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COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Breastfeeding Rates in Northern Ireland

9 November 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Dr Heather Livingston	)	Department of Health, Social Services and Public Safety
Dr Elizabeth Mitchell	)	
Ms Janet Calvert	)	Public Health Agency

The Chairperson:

I welcome Dr Elizabeth Mitchell, Dr Heather Livingston and Ms Janet Calvert. Elizabeth, you are going to give us a short presentation. The venue is quite open, so I ask you to speak as loudly as you can. If members are struggling to hear, the people behind them will be finding it very difficult. Elizabeth, I know that you are very soft spoken, but you will have to gulder today.

Dr Elizabeth Mitchell (Department of Health, Social Services and Public Safety):
I will do my best, Chair. I thank you for inviting us here today to give evidence on this subject. With me today is Dr Heather Livingston, a senior medical officer in the Department, who is chairing the group that is working on the new strategy for breastfeeding. My other colleague is Janet Calvert, who will be well known to the Chair and maybe to some other Committee members. Janet is the regional co-ordinator for breastfeeding and has been in that post since 2002. She is very modest, but she has been very influential outside Northern Ireland and has developed many materials that have been used elsewhere to help to promote breastfeeding. Therefore, we have an expert in our midst, and I am very grateful to her for coming today.

I want to acknowledge your role, Chair. You have been a very powerful advocate for breastfeeding and have offered great support on this issue over many years.

From our point of view, the evidence session today is timely because we are nearing the stages of finalising the draft of the new strategy. It will be helpful to us to hear Committee members' views so that we can feed them into the final version. It is good timing.

We heard from your researcher some of the evidence with regard to breastfeeding. I will reiterate some of that. It confers health benefits to both the child and the mother. Clearly, it is a very important public health issue. It is the best means of giving infants a healthy start in life. It does that in three main ways: through nutrition, immunological protection and enhancing the bond between mother and baby. Research shows that breastfed babies have less chance than formula-fed babies of having diarrhoea and vomiting. They have fewer chest and ear infections. As a result of that, they are much less likely to be admitted to hospital. In addition, they have less likelihood of becoming obese and of later developing type-2 diabetes. Therefore, the benefits continue into later life. They also have less chance of developing allergies and eczema. Indeed, there is less risk of cot death or sudden infant death syndrome. So, there are a great number of physical and health benefits.

We recognise that some ill and premature babies are unable to breastfeed. Those babies, especially, would benefit from the antibodies, hormones, enzymes and other growth factors that are contained in breast milk. Babies who are born early are also particularly vulnerable to some dangerous conditions such as neonatal necrotising enterocolitis, which is a very serious bowel disease. Again, breast milk helps to protect against that.

Given that breast milk is so important for vulnerable pre-term babies, the human milk bank in Irvinestown provides a vital service, not just for neonatal units in the North but for neonatal units throughout Ireland. Members may have heard recent media coverage that highlighted the fact that the bank had low reserves of milk. I am pleased to inform you that the publicity has resulted in a lot of donors coming forward to offer their own breast milk. I also want to reassure members that the bank was at no time unable to supply breast milk to any of the units that had requested it. Despite the difficulties, it was able to continue to supply breast milk.

We have talked about the benefits to babies. There are benefits to mothers' health outcomes as well. Breastfeeding mothers have a lower risk of osteoporosis, type-2 diabetes and certain cancers, including uterine, breast and ovarian cancers. Another plus is that they are able to lose weight gained during pregnancy more easily.

As well as the benefits to the physical health of the baby and mother, there are important psychological and emotional benefits. Those benefits have positive repercussions both for the individual and wider society. One observation is that children who are breastfed do better educationally and have better social outcomes. Therefore, the benefits are long term and long lasting, and they are psychological, mental and emotional as well as physical.

It is disappointing that despite the evidence of those benefits, as you have heard, we have the lowest rates of breastfeeding in the UK and, indeed, one of the lowest rates in Europe. Members will have heard that the results from the infant feeding survey in 2010 did not show any significant improvement since 2005 in the initiation of breastfeeding rates. I must say that we were disappointed with that outcome, particularly as local data from the child health system, which gives us the rates of breastfeeding on discharge from hospital, had suggested a modest year-on-year increase. Therefore, it was particularly disappointing that the five-year survey did not actually show or replicate that in any way.

We know from local, national and international evidence that the reasons why women choose not to breastfeed or to stop breastfeeding early are varied and complex. We have commissioned local research, both quantitative and qualitative, which tries to understand the reasons why women may choose not to breastfeed and what the barriers to breastfeeding are for them. That is the evidence that we use to inform our policy and practice.

The Department is committed to supporting breastfeeding and to improving our breastfeeding rates. As you heard, we published the first breastfeeding strategy back in 1999 to try to facilitate an increase in the breastfeeding rates. Janet was appointed as the co-ordinator in 2002, and she has provided much leadership, including help to health and social care trusts in implementing the Baby Friendly Initiative. That aims to help them to put in place best practice standards to support and help mothers to breastfeed. Under Janet's guidance, the Health Promotion Agency and now the Public Health Agency (PHA) have taken forward a number of work strands to try to implement the 1999 strategy. Those were highlighted in the briefing paper that was circulated to the Committee.

It is very important that breastfeeding is encouraged by front line healthcare workers, particularly midwives, health visitors, neonatal nurses and the medical profession dealing with those areas, and that they build that into their routine care and practice. That is why the training and education that has been provided for healthcare professionals, and supported by Janet over the years, is so important. It gives them the skills and knowledge to enable them to implement best practice. However, we have to recognise that healthcare professionals are, first and foremost, people too, and they may have their own issues. We have to recognise that and to help them where they may have their own difficulties or, perhaps, feelings of guilt about their own practices. It is not easy and straightforward. There are emotional aspects to it, not just for the mothers who we are trying to encourage to breastfeed but for many of the practitioners who are working with them.

Underpinning the education and training that has been put in place over the years has been the establishment of the Breastfeeding Coordinators Forum and the organisation of conferences, seminars and other events to raise awareness and to share best practice throughout the region. Another key element is the provision of accurate, user-friendly information to the women, both before and after delivery. Since 2009, the Public Health Agency has made available a copy of the 'From Bump to Breastfeeding' DVD to every expectant woman. The DVD is provided by midwives in antenatal outpatient departments. Janet has examples of some of the materials with her today, and we are happy to leave those for members, if you are interested.

The Public Health Agency also provides a booklet entitled 'Off to a good start' to every breastfeeding mother. We have some copies of that with us as well. That booklet is usually

given by the midwife in the early postnatal period. So, good materials are available to support the healthcare professionals working with the women, and there is good information for the women themselves. There have also been a number of public information campaigns over the years, including one, in 2007, that specifically targeted fathers to encourage them to support their wives and breastfeeding partners. The agency also has a dedicated website on breastfeeding to support parents.

We recognise that not only the partners or husbands but the wider family — the mothers and grandmothers, as your researcher mentioned — can be crucial in helping a mother to make a decision about how she will feed her baby. We also recognise the importance of getting the benefits of breastfeeding through to future generations. Therefore, in 2008, the Public Health Agency developed a CD to raise breastfeeding awareness in partnership with the Council for the Curriculum, Examinations and Assessment (CCEA). The CD is provided to post-primary schools, and schools continue to request it. An evaluation was done in the early stages, and I think that the CD is continuing to be used widely in schools.

A number of recent initiatives have provided opportunities through extended services, such as the Family Nurse Partnership, to encourage and promote breastfeeding to groups of new, vulnerable and young mothers. I think that we must take every opportunity where such schemes exist. Indeed, as Kieran mentioned, Sure Start is a good example of that. The benefits of peer support from groups of mothers who have been through the process themselves and who can encourage others are really crucial.

That brings me on to my next point. We recognise and greatly appreciate the contribution of the voluntary and community sectors in this area. Over the years, they have made a great impact in helping to raise awareness, to support mothers and, indeed, to support healthcare professionals in that work.

As you heard from the researcher, the Department and the agency carried out a review of the breastfeeding strategy. Some of the key developments that they highlighted included the increase in the number of local breastfeeding co-ordinator posts. At the time of the review, seven out of 10 maternity units had a co-ordinator. In fact, compared with the rest of the UK, we have the highest percentage of births — 61% — in baby friendly hospitals. Community support for breastfeeding has been developed through peer support programmes, and there is at least one peer

support programme in each health and social care trust area. We see that as an important area for future development.

The Breastfeeding Welcome Here scheme has almost 300 members across Northern Ireland, from local councils to businesses, including cafes, restaurants and shops. The nearest participant to here is in Newtownards. So, perhaps, we could encourage the good residents of Kircubbin to support the scheme by getting some local members to join. The whole idea of the scheme is to make breastfeeding more socially acceptable to the public in Northern Ireland.

The promotion of breastfeeding is woven throughout a number of departmental policies, including those in maternity services and obesity prevention. In particular, I want to highlight the Healthy Child, Healthy Future health promotion framework, which has interventions aimed at improving breastfeeding rates. It recognises the important contribution that breastfeeding can make to reducing infant mortality, improving life expectancy and promoting healthy weight and nutrition in all children. However, we recognise that the review and the infant feeding survey tell us that there is still a lot more to do. We have established the writing group, which Heather is chairing. It has a wide and inclusive membership. The group's aim will be to improve breastfeeding rates, to promote positive attitudes towards breastfeeding and to support those least likely to breastfeed. We know that the reasons for not breastfeeding are complex. We need to address some of the underlying cultural and social barriers as well as factors at an individual level to support women to breastfeed.

As part of the strategy's development, Dr McBride, the Chief Medical Officer, has requested that we give consideration to the case for introducing legislation similar to that which was introduced in Scotland. Members may be aware that the Scottish Parliament enacted the Breastfeeding etc. (Scotland) Act 2005, which aims to increase public awareness and acceptability of breastfeeding in public areas. One of the questions in our consultation will cover that to gauge the level of public support for legislation in Northern Ireland. I think that that is very important. If you look at the smoking ban in public places, for example, you see that legislation can do a lot to promote and raise awareness of an issue. That is where this would be particularly important.

The writing group is currently finalising the document. It would be really good to hear good ideas expressed today, and we will try to reflect and incorporate them in our drafting. We want to

protect, promote and support breastfeeding in Northern Ireland and, indeed, to normalise it and make it the usual practice rather than the exception.

We are very happy to take your questions. Heather and Janet have a great deal of knowledge and expertise in this area. I am sure that we will be able to answer your questions.

The Chairperson:

Thank you, Elizabeth. Michaela will ask a question first.

Ms Boyle:

Thank you for your presentation. You are very welcome. I have a couple of questions, and I will start with the one that I asked earlier. You said that there are co-ordinators in the different trust areas. I speak from my experience, a long time ago, when I was a young mother. My last-born child is 18, so it is 18 years ago. Breastfeeding was promoted only in the antenatal clinic, and there was not a lot of discussion outside it. Midwives were the ones who were promoting it, but times have changed. I know that there is a co-ordinator, but how does that co-ordinator work in each trust area?

I am delighted with the review of the strategy, and the fact that the Public Health Agency has requested it must be welcomed. Locally, I hear from a lot of young mothers that one reason why they do not breastfeed is that they want the child to bond at an early stage with the father as well. There are ways of doing both; obviously, expressing milk is a way of doing that. What help and assistance is there for young mothers who want to express milk? It is not easy to do.

I totally agree with everything that you said. However, one thing stood out, and I would like more information on it. You said that breastfed babies do well educationally. I would like more information on that. I am not won over on that one yet.

Dr Mitchell:

I will ask Janet to speak particularly about what is happening in each trust and how the co-ordinators work with the midwives. She might like to talk about how fathers can bond as well with the baby and how they can get involved in feeding the baby if the mother is breastfeeding.

Ms Janet Calvert (Public Health Agency):

Thank you for your question. Some of the breastfeeding co-ordinators are based in hospitals and some in the community. The hospital post is there to support implementation of best practice. Where trusts are working towards the UNICEF UK Baby Friendly Initiative award, the breastfeeding co-ordinator's post is about providing training and audit to see whether those standards are being implemented. Each trust has a breastfeeding policy, and we try to ensure that those standards are assessed to see whether the policy is being complied with by staff.

The breastfeeding co-ordinator post is primarily about levering or improving practice. Part of that role, in some of the units, is to provide a breastfeeding helpline. When mums are discharged from hospital, if they need to ring the unit and speak to a breastfeeding specialist, they can go to the helpline. We ensure that women have access to the local breastfeeding support groups, which is where we signpost them to receive support. There are various helpline numbers as well.

The answer to your question about the role of the co-ordinator is that they support the midwives and health visitors to continue to implement best practice. They might have a role in dealing with some unusual or specific lactational problems, but, realistically, they will not necessarily be able to see every breastfeeding mum. The midwives still have primary responsibility for supporting breastfeeding women. Does that answer that part of your question?

Ms Boyle:

Yes, thank you.

Ms Calvert:

You asked about the issue of ensuring that dads get the opportunity to bond with their babies and whether we support mums to express milk. We encourage mums to be the first contact in the very early period, just after the baby is born. When a unit is putting in place the Baby Friendly Initiative standards, which are part of the National Institute for Health and Clinical Excellence (NICE) guidance — NICE recommends that we do this — we encourage a practice whereby babies have early skin-to-skin contact first with the mum, and then, if the opportunity arises or if mum is not available, they have early skin-to-skin contact with the dad. The legacy Health Promotion Agency delivered a campaign aimed at fathers, and we have produced some lovely materials for dads. I have with me the leaflet, 'What dads should know about breastfeeding'.

Mr Dunne:

Will you give one to John here? *[Laughter.]*

Ms Calvert:

The leaflet talks about how dads can be encouraged to be active in the care of their babies. Breastfeeding can be established quite quickly for some women but for others it can take a little bit longer if they have had a difficult delivery or if the baby has had feeding problems. We encourage the midwives to teach mothers how to express a little bit of milk off by hand so that they can manage any problems they may have. Later on, the community midwives and health visitors will be able to give mums support with expressing milk. In the leaflet for dads, the emphasis is on encouraging dads to connect with their babies by cuddling and talking to them, changing nappies, bathing and doing all the other things, and then, once the feeding is established, to enable dad to feed the odd bottle of expressed breast milk to the baby if mum can do that. It is all about choice and what suits each family.

The Chairperson:

Who wants to cover the question on the educational aspect?

Dr Mitchell:

As I mentioned, there are a lot of benefits psychologically, emotionally and socially for the baby. That comes out in the stimulation, behaviour, speech, sense of well-being, confidence and how the child relates to others. All those impact on whether they are ready to come to school and how ready they are to start learning. It has been shown that children who were breastfed have good educational outcomes. We are not saying that every breastfed baby becomes a genius or anything like that, but it does help a child to get a secure emotional start and to be ready to learn. In addition, there are fewer incidences of allergic eczema et cetera. Some of those things will affect a child and their ability to attend school or to concentrate and learn. A lot of factors influence why they do better educationally and socially in their outcomes.

The Chairperson:

To pick up on the point about education: I think that breastfeeding is a help. If your child is struggling and has had the benefit of breastfeeding, I think that that will help — whether it is two, three or four IQ points more — with the range of other things that could affect them, especially if the child is on the cusp of just being able to manage. Those two or three IQ points can certainly

help. I attended the first all-Ireland breastfeeding conference in 2005. One contribution was that quite a bit of testing is done around the world on a baby's ability to figure things out. They were with doing tests with very small babies, and breastfed babies continually came out ahead of bottle-fed babies in terms of their ability just to work out that by pulling a piece of paper they will get the toy quicker. They can do a lot of tests to show just how further on breastfed babies are.

The figures in your paper, Elizabeth, do not do it for me: £275,000 or thereabouts spent yearly on breastfeeding promotion and support. Given our very low position, we need to look at that. I have heard the Minister say on a whole lot of occasions that throwing money at something does not make the problem go away, but we spend on breastfeeding promotion each year the equivalent of fewer than 10 hip operations and that is not enough. I stood with my local Uplift group selling Christmas cards in Dungannon shopping centre to raise money to keep the helpline open, for example. So, to me, there is a big gap in the budget that you have to spend on breastfeeding promotion, and that is reflected in our figures.

I also think that legislation is the only route we can go. You have done so many things to try to get our figures up, and they have not worked. God only knows where we would be had it not been for the past decade's work on all this, but I think that we are going to have to legislate. To me, there is no other way of doing it. I have never been on the receiving end of somebody asking me to remove myself from a cafe or restaurant because I have been breastfeeding but, God, I would have relished the chance.

Mr Wells:

It would be a brave man to do that. *[Laughter.]*

The Chairperson:

I have gone to places where they have chased breastfeeding mothers the week before, and I have sat in the middle of the place and breastfed with a "come on" emanating from me.

Mr Wells:

That would scare me anyway.

The Chairperson:

I have never been asked to remove myself. Breastfeeding in public is not always easy, and

probably the hardest place I did it was at the Executive with Jim's colleague Gregory Campbell, who is probably the scariest person around the Executive table — I breastfed in front of him, Peter Robinson and others. If you can do it there, you can do it anywhere.

To me, as a working mother, there were benefits of breastfeeding. I made an early decision to breastfeed because my husband suffered from both eczema and asthma, and I knew that his genes would probably mean that my children had a predisposition to those conditions. I chose to breastfeed to try to give them a better chance. I had no idea how much I would get out of my experience as a breastfeeding mother, and I increased quite a bit on each subsequent baby — that answers John's question from earlier. My milk dried up after around 10 and a half months with my first baby, but I fed my second baby until he was 19-plus months, and my third baby was almost three before she was weaned. That was because, every time I gave it up, I missed it so much. I missed the express bonding, if you like, that it enabled me, as a working mother, to have with my children. While I was working long hours in a difficult job, breastfeeding was my grip on sanity, and I do not think that I could have done my job without the benefit of breastfeeding.

So, I am eternally grateful to all the people who helped to support me. Janet, you were one of them, but I am also grateful to Geraldine, Conall and Ally, the nurses in the Erne Hospital who kept me there for five days so that my milk would be in and so that they could send me out to advocate for breastfeeding. All the people who helped me on my pathway were invaluable, including the midwife who suggested a different position. The help and support that I got with my three children was huge. I also donated milk to the human milk bank in Irvinestown, and, when I heard the report a couple of weeks ago, I was nearly annoyed that I had given up because I could not help out. However, to me, everybody has a role to play.

Elizabeth, you talked about the guilt that is associated with it. Midwives are extremely busy, and midwifery units in hospitals are very busy places. It is sometimes easier for somebody to hand you a bottle than to sit and help you through, and that is where I feel that the funding is not doing us a service here. We could double, triple or quadruple the amount of help and support we have because we need antenatal support and guidance. My breastfeeding support group encourages mothers to come in antenatally so that they can see what is going on so that that decision is not left until after, possibly, a difficult birth. It helps a family to make a decision before the baby is even born, and, to me, that is very important.

In my constituency, we have a high number of eastern European mothers for whom the culture is to breastfeed generationally. However, I find it sad that, when they come to Dungannon — the group has done a huge amount of work on baby friendly policy and the UNICEF guidelines — and to other parts of our country, women who have done it for generations do not want to breastfeed here. The cultural and social aspect of breastfeeding in the North of Ireland has put off mothers who have had all the advantages that we have not had, yet they come here and do not want to breastfeed. What does that say about our society and culture?

So, as far as I am concerned, the legislation is critical. I, personally, want to make a pledge today that, whatever the Minister decides to do, he will have my full support to bring that legislation forward. I have spoken to the Chief Medical Officer about it, and I believe that, without the legislation, we are on a hiding to nothing. However, I also believe that the message needs to go back to the Minister that £275,000 is nowhere near enough to encourage mothers and families to breastfeed.

I cannot put into words how much it meant to me when I was breastfeeding my children and how good it was for all of them. You talked about obesity, asthma and eczema. Each of my children who were breastfed longer had fewer problems. I see a direct correlation between the length of time that they were breastfed and their health and well-being.

I do not have a question as such —

Mr Dunne:

After all that?

The Chairperson:

— I just want to say that finance is a big thing, as is legislation. I will get off my soapbox and let Mickey and John come in.

Mr Brady:

Thanks very much for the presentation.

Mr McCallister:

Who are you thanking?

Mr Brady:

I should declare an interest. My mother tells me that I was breastfed, but I will leave it to other people to decide on my intellectual prowess or otherwise. *[Laughter.]*

It seems to me that the social and cultural barrier is one of the big issues. We have guilt complexes about everything in this part of the world. Breastfeeding is one of the most natural things in the world. However, if it is done in public here, it is almost as if the woman is committing a mortal sin. It is a taboo subject. Hopefully, education will overcome that.

My question concerns the 2005 Scottish legislation. Has any monitoring been done of the enforcement or effectiveness of that legislation? Some people might regard it as prescriptive. Has anyone been charged for stopping a woman breastfeeding in public? Legislation is probably necessary — I would support it if the Department felt that it was necessary — but how has its enforcement been rolled out?

Dr Mitchell:

My understanding is that enforcement has not been a big part of the legislation. It has been more about raising awareness, changing the culture and acceptability. I will ask Heather to come in with some of the detail of that.

Dr Heather Livingston (Department of Health, Social Services and Public Safety):

The Breastfeeding etc. (Scotland) Act 2005 not only promotes breastfeeding but states that infants under the age of two are entitled to be fed by breast or bottle anywhere that they are legally allowed to be. It carries a potential fine for breach, but it was never envisaged that there would be large numbers of prosecutions. I have spoken to colleagues in Scotland, and they say that the development of the legislation highlighted to the public the fact that stopping breastfeeding is unacceptable and that that was useful in itself. It was a public campaign, if you like.

I fully appreciate what the Chair said. Some women are confident about going to places and breastfeeding. We support women and teach them to breastfeed in ways that make it unlikely that anyone, other than those immediately beside them, will even know that that is what they are doing. We talk to them about the use of shawls, the types of clothing to wear, and so on. However, many women are not as confident about their body or breastfeeding.

A formal evaluation has not yet been published, but the informal feedback is that simply knowing that no one can come and ask them what they are doing gives women a degree of empowerment. That is one of the benefits of the legislation. It has not resulted in many prosecutions, but that is not really a surprise as it is more about supporting the change.

Mr Brady:

It is not a coincidence that in Scandinavia, which has a totally different cultural outlook and is so far ahead in social care, social welfare, care of the elderly and all those issues, women breastfeed the most. It can be a cultural thing, but legislation may create a better environment for people to participate without the guilt complexes that we were brought up with.

Dr Livingston:

You are right, and introducing such legislation would send out a strong message.

Ms Calvert:

Until we get our legislation, we are trying to encourage midwives and health visitors to empower women to develop strategies for coping with feeding outside the home. We teach them how to feed discreetly and signpost them to business and council facilities that are part of the Breastfeeding Welcome Here scheme, which has 300 members throughout Northern Ireland. There is a bit more uptake in some areas than others, but we recognise that where to breastfeed is an issue for mums, so we need to ensure that we give them information now so that they know what they can do should they need to feed their baby outside the home.

Mr McCallister:

On the basis of the researcher's figures for babies aged up to three months, nobody touches the Hungarians when it comes to their breastfeeding rate, which sits at well over 90% and makes the UK collectively look pretty poor. Whatever Hungary is doing, it works. That may support the Chair's point that breastfeeding is much more part of the culture in parts of eastern Europe.

I scanned your booklet, and thank you for allowing me to take that home. May I hear your thoughts about support groups and how we could roll them out better? How do we help to give both partners, particularly the mother, the confidence to go along and get involved in what is becoming pretty much a social gathering? The support is there, but it can be fun, relaxing, and so

on, which is vital when a woman hits a crisis, the obvious one being mastitis. How can we get more people involved in such groups? It is vital that we achieve that. If we get a good number of mothers in the first week, how do we maintain that level through two months, three months, and so on?

Ms Calvert:

That is a very good point. The existence of support groups, access to them and mothers knowing that breastfeeding is worthwhile are all issues. To complement breastfeeding support groups, we also provide mother-to-mother, or peer, support. In some areas, local women who breastfed have undertaken some training and now act as voluntary workers. They go into a maternity unit to meet mothers before they leave hospital, offer to give them a call in a few days and are there to support and encourage them to go along to a breastfeeding support group. In some areas, peer supporters run support groups. However, the evidence base suggests that the most effective breastfeeding support group tends to be that at which both a health professional and volunteer mums are present. That is because women will go there if, as you said, John, they have any issues or problems. That said, some of the peer support workers are incredibly knowledgeable, skilled and have much to offer.

In some areas of Northern Ireland, we have projects such as Uplift, which involves a group of women who have trained for two or three years as National Childbirth Trust (NCT) breastfeeding counsellors. They have huge expertise and much to offer. We need to put in place various models through the health service and the voluntary sector. The breastfeeding support groups are run from Sure Start premises and some health centres. We welcome their attachment to Sure Start, which works extremely well, as does the peer support programme. The Public Health Agency hopes to examine where we are with peer support to determine whether we could increase its capacity in the future. At present, we are improving and developing a regional training pack, which we certified in association with Open College Network Northern Ireland. NICE said that we should run externally certified peer support programmes and be proactive in our approach. Rather than expecting women to pick up the phone and ring for help, we should be there to meet them or give them a call. That works extremely well, and we hope that that approach can be used more frequently in future.

Mr McCallister:

As with many things, it is a matter of taking that first step and making the initial contact. That

could take place in a building such as the one that we are in today. Not many people are good at taking the first step, and, sometimes, it is a question of giving them confidence. That might start right back at antenatal classes. Before Molly was born, Jayne and I attended antenatal classes in Banbridge and were told that there was a support group there that we could use.

I support the remarks that the Chair and Mickey made about legislation, and I feel quite strongly about that. Janet and Elizabeth made the point about an awareness-raising campaign in the build-up towards legislation. From a slightly different angle, as well as protecting the mother, legislation could protect a business owner who, perhaps, has a conflict between two competing clients, one of whom is complaining about breastfeeding. We all agreed that it would be a brave man who would complain about the Chairperson or try to have her thrown out of a building. Business owners would be on firm ground if they could say that the law protected them. The legal perspective is, therefore, also important.

I am keen to know how serious the Department is about legislating. Sometimes, with the greatest respect, you tell us that you will look at an issue but that nothing will happen in this Assembly term or the next and that any legislation will be at some distant time. If you are serious about legislation, let us see how we could make it work. Alternatively, perhaps the Committee could consider how to progress the issue.

Dr Mitchell:

It is important to include the idea of legislation in the consultation. We want to test the public's attitude, and the more positive responses that we get to the consultation, the more it will help. Positive feedback on that being the way to go would clearly help.

The Chairperson:

Good man, John.

Mr Durkan:

There is not much left to ask — you could say that the subject has been well and truly milked.

Mr Wells:

Oh, Mark, that is diabolical. Stick to your day job.

Mr Durkan:

It is vital that we do everything that we can to break down the barriers. Although legislation would be a great way of raising awareness, there is still much more that we can do in its absence through, for example, the scheme that was mentioned earlier. However, with only 300 members having signed up to the scheme throughout the North, that is not a great return. There is, obviously, something inherent in our psyche on this island. Our rate is bad, but the Republic's is even worse. A great deal of work needs to be done to break down those barriers. The peer support groups are definitely the way to go, because people are much more responsive to their peers than to perceived state nannyism. It cannot be forced down people's throats.

My next question might be one for the researcher, but it occurred to me only when you were giving your evidence. Have any studies been done on the socio-economic backgrounds of women who breastfeed? Is there any correlation, in our society or in other countries, between the rate of breastfeeding and the access to and availability of free formula?

Dr Mitchell:

There are a couple of issues with the research on socio-economic groups. There is good evidence that breastfeeding rates are higher in the professional groups and lower in economically deprived groups, and evidence from Northern Ireland demonstrates that very clearly. I think that the difference between the 20% most deprived communities and the Northern Ireland average is that the rate in the former is two times lower. Is that right?

Ms Calvert:

There is a huge variation. The lowest wards have a rate of about 11% on discharge from hospital, and the highest wards, which are the least deprived, have rates as high as the mid-80s.

Mr Durkan:

That challenges the myth or perception that not breastfeeding might be because people are in a rush to get back to work, or whatever.

Dr Mitchell:

There is evidence that going back to work is an influence on the duration of breastfeeding. There is no doubt that it also influences people when they are deciding how to feed their baby.

Will you repeat your question about formula milk?

Mr Durkan:

My other question touched on the socio-economic issues: is there any relationship between breastfeeding and the availability of, or free access to, formula milk?

Dr Mitchell:

Currently, there are Healthy Start vouchers, before which were vouchers specifically for formula milk. Research showed that mothers did not base their decision on voucher availability, so that did not influence whether they breastfed. Research in 1999 showed that 38% of mothers who bottle-fed had received milk tokens, and some 95% of those women said that the milk tokens had not been an important influence on their decision.

Mr Durkan:

Is that 95% of the women who received them?

Dr Mitchell:

Yes.

Mr Durkan:

What if they had not received them?

Dr Mitchell:

The voucher is an important safety net. The new Healthy Start scheme vouchers can be used for fresh or frozen fruit and vegetables, not just for infant formula. They can be used by the mothers during pregnancy and for children up to four years old. It is a much wider scheme than just —

Mr Durkan:

I am not advocating that we do away with them or anything; do not worry about that.

Mr Wells:

Madam Chair, meeting you in a dark alley and telling you not to breastfeed would be a very frightening experience. I certainly would not advise it to any normal human being.

A few years ago, I heard a statistic that initially encouraged me and then did not. It was that vegetarians live seven years longer than meat-eaters. I am a vegetarian, so I thought that that was great; that is another seven years in the nursing home to look forward to. Then, I analysed that figure and realised that vegetarians tend to be non-smokers, tend not to drink to excess and tend to be exercise freaks. It may not be the fact that they are vegetarians at all that makes them healthier; it may be just that they tend to be people who take an interest in their lifestyle.

I am worried about the suggestion that children who are breastfed are brainier — that would explain my predicament, anyhow. However, that may not be the reason why they are more intelligent at all; it could be that parents who take an interest in breastfeeding are more likely to spend time with their children, read with them and try to stimulate their learning. It might be absolutely nothing to do with the mechanical aspects of how they are fed. One of your statistics shows far more breast-feeders on the Malone Road than on the Shankill Road. That tends to lend weight to the argument that it is parental influence rather than the actual mechanics of the child being fed. Is there any chemical in breast milk that makes children more intelligent, or is it just that they have better parents?

Dr Mitchell:

You are absolutely right that these are, undoubtedly, complex and inter-related issues. Often, people who choose a healthy lifestyle in one aspect of their lives will follow it in others. However, a lot of evidence and research supports the improved emotional and psychological outcomes for breastfed babies. We are not saying that a child who is breastfed will become a nuclear physicist or whatever; we are just saying that breastfeeding gives the child the best start in life.

Mr Wells:

I have been on the scene for quite a long time, and I must say that no one has ever complained to me about being excluded from a shop or restaurant because she was breastfeeding. I take the point that the possibility of being excluded deters folk from breastfeeding in public.

At the behest of your good selves, we are about to embark on a series of items of legislation, and rightly so. Legislation may be introduced on cigarette vending machines and on smoking in the presence of children under five, both of which are great ideas. Undoubtedly, the libertarians will say that that is the nanny state junta trying to force people to do everything that they say is

appropriate and that there is no freedom. Is breastfeeding legislation, therefore, not likely to devalue the currency? We have more of a need for an educational programme, rather than public health officers from councils or your staff going around and forcing restaurant owners and shopkeepers to comply. That would be going too far down that route, and, using the same argument, it will be hard enough to sell the legislation on smoking in cars in the presence of children under the age of five. The other argument that libertarians will make is that this is only the thin end of the wedge and that there is more to come, which there is. People will want to know where it will all stop.

The Chairperson:

Before you come in on that, Elizabeth, I should. Earlier, in response to Michaela, I said that the IQ tests were carried out on very small babies who did not have the advantage of parents who bought jigsaws for them, and so on. The tests were on very young children to whom other elements did not apply.

I believe that there is a need for legislation. We have heard what the Department and the Public Health Agency have been doing for years to try to increase breastfeeding rates. The problem is that women do not feel comfortable breastfeeding here, and many have complained to me about restaurants and other places asking them to move while breastfeeding, to leave the premises or simply stop. That happens frequently. Sometimes, such a story makes the media, but not always. When it happens, it can be very humiliating and disheartening. When people have been asked to remove themselves from an establishment because they were breastfeeding, it takes a lot of courage for them to breastfeed again in public.

The key point on the need for legislation is to do with the health benefits of breastfeeding. The educational benefits are almost an aside. The whole raft of huge health benefits to babies includes increased immunity. The Department and health professionals are planning how to deal with a population that will have very high levels of obesity in the future. In the Chamber, the Minister talked about bariatric, or gastric band, surgery. I spoke to people in the South Eastern Trust who talked about how the plastics department was going to change because, instead of dealing with people involved in accidents, it will be dealing with people who have had gastric band surgery and then need plastic surgery because of resulting issues such as excess skin.

We are planning for a society in which quite a number of people will be seriously obese. The

way to avoid that happening is to commit investment, and this is among the best invest-to-save measure that we can take. If the Department puts the right resources into preventative care, including supporting mothers to breastfeed, in 30, 40 and 50 years' time, we will not have people in excess of 25 stone with serious health problems. That is one of the main reasons why we need the legislation; the health benefits are key.

Mr Wells:

Madam Chair, you may have heard on the radio that the A5 scheme has been shelved. That means that there is an extra £400 million for which we can all pitch for worthy programmes.

The Chairperson:

I wondered how long it would take you to get that in, Jim.

Mr Wells:

There is £400 million to pitch for, and that would be more than enough to implement a proper breastfeeding programme. I accept the physical evidence, which is irrefutable, but I am worried about the view that, if you breastfeed, your child will be cleverer than if you do not. There are many more complex problems to be looked at than the mechanics of breastfeeding. I am always worried about the view that how a child is fed determines his or her IQ.

Dr Mitchell:

We have emphasised over and over again that the issue is complex and societal. It is bound not only to individual factors but is generational. We need a multi-faceted approach. We have been trying and testing methods over the years, and the results have been disappointing, so we need to think of new approaches.

We need to test the public's attitude to whether legislation is the way to go. I am not saying that a higher rate of breastfeeding will turn the next generation into Einsteins, but it will give them the best start in life; evidence from around the world shows that. To give the next generation the best start, we should be doing everything we can to promote breastfeeding. We should do everything we can to support mothers, and legislation is one avenue that we should consider. It may help to protect the right of women to breastfeed. The embarrassment felt by women is a major issue. Some may not want to test the possibility of being rebutted or advised to stop breastfeeding. Just because women may not report such incidents does not mean that they

are not suffering embarrassment or concern that they cannot breastfeed in public or cannot find places where they would be comfortable breastfeeding.

There are many issues, some complex, but I think that we agree that the evidence demonstrates that breastfeeding has important health benefits for babies and mothers and that it is the way to go.

Mr Dunne:

Thank you very much, ladies, for a very informative presentation. You talked about the health benefits to the mothers and mentioned the reduced risk of cancer, and so on. Is there clear evidence of that?

Dr Mitchell:

There is evidence from international studies of societies in which breastfeeding is more prevalent. They considered the pregnancy and breastfeeding history of women in the context of who developed cancers, so there is strong research.

Mr Dunne:

Is that evidence generally promoted? Are people aware of that?

Dr Mitchell:

Janet, do you want to cover what is in the information given?

Ms Calvert:

Yes. The information that we give out, which is in the form of a DVD given to all pregnant women and a booklet given to women just after they have their baby, clearly states that breastfeeding reduces the risk of breast and ovarian cancers. That evidence base comes from two extensive systematic reviews published in 2009: one by the World Health Organization and the other by the Agency for Healthcare Research and Quality in America. We have some really good statistics from that. For every year that a woman spends breastfeeding, she reduces her risk of breast cancer by 4.3 %, so the message is: have lots of babies, feed them for ages, and you will reduce your risk. *[Laughter.]* It is a bit like what the Chairperson said in that the benefits are dose-related: the longer the period of breastfeeding, the more health benefits there are for mothers and babies.

Mr Dunne:

Is that clearly the case?

Ms Calvert:

It is very clear. The World Cancer Research Fund published a report stating that one of the top ten things to do to reduce your risk of cancer is to breastfeed.

Mr Dunne:

The other important point is the emphasis on work-life balance, with both parents working and trying to get back to work as soon as possible. There is an urge in society for that to happen. We are all keen to maintain our standards of living and worried about what would happen if they dropped. We want to maintain the pattern in the home, which may be well established. Those pressures are surely big factors and act as a deterrent. That was an issue in my family. Breastfeeding was tried for a while but dropped because, I think, of the pressures of life. It is difficult to balance the pressures on families, and breastfeeding is simply not the priority that it should be. What more can be done to encourage it? It would mean a big change in society, because the pressures that I outlined are more real now than ever, bearing in mind that the state of the economy is another factor.

Can health visitors and other professionals do more to help to promote breastfeeding? My mother was a health visitor, and I am aware of the job that she did. She talked a lot about children and their growth, and she was very much involved in the care of babies and children. However, I wonder whether the emphasis on such professionals is as strong as it should be.

Dr Mitchell:

I will ask Janet to come in on that, as she is involved in much of the training for front-line health professionals, such as midwives and health visitors. You are right that there is great pressure on families and that it is likely to increase as a result of the economic situation. We all acknowledge that being a working mother and breastfeeding is not easy and that there are challenges. The support groups are important, because they can help women to find a way of balancing a demanding job with continuing to breastfeed their baby for as long as possible.

Ms Calvert:

Health visitors have a very important role to play in helping women to sustain their decision to breastfeed. I agree that there are many pressures on families, which means that family support is incredibly important. In the strategy review, women expressed a need to educate grandmothers to have more confidence in breastfeeding.

Through our new health-visiting programme, Healthy Child, Healthy Future, much more emphasis is placed on breastfeeding. In many areas, health visitors are able to make antenatal visits, and, when the opportunity arises, they can start the discussion about how mothers will feed their baby. They can continue that support when they carry out their initial health review at the primary visit, which is at the crucial time between day 10 and day 14. The time at which a baby is about two weeks old is when many women struggle and stop breastfeeding. Health visitors are extremely important in helping women to sustain the decision to breastfeed and in signposting them to their local support group.

By the way, there is a very active breastfeeding support group in Banbridge. It held a lovely celebration event during Breastfeeding Awareness Week this year. I went along, and there were between 40 and 50 mothers and babies at the event. Such networks are available, and you are absolutely right, Mr Dunne, in saying that community healthcare staff have an important role to play.

Ms Boyle:

I have an important point, which follows on from what Mark said earlier. It is right to put in place a safeguard for vouchers, and, perhaps, welfare reform will dictate that, not the legislation. The vouchers for the formula milk are given to those in most need, such as mothers on a low income. I am an advocate of breastfeeding, but it is also important for the legislation to ensure that the vouchers are safeguarded, because they are much needed in many deprived areas and go a long way in helping to feed a family.

Mr Durkan:

Absolutely. Newborn babies appear to be under particularly fierce attack in the Welfare Reform Bill.

The Chairperson:

The vouchers can be used for fresh or frozen fruit and vegetables. On the back of what Gordon said, the point should be made more often that breastfeeding is free. Women who get a voucher can buy healthy food for themselves and feed their baby, so they are feeding two people with the voucher instead of one.

Mr Dunne:

Is that like Tesco?

The Chairperson:

I would not normally plug Tesco in Committee meetings, Gordon. However, this is far better than buy one, get one free. Breastfeeding is free, and, apart from all the health benefits, it is better for anyone struggling and trying to manage on a budget. How much does a tin of formula cost now?

Ms Boyle:

It is about £8 or £9.

The Chairperson:

How long does it last?

Dr Livingston:

On average, one tin is used every week over the first six-month period. Naturally, small babies need less than a tin a week, and older babies need more than a tin. It costs a considerable amount.

Ms Calvert:

Twins need more.

Mr McCallister:

Do not attack twins; I am a twin.

The Chairperson:

I hope that the other one is better looking. *[Laughter.]*

Mr Wells:

The other one got all the brains. *[Laughter.]*

Mr McCallister:

I would like to point out that no, she is not better looking. *[Laughter.]*

Mark and Michaela touched on the different socio-economic groups. Are some support groups better at reaching difficult-to-reach communities? Your presentation and that from Lesley-Ann stated that the rate of breastfeeding was higher among professional women. In fairness to the Chair, when she had her most recent baby, she had to juggle the busy roles of MP, MLA and Minister.

How do we prevent the support groups from becoming merely nice middle-class get-togethers? That might be unfair, as I am familiar with the Banbridge group that Janet mentioned. Indeed, Jim said that it would be a good photo opportunity for me, so perhaps I should make an appointment to visit. *[Laughter.]*

We struggle with many of the issues for which most help is needed. Generally, we struggle with getting out positive messages about health benefits and providing encouragement. How do you reach those most difficult groups?

Dr Mitchell:

There are some early encouraging results from the pilot of the Western Trust's Family Nurse Partnership, which gives intensive support to young mothers and mothers from low-income groups. There has been some success in raising breastfeeding rates there. It is early days, but it looks as though that could be one way in. Similar work is ongoing in the South Eastern Trust, which has also reported good increases in the breastfeeding rates among the most vulnerable and mothers from deprived groups.

Mr McCallister:

Is that the core group that we fail most and the group that pulls down the overall figures?

Dr Mitchell:

I think that, apart from in one or two areas, such as the likes of the Malone Road and Stormont,

we could do better in all groups. In one or two such areas, the breastfeeding rate is equivalent to areas across the rest of the UK, but, on the whole, we are not doing that well. The rate is particularly bad in the deprived and lower socio-economic groups and among younger mothers, but we could do better across the board. Janet mentioned peer support and experienced mothers helping out. That is a good way in to helping those groups that you mentioned and an approach that we want to try to develop.

Ms Calvert:

There is some encouraging work going on within Sure Start. Sure Start runs in north and west Belfast, the Smile project is in Shankill, and there are projects in Clan Mór and Glenbrook. Sure Start is working towards achieving the baby friendly accreditation. It has made some progress in trying to develop targeted interventions. It is considering how to get women to attend antenatal classes that are specifically tailored to meet their needs and how to introduce some element of breastfeeding. Also, the Public Health Agency has commissioned a peer support breastfeeding co-ordinator post in the Belfast Trust area. She will aim to get into those areas by training the one or two women who breastfeed and getting them to talk to the women in their own community, because women will accept information from them more readily than from health professionals. They like to hear other mothers' stories, and that can help.

The Chairperson:

You have 10 seconds, Mickey.

Mr Brady:

I have one quick point. Jim mentioned good parents, and it was mentioned that the "professional" classes may have more time and be more inclined to breastfeed. It is important to make the point that, in the term "socio-economic", there is a division between the "socio" and the "economic". We should not send out the message that people who live in deprived areas are worse parents than people who live on the Malone Road.

The Chairperson:

That takes us back to the Scandinavian countries, in which there is no correlation between a child's life plan and that of his or her parents: if both parents work in a factory, that does not stop the child from becoming a brain surgeon. Equality of society in Scandinavian countries is also much better than it is here. I fully concur with your point, Mickey, and I am glad that you made

it.

Thanks a million, Elizabeth, Heather and Janet, for a very interesting evidence session. We hope to see you again. If I can, I would love to have a look at a copy of the draft strategy. We will want to press the Minister to think seriously about introducing legislation. I hope that the next time that we see you will be on the back of the introduction of your strategy and to hear your ideas about legislation.