leeds: The NHS Information Centre for health and social care and National Statistics, 2007.
18. Bellisle F. Effects of diet on behaviour and cognition in children. British Journal of Nutrition. 2004;92(Suppl 2):S227–S32.
19. Center on the Developing Child. The Foundations of Lifelong Health Are Built in Early Childhood. Cambridge, MA: Harvard University, 2010.
20. Hoxhallari L, Conolly A, Lyon N. Families with children in Britain: findings from the 2005 Families and Children Study (FACS). Research Report No 424. London: 2007 Contract No.: Research Report No 424.
21. Scientific Advisory Committee on Nutrition. SACN Position paper on the low income diet and nutrition survey (LIDNS). London: Scientific Advisory Committee on Nutrition, 2009.
22. Barnes M, Conolly A, Tomaszewski W. The circumstances of persistently poor families with children: Evidence from the Families and Children Study (FACS). Research Report No 487. London: Department for Work and Pensions, 2008 Contract No.: Research Report No 487.
23. Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J, et al. Foresight Tackling Obesity: Future Choices – Project report. 2nd Edition. Foresight. Government Office for Science, 2007 Contract No.: DIUS/PUB 8654/2K/12/07/AR.
24. Wardle J, Parmenter K, Waller J. Nutrition knowledge and food intake. Appetite. 2000;34:269-75.

25. Grunert KG, Wills JM, Fernandez-Celemin L. Nutrition knowledge, and use and understanding of nutrition information on food labels among consumers in the UK. *Appetite*. 2010;55(2):177-89. Epub 2010/06/16.
26. Dyson L, Renfrew MJ, Jenkins R, Thomas J, McCormick F, Pearce A, et al. Approaches to evaluating Healthy Start - a scoping review. York and London: Public Health Research Consortium, 2007.
27. Hills D, Child C, Junge K, Wilkinson E, Sullivan F. Healthy Start. Rapid evaluation of early impact on beneficiaries, health professionals, retailers and contractors. London: Tavistock Institute, 2006.
28. Diment E. Children's BMI, overweight and obesity. In: Craig R, Hirani V, editors. *Health Survey for England Volume 1: Health and lifestyles*. Leeds: The NHS Information Centre for health and social care; 2009. p. 187 - 96.
29. Ebbeling CB, Pawlak DB, Ludwig DS. Childhood obesity: public-health crisis, common sense cure. *The Lancet*. 2002;360:473-82.
30. Lucas P, Arai L, Baird J, Kleijnen J, Law C, Roberts H. A systematic review of lay views about infant size and growth. *Archives of Disease in Childhood*. 2007;92(2):120-7.
31. Statistics OoN. *The National Food Survey 2000*. . London: Department for Environment Food and Rural Affairs, 2001.
32. Dowler E, Calvert C. *Nutrition and Diet in Lone-parent Families in London*. . London: Family Policy Studies Centre, 1995.
33. Scientific Advisory Committee on Nutrition. *The Nutritional Wellbeing of the British Population*. London: Scientific Advisory Committee on Nutrition, 2008.
34. Rasmussen M, Krolner R, Klepp K, Lytle LA, Brug J, Bere E, et al. Determinants of fruit and vegetable consumption among children and adolescents: a review of the literature. Part I: quantitative studies. *International Journal of Behavioral Nutrition and Physical Activity*. 2006;3(22).
35. Nelson M, Erens B, Bates B, Church S, Boshier T. Low income diet and nutrition survey Volume 3. In: Agency FS, editor. Norwich: The Stationary Office; 2007.
36. McAndrew F, Thompson J, Fellows L, Large A, Speed M, Renfrew MJ. *Infant Feeding Survey 2010: Early Results. Summary*. Leeds: The NHS Information Centre for health and social care, 2012.
37. Department of Health. *Help pregnant women, new mothers and children get their free Healthy Start vitamins*. 2010.
38. McCormick F, Moreton JA. Review 5: The effectiveness of public health interventions to improve the nutrition of young children aged 6-24 months. London: NICE, 2007.
39. Department of Health. *Weaning and the weaning diet: report of the working group on the weaning diet of the Committee on Medical Aspects of Food Policy*. . Norwich: HM Stationary Office, 1994.
40. Hills D, Child C, Junge K, Wilkinson E, Sullivan F. *Health Start. Rapid evaluation of early impact on beneficiaries, health professionals, retailers and contractors*. London: Tavistock & Symbia, 2006.
41. Ford F, Fraser R, Wademan S, Mouratidou T. Preliminary results of the effect of 'Healthy Start', a new food benefit, on the dietary behaviour of women during pregnancy and post partum in Sheffield, UK. *Proceedings of the Nutrition Society*. 2008;67(OCE8).
42. Ford FA, Mouratidou T, Wademan SE, Fraser RB. Effect of the introduction of 'Healthy Start' on dietary behaviour during and after pregnancy: early results from the 'before and after' Sheffield study. *British Journal of Nutrition*. 2009;101(12):1828-36.
43. Tobin J. On limiting the domain of inequality. *Journal of Law and Economics*. 1970;13(2):263-77.
44. Currie J. Welfare and the Well-Being of Children: The Relative Effectiveness of Cash and In-Kind Transfers. *Tax Policy and the Economy*. 1994;8:1-43.
45. Food and Nutrition Service. *Women, Infants and Children*. USA, the U.S. Department of Agriculture: Food and Nutrition Service; 2005 [updated 11/02/2005 cited 2012 13 April 2012]; Available from: <http://www.fns.usda.gov/wic/>.
46. Oliver A. Can financial incentives improve health equity? *British Medical Journal*. 2009;339:b3847.
47. Burr ML, Trembeth J, Jones KB, Geen J, Lynch LA, Roberts ZES. The effects of dietary advice and vouchers on the intake of fruit and fruit juice by pregnant women in a deprived area: a controlled trial. *Public Health Nutrition*. 2007;10(6):559-65.
48. Mein J, Bullen R, Millard F, Murtha K. Apunipima baby baskets. *Indigenous Health*. 2011;13(3):21-3.

49. Food and Nutrition Service. Frequently Asked Questions about WIC. Undated [cited 2012 13 April 2012]; Available from: <http://www.fns.usda.gov/wic/FAQs/FAQ.HTM#6>.
50. Chatterji P, Brooks-Gunn J. WIC participation, breastfeeding practices, and well-child care among unmarried, low-income mothers. *American Journal of Public Health*. 2004;94(8):1324-7.
51. Kowaleski-Jones L, Duncan GJ. Effects of participation in the WIC program on birthweight: evidence from the National Longitudinal Survey of Youth. *American Journal of Public Health*. 2002;92(5):799-804.
52. Hoynes H, Page M, Stevens A. Can targeted transfers improve birth outcomes?: Evidence from the introduction of the WIC program. *Journal of Public Economics*. 2011;95(7-8):813-27.
53. Sutherland K, Christianson JB, Leatherman S. Impact of Targeted Financial Incentives On Personal Health Behavior A Review of the Literature. *Medical Care Research and Review*. 2008;65(6):36S-78S.
54. Richards R, Merrill RM, Baksh L, McGarry J. Maternal health behaviors and infant health outcomes among homeless mothers: U.S. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) 2000-2007. *Prev Med*. 2011;52(1):87-94. Epub 2010/11/06.
55. Khanani I, Elam J, Hearn R, Jones C, Maseru N. The impact of prenatal WIC participation on infant mortality and racial disparities. *Am J Public Health*. 2010;100 (Suppl 1):S204-9. Epub 2010/02/12.
56. Whaley S, Richie L, Spector P, Gomez J. Revised WIC Package Improves Diets of WIC Families. *Journal of Nutrition Education and Behavior Journal of Nutrition Education and Behavior*. 2012. Epub 14 March 2012.
57. Hillier A, McLaughlin J, Cannuscio CC, Chilton M, Krasny S, Karpyn A. The Impact of WIC Food Package Changes on Access to Healthful Food in 2 Low-Income Urban Neighborhoods. *J Nutr Educ Behav*. 2012. Epub 2012/03/13.
58. Food and Nutrition Service. WIC Farmers' Market Nutrition Program Fact Sheet. In: USDA, editor. 2011.
59. Herman DR, Harrison GG, Afifi AA, Jenks E. Effect of a targeted subsidy on intake of fruits and vegetables among low-income women in the Special Supplemental Nutrition Program for Women, Infants, and Children. *American Journal of Public Health*. 2008;98(1):98-105.
60. Kropf ML, Holben DH, Holcomb JP, Jr., Anderson H. Food security status and produce intake and behaviors of Special Supplemental Nutrition Program for Women, Infants, and Children and Farmers' Market Nutrition Program participants. *Journal of the American Dietetic Association*. 2007;107(11):1903-8.
61. Anderson JV, Bybee DI, Brown RM, McLean DF, Garcia EM, Breer ML, et al. 5 a day fruit and vegetable intervention improves consumption in a low income population. *J Am Diet Assoc*. 2001;101(2):195-202. Epub 2001/03/29.
62. DTA. Healthy Incentives Pilot (HIP) MA Department of Transitional Assistance. USDA; 2011 [cited 2012 13 April 2012]; Available from: <http://www.fns.usda.gov/snap/HIP/docs/031011.pdf>.
63. Abt Associates Ltd. Healthy Incentives Pilot Evaluation. Updated Study Plan. 2011 Contract No.: Task Order # AG-3198-D-10-0044.
64. Government Accountability Office. FOOD STAMP PROGRAM. Options for Delivering Financial Incentives to Participants for Purchasing Targeted Foods. Report to the Chairman, Committee on Agriculture, Nutrition, and Forestry, U.S. Senate. Washington, DC: United States Government Accountability Office, 2008 Contract No.: GAO-08-415.
65. Rosenberg TJ, Alperen JK, Chiasson MA. Why do WIC participants fail to pick up their checks? An urban study in the wake of welfare reform. *American Journal of Public Health*. 2003;93(3):477-81.
66. Briggs S, Fisher A, Lott M MS, N T. Real food, real choice: Connecting SNAP Recipients with Farmers Markets. In: Coalition CFS, editor. Portland, OR: Community Food Security Coalition 2010.
67. Broad E, Bailey E, Blake M, Brand L, Policicchio J, Greenfield M, et al. Food Assistance Programs and Mississippi Farmers Markets: Increasing Federal Food Assistance Access at Farmers Markets in Mississippi: Analysis and Recommendations. . 2010.
68. Apunipima Health. Apunipima Health Newsletter. Apunipima Cape York Health Council 2008.
69. Apunipima Health. Maternal and Child Health. Apunipima Cape York Health Council; Undated [cited 2012 13 April 2012]; Available from: <http://www.apunipima.org.au/index.php?page=healthy-lifestyles>.
70. Waldfogel J. Welfare Reforms and Child Well-Being in the US and UK. *Swedish Economic Policy Review* 2007 14(2):137-68.
71. Blow L, Walker I, Zhu Y. Who Benefits from Child Benefit? Working Paper 749. Warwick: 2006.

72. Connor J, Rodgers A, Priest P. Randomised studies of income supplementation: a lost opportunity to assess health outcomes. *Journal of Epidemiology and Community Health*. 1999;53:725-30.
73. Bronfenbrenner U. Developmental ecology through space and time: a future perspective. In: Moen P, Elder G, Luscher K, editors. *Examining lives in context: perspectives on the ecology of human development*. Washington, DC: American Psychological Association; 1995. p. 619-47.
74. Department of Health. Next steps for Healthy Start. Adding plain frozen fruit and vegetables and minimising voucher misuse. A joint consultation by the Department of Health, the Scottish Government, the Welsh Assembly Government, and the Department of Health, Social Services and Public Safety in Northern Ireland, 2010.
75. Cleghorn S. Do health visitors advise mothers about vitamin supplementation for their infants in line with government recommendations to help prevent rickets? *Journal of Human Nutrition & Dietetics*. 2006;19(3):203-8.
76. SPA Future Thinking. Healthy Start Evaluation. Unpublished.
77. Her Majesty's Revenue & Customs. Child Benefit, Child Tax Credit and Working Tax Credit Take-up rates 2009-10. London: Her Majesty's Revenue & Customs. KAI Benefits and Credits, 2011.
78. Department of Health. Delivering a Healthy Start for Pregnant women, new mums, babies and young children; A guide for health professionals. 2010.
79. Leaf AA. Vitamins for babies and young children. *Archives of Disease in Childhood*. 2007;92(2):160-4.
80. Jean-Marie S. Vitamin supplements: ensuring a healthy start in life. *Nursing in Practice: The Journal for Today's Primary Care Nurse*. 2007(33):43.
81. NICE. Promotion of breastfeeding initiation and duration. London: National Institute for Health and Clinical Excellence, 2006.
82. Leung WY. A qualitative study of Healthy Start - perceptions of Chinese beneficiaries and Chinese store supervisors [Masters Dissertation]. Bristol: University of Bristol; 2011.
83. Fowles ER, Fowles SL. Healthy eating during pregnancy: determinants and supportive strategies. *Journal of Community Health Nursing*. 2008;25(3):138-52.
84. Lloyd S, Lawton J, Caraher M, Singh G, Horsley K, Mussa F. A tale of two localities : Healthy eating on a restricted income. *Health Education Journal*. 2011;70(1):48-56.
85. Treviño LK, Weaver GR, Reynolds SJ. Behavioral Ethics in Organizations: A Review. *Journal of Management*. 2006;32(6):951-90.
86. Department of Health. Healthy Child Programme. Pregnancy and the first five years of life. . London: Department of Health, 2009.
87. Citizens Advice. Response to the Social Security Advisory Committee consultation on passported benefits under the Universal Credit 2011.
88. Solutions Research. Healthy Start Retailer Research. Qualitative Research Report. Not yet published.