DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 12 Bealtaine 2021

Wednesday, 12 May 2021

Tháinig an Comhchoiste le chéile ag 9.30 a.m.

The Joint Committee met at 9.30 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Colm Burke,	Lorraine Clifford-Lee,
Sorca Clarke,	Martin Conway,
Cathal Crowe,	Annie Hoey,
Bernard J. Durkan,	Seán Kyne.
Neasa Hourigan,	
Gino Kenny,	
Róisín Shortall.	

* In éagmais / In the absence of Deputy David Cullinane.

Teachta / Deputy Seán Crowe sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: Apologies have been received from Deputy Cullinane. His party colleague, Deputy Clarke, will substitute for him. Before we commence our formal proceedings this morning, I must address a housekeeping issue. The draft minutes for our meetings of 20, 27 and 28 April and 4 and 5 May were circulated earlier. Are they agreed? Agreed.

Updates on Breastfeeding: Discussion

Chairman: I welcome our witnesses to the meeting. We are joined by Ms Deborah Byrne and Ms Megan Etherton from Bainne Beatha and Ms Geraldine Cahill and Ms Fiona Rea from Cuidiú. Bainne Beatha and Cuidiú provide education and support for parents and of particular concern for them today is the lack of support for breastfeeding in maternity services.

Before we hear their opening statements I must point out to our witnesses that there is uncertainty as to whether parliamentary privilege applies to evidence given from a location outside the parliamentary precincts of Leinster House. Therefore, if witnesses are directed by me to cease giving evidence in relation to a particular matter, they must respect that direction. I call Ms Byrne to make her opening remarks.

Ms Deborah Byrne: I thank the committee for inviting us and the members for attending. Behind Bainne Beatha, our campaign for improved breastfeeding support services in Irish maternity units, are four working mothers: me, Megan Etherton, Lucia Prihodova and Felicienne Rahill. We launched in February 2021, and are running this in our spare time without funding or political affiliations. We are not a breast is best group. We respect a parent's choice to formula, combination or breastfeed. However, the Irish maternity service does not appear consistently to support those who wish to breastfeed.

We hear often about Ireland's breastfeeding rates being the lowest in Europe, but there is judgement of mothers in that language. Mothers in Ireland know about the importance of breastfeeding, and according to the Irish Maternity Indicator System, IMIS, report, at 63.8%, the majority of them do initiate breastfeeding, but by the time they leave the hospital, this figure is almost halved to 37.3%. What happens in those days between birth and discharge from the hospital? Our report, personal experiences and the stories we have heard since launching provide some insight into the reasons behind this sharp decline. We would like to share some of those insights with the committee and five key asks of our Government and action by the Houses of the Oireachtas to make vital interventions.

From our report, 37% of mothers reported that midwives were too busy and overworked to provide the assistance needed. A quote:

> I have had 3 babies and while the hospital did support breastfeeding, I never saw a lactation consultant despite requests each time. I was a section mum so in for several days - never available. Saying you support is not the same as providing hands-on support. Midwives were v good but v busy with everything else.

I also experienced this on the birth of my first child. Therefore our first ask is for adequate staffing, and for the number of international board-certified lactation consultants to be increased in line with international benchmarks and to be accessible in all Irish maternity units.

One in three mothers in our report received conflicting advice about how to breastfeed. One respondent said that "All of the midwives said different things which was really hard to filter through as a new mother". I too faced conflicting advice during my time in hospital. Our second ask is to see mandatory evidence-based continuing professional development on breastfeeding for midwives and certified lactation consultants.

In our report, one in three mothers were offered formula despite stating their wishes to breastfeed. One mother wrote, "New mothers shouldn't need an advocate to defend their intention to breastfeed, fending off formula or conflicting advice from the 'experts' when they are exhausted and post partum in the middle of their baby's first night." I too left the hospital formula-feeding my baby against my wishes. Our third ask is a national audit of the implementation of the national infant feeding policy for maternity and neonatal services, and a review of the promotion and distribution of formula practices across all maternity units.

The national maternity experience survey of 2020 results showed 47.3% of women did not know how to give feedback or make a complaint about their maternity care. Therefore our fourth ask is for the national maternity experience survey to expand to evaluate comprehensively service user experiences of breastfeeding support in maternity care, and to have service user representation on the national breastfeeding implementation group for current and future action plans.

In our report, we found 60% of mothers sought help with breastfeeding privately, spending an average of €440. I personally had to spend almost €700 to be able to breastfeed after a difficult experience in hospital. Maternity units can be a level playing field, offering a great opportunity to reach a cross section of the 60,000 plus women who give birth in Ireland each year and to extend the opportunity to anyone who wishes to breastfeed. Therefore our final and most important ask is for the full implementation and assessment of the breastfeeding action plan to ensure proactive, skilled, timely breastfeeding assistance for mothers and babies, regardless of location, demographic or ability to pay.

There are amazing midwives, public health nurses, voluntary support groups, including Cuidiú, representatives of which are present today, and lactation consultants who manage to save mothers' breastfeeding journeys after their difficult experience in hospital. However, thousands are falling through the net every year, bringing about added potential health risks for mothers and their babies. Not investing in this crucial period is a sure-fire way to guarantee we are cutting our breastfeeding rates within hours of birth. We need to flip the narrative which blames mothers and instead address low breastfeeding support rates in Ireland. Breastfeeding is a component of the national maternity strategy, the strategy on women and girls from the Department of Justice, the national obesity plan and the national cancer plan. Fianna Fáil, Fine Gael and the Green Party identified breastfeeding as a priority in the programme for Government and we would like to see them honour this commitment.

We are grateful for the opportunity to be able to share these stories with the committee. Now we are looking for the full implementation of what has been promised in the national maternity strategy and the breastfeeding action plan. Breastfeeding reduces risks of multiple health issues for mothers and babies and they deserve the protection of the Government.

Chairman: I thank Ms Byrne and ask Ms Cahill to give Cuidiú's opening statement.

Ms Geraldine Cahill: Breastfeeding is one of the smartest investments a country can make to build its future prosperity. It offers children unparalleled health and brain-building benefits.

It has the power to save the lives of women and children throughout the world and the power to help national economies grow through lower healthcare costs and smarter workforces.

Ms Fiona Rea: Cuidiú's vision is education and support for parenthood. Our mission is to provide evidence-based information to parents allowing them to make informed choices about pregnancy, childbirth and breastfeeding. We also aim to provide a supportive background to empower parents to act upon their decisions in the areas mentioned.

Ms Geraldine Cahill: Cuidiú has gradually developed into a formal structure with 26 branches and groups throughout the country, offering a diverse variety of support services to parents. Branches have evolved differently according to the interests and expertise of the membership, but the ethos of every branch is overseen and directed by a central board of directors and members of teaching panels for antenatal, breastfeeding and parenthood support.

Ms Fiona Rea: Consistently since the early 1980s the backbone of Cuidiú has been made up of dedicated volunteer parents who train as antenatal educators, breastfeeding counsellors, parenthood supporters and who have served on local and national branches as committee members.

Ms Geraldine Cahill: Breastfeeding is normal, and natural, and like all other mammals, we are designed to feed our babies. Healthy newborn infants are born with a host of natural reflexes and instincts that help them to breastfeed. Accurate information and a good support network can help make breastfeeding an easier and more enjoyable experience.

As part of our organisation, we have 170 active, fully qualified voluntary breastfeeding counsellors, BFCs. Our BFCs offer telephone support and host breastfeeding support groups and coffee mornings throughout the country. During the recent pandemic, most groups swiftly pivoted to online support. Whatever parents' needs, Cuidiú is there to provide a listening ear.

Ms Fiona Rea: The overarching aim of the Health Service Breastfeeding Action Plan 2016–2021, Breastfeeding in a Healthy Ireland, is to increase breastfeeding initiation and duration rates by supporting, and enabling, more mothers to breastfeed. The parts that particularly relate to Cuidiú are as follows: "3.5 Provide infant feeding antenatal education for all pregnant women." This has been allocated to the acute hospitals but there is also a place for Cuidiú, and other services, to provide breastfeeding education; "3.6 Develop a clear referral pathway for mothers requiring additional breastfeeding support before and after birth, to Lactation Consultants." Again, we would see that Cuidiú could have a role here, giving us clear guidelines as to who we can and should refer to, and also having GPs and public health nurses, PHNs, refer to us when mums need support rather than clinical help; "3.9 Provide breastfeeding support groups in all CHO areas through: Maternity and public health nursing services. Grant agreement with voluntary organisations such as La Leche League and Cuidiú. Provide social support groups through grant agreement with Friends of Breastfeeding." Cuidiú and the other groups have been working steadily in this area over many years now with support from the HSE. We note, however, that the funding has been steadily decreasing while expectations grow; and, "3.11 Implement evidence-informed programmes and initiatives to promote breastfeeding, provide support and address barriers for women least likely to breastfeed." We would see a role for Individuals who have been trained by Cuidiú, in being part of a multidisciplinary task force of stakeholders who have expertise and can help communities to set up their own support systems.

Ms Geraldine Cahill: As we said at the outset, breastfeeding lays the foundation for good health. *The Lancet* has estimated that scaling up breastfeeding to a near universal level could

prevent 823,000 child deaths per year. By supporting mothers to breastfeed, nearly 50% of diarrhoea episodes and a third of respiratory infections would be avoided. Breastfeeding has been found to reduce the risk of childhood obesity and diabetes. Breastfeeding contributes to delayed return of menstruation and, thereby, to birth spacing. *The Lancet* has estimated that 20,000 breast cancer deaths could be prevented annually as a result of optimal breastfeeding. *The Lancet* reported that shorter durations of breastfeeding for children were associated with a 2.6 point loss in intelligence quotient, IQ, scores. We see Cuidiú being a partner in achieving the above goals for the Government and the new plan that will be organised going forward from 2022.

Chairman: I thank the witnesses. I call on members to ask their questions and the first group is Fine Gael with Deputy Durkan.

Deputy Bernard J. Durkan: I welcome our guests this morning. I thank them for the work that they have done, and are currently undertaking, on behalf of women and babies. To what extent have they found empathy throughout their negotiations and discussions with the maternity hospitals?

Ms Deborah Byrne: We have not had a response from the hospitals, as of yet.

Deputy Bernard J. Durkan: Is work being done on that? Is it proposed to bring the campaign directly to the hospitals? Is it proposed, as part of the campaign, to engage with the hospitals to promote the issue on behalf of women and in general?

Ms Deborah Byrne: We sent the report to the hospitals and requested a meeting. We have not heard a response. We would very much like to meet to discuss what it is like to be a service user. One of our asks is to have service user representation on the implementation group. I believe that there are hospital representatives on the implementation group so any service users selected could engage with the hospitals at that point. Yes, we are very much interested in speaking to representatives of the hospitals.

Deputy Bernard J. Durkan: Has contact been made with all of the maternity hospitals or just one?

Ms Deborah Byrne: My colleague, Ms Etherton, might be able to correct me but I believe that we have contacted all of the maternity units.

Ms Megan Etherton: Yes, and we also forwarded the report at hospital group level.

Deputy Bernard J. Durkan: Have the health issues that benefit women been pointed out and what has been the response from hospitals?

Ms Deborah Byrne: We have not had a response.

Deputy Bernard J. Durkan: My next question is on choice for women. I have discussed this with a number of women because obviously they are better able to tell me about these things. Some women have a preference for breastfeeding but some do not. To what degree have the organisations accommodated both views, and can they accommodate both, yet at the same time provide the service that the organisations have in mind?

Ms Geraldine Cahill: I honestly believe that if women do not have information about the risks of not breastfeeding then they are not in a position to make a decision about breastfeeding. We do not give information to people about the risks of formula feeding so women are not mak-

ing an informed choice. Let us remember that breastfeeding is a human right of the baby and that is declared in the Innocenti Declaration of 1990. It is a baby's human right to be breastfed. While it is a woman's choice to breastfeed, if women do not have the information on the risks that they are causing their babies then they cannot make proper choices.

Deputy Bernard J. Durkan: Some women may or may not agree with that, which is something that I have picked up in the course of my own inquiries. I am a little concerned that women would feel hustled into a situation. I would like to see a situation whereby women had a choice. I mean that all of the information that is needed would be made available to women to enable them to make an informed choice and that is what I would seek.

Ms Geraldine Cahill: Women make choices already. Let us remember that fewer people breastfeed than use formula milk or feed artificially. I do not understand where the choice comes in because choice already exists and fewer people choose to breastfeed. While women might want a choice they are not being given it, and supported, to make the choice to breastfeed. The *status quo* is formula feeding. That is what everybody reverts to so I cannot see where the Deputy is coming from in his argument about choice because, in fact, it is being able to choose to breastfeed that is the problem, not the other way around.

Deputy Bernard J. Durkan: I stand corrected.

Ms Megan Etherton: We have been very clear that we are not a "breast is best" group. There definitely are camps that have been set up that divide women into groups of "breast is best" versus "fed is best", which does not benefit either the mother or the baby. We believe that women generally are aware of the benefits of breastfeeding and are very much encouraged to breastfeed but are extremely let down in maternity hospitals. Sometimes there is shock from being led along the path of being told they would be helped and that women should do it because it is wonderful but then the choice to breastfeed is taken away because the women are left without any help or resources. That does not happen in every case but in many of them. We just want to level the playing field and, as Ms Cahill has pointed, ensure the choice to breastfeed is available to women.

Deputy Bernard J. Durkan: I thank the witness as it is very important a woman should be able to acknowledge and assess the available information to make up her own mind on what is best for her, taking into account that helpful information. I thank the witnesses.

Deputy Sorca Clarke: I thank the ladies for their time this morning and the incredibly informative presentation they gave. In the spirit of full disclosure, I should say that breastfeeding is something close to my heart and I have nursed four children through various mechanisms because of different influences. I will come back to that as we go through the questions.

I agree that choice is key but that choice must be fully informed. The education should start before a woman becomes pregnant or a baby is born. At a much younger age we should educate women about breastfeeding and how it can fit into a lifestyle, along with the difficulties it may present. Having a baby disrupts a lifestyle as people may know it. We can accept that and the universal health benefits to both the baby and the mother.

There is now a position where women are leaving hospitals, where most births take place, much earlier than they would have before. That golden window of time and the first few days before a woman's milk comes in fully are absolutely key. If there is no support or ineffective support, we will simply not have the level of breastfeeding we want to see and we need to see

taken at that early stage. The more women we have breastfeeding at the start clearly leads to higher rates of longer term breastfeeding. That is a question that must be addressed.

I had conversations with various people before coming here this morning but I know from personal experience that we must see a societal shift in how we view, support and encourage breastfeeding mothers and remove some of the barriers that exist. Another Deputy told me yesterday of her experience breastfeeding, and I told her how I nursed one of my children on the floor of a shopping centre, which was unacceptable. That is an example of a real barrier that could be quite easily challenged or changed. Again, it would rely on a societal shift.

We can consider the professional needs that exist, including lactation consultants, counsellors and peer support, and they must be matched on the other side with a societal shift in how we view breastfeeding. I agree with Ms Byrne that we need an audit of the infant feeding policies of hospitals. I would like to see formula being offered as opposed to being the predominantly accepted way in which a mother would feed a child. It absolutely should be there and there is a role for it but it should be available on request. Many more women would breastfeed if they knew they would be fully supported from those very early days right through whatever length of time they chose to nurse their children.

We must also have a review of our tax system to go with that. We need to look at how it is we apply VAT to the likes of hospital-grade breast pumps, breast pads and nipple guards. These are all tools to help a woman breastfeed for longer. We do not acknowledge they exist and we certainly do not encourage women to use them. Although we acknowledge there is a problem, we need to get to the point where women know they exist.

I say this as a woman whose second child was in the special care baby unit, SCBU, and due to various medical influences at the time, I was pumping and dumping. I never knew I could hire a hospital-grade breast pump until somebody happened to mention it to me in passing. It is a question for us to consider. When we look to address these challenges and encourage women, we must be more varied in our thinking and have a more multifaceted approach to how we do this. When we identify a challenge or barrier, we must approach it with evidence-based and target-based outcomes for what we want to see.

I spoke to a number of providers of breastfeeding support equipment and it was interesting that their view is the practice must be more accessible with better uptake. When a woman experiences a problem without support or education, the first reaction is to stop, which presents a real challenge. It is something we should take on board and listen to women about.

We must challenge the information and disinformation out there. There is a lot of information bandied about and some of it is based on tutti-frutti or pie-in-the-sky type of stuff, and that must be challenged. We must also actively promote the positive aspects of breastfeeding, which are varied. When we speak of breastfeeding we tend to concentrate on the challenges but there are many positive aspects of breastfeeding.

We also need to see a network of professional supports. Community healthcare organisations, CHOs, were mentioned and mine runs from Westmeath to Louth, so I ask for a significantly greater network than asking a woman in Westmeath to travel to Drogheda. These networks must be accessible, fit for purpose and almost tailored to what a lady needs. No two women encountering difficulties with breastfeeding will have the same problem, so such networks must be professional and easily accessible. The people involved must be aware of a lady's need.

GPs and public health nurses are wonderful people but they must have more education and be aware of the supports in the communities in which they work. When they encounter a lady experiencing difficulties, they should be able to refer her to the support groups, even if they are peer support groups. They should also put the idea in the mind of a lady who is doing well that she might be able to encourage other women in her network who might be struggling a little bit. We must have greater education around the supports and ask those who are doing well to relay their experience and perhaps promote breastfeeding.

I would like to see a new mother pack for every new mother in the country. This would be a small pack with various travel-sized bits and pieces. In that pack there should be more information on breastfeeding. It could include a couple of breast pads or a nipple protector. Something along those lines should be included in those packs. This recognises there are women breastfeeding, feeding with formula or a combination of both.

I thank the witnesses for their time as this has been a very informative discussion. I hope to meet them again.

Ms Fiona Rea: I thank the Deputy and I agree with all she has said. Cuidiú's role in the community is to provide continuity of care, including to mothers coming from hospital. Not only that, we provide education and support ahead of birth. A big section of our organisation is antenatal education and we also give postnatal support. Cuidiú sees community care and continuity of care as important. As the Deputy and Ms Cahill have said, this is about information, and if mums do not have the information, they cannot be in a place to make a decision. We need to improve the support we give to mothers ahead of birth.

Our group is really trying to remove isolation, not only arising from a lack of family support but also through women feeling they are not getting support with their breastfeeding. This is one of the aims of Cuidiú and something we strive to continue to do. We are trying to protect the mental health of mothers as well as the health of their babies and the physical health of mothers through breastfeeding. As an organisation we are trying to hit all of these marks.

The funding we get is terrific and we are delighted with it. It is fantastic to hear that €1.58 million is being put into breastfeeding and that the WHO code will be fully adopted. However, it is only a drop in the ocean. Society needs to change its attitude towards breastfeeding. Human milk is for human babies. There is no two ways about it. There are many reasons human milk is for human babies. Anything else is substitute. I agree that some people may feel under pressure but, as we have said, if they do not have any information, it takes away their choices. We are all for choice and nobody wants anybody to do something they are not happy or comfortable to do. As has been said, feeding on a shop floor is not acceptable so who will be comfortable breastfeeding if they have to feed in a toilet? We have all heard the stories time and again. It is disgraceful that in 2021 we still hear them. These are the issues we have to address and move on from.

Ms Deborah Byrne: I thank the Deputy for her comments. She mentioned the cost of breastfeeding and we have spoken about this previously with regard to the material required. It has been a significant barrier. In my opening statement, I mentioned that 60% of mothers who responded had to spend an average of €440. If a mother is struggling financially in any way, €500 is a lot of money to have to hand when in a vulnerable state and already spending a lot of money on all of the baby paraphernalia required. Breastfeeding is spoken about as the cheaper option but until the supports are in place so they can be accessed in hospitals and through community and peer groups, and all the areas are covered, mothers have to hire private lactation

consultants and hire or buy pumps. This adds up. We agree that currently the price of it is exclusive and it should not be.

Ms Geraldine Cahill: One of the points I want to come back to is the interaction between the agencies and the voluntary groups. We have some representation. For instance, Cuidiú sits on a committee in the children's hospital in Tallaght but does not appear to have representation in Our Lady's children's hospital. We sit on some of the maternity units but not all. As volunteers it is quite difficult to get people to volunteer to be parent representatives on these committees but it is vital that women's voices are heard in this sphere. In the past year, none of these committees has sat anyway as everything seems to have stopped, just like the public health nurses who do the well-baby care visits are no longer always doing so because they have been shifted to Covid and vaccination programmes. Our mothers and babies are left in the community with absolutely no support. Having to resort to a private lactation consultant is fine if people have the funding but if they do not have the funds, it means they go completely without help, including State help. A lot needs to be done on hospital interaction with voluntary groups and with private lactation consultants. There needs to be a multipronged approach so that stakeholder voices are heard rather than deciding from the top down what is needed in the country.

Deputy Sorca Clarke: In the witnesses' experience, how many women donate to the human milk bank in Irvinestown? Do they know of any ladies who are still doing it?

Ms Geraldine Cahill: Yes, there are quite a lot. They do it voluntarily themselves.

Chairman: There is a problem with the sound and I ask members who have headsets to wear them because it is not very clear and when people make contributions it is very hard to pick them up.

Deputy Róisín Shortall: Can I be heard all right?

Chairman: You are quite clear, believe it or not.

Deputy Róisín Shortall: I welcome our guests and thank them not only for coming before the committee but also for the incredible work they do on a voluntary basis, very often at a time when they are all very busy themselves in their own lives. Given that our breastfeeding rates are disappointingly low at present, we have to wonder how much lower they would be if the voluntary groups were not involved. At an official level in the health service clearly there are major gaps in the supports that should be available as a matter of course. From this point of view I thank the witnesses for the work they are doing, as they are making a significant contribution.

I want to direct questions to Bainne Beatha. I thank the witnesses for the documentation they sent in and for the report. What do they think are the impacts on mothers who do not receive adequate breastfeeding support in hospital? This seems to be the key period. We know a large majority of women intend to breastfeed during pregnancy and when they go into hospital but at the point they are leaving hospital and going home these figures have dropped significantly. Will the witnesses speak to us about this?

Ms Deborah Byrne: I thank the Deputy. Cuidiú might also respond because it sees mothers after the hospital experience. When we launched in February, we received an onslaught of messages and we continue to do so. They are very lengthy messages and some are based on multiple births dating back years. What has come across very strongly is a feeling of grief and trauma. There is new research going into breastfeeding grief, which can last for many years.

Part of it is the feeling that choice was taken away. Mothers might have decided to breastfeed but because of not receiving the support they needed they felt abandoned and vulnerable. They feel isolated, particularly at present. People very much look to the experts for guidance when at a vulnerable stage. They might be after operations and after labour. They are physically recovering. They may have sleep deprivation. New mothers are presented with a little infant and they have to figure out how to care for it. It is very overwhelming. To feel abandoned and to ask for help and not receive it is a very painful experience, particularly if someone has really hoped to breastfeed and then have the choice taken away. These are some of the feelings we have heard.

Ms Geraldine Cahill: I would like to step in here and say it is definitely an issue, to the point that Cuidiú is creating a programme to train our breastfeeding counsellors in trauma. This is how much we see it as an issue. We as a voluntary organisation are looking at the mental health of parents and we are going to train our breastfeeding counsellors in trauma and how to deal with it. It is not something we would have had to do 20 years ago perhaps, but it has been coming to the fore in the last ten years or so. It is getting more and more difficult, and this trauma-informed care also needs to be part of our HSE system. I am not sure, however, if it is looking at this aspect, and yet the voluntary organisations are. Therefore, there is work to be done in this regard.

Deputy Róisín Shortall: Normally in these circumstances, where services are inadequate, we would be talking about the need for an action plan. However, there is an action plan on breastfeeding. The difficulty is with the slow pace of implementing it. This committee can play a role in respect of taking this issue up with the Department. Has anyone got an estimate of the cost of fully implementing the action plan?

Chairman: Ms Etherton would like to come in.

Ms Megan Etherton: In our capacity as service users and running the campaigns, it is not within our remit or capability to assign costs to the action plan. The biggest gap in understanding regarding the potential cost of the action plan is the lack of reporting on progress to date. The most recent report we could find dates from 2017. The HSE has offered to forward us the implementation reports we have not been able to find online, but which we have been told are public. It would appear to a lay person that the costliest elements of any strategy will concern ongoing staffing costs. A key part of the action plan we would like to see implemented is proper staffing and to see the ratio of births to support staff increase. We were very happy with last night's announcement of the additional lactation consultant posts for maternity units.

However, the births to support staff ratio is not defined within the action plan. It is difficult, therefore, to quantify what level of support we might be aiming for. The New Zealand ratio was used as the benchmark for the additional posts announced last night. It seems most important, however, to focus on the impact of not investing in this regard. What will be the opportunity cost if we do not invest in women initiating breastfeeding? That is not just a financial cost. There are potential long-term impacts on the health service in respect of the health outcomes that women are missing out on by not being able to feed. I refer to cancer risks, potential osteoporosis and also impacts on the health of the child. There is an ongoing burden for the health service in that respect. Obesity is also another long-term concern, and that is connected with last night's announcement regarding the Healthy Ireland concept and Sláintecare.

We are also talking, however, about the environmental impact of endorsing all this use of formula, when it is not necessarily wanted or needed by every woman. It should definitely be

available as an option, but we are now forcing people to use formula who might not necessarily want or need to do that. In addition to increased healthcare costs, there is also the question of how not investing in our human capital impacts our society. The financial costs involved in this regard must be considered as well. In some situations, significant costs are associated with breastfeeding, but we must also consider the ongoing cost of formula use for a family that may not want to take that approach. Equally, there is also the trauma we have just been speaking about. We could go through numerous stories from women who shared their experiences with us and how long those experiences have been sitting with them. They have told us that it has been such a relief to get this off their chests and to process their experiences.

As Ms Cahill mentioned, Cuidiú has recognised that aspect and the impact of the trauma. We would like to see some comparison made between the cost of the action plan on one hand and then the cost of not investing in this area on the other. We must understand the cost of not breastfeeding, and that has been done in other countries. Endeavours such as the World Breastfeeding Trends Initiative exist to allow us to benchmark how we are progressing and to see some transparency in respect of our progress. We are obviously headed in the right direction with these new lactation consultant posts, but we need to be able to see the outcome of a comparison and understand exactly where we are now. That is what is needed.

Deputy Róisín Shortall: I thank Ms Etherton. I have two more brief questions. First, the research Bainne Beatha has done is excellent. It is a really good report and I thank the witnesses for sending it to the committee. Turning to the wider context of academic research, what added value does an informal project undertaken by Bainne Beatha, Cuidiú or any of the other support groups provide to the formal health system? My second question concerns the issue of formula. To what extent do the witnesses think that commercial interests are having a bearing on policy in this regard? I refer not only to breastfeeding in Ireland, but also in other countries, where there may be a commercial interest in the export of formula.

Chairman: I call Ms Etherton first.

Ms Megan Etherton: I thank Deputy Shortall for her questions. This undertaking was never intended as research. We have a disclaimer in the report stating this was an informal questionnaire that Ms Byrne created and then the project grew legs. The respondents self-selected, and the results we have were determined by those people who wished to share their stories, and those were potentially more likely to be the more negative stories. However, the national maternity survey 2020 has shown that over 40% of women did not know how to submit feedback about their maternity experience. Our initiative therefore fills a gap in the absence of any larger project exploring the experience of breastfeeding support in hospitals. Women would not be pouring their grief out on Instagram if there was some other way in which their experiences were being fed up to a national level, being acted upon and associated changes implemented in a realistic way.

The national maternity experience survey does not ask about specific breastfeeding experiences in maternity hospitals and that is a gap in the research. We hope this qualitative information provides an impetus for a larger and more comprehensive study which will explore the characteristics of the environment. Rather than just focusing on women who do or do not breastfeed, we want to understand the larger factors at work in this regard. I refer to women coming out of a hospital, being told their experience may not have been as they might have wanted it to go, and that if their babies are being fed with formula, or however, they should be happy with that and that their babies are healthy and happy and what are they complaining about. That type of attitude just negates the whole experience for women who may have

intended to breastfeed. Providing an open and independent questionnaire, as we did, allowed those mothers to speak freely and get these experiences off their chests. It does allow people to coalesce around the issue, and I guess that is why we are here and why these stories have grown legs.

Turning to the Deputy's second question about formula, I will pass that over to be answered by Ms Byrne, Ms Cahill or Ms Rea from Cuidiú.

Ms Deborah Byrne: I do not have that much of an answer for the Deputy either, but baby feeding loggers have done much work in that area. We will certainly connect Deputy Shortall with them to see if they may be able to provide an answer to the question. It is outside the remit of our committee, however.

Deputy Róisín Shortall: The committee may contact the baby feeding logging group, because this is an area that needs exploration. I thank Ms Etherton and Ms Byrne for their replies.

Chairman: Would Ms Cahill like the final word?

Ms Geraldine Cahill: Regarding the 24 new posts, it is amazing that we are going to get those new lactation consultants. Unfortunately, these new lactation consultants are likely to be midwives as well, and therefore are also likely to have a midwifery role in addition to a lactation consultant role. Sometimes, that midwifery role takes precedence over the lactation consultation role, which is what has happened with those consultants in post already. They are not roles purely devoted to lactation consulting. The people *in situ* are there in other roles, and the aspect of lactation consultant is almost an add-on element. There might be one dedicated lactation consultant in Cork, one in the National Maternity Hospital and one in the Coombe Women and Infants University Hospital, and those are the only people who have roles purely as lactation consultants and not as midwives as well. The joint role of lactation consultant and midwife is muddying the waters for the postholders, because sometimes they have to go to a birth when instead they would like to be there in the role of going to see a mum postnatally with her baby. That is not always possible. Therefore, we must clarify these international board certified lactation consultants posts more than we do now.

Deputy Róisín Shortall: I thank Ms Cahill, and that is a very useful point for us to bear in mind.

Deputy Neasa Hourigan: Perhaps we could stay in the area of midwives and lactation consultants, on which Ms Cahill made a good point. It is fantastic that we have seen some movement from the Department on this with the announcement last night. That is in no small part down to the huge amount of highlighting and work that both of our organisations have done on this issue. Well done to them.

I want to go into that issue a little bit more. Certainly, my experience was that the midwife is the first point of contact in those first few moments when a mother meets her baby. The midwife is one's first direction about how to do all this. I wish to talk a little bit about the role of the midwife. The importance of the lactation consultant being a separate post is a point well made. It seems to me that midwives will all have a role to play here. Ms Rea spoke about the announcement last night being a drop in the ocean. If midwives are the first circle that a person meets, perhaps the second circle includes community nurses and GPs, who have such a central role in many women's experience but who are often hugely overworked and underresourced.

I would like to hear the witnesses' opinions. In the next few years as we move into Sláin-

tecare, how do they see those tiers of influence in women's experience? How can we support midwives to all be lactation consultants? How can we carve out lactation consultants who have only that job to do? What would that other support for GPs and community nurses look like?

Chairman: Does Ms Cahill wish to come in first?

Ms Geraldine Cahill: It takes a multipronged approach in that everybody needs education at every level. Even the lady who does the cleaning on the maternity wards needs to have some training in breastfeeding because she is interacting with a new mum. Even if all she ever says to her is that she is doing great, that makes a difference to a mother's experience. We need, therefore, training at every level, particularly at the neonatal level and the obstetrician and GP level.

Very few GPs will refer women to lactation consultants. They will refer for a skin disease or a little knobbly bit somewhere on a person's body and yet, women go into GPs with nipples that are literally torn apart and they do not refer them to a lactation consultant. There is something missing in their education that GPs do not value this role of the specialist in breastfeeding. That seems to happen right throughout the whole system.

Midwives are crucial and play a pivotal role in breastfeeding. They do a tremendous job with the lack of resources they have. Some of them will be really interested in breastfeeding and will go to loads of education sessions. Some of them will not be that interested and will concentrate on the birth and pregnancy care, which is their main role. We need them to have some education. The lactation role is very separate and very postnatal, however. That specialism is needed in order that people can get educated and develop their own skills and competencies in that area.

My view is that the competencies have not been put in place. We have education into which people can go. It is out there all the time. However, we have not put in place competencies and we are not checking people's competencies. The World Health Organization has much of that and the World Breastfeeding Trends Initiative, WBTI, looks at it. Many tools are, therefore, available. It is up to us to start using them. That needs the Government to show the willingness to take that step to look at competencies.

Deputy Neasa Hourigan: I want to return to the issue of data, which came up in the submissions today. A lack of data and of reporting on progress seems to be a recurring theme. I am very much a supporter of evidence-based policymaking, which is built on data. Data is a huge challenge to the system if we do not have it readily available. The counterbalance to that, however, is creating a space within a system in terms of service development that listens to the lived experience of people who are having babies.

I believe Ms Cahill said earlier that there are some hospitals in which she has a role or is included in the conversation and others in which she is not. I am interested in what Ms Cahill would like to see in terms of data gathering. In terms of that counterbalance, how can we integrate women's actual experiences of the system into decision-making around service provision through both the Sláintecare model of community health services, but also within hospitals?

Chairman: Who would like to reply?

Ms Geraldine Cahill: I see that there is plenty of research in this country. People doing PhDs carry out research every day of the week . It is all available in places like Trinity College Dublin. We know people who are doing research. It is about getting people within the Government to read that research and interpret it in a way that applies to policy. There seems to be a

gap in research into policy.

The Economic and Social Research Institute, ESRI, used to do much work in this area. I am not sure it is being funded to do any work in that area at the moment . Again, that is a lack of knowledge on my part but it is also that idea of not giving us full information because we do not know. We used to have a multi-stakeholder national breastfeeding committee but that is gone. It does not exist anymore. We do not, therefore, know what is happening in the field. That data needs to be gathered. Again, however, it is also the Government's-----

Deputy Neasa Hourigan: How long is it since the national breastfeeding committee was disbanded?

Ms Geraldine Cahill: Approximately four or five years.

Deputy Neasa Hourigan: I will finish with one quick question to both groups. I realise this is probably a very niche question. For those of us with children who were born with a disability or a particular challenge, is there work or research in the area with which the witnesses are familiar, or that they have available to them, around supporting families of children with disabilities to breastfeed?

Ms Geraldine Cahill: I am not sure there is research but there are definitely supports available.

Deputy Neasa Hourigan: Ms Atherton wanted to come in.

Ms Megan Etherton: We are not aware of anything. It has not come up for us at all. It is interesting that it has not come up either through the quantitative or qualitative data. It is not something that has been raised yet so it is definitely a really interesting point.

Chairman: We will move on to Senator Kyne.

Senator Seán Kyne: I thank the Chairman. I welcome all the witnesses from Bainne Beatha and Cuidiú.

I am conscious that I am male. I considered handing the slot over to one of my female colleagues, particularly as my wife and I, unfortunately, have not been lucky enough to have children. I felt, however, that men also have an important role here because there are men in positions of influence within the Department of Health and the HSE.

On that point, would the witnesses agree that perhaps husbands and male partners of mothers, who have experience of their partners breastfeeding, are more likely to be sympathetic to the issues? If men in positions of power have that experience, they are possibly more likely to be able to influence or be sympathetic to that issue. That is the first point I will make.

What would be regarded as best practice internationally? Is there any particular country? Is it all a matter of finances? Am I right in suggesting that witnesses would wish for full-time lactation consultants working exclusively in that role, who are available 24-7 in maternity hospitals and in the community after mother and baby go home? Is this the gold standard that should be in place right across the country?

Ms Megan Etherton: l thank the Senator for his questions and I shall speak to the first one. We, in our campaign, are very aware that we are preaching to the masses. All of our Instagram followers tend to be female. Many men have signed the campaign once they became aware of

it. The Senator has mentioned that it was his first instinct to hand this issue over to somebody else because it is not his area of expertise and he has no direct experience. I am delighted to see that he changed his mind because we need male champions of change. In the same way that the mother and baby dyad needs a partner to support them, and actually a whole village of support around them, to help the mother and baby achieve breastfeeding, the whole idea of breastfeeding and making a societal change needs everybody involved because, as we mentioned earlier, the knock-on effects of breastfeeding or not breastfeeding affect everyone. Breastfeeding is a health equity issue that is not just limited to the mothers and infants that we are talking about.

In response to the question, potentially, it is easier for people who have had some direct experience of breastfeeding, whether they are male or female, to engage with this and feel that they have either a right or a responsibility to engage with it. We have tried to make breastfeeding as accessible to anyone regardless of their experience, and regardless of whether they used formula, would like to use formula, did breastfeed, did not breastfeed, will not breastfeed, do not have children, plan on having children or whatever. Breastfeeding is a bigger societal issue so our goal is to make sure that it is accessible and to get people, like the Senator, on board and feel engaged in the issue, and feel entitled to speak about the issue.

Ms Fiona Rea: I agree with Ms Etherton. We very much see the partner's role as hugely important. Support is key when it comes to breastfeeding. It is very difficult to start out on one's breastfeeding journey alone without any support and who better to be one's primary supporter than one's partner? In that regard, our membership is made up of families as opposed to just mothers.

Yes, lactation consultations must be available and, ideally, without cost or through a system where cost is not the reason people do not lift the phone to ask for help. Primarily, from the hospital, we would have a referral pathway and midwives would send mothers home with a list of numbers for them to call, and GPs would have a list of numbers for the mothers to call. All that would be great so there is never a question in any mother's mind that if she needs help and support, she has numerous numbers to ring, and will get support without question.

Mothers should be checked on more regularly. There are baby checks and a six-week check for mums but we do not have check-ups where mums are asked how they are getting on with breastfeeding, whether they need support with breastfeeding or are having difficulties. Many people will not speak up if they are not asked questions and they may feel that they lack something because they are unable to breastfeed. We all know that breastfeeding is difficult to start with and having someone checking to see how one is getting on would really encourage mothers to avail of support. Also, word would go out that it is not unusual to need support with breastfeeding. We are busy in Cuidiú. Ms Cahill has been involved for 30 years and I have been involved for 20 years. We can attest to the fact that many mothers have come through the system and gone on to train as counsellors, which is lovely.

Education is hugely important. All of the lactation consultants in Ireland, as part of their qualification, re-certify every year with Continuing Education Recognition Points, CERPs, and by exam every five years. We continually go to study days and educate ourselves because things change. Breastfeeding is not rocket science but one learns more about it as the years go by and we top up our education. All of the Cuidiú tutors make sure that they keep up to date with the latest research and avail of the latest conferences to educate themselves. The same should happen for health nurses, GPs and midwives. Twenty hours of breastfeeding education is not sufficient and that is perfectly clear.

Senator Seán Kyne: What is the antenatal role like in terms of getting information out there? I presume that it is not non-existent. Does it need to be improved?

Ms Fiona Rea: Cuidiú works really hard on its antenatal education and an informed decision is key. Yes, there is lots of education going on but breastfeeding is not promoted in the way that it should be. Certainly, over the last year with Covid, classes have been delivered online and have worked well. Obviously face-to-face classes would be better but we are trying to bridge the gaps. We need continuity of what we are telling mothers and what they see in action, which is where there is a huge gap. We are telling mums about their choices in antenatal classes yet when they arrive into maternity units to have their babies and try to breastfeed, what they are told is not the same as the information we give them and choice has been taken away from them. A lot of the time midwives do not have time to spend with mothers. I do not blame the midwives, they do a fantastic job. However, staffing and education are issues. What difference does the first bottle of top-up formula milk make to a baby? Why should we not do that? What should the first few hours of birth look like? What should the start be for a baby? Babies are not born starving. The provision of simple information would have a huge impact on the start of a baby's life and on the start of a mother's breastfeeding journey.

Ms Geraldine Cahill: Cuidiú pivoted very quickly to provide antenatal classes within the Covid situation. For instance, Cork started providing antenatal education last week for the first time since Covid started. So there has been a gap in the health system and nobody has had a class in Cork, from the hospital, since Covid started. The classes are very infrequent anyway, and the number involved is very large. We need to consider antenatal education in the health system as a whole both for birth and breastfeeding.

Senator Annie Hoey: I thank all of the witnesses for their informative presentations. I asked my friend who works in the medical circle many questions on this topic and gave them my thoughts on the matter as breastfeeding is such a raw and lived experience for people, not one of which I have direct experience. I cast the net far and wide, and the responses were revealing. People mentioned two areas when I told them that this meeting was coming up. There was the issue of support for the person who wishes to breastfeed her baby and the need for structural supports that support continued breastfeeding.

I commend my colleagues in Fórsa on the campaign for breastfeeding rights for special needs assistants, SNAs, that equal those enjoyed by teachers. While we are talking about a breastfeeding strategy and stuff there is a huge role to be played in terms of the wider population and workplace to properly support anyone who wishes to breastfeed and express their milk.

One of the questions that arose, and I wonder whether it is something that the witnesses have come across or had a huge amount of discussion on, is the provision of breastfeeding and supports for mothers who have chronic diseases. Many women with conditions like Crohn's disease, rheumatoid arthritis or Lupus must take very strong medications, including immunosuppressants, but would like to breastfeed. There is now an accumulation of evidence that the benefits to mother and baby outweigh any risk of the baby's immune system being suppressed by the minuscule amount of drugs that cross into breast milk. Do the witnesses have any thoughts on that? The person I spoke to said women should be supported to breastfeed through counselling and adjustments to the vaccination schedule for babies. Some live vaccines may be best deferred in babies being breastfed by mothers taking certain medication. Is it something that has ever arisen for the witnesses?

I will throw the questions out and they can answer them. This is quite an unusual format.

Sometimes we ask questions in a pow, pow, pow format to try to get juicy answers. The witnesses represent an advocacy group which is doing incredible work. This is a very pleasant format in which to be able to converse.

There is a human donor milk bank in the North. Are there any commitments towards developing and funding such a bank in the Republic? The phrase used was "human milk is for human babies", yet it seems mad to me that we do not have such a facility and people instead have to go to the North. We have talked about the low number of lactation consultants in maternity hospitals and, as was mentioned, often midwives do the bulk of this work. Someone said to me they felt that there was a lack of information in antenatal classes and breastfeeding was very swiftly moved over. Perhaps there need to be extra antenatal classes or an antenatal GP service for mothers focused on preparing for breastfeeding.

We talked about hospital grade pumps. A woman told me she would love to see the option of one free visit at home from a qualified IBCLC and the continuation of care at home. We discussed workplaces. It would be great to amend the regulations to allow mothers to take breastfeeding or pumping breaks for up to one year post birth. The current regulation allows for such breaks for up to six months. Many people shared many thoughts with me and I do not want to leave anything out.

Some of the people I spoke to said they felt they were being aggressively marketed formula through algorithms and stuff like that, as well as through their own spheres, friends and so on. Would I be correct in saying that Ireland is quite poor at enforcing the WHO code on marketing formula? Lots of events are sponsored by formula companies.

People said there is a wider cultural problem. The generations before us were sometimes discouraged from breastfeeding. Do the witnesses have any experience of what needs to be done to address what is being passed down through the generations? It is an eternal cultural problem and not one that exists solely in our hospitals. I have thrown a bazillion thoughts and questions out there.

Ms Geraldine Cahill: I will respond to the question on medication. In situations like those outlined by the Senator, they have to be dealt with on a case by case basis. I come back to the education of obstetricians and people in other medical fields. The first thing they say to women is an almost blanket statement that they cannot breastfeed because they are on medication. In fact, a lot of research has been done on medication. Some people may need to check change their medication to a lower risk one in order to breastfeed their babies. Others will not need to do that. It depends on the severity of their condition and what medication they are on.

Dr. Tom Hale in Texas is doing a lot of work on this area. He has done a lot of testing. Every lactation consultant that I know has an app with all of his information on the risk factors for every drug so that people can discuss with mothers who have a condition what the risk factors are and whether medication is high or low risk. Mothers can then make their own informed decisions as to how they are going to feed their babies.

On the implementation of the WHO code, the Government said today that it will fully implement all of the recommendations and resolutions. That will mean that all of the formula advertising will disappear off our televisions. That will be significant. There are two and three year olds who are able to say, "That is the best milk" because they have seen advertising on all sorts of platforms. That is significant. I cannot remember any of the other points so I will stop now.

Ms Deborah Byrne: I thank Senator Hoey for her questions. On antenatal training, in a report we found 21% of mothers said the lack of such training through hospitals was a roadblock and that many women wanted to know about the challenges of breastfeeding. I appreciate it is a fine balancing act because if all people hear are the challenges, that will be less appealing and people will not learn about the amazing benefits and rewards of breastfeeding, not just for the baby but also the mother. There are long-term physical health benefits as well as emotional benefits.

I am in a WhatsApp group with several other mums and all of us said that we would breastfeed to six months. Due to lockdown we have been at home with our babies for a lot longer and are extending breastfeeding until our children are one or two years old. That is in line with the WHO recommendation to breastfeed to two years of age. I had such a difficult start that it has been a real privilege to breastfeed my son for that long.

Women need to know about the realities of breastfeeding, and realise that when things are not working it is not just them and help is available. Often difficulties require very simple solutions and IBCLC could assist them. There may be difficulties with positioning. Ms Rea and Ms Cahill are much more expert on this than we are.

Senator Hoey referred to the WHO code. It is not an area we have researched. The Baby Feeding Law Group Ireland, BFLGI, has done a lot of work on that and I recommend talking to it. One mother in our report referred to formula being handed around like cups of tea in the hospital. There seems to be a very heavy reliance on formula and anecdotally we have heard that is because midwives are very busy. Given that establishing breastfeeding can sometimes take a lot of time, formula is a much easier way to ensure they know babies are being fed. We need to examine staffing in order to make sure midwives have time to help women one and that there are lactation consultants whose specific role is to address challenges as they arise. Like Ms Cahill, I cannot remember everything else the Senator said.

Senator Annie Hoey: Based on conversations I have had, would it be reasonable to say that the majority of the restrictions over the past year could and will have had an effect on breastfeeding? There was lack of partner support for breastfeeding, which is not an island and is not just about one person doing it. Lots of negatives have come with the restrictions. Could they also have had an impact on breastfeeding success for mothers?

Ms Megan Etherton: I thank the Senator for the question. Our responses relate mainly to pre-Covid experiences. We have received follow-on feedback from mothers on their experiences during Covid. The negative impact on women labouring, birthing and establishing breastfeeding alone in maternity hospitals has been well covered in the media.

We see a shocking consistency pre-Covid and during Covid. The only difference is that the sense of isolation, vulnerability and lack of support has been exacerbated by Covid. We have not conducted any research on that, but the anecdotal evidence from women is that the sense of feeling and being left alone has been exacerbated.

Other research being carried out suggests that women who, like Ms Byrne, have already initiated breastfeeding are breastfeeding for an extended period. There are also some reports that contradict that. I am not aware of any final summary or decision on whether the restrictions have had a positive or negative impact on breastfeeding rates overall. I am sure Ms Cahill and Ms Rea will be able to speak to that much more, given that they are speaking to women every day.

Ms Fiona Rea: As Ms Etherton has said, anecdotally there is no research on it. I am seeing no great rise in numbers but my fear at the beginning was that many mothers were not getting the help they wanted due to the lack of support. I had a fear that the rates would really plummet but it has been the case that many mothers who are concerned about Covid and their babies' health are breastfeeding where they may not have done so previously. We are certainly seeing a rise in numbers in that regard. I believe we will come out of it probably where we went into it. The early studies on breastfeeding and protection for the baby came out quite quickly. This impacted a lot for some mothers and it certainly had a bearing on the decisions made by a lot of mums.

Reference was made to donor milk. It would be terrific if we had a donor milk bank down south. They offer a terrific service and they are always looking for donors. They are in very short supply. A lot of the time they have busy times when they would be a little short. We know it is so important for babies in a neonatal intensive care unit to receive donor milk if mum is not able to produce the milk herself. A very informal system of milk sharing goes on around the country. Lots of mothers share breast milk informally. It would be terrific if it could be formalised in some way. This, however, brings money into it and it would exclude some mothers from having the service. A lot of it comes down to money and that should not be part of a mum's choice to breastfeed.

On the issue of antenatal classes and mothers feeling that they did not get enough education, Ms Cahill and I are both antenatal educators with Cuidiú, and we do cover it. Anybody who has had a baby will know that on the first baby, one's thoughts are "How am I going to get this baby out?" The mother hears all of the other bits about the baby such as changing nappies, but breastfeeding is on the periphery and she may not be focused on it until the baby arrives home. Then she realises that perhaps she should have taken that information on board a little more. Yes, it is absolutely included in all of the antenatal education, but potentially there should be a class very quickly after birth. I love the idea of a free lactation consultant visit for everybody. That would make it such an even playing field. It would make it so much easier for mothers to get the help in a timely manner. Very often it is just too late: they have made their decision and there is no going back for them. As Ms Byrne and Ms Etherton have said through lots of their stories, those decisions live on for mothers. They do not make those decisions lightly and they find it very hard to reconcile afterwards. We find that with antenatal education, meeting a mother on her second baby is a totally different story to meeting a mother on her first baby. She is a different person and her decisions are much firmer. Mothers educate themselves so much differently at that point. If we could somehow channel that for first-time mothers we would certainly make big strides and help lots more mothers in that way.

Chairman: I invite Deputy Gino Kenny. The Deputy appears to be on mute. We cannot hear the Deputy at the moment, so we will revert back to him. I call on Deputy Cathal Crowe.

Deputy Cathal Crowe: I join the Chairman and others in thanking Bainne Beatha and Cuidiú for being here this morning. I have read the witness statements and I thank them for all the work they are doing. Overnight we heard the positive announcement by the Minister, Deputy Donnelly, of €1.58 million to hire an additional 24 lactation consultants for hospitals. I am also really delighted to hear that the Government accepts the WHO guidelines that will see a phasing out of the in-your-face marketing and advertising of formula products. I believe this to be a good thing because a number of things are competing against each other here, including preparing for birth and getting ready, with all that this involves. There is also the fact that people are consumers. From a young age and from knee height we are bombarded with adver-

tisements and all sorts of messages, be it from Smyth's Toys or Coca Cola. This gets inside our heads. We are brand people. We go to supermarkets and it has been proven time and again that we pick up items such as Brennan's bread, for example, and certain other brands because we stick with what has been marketed to us. I believe that the same applies to formula milks. We need to break away from that.

It is good that in the opening statements the witnesses from Bainne Beatha stated that it is not a "breast is best" group. This can often pressurise new mums who may feel they are doing something wrong by not breastfeeding and going the formula route. It is good that the representatives have said that the groups are there to support and find avenues of making this more feasible and possible.

I will jump into a few comments and then I have a number of questions. The first point is the obvious elephant in the room. We are discussing babies, birthing and breastfeeding. The real elephant in the room is that so many partners still cannot accompany the expectant mother to appointments at hospitals. We have had the political statements and I heard what the Taoiseach said yesterday. We have had a lot of talk from mums. Joe Duffy's "Liveline" covered this. Now we need each hospital group to standardise what they do around partners attending appointments. In general terms, but not in all cases, a woman who is expecting a baby is healthy. Giving birth is a medical condition but it is different to other hospital contexts in that the person is, generally, not unwell going into hospital to give birth. Of course there are cases where it happens but, in general, the woman is going in for a few days to give birth to a healthy child, hopefully, and to go home again. Those appointments leading up to birth are so important. We need to see some standardisation very quickly on this.

My next point is for Ms Cahill. I was absolutely shocked. One of my take-home points from her contribution is that antenatal classes have not been happening. I did not know that or understand that. This amplifies the whole problem I have just referred to where partners cannot attend some appointments with expectant mums. I am dad to three smallies - a six-year old, a four-year old and a two-year old. We went to the antenatal classes for the first child because it is the big unknown at that point. My knowledge of birthing was leaving certificate biology, a time when I would have been doodling in my copybook and not listening. Fast forward 12 years, however, and suddenly I needed to know all about this. My ears pricked up when they started talking about what would happen if we did not make it to the maternity hospital and if I as the dad had to help my wife to give birth at the side of the road. Suddenly, God almighty, a dose of reality of what may be involved was like a smack in the face. There has to be some capacity or some way, at least online, to address the lack of classes. We have all embraced Zoom. We are meeting today virtually. There must be some capacity to get those classes up and running, pretty much immediately.

Will the witnesses comment on if there is a need in Ireland for postnatal classes? Breastfeeding comes into that realm. As Ms Cahill and Ms Rea have said, when one goes to an antenatal class the focus is on how a baby is born and on the whole process from labour to birth and everything in between. Is there a need for postnatal classes? New parents have nothing to benchmark against. We phone sisters and brothers, or go to Google and get atrocious answers. We have people telling us our lives will never be the same again. This is just from my perspective as dad: it is way worse from the mum's perspective. There is probably a need, but not everyone will take it up, for postnatal classes. The same cohort that goes together to antenatal classes may be giving birth in and around the same time. It makes sense that the same service would be offered to them as a group after the births. Perhaps the HSE would consider that.

I was quite shocked to see Ms Etherton's analysis in her opening statement that 60% of mothers sought help and advice privately on breastfeeding. This is some 36,000 mums last year, at an average cost of €440 each, who left the net of our public health service to go and get this advice. This makes it even more important that the lactation consultants are hired.

On the points made by Ms Rea, as a person who has been in maternity hospitals a few times, I found that it is very hard to identify who is who. They are all wearing scrubs. I remember going down corridors and tapping a person on the shoulder, but they could have been a cleaning attendant, kitchen staff, an obstetrician, or someone on their way down to deliver an antenatal class. It is very hard to identify people. Identifying who is the lactation consultant could be a very simple thing each hospital group could do. It is very hard for a person who is not in a hospital every day to see who is who in that context. That more or less covers it. Could the witnesses respond to some of those questions? I encourage them to keep up the great work. I wish all expectant mothers the very best over the months ahead. Hopefully, their partners can start attending appointments with them.

Ms Fiona Rea: We provide postnatal classes. Antenatal classes would involve a post-natal reunion. The normal groups run by Cuidiú would run act in that way. It is mother-to-mother support at that stage but they would have an antenatal educator or breastfeeding counsellor there so it is quite informal at that point where mothers are discussing issues among themselves and there is somebody there who has that bit more knowledge and training and is able to steer the conversation in the right direction. In that regard, it is happening but it is online at the moment. There is a massive amount of classes available online. It is about getting people to attend them and getting the information out there.

Regarding partners being present at births, the Deputy said he was able to attend the birth of his child and was panicked and worried by the thought of not being able to attend it. It is incredible that partners are still unable to be with their partners during birth because they are not a visitor. They are part of that family that is about to be extended and it is a disgrace that this has not happened even now that the advice is that they can be there. It should have happened as soon as there was mention of it being allowed to happen. Their support is key. They are going home with mum. Their support is huge when it comes to birth and moving forward into their breastfeeding journey. It should be recognised that they are not visitors; they are part of that same birthing team.

Cuidiú tries to bridge those gaps but it is about getting the information out there, getting people to attend and getting the likes of GPs and public health nurses to help mothers find supports in their area. Cuidiú is dotted around the country. Each area has its own little branch or group and there is a Facebook group associated with each branch so we very much encourage mothers who are in the same area to mix because we are building a community. We are helping mothers build the village they need because, as an earlier speaker said, culturally, we are not seeing breastfeeding. We did not see breastfeeding when we were growing up so we need mothers and babies to see it in order for them to take it on as something for themselves.

Deputy Cathal Crowe: I have seen very few people breastfeeding - perhaps in somebody's living room. I have not seen anyone breastfeed in a public space, although we have not been in restaurants and cafés in many months. Are there still major social barriers?

Ms Fiona Rea: Absolutely.

Deputy Cathal Crowe: Is it society at large? Is it businesses? Is it men?

Ms Fiona Rea: I would not single men out. It is everybody. A mother would not find somewhere to feed the baby in every shopping centre. The expectation is that the mother goes to the toilet, which is disgraceful. Mothers who were sitting on benches in Dundrum Shopping Centre feeding their babies have been asked whether they would feel more comfortable doing it somewhere else and the suggestion is the nearest toilet. Nobody wants to eat their lunch in a toilet.

Deputy Cathal Crowe: It is very unsanitary.

Ms Fiona Rea: It is across the board. If we had the same amount of advertising for breastfeeding as we do for formula feeding and follow-on formula, we would be laughing. It would be so much more normalised.

Deputy Cathal Crowe: I have heard many doctors in the Covid realm say over the past few months that healthcare would be revolutionised by Covid. Perhaps it will be the start of a movement here because it needs to be normalised. We have far too many hang-ups in Ireland about small things like this. So what if the woman in the corner having her lunch is breastfeeding her baby. Is it not wonderful and why should that baby go without food while everyone else in that café can eat? It needs to be normalised. This committee needs to champion this becoming more normal practice in terms of State advertising.

Ms Deborah Byrne: Regarding the point about the €440, a very small sample of women responded to our questionnaire. A total of 145 mothers responded. Regarding those who wished to breastfeed, the rate might not be directly comparable with the national rates. We do not have access to data on those who have decided they wish to breast feed exclusively. It may not be directly transferable but what was striking for us was the €440, which is not an insignificant amount, particularly if somebody is on social welfare. That is more than two weeks worth of social welfare so it is just not affordable. We said in our opening statement that the hospital provides a level playing field and proactive support from the moment of birth will reduce the need to spend at a later stage, particularly in light of the fact that we have so many wonderful voluntary groups like Cuidiú. I thank the Deputy for his comment and support.

Deputy Cathal Crowe: I thank the witnesses. They have our full support.

Chairman: Does Deputy Gino Kenny wish to come back in?

Deputy Gino Kenny: I have to step out for much of the discussion because of our Private Members' Bill. I thank all the witnesses for appearing before us today. I do not know a huge amount about this issue but I am obviously learning. It is a fascinating subject. I am not sure if anybody has mentioned a perinatal division in Ireland. Approximately a year ago, I saw a report on perinatal care and mother and baby units in Great Britain on the BBC and was really struck by it. These are specialised units for women suffering from postnatal depression. I looked at the NHS website. According to its research, 20% of all new mothers could experience mental health difficulties prior to birth, giving birth and after giving birth. It was a fascinating report. During the past year, there have been discussions about a mother and baby unit. Obviously, that name has connotations in this country but this is a different type of unit. I think it is going to be on the campus of St. Vincent's Hospital. What are the witnesses' thoughts on perinatal care? This unit would be the first of its kind in Ireland. What outlet do such units give women? When I watched that report, I was shocked. When a woman gives birth, in some circumstances, she can experience terrible depression that can have a significant impact on her and her baby. What are the witnesses' thoughts on a perinatal division in this country and the proposed mother and baby unit on the campus of St. Vincent's Hospital?

Ms Geraldine Cahill: I am not 100% sure but I think the St. Patrick's unit in Dublin is the only place where somebody with very severe puerperal psychosis can be hospitalised. There is a difference between puerperal psychosis where somebody needs to be hospitalised and postnatal depression. A woman cannot have her baby with her when she is in St. Patrick's unit. It is just not possible so there is always separation in the case of puerperal psychosis sometimes for the safety of the baby but usually because of staffing. There are issues around that. There should be a mother and baby unit but there is none. In most cases of postnatal depression, and there is a lack of services for those with very severe postnatal depression, medication is the first route that people will go down and that will usually be accompanied by the statement "and you will need to give up breastfeeding". In fact, the research shows that giving up breastfeeding will make their depression worse and that if they continue to breastfeed, their depression will eventually begin to drop. They may still need medication, however, and many medications for depression are okay to use while breastfeeding. Puerperal psychosis is a very different condition and needs to be medically supervised because it is very severe. As far as I know, the mums and babies are separated and we do not have a mother and baby unit in this country.

Deputy Gino Kenny: There is a proposal on the HSE website for a mother and baby unit on the campus of St. Vincent's hospital, which is very welcome.

To return to the statistic from the NHS that I read out in regard to some women having mental health difficulties, the problem is difficult to quantify. How common is postnatal depression and how is it treated? The mental health of a good friend of mine deteriorated in a number of months and I could not believe that somebody who had just given birth, who was in the throes of happiness and all that comes with that, suddenly went down a road of severe depression. I could not understand it but she explained why, and others explained what can happen in such cases. I was learning. Is postnatal depression common or rare?

Ms Fiona Rea: The latest study I have read, which was not so recent, suggests that the figures are about 6% to 10%. Postnatal depression can affect mums of children up to two years of age and they can show signs at any point during that time. We also have to recognise that much postnatal depression can be a result of the mother's experience. It can be driven by disappointment or upset. Birth and breastfeeding are very much hormonally driven, and when many hormones are involved, there will be an imbalance some of the time. These mothers need care and, as Ms Cahill said, it does not always need to be medication. Support is the key in those circumstances. Sometimes medication will be needed, and that is where they need proper guidance and GPs need proper information on what medication is suitable to continue with breastfeeding. Stopping breastfeeding abruptly is never a good idea either. We know there will be that drop of oxytocin and prolactin, which will send mothers into a low mood. The experience of birth and breastfeeding for a particular mum is tied in greatly with the hormones of birth and breastfeeding. There could also be a predisposition to it. There is plenty of information out there on the matter. I do not have the exact figures to hand but, according to the last study I read, the figure is between 6% and 10%.

Deputy Gino Kenny: Ms Cahill talked about cases where women could develop psychosis. How does that manifest itself? Is it before or after giving birth? How does it develop in new mothers?

Ms Geraldine Cahill: I have come across only a handful of cases in all my years in practice. It usually manifests itself within a few days of birth whereby somebody will exhibit extreme, manic behaviour, with a great deal of fear. A couple of women I have worked with stated they were afraid that they themselves would drop or kill their babies. They just did not feel in

any way in control of any of their emotions, and usually went into a corner somewhere in their house and hid from their baby. The first signs might be that a mum does not want to pick up her baby at all, and when that is explored with her, it is because of fear.

As people leave the hospital now after two or three days, it is not picked up. When I was having my babies, mothers were in hospital for nearly a week and it was usually picked up within those five to seven days, whereas now people leave within two or three days and it is much more difficult to pick it up. The partners, therefore, see this very strange behaviour and have to bring in a GP or whatever. It is not picked up in the acute services, which is where it should be picked up.

Deputy Gino Kenny: I thank Ms Cahill. That was very useful.

Deputy Colm Burke: I thank our guests for their presentation and the work they are doing in this area. I am married to someone who has worked in maternity services for many years, so I have for 25 years been getting a daily briefing on the challenges in the maternity services. To give an example of where we have come from, when my wife was applying for a job in Dublin many years ago, she was asked how she could apply for a job in Dublin when her husband was working in Cork. I think we have moved on a bit from that kind of approach in respect of maternity care and there have been many changes, but there remain many challenges in this area of breastfeeding and the supports required.

One of our guests stated that 29% of women said they had received conflicting advice from hospital staff. How can we deal with that kind of challenge? Obviously, there are rotas of staff, with different staff at work at different times of the day and night. How can we ensure there is a co-ordinated approach to how individual patients and mothers are handled, given that almost one third receive conflicting advice?

Ms Megan Etherton: Ms Cahill and Ms Rea spoke to this earlier in regard to establishing competencies and being able to measure them and ensure there is continuing professional development for everyone within a hospital setting who comes into contact with a woman who is attempting to breastfeed. We are not competent to make a decision on what those levels should be but the 2015 competence framework sets out three levels, namely, awareness, generalist and specialist competencies, within the area of lactation consultancy or lactation support in the hospital. The intention, as set out by the HSE at a recent meeting we had with its representatives, is that that role of lactation consultant should operate at that higher level of specialty, offer in-depth care to people with complex challenges and provide education and support to other staff within the hospital setting. I guess it is a trickle down mode of education in that a mother might present with a challenge, the lactation consultant is called and then that midwife learns how to deal with that challenge for the next time. We would see that the two main issues. There are obviously the ongoing education and establishing international board certified lactation consultants, IBCLCs, with specialist skills in the roles and having enough of those lactation consultant roles and having appropriate staffing of midwives within the hospital. They may have the skills and knowledge already but they do not have the time to transmit it. What will change in the future if they have the skills and knowledge and they still do not have time to transmit it and to sit down with a woman? I am not sure that fully answers the question.

Deputy Colm Burke: I wonder is it a case that someone gives advice in the morning and whether there is a note put in? Is it a case that there are not proper follow-up notes put in place. For instance, that if nurse A or whoever is attending - whether it be a doctor or a nurse - giving advices, sets out on a chart what advice was given so that whoever comes on at 8 p.m. will know

exactly the line that was being taken by his or her predecessor? Is that one of the problems that is occurring as well?

Ms Megan Etherton: There are probably a few different levels of issue that are falling within that statement of that number of people who felt there was inconsistent advice. Sometimes it is at a very simple level. One woman said:

> I got mixed advice from midwives in the hospital about feeding and ended up YouTubing videos about getting a deeper latch as my nipples were already bleeding 12 hours after the birth. The midwife I asked about it said it was normal to be sore and bleeding.

That is not something I would imagine would be necessarily charted and available there for the next person. Somebody who has done her antenatal classes and done the breastfeeding research following the IBCLCs on Instagram knows full well that her nipples should not be bleeding 12 hours after birth when she is attempting to breastfeed. There is inconsistency there. There are issues at that minute practical hands-on help level. Some of the help that one would get is nuanced. It can be around positioning and attachment.

Deputy Colm Burke: I have only one minute left. Pacify, which is a company based in the US, is looking to come to Ireland where it is offering 24-hour support to women who want to breastfeed. Obviously, it sees a gap in the market in Ireland if it wants to come in. In relation to support if a mother has a difficulty, say, at 10 p.m., and she is at home, what range of services are available for someone at that hour to contact anyone here in Ireland? Is what we should further develop a 24-hour service? Somebody might clarify what is available at present?

Ms Fiona Rea: As far as the support groups would be concerned, certainly with Cuidiú, we have breastfeeding counsellors who are available. I would not say 24-hour availability for sure, but some will be available late in the evening and at weekends. Some of the lactation consultants working in private practice will state on their information that they are available all of the time. The HSE has lactation consultants who mothers send questions to online. They are available five days a week, not 24-hours a day either. We do not have that system but certainly a mother in the hospital should be getting the same level of care for the 24 hours - however many of those she is in the hospital.

To go back to the Deputy's point about the note-taking, that would cut out much of the misinformation. If somebody was seeing the plan for that particular mother as noted in the chart, he or she will not sweep into the room and completely change what information somebody else has given. Many of the stories that the Bainne Beatha ladies have heard are sweeping statements that are made with very little thought, whereas if it had to be charted there would be much more thought given to the information that is being given to that mother.

It is such a vulnerable time for mothers. They are exhausted. They have had the best gift of their lives given to them but they are at a loss as to the right thing to do. Any education they have had prior to that goes out the window. They are looking for solid information. It is not acceptable at this stage to tell a mother that bleeding nipples at 12 hours is normal and she will just have to toughen up and get over it. We have all heard it frequently and we are still hearing it.

If they note everything throughout the birth, they should continue noting everything. One can be sure the medications are noted. Any checks that are done on mum are noted. It is only one other step.

Deputy Colm Burke: Should we strive for a 24-hour backup support service?

Chairman: Colm?

Deputy Colm Burke: It is a simple question.

Chairman: I know, but you are way over time. You are cutting off your colleagues, but go on. Finish the question.

Ms Fiona Rea: It can only be helpful. It can only be useful to mothers. Yes.

Deputy Colm Burke: I thank the witnesses.

Chairman: Who is our last contributor?

Senator Lorraine Clifford-Lee: I think that is me.

Chairman: Yes.

Senator Lorraine Clifford-Lee: I thank all the witnesses for their wonderful contributions. They are very knowledgeable. I would count myself as somebody who would know a little about breastfeeding but I have learned a great deal about the structural problems that exist currently.

I would be of the opinion that we need a strong public information campaign on breastfeeding to break that intergenerational cycle in relation to breastfeeding. Many of us would come from families in which nobody that we would know, not our mothers, aunts or other extended family members, would have breastfed. It is not the norm in Irish families because we have such a low breastfeeding uptake. A public awareness campaign should definitely be looked into to raise the possibility.

I found when I was pregnant that breastfeeding was almost mentioned to me as an afterthought. It was almost sprung on me the week before I gave birth as to what I would do. One is completely bombarded. One is trying to process all this information. Having that conversation at such a late stage is not healthy and it is not good. It should be incorporated into secondary school education. It should be a much broader education for society, not only women but their partners because they are such a vital part in the breastfeeding journey. One needs the full support of one's partner because it is so difficult. There is almost pressure on some women to ease the burden at home and give it up, as though it would make everybody's lives much easier if one stopped with this kind of almost nonsense. Without firm support from one's partner at home, it is very difficult.

There are many women who might not have breastfed on their first child. We need to get the message to them that it is okay, that was their experience but when one is having a second child and subsequent children, perhaps a different choice is there for them. It is to give women the confidence to say that they want to change their mind on it. It is not any reflection on their initial decision but that they want to try something different now.

I would like to ask a question in relation to the initial outlay on breastfeeding. The witnesses mentioned it was in or around €500. That is a huge amount of money for anybody. It lends credence to the idea that breastfeeding is some sort of middle-class pursuit and it is not suitable for women who would not fall into this well-off, middle-class category. Would they support a grant being given to women who choose to breastfeed to cover those initial outlays that one would have? Can they suggest any other measures that can be taken to encourage and support more women who would not be from a middle-class background who would not have many

financial resources to breastfeed because it is a costly outlay at the start?

My second question would be in relation to the role of local authorities in creating public spaces to allow breastfeeding in our communities out and about in town. One of the witnesses mentioned Dundrum Shopping Centre. If we are to rely on commercial entities to provide public spaces, we will not get them. That is the bottom line. Should local authorities have a role in providing breastfeeding supports? What do the witnesses see in relation to that?

Another issue, which may have been touched upon in earlier contributions, concerns the impact of the pandemic on breastfeeding rates. Like Ms Byrne, I have many friends who have actually extended their breastfeeding or who initially thought they would do it for a couple of weeks but have continued to do it far beyond it because they are at home, they are not being disturbed, there is no pressure to get out and about and bounce back to normal and carry on like nothing has happened, so for them it has been positive.

However, there has also been a negative impact, and a number of contributors spoke about the maternity service restrictions. Do the witnesses feel that a lack of support in relation to the other maternity issues and the lack of an advocate standing by their side to speak up for them impacts on the number of women who are choosing to breastfeed? Do the witnesses feel that because all of this has been so difficult and women do not have someone to speak up and advocate for them in the couple of days after they give birth, perhaps they want to make things easier for themselves? Perhaps the witnesses have some further views on that.

Ms Deborah Byrne: On the cost issue and the suggestions as to how perhaps to overcome the barrier to breastfeeding, we mentioned the hospital being a level playing field. That is an area where people of all different backgrounds will be, so if they get the support from the get-go, it is to be hoped the 63% of mothers who do initiate breastfeeding will be converted to continuing to breastfeed beyond hospital discharge.

We focus a lot on the low rates of breastfeeding, but it is also about enabling those who have decided to give it a go and helping them continue with it. Basically, the more we see breastfeeding in society, the more people will do it. I have friends and family who work within the maternity services and I did not know that extended breastfeeding reduces the risk of ovarian, cervical and breast cancers. Therefore, there is work to do on the promotional and educational piece.

I believe Ms Cahill mentioned having a free international board certified lactation, IBCL, consultant visit as part of the public health service. The public nurse does these checks, but if that proposal could be incorporated, it would also enable people of different backgrounds and incomes to address issues at an early stage.

Chairman: We are coming to the end of the meeting and we are over the time limit for using the room. I ask Ms Cahill to sum up.

Senator Lorraine Clifford-Lee: Excuse me, a Chathaoirligh. Many other contributors went well over their time and I feel that I should be given the appropriate time for people to be able to respond to my questions.

Chairman: My problem is we have to exit the room at a specific time.

Senator Lorraine Clifford-Lee: Well, many contributors went well over their time and I want adequate time to finish my interaction with the witnesses.

Chairman: I will make a decision in relation to finishing the meeting. The difficulty is we are under Covid rules and we have to vacate the room. The meeting is supposed to finish at 11.30 a.m.. I call Ms Byrne.

Senator Lorraine Clifford-Lee: Many contributors went over their time and they were not called back in, and now my questions cannot be adequately answered.

Chairman: I know that. Every week, members go over the time allotted. I apologise, but-----

Senator Lorraine Clifford-Lee: I have sat through the whole meeting and I do not want to eat into the rest of the time, but it is very disrespectful. I have a personal interest in the issue of breastfeeding.

Chairman: Does Ms Cahill wish to finish her contribution?

Ms Geraldine Cahill: Yes. To answer the Senator's question on the cost, lactation consultants in private practice usually give a patient two hours. That is a huge difference in timing. Referrals could be made to lactation consultants in private practice. Public health nurses spend a maximum on 20 minutes with a mother. If, upon the identification of a problem, they could refer a mother on to a private lactation consultant who would have the time to visit the mother and get paid by the health system to do so, it would be ideal for everybody, but that is not what is happening. Therefore, breastfeeding is still, more or less, a middle-class pursuit. That is just the way of it, really.

Ms Fiona Rea: I just want to touch on the Senator's point about public spacing and making amenities for breastfeeding. I am absolutely in favour of that, but is it not appalling we are even talking about it as a thing? Women should not need a special place to go to breastfeed. There should not be a question of a mother being moved on from sitting on a park bench or feeding her child wherever she chooses to do so. Yes, it would be terrific if there were some public spacing given to mothers so they felt comfortable and there was no question of them being asked to move on, but it is disgraceful we are even talking about it as a thing.

Chairman: I appreciate all the contributions. I apologise that the last member had to be cut off, but I am working to a schedule.

If the witnesses feel there is anything further that they wish to contribute to the committee on this matter, they might forward it in writing. I would certainly like to hear more of their views on why breastfeeding rates in Ireland are so low, and in particular, the drop in rates from the 63.8% majority that do breastfeed in hospital to the rate of 37% after leaving hospital. That issue would be well worth further exploration in respect of questions. I would also like to hear more about the actual supports that are in place, the fact that, as the Bainne Beatha report states, people have to go to private practice to access supports, and the importance of that.

I appreciate the contributions made. I know other groups wanted to take part in the proceedings but there would not have been time. We have also had technical difficulties in these meetings, whereby if more than two groups attend remotely, the system seems to break down.

I thank the witnesses for their contributions. That concludes our business for today.

The joint committee adjourned at 11.37 a.m. until 9.30 a.m. on Tuesday, 18 May 2021.