Irish Nurses and Midwives Organisation
Working Together

45 Annual Countess Markiewicz Lecture

Women in the Frontline

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24th November 2021

Is mór an onóir dom léacht cuimhneacháin Countess Markievicz a thabhairt agus mo thurairimí i dtaobh mná agus iad ag obair i rith na paindéime a chur os bhur gcómhair inniu.

Thank you for this opportunity and it is a great honour to present some thoughts on the issues posed by the Pandemic for women workers including those represented by the INMO. I will open with a brief account of the establishment of the INMO 102 years ago. I do so to highlight some historical connections that are of interest in the context of the countess but also the Industrial relations community supporting this lecture series.

In 1919 in Dublin's Esperanto Club twenty nurses and midwives held a meeting. They discussed their poor employment conditions and took '*the controversial decision to establish a trade union'*. This union the Irish Nurses' Union (INU) was declared the first trade union for hospital nurses in the world. This claim according to Mark Loughery, author of the history of the INMO, is legitimate. (Loughery, 2019)

One of the first notice to members issued warned nurses against those who would; '*give balls for us, provide us with a club perhaps, or a holiday home and invite us to tea parties in their*

country homes, but who, when questions of higher salaries or shorter hours are raised, gently explain to us why the present time is not a suitable one to give them to us!'

Louie Bennett secretary of the IWWU was nominated as the first President and Marie Mortished as first General Secretary of this new trade union. Marie had trained as a nurse in England and returned to work in Ireland and was steeped in trade unionism. She was born Marie Shields and her father Adolphus, a compositor, is accredited with first inviting James Connolly to Dublin. Marie's husband Ronald Mortished was the assistant secretary of the labour party and Trade Union Congress. He became the first chairman of the Labour Court and the minutes of early IWWU meeting refer to both Ronald and Marie supervising the INUs work in the early days.

Some years later as General Secretary she received a letter from the Minister for Labour Countess M which sought an explanation for the advertisement of a nursing matron post. There is a lot more interesting history relating to this period contained in 'A Century of Service' by Mark Loughery and I encourage those who are interested to read on and enjoy!

It is my sincere privilege, to follow these great women and the many committed general secretaries in the 100 years since the foundation of the INO/INMO. Today this union has the largest female percentage membership of any trade union in the Republic of Ireland. My address today is focused on the women on the frontline especially those I know best – our nurses and midwives and also their working environment.

Background - Before the pandemic

We cannot examine how the Pandemic affected working nurses and midwives without looking at the approach to their conditions of employment in the preceding period. Under investment in nursing and midwifery posts in the public sector led to real issues when the pandemic hit. As did the policy of outsourcing care of older person services to the private sector, where minimal staffing levels quickly collapsed, this has been a very harsh lesson relating to the flaws in this policy.

The necessary role of the public health sector is crucial in handling a health care emergency, and the current pandemic must be a wakeup call in relation to investment and forward planning. We have, fought against insufficient staffing levels over the last decade and through the Industrial relations machinery of this state, developed industrial agreements which attempt to correct understaffing.

Staffing levels can now be determined by means of a scientific process- I will say more on that later. Staffing levels are important as they determine the level of care that can be provided. Because successive Irish governments have neglected this area of public health, we have not been able to develop and grow our bed numbers in line with population needs or develop specialist practice or retain our best assets – our well educated and trained HCW s including nurses and midwives, to staff these beds.

Announcements about beds are irrelevant if the staffing plan is not funded and staffed. To put this in perspective to open an ICU bed, you need 6 nurses who are trained and education in this specific nursing area. (To train as an ICU nurse you must firstly have completed a four-year honours degree in nursing science, then work in the area and seek a place in one of the 100 available places to undertake the level 9 QQI higher diploma in Intensive care nursing).

One month ago, the HSE identified that we only had 15 adult ICU beds available, out of a total of 298 staffed beds. (We dispute this figure as we know the staffing is suitable for 250 ICU beds). This staffing was based on a combination of directly employed and agency staff and a reliance on part-time staff working additional hours. Remember this figure when the ICU capacity is described as 'surging up' – since then we have seen the increase of patients with covid 19 admitted to ICU beds and areas on wards and theatre recovery rooms being used to provide overflow intensive care. Without the necessary skills or experience of working with ventilated and critically ill patients, that is the longest 12 hour shift a nurse will work. (Surging capacity is a major requirement for a health service to deal adequately with a crisis including a pandemic. Definition is the availability of excess or redundant capacity that can quickly be brought online)

We started this period in January 2020 with trolly figures at 12,024; conservative estimates of a shortage of 250 critical care beds; and the capacity review estimate that by 2030- we would need an additional Minimal 2,590 acute hospital beds – (this is supposing reforms to move care to community has been implemented – more if not). (Department of Health, 2018)

264 surgical and medical wards in our 29 acute hospitals are now catering for very sick patients, requiring interventions which up to now would have only been provided in ICU. Leaving home, facing into a 12-hour shift in a ward, ED or ICU or any area of the hospital system since February 2020 has been a scary prospect for these nurses. They report being afraid that they would: Miss care and be unable to attend safely to all those that need them. They report fearing the mental and physical exhaustion dealing with the high volumes of death,

isolation and sheer terror experienced by some patients and their families facing this unpredictable virus. They reported being so exhausted at times thy they worried about their own ability to keep going. This was before they mentioned their worries their own health and bringing this virus home to their family.

What was their response to this fear? They met the challenge head on, they went to work, they gowned up and bravely faced the worst of the invisible but deadly virus. Many comparisons to soldiers going to war have been used in describing the health care workforces' approach to the early days of the virus. The main difference was that this army was predominantly female.

There is little doubt but that the value of these caring professionals, their focused approach to putting the patient first, have long been underestimated and undervalued.

Let us remember again that first notice to members a century ago and reflecting on the 100 years that followed described in the foreword to A Century of Service by Liam Doran, as years 'filled with warm words of praise', but times which were never right to recognise the contribution of nurses and midwives, or to include them in decision making forums relating to the development of the Health service. He also stated that he could not remember one situation in the history of the union where progress was made for members WITHOUT pressure from the INMO. Michael D Higgins on international nurse day 2020 summed it up very well**:**

> *It would be regrettable, egregious even, if through some form of collective amnesia, we as a society were ever to disregard or forget your heroic efforts and revert to where you were before the Pandemic- a society that sometimes failed to value you fully. (Higgins, 2020)*

Women on the frontline

The last year has made us re-evaluate what exactly the term essential workers mean to us as a nation.

At the very start of the pandemic, it became clear who our essential workers were – nurses, midwives, doctors, healthcare assistants, porters, cleaners, catering staff, ambulance workers, and those who worked in our local shops, our defence forces, our gardaí and those who worked in our Social Protection offices and local authority workers were part of the glue that held our society together in the dark days when COVID first descended on us.

According to the ESRI, over 70% of essential workers are women, and they predominantly work in health and retail sector.[1] (Redmond & McGuinness, 2020)

To break it down further, women make up 91% of the Nursing Profession[2]. In fact, women make up the majority of all grades in the Health Service Executive except for Medical & Dental consultants where men hold 59% of the positions (HSE, 2021). 53.4% of all workers in Trade unions in Republic of Ireland affiliated to the ICTU, are women.

Women are overrepresented in insecure, low paid and temporary work such as retail and hospitality which places them at a greater risk of poverty than their male counterparts. We know that there is a societal expectation on women to be carers in their families which can limit employment opportunities. This in turn has an impact on our gender pay gap, which currently sits at 14.4%. (Eurostat, 2021)

Women are significantly outnumbered in our Oireachtas and the Irish Government and are therefore underrepresented in the decision-making processes. The gender disparity in political decision making is further magnified by the fact that since June 2020, not a single woman is a permanent member of the Cabinet Sub-Committee on COVID-19.

While women made up the majority of workers on the frontline, the really important issues for them, to a large extent, haven't been prioritised at the decision-making process at Government level. The pandemic was raging a full year before the chief nurse was appointed onto NPHET despite nursing and midwifery making up 1/3 of the total health workforce.

For daily NPHET briefings we were used to seeing men at podiums Taoisigh who addressed the nation flanked by fellow male ministers in the follow up press conferences. Decisions were made that had serious consequences for women at work and at home – without in my view sufficient female perspective being taken into consideration. The main issue for working women was provision of childcare and the difficulty of home-schooling while working from home and this was not given the level of scrutiny that was needed. Some studies into countries with more women at political leadership and at the senior decision-making tables, have found that the decision to close schools were delayed for these reasons, the point being the effect on women of school closures was a consideration.

[1] Redmond P., MCGuinness, S. (2020) *Essential Employees During the COVID-19 Crisis* ESRI
[2] CSO (2019) Women and Men in Ireland Survey

The case of the childcare provision for essential health care workers became a matter of protracted debate within four different government departments. The ultimate proposal was unfortunately unworkable and when- the proposal to allow co-parents of essential workers remain at home to provide childcare- was announced it was acknowledged by the Tánaiste, that it would not help essential Health care workers co- parenting with other health care workers or lone parents.

For nurses and midwives, of whom 91% are female, the lack of adequate childcare for frontline and essential workers was of particular concern. In a survey of INMO members, almost 60% of respondents stated that they are co-parenting with an essential worker or healthcare worker, resulting in neither parent being available to provide childcare during the pandemic (INMO, 2020). 60% of lone parents stated that they accrued additional childcare costs (Survey: 4th and 11th of June 2020).

Not a great plan to assist the predominantly female frontline workers trying to provide care for their children when schools and creches were closed and grandparents were prevented on public health advice from helping.

The Pandemic and the state of the Irish health service.

I want to bring you back again to a time BC – Before COVID. January 2020 – hospital overcrowding was a dominant issue, in fact we know it was one of the reasons a General Election was called in early January 2020 to take place in February 2020, because the numbers of patients on trolleys was spiralling out of control, hospital waiting lists were growing and the health service was not coping.

While politicians hit the doorsteps, 12,024 patients were recorded on trolleys in the month of January. One of the worst Januarys on record since the INMO began counting trolleys. February was just as bleak with over 10,000 patients on trolleys. The picture I am trying to paint for you here, is that even before COVID arrived in our hospitals, nurses and midwives were exhausted.

Many members of the commentariat say that winter is hell in our hospitals, and they are right but for many nurses and midwives it is a perpetual winter in their place of work, with very little let up. Hospital occupancy constantly over the recommended safety level of 83-84% is unsafe for the workforce as well as the patients. (Irish hospital occupancy rarely falls below 100%)

As Winter began to turn to Spring, a new crisis that we knew very little about was on the horizon, COVID-19.

As someone who represents healthcare workers it can often feel like we are trundling from one avoidable crisis to another but what COVID had in store was something none of us could have imagined.

In almost a sense of irony, 2020 was designated by the WHO as International Year of the Nurse. Dealing with a global pandemic was not on the cards in how we had planned to celebrate the contribution nurses and midwives make to communities across our country.

Interestingly help with capacity that was once an impossible dream in our health service became a reality practically overnight - One of the most dramatic policy decisions during the health emergency was the move by the Government to take over, by agreement, most private hospitals, to have access to surge capacity during the pandemic. It effectively made private hospitals public facilities. This is a policy decision as a trade union leader I call for often to help deal with the crises we face in our health service year on year. Often, we have been stonewalled or told it wasn't possible. But now we know what the State can achieve for our health service when it really must.

While we saw quick movement in many aspects of the State's reaction to COVID-19, the fact that it took so long to get an adequate amount of PPE and a coherent policy on the wearing of facemasks in healthcare settings led to a huge amount of despair for workers. It took until April 21st for the HSE to implement a universal facemask policy in our hospitals

Testing and tracing was never introduced as a universal policy in the acute hospital workplace.

The provision of timely vaccinations and booster vaccinations required trade union advocacy and lobbying, and the acknowledgments already made by governments to their health care workforces in many countries right now remain outstanding in Ireland.

What was it like for those working in the frontline?

Recent surveys carried out by the team in the INMO have highlighted really concerning levels of burnout among nurses and midwives (INMO, 2021). Of the nearly 2,000 nurses survey, over 90% have admitted to being mentally exhausted. 62% indicated that they had cared for a patient that died as a result of COVID. Death is a sad but normal part of our profession but the level of deaths that occurred and the manner in which they occurred, not getting to say a final

goodbye to a loved one and dying among strangers would inflict a certain amount of trauma on anyone.

Nurses and midwives have faced an unprecedented increase in workload demands resulting directly or indirectly from the pandemic. Coupled with caring for patients with the virus, witnessing the physical and emotional effects on patients, families and loved ones has taken a psychological toll. The vast majority of our members are now telling us they're mentally and emotionally exhausted, and this is going to have an impact on their safety and the safety of their patients and their long term ability to stay working in this profession.

Nurses and midwives have been at work in a hazardous environment without reprieve for over twenty months. They must gain relief from the constant overcrowding work situations faced daily, be provided with healthier and safer working environments and have available and fast tracked clinical supportive measures in place to support their physical and mental health issues when they arise. Occupational health services are simply not available nationwide and many members report long waiting times for an appointment.

They are burned out and need a break. I often get asked what we can do aside from hiring more nurses:

- We need to ensure that the environment that a nurse or midwife is working in is a safe one.
- Implement all agreements on pay and reducing hours as agreed and on time.
- We need to plan and fund staffing at least four years in advance – relying year on year on an increasing overseas recruitment policy- taking nurses from Countries that are themselves struggling is a flawed long-term plan.
- we need to ensure public policy such as Slaintecare and the maternity strategy are not diluted but implemented to fast track development of our public health systems and provide enhanced roles for nurses and midwives;
- The Government have adopted the previously mentioned Safe-Staffing and Skills Mix Framework as policy but have yet to implement it across every hospital.

You might wonder what a policy like this means – to break it down for you is to compare it to the Pupil-Teacher Ratio. We know that Government recommends that there should be no more than 24 children to one teacher in a classroom. That is the optimum for a child to get adequate attention from a teacher. This policy is funded annually to reach that ratio.

The Nursing Safe-Staffing framework advises what the safe mix of nurses and Health Care Assistants is, the levels required to provide optimal care and most importantly safe care. (Department of Health, 2018) recommended Nurse : patient ratio1:6 -medium dependency areas- today that is regularly 1: 14 or worse in high dependency areas. Maternity midwife to birth ratio: 1:29.5 recommended, average 1:40 today in most maternity services).

Several research studies have demonstrated an association with poor nurse staffing levels and adverse patient outcomes. In addition, low staffing levels have also been associated with low levels of job satisfaction, high staff turnover and missed or delayed care.

In hospitals where this framework has been implemented, there has been significant improvements to care, governance and oversight and it has changed the culture in the workplace, which is hugely significant when it comes to attracting young nurses back to Ireland.

Wards that have implemented this framework have seen their dependency and spend on agency staff plummet, retention of staff improved, and delayed care and readmission reduced. (Aiken et al, 2013; Ball, J. Murrells T, Rafferty AM et al, 2014 The reduction in agency spend following the implementation of the recommendations was, on average, €82,480 per month, only 36 of the 264 surgical and medical wards had this policy funded and implemented by the end of 2020, despite the labour Court recommendations to settle the nurses strike in 2019; to properly fund and implement by end 2021.

Infection Numbers:

As of November 19th, over 37,282 healthcare workers in ROI have been infected with COVID-19. A significant number have long covid.

Long Covid refers to symptoms lasting for protracted periods due to a COVID infection. Evidence around the impact of long covid is only emerging. This area will require further research, according to a study in the UK, approximately, 1 in 5 respondents testing positive for COVID-19 exhibit symptoms for a period of 5 weeks or longer and 1 in 10 respondents testing positive for COVID-19 exhibit symptoms for a period of 12 weeks or longer (Office of National Statistics, 2020). The International Council of Nurses (ICN) in their recent report (2021) warns that the potential long-term impact of COVID-19, including PTSD and long covid is currently unknown but potentially extremely significant. A recent survey of INMO members also

identified that almost three-quarters of respondents who had contracted COVID-19 were experiencing long-term physical effects.

Currently infections amongst healthcare workers amounts to 7.2% of all cases. At one point it was over 30% and that was down to a lack of adequate PPE. Consistently nurses and midwives have made up 25%, the highest cohort, of healthcare workers who were ending up infected with COVID.

International comparisons

The World Health Organization (WHO), whose work on these figures has been supported by the International Council of Nurses' own analysis, recently confirmed that up to 180,000 healthcare workers have died from COVID-19, a death toll which ICN believes is a conservative estimate. With nurses still having to work unvaccinated and without proper personal protective equipment (PPE) in many parts of the world, ICN and others are calling for coordinated action to 'lift the patent', fund the provision of vaccines for poorer nations, otherwise more healthcare staff will die, and the pandemic will drag on and on.

Childcare

As previously stated Just over half of essential employees have children – 43% are part of a couple with children while 9% are lone parents.

As Ireland entered the first COVID-19 lockdown, the

closure of schools, childcare facilities and reductions in home and social care led many women to provide even more care.

For women working on the frontline, they were locked out of all formal childcare options. They were forced to turn to expensive, informal child-minding; forced to rely on family members while worrying about potentially infecting loved ones; and many taking unpaid leave or annual leave to ensure their children were looked after.

Over 1,800 INMO members with childcare needs responded to the union's survey, which found:

- 62% had to take annual leave to care for children,
- 22% had to secure and pay childminders to allow them to go to work.
- 10% continued using grandparents to care for children,

- 69% did not have a partner available to provide childcare – often because they are a single parent, or their partner is another essential worker.

Many parents were working essentially a "double day" while trying to juggle work with home schooling, but this was proved to be even more correct for those who were working in our hospitals.

Imagine working in a country where you are told Frontline workers are our heroes and applause sessions are held in your profession's honour in the national parliament but childcare for these same workers is not provided.

Is it because both the healthcare sector and early years' providers are predominantly women, and the key decision-makers were men that such a mess was made of childcare for frontline workers?

Research by the National Women's Council showed that those working on the frontline were taking on 'parent-guilt' when in work and 'frontline-guilt' when at home.[3] (NWCI, 2020)

Violence and Abuse

While COVID has shone a light on all that is and can be good about Irish society – how we as a people come together in times of hardship and how we cope when we can't do the things that make up our social fabric – like visit loved ones, come together as communities, and mourn loss, it was also the worst of times for some women. The shadow pandemic that plagued so many during this crisis, especially during the 16 days of action against gender-based violence – the rise of domestic violence cases.

Women's Aid saw their phone calls increase by nearly 40% and visits to their website increase by 75%. (Women's Aid, 2020) During the pandemic we know that women who were victims of abuse were living in more intense situations, and many were cut off from their support systems. Most of us feel like we are at our safest and most authentic selves when we are in our own homes, this was not a reality for so many women during lockdown.

Nurses and midwives weren't immune from abuse in the workplace despite a pandemic. Figures obtained through the HSE's National Incident Management Scheme show that in 2020 over 8,667 staff reported physical, verbal and sexual assault in the workplace. Nurses and midwives made up 48% of this cohort with 4,166 nurses and midwives reporting some type of

[3] Hayes, M., Loughnane, C. Dr.(2020), *Women's Experiences of Covid* National Women's Council of Ireland

assault. We need to know what measures are being put in place to protect a largely female work force. The employer's legal duty is to provide a safe workplace, and additional safety requirements have been introduced since November 2020 in the healthcare workplace, due to the higher risk from Covid 19classified as a Biological Hazard.

Care of older people

The pandemic exposed our over-reliance on the private sector when it comes to care of the older person.

The private care for profit model with a concentration on cost of care must cease. Over 80% of long term care is provided in the private sector. This industry is increasingly staffed by migrant non-EU workers, mostly women, on working visas or critical skill visas, which tie them to that employment. in some OF the cases that we have been representing migrant nurses on, there have been very serious violations of workers' rights, which, in many cases they are afraid to raise as their right to work in Ireland is dependent on the job.

The Oireachtas committee report into nursing home care during covid highlighted the need to examine the conditions of employment in this sector. (Houses of the Oireachtas, 2020) There is a real urgency to this, in the interest of staff and the elderly people in their care - if the state is unwilling to provide the care, then those that they outsource this care to, must have any state funding they receive contingent on the right to collective bargaining for all staff categories.

Maternity

When we reflect on how our hospital system managed pregnant women and their chosen birth partners during the pandemic we must look at decisions made in the context of the dangers this virus poses to pregnant women but more importantly why in Ireland in 2021 women still have so few choices about where their baby can be born.

The disgracefully slow pace of implementation of the maternity strategy, concentrating birth choices for the majority of women to hospitals is a national scandal , it's not alone in that category as the approach to women's health care issues in general - (cervical screening, birth control, management of menopause to name but a few) are still struggling to break free from the roots set in the past century, where undoubtedly women's choices over their own bodies and medical needs were determined by a male focused authoritarian state. If the maternity strategy and the choice to deliver at home had been in place, the level of anguish experienced

by pregnant women attending maternity hospitals during this pandemic could have been avoided.

Sláintecare and evolving care out of acute hospitals.

Likewise, the slow pace of moving most of the health care from our hospital system to community-based care has left us in a terrible situation in battling this pandemic. Our hospital system can barely cope with population care needs, and every winter becomes completely overcrowded, as elective care is cancelled due to emergency presentations. This is caused by a hospital centric delivery model, an underdeveloped primary care service, which requires hospital admission for many basic diagnostic tests.

Any crisis tests this model of delivery, never mind an airborne transmissible pandemic. The delay in implementing universal health care – set out in Slaintecare, has seriously impacted in our ability to provide anything other than crisis care. It has impacted on the health and wellbeing of those that work in this high activity high pressure environment on a daily, week in week out, year in year out, to a level that is not recognised as the lack of duty of care that it is. While Slaintecare remains a concept and not a funded reality this problem will continue.

Even though it was developed with all party-political consensus, early indications were that government support was lukewarm.

Sláintecare has a broad agenda of reform. It proposed to increase capacity, remove private beds from public hospitals, and to build three major standalone acute elective hospitals. It has also promised to increase inpatient beds and develop primary care and care delivery outside of the hospital setting to ensure better use of acute hospital beds. That is a broader agenda than the USA (Affordable Care Act) Obamacare. But similar to the US, it takes on a powerful insurance industry and many entrenched interests. It aims to mandate conditions, quality of care and a human rights approach to healthcare access.

In Ireland we must underpin Sláintecare reforms with legislation. Including, having a legislative requirement for a funded-nursing and midwifery workforce plan. That kind of change requires political will. It requires the return to the original all-party consensus, and it requires big taxation changes to create the health fund to ensure change occurs.

It is unlikely that we will we now reach that point by 2027! I believe the reasons we must try are now exposed by the pandemic. We saw the crucial role played by the public health services,

the limitations were historical underinvestment and outsourcing policies, resulting from the lack of real reform.

Slaintecare 'lite' is not an option, administrative regional reconfiguration is not enough. The recent announcement that the three elective hospitals will be catering for day cases only also required revising. Real reform requires the planners to plan for the inevitable shocks that will continue to hit our world and require our public health services to react. These plans must be ready by advance building of capacity, educating, and attracting the necessary professional that are required to do what they do best, provide a world class health service based on need not ability to pay.

This challenge is with the planners now as I believe the workforce have proven their ability to rise to the biggest of challenges which they faced with innovation, flexibility, bravery, and without doubt showed that were the best return on investment and the very best value for money this state every made.

Training places for nursing and midwifery.

The global pandemic has restricted overseas recruitment, which we have become very dependent on to staff our health services.

We need an urgent increase in the number of undergraduate nursing and midwifery places and a clear message that a moratorium, pause or any other measure to slow down recruitment cannot ever again be countenanced.

There are 1,800 spaces on nursing and midwifery courses available each year. In 2021, 5,951 leaving cert students put nursing or midwifery as their first-preference choice in the CAO. We must increase the undergraduate places, as science evolves, and we get better at treating diseases we need more specialist nurses and midwives. They come from the same pool of qualified nurses; therefore, we must increase the undergraduate numbers to allow specialisation and expert practitioners develop at a pace that a modern health service needs.

The important role that Trade Unions played in furthering protections.

The latest research by the ILO[4] confirms that, despite the challenges associated with the crisis, the surge in violations of trade union rights, loss of members and a hostile environment in some

[4] André, M., (2021) *COVID-19 and Recovery: The Role of Trade Unions in Building Forward Better* International Labour Organisation

countries, trade unions have stood their ground and helped to better protect workers and their jobs around the world. (André, 2021)

Collective representation and the collective worker voice have played a key role in protecting the interests of workers in the face of this pandemic in Ireland. Consequent on successive lockdowns, many thousands of workers were facing layoff and possible job loss. It was crucial that the trade union movement played a central role in putting forward solutions to address these unprecedented circumstances.

Led by Patricia King the general secretary of ICTU, the trade union movement adopted a position at the 'Labour Employer Economic Forum' to maintain the link between employers and their workers by ensuring the payment of wage subsidies, the payment of an enhanced State Benefit (PUP) to those workers being laid off, and a safety protocol, including a Lead Worker Representative, applying to every workplace in the state. Over 50% of all trade union members in the republic of Ireland are women, many of whom work in low paid and insecure industries. The loss of work and consequential income loss, due to lockdown, would have been catastrophic for this group were it not for the PUP and wage subsidies.

The need to provide statutory sick pay in the private sector was also driven by trade unions. The inadequacy of the State Sick Pay benefits and the absence of employer supported schemes were graphically highlighted by the plight of Meat factory workers. Workers who had to go to work sick, because they couldn't afford to stay at home while unwell.

Likewise In healthcare we took our role very seriously in ensuring maximum protections were provided to our members who were facing the pandemic head on. (We introduced an out of hours free phone line to ensure members had access to advice- main queries were relating to lack of access to PPE, childcare and covid derogation decisions. We provided quicker decision making in relation to INMO benevolent fund requests – subcommittee established to meet to consider requests as required- main requests were costs of unpaid sick leave absences – and funeral costs.). This has not been an easy road, we have had good co-operation in the main from health employers, but it is still not accepted, in my view by government or those state authorities entrusted with regulation of worker health and safety, that the health services are employment locations and must apply the same and better protections to their workforce as other industries. I look to the construction industry with envy when comparing the health and safety advances they have achieved for workers. Is it because the health care workforce is predominantly female? or is it because the state watchdogs for regulation in health- HIQA and

the Health and Safety Authority- when looking at the environment of work, allow too many mitigations when non prioritisation of the legal duty of care to the workforce is constantly excused by the pressures on the services?

In the face of this Public Health emergency, it was extraordinary that the State did not, and still does not, recognise Covid-19 as a health hazard generally in the workplace.

Health Sector trade unions had to lobby hard at European and domestic level to have the Biological Hazards Directive amended and included in its definition of a workplace biological hazard i.e.– Covid 19. Eventually this led to its categorization as a level 3 hazard of the pathogen for health services which was transposed into Irish Health and Safety legislation in November 2020. (HSA, 2020)

Either way the role of both the regulators and the worker health authorities will have to be examined independently when this crisis ends, to ensure we have a system that better supports the health service workers in the next crisis when it hits.

Pandemics are not Gender Neutral

We can conclude from all we know now about COVID-19 that this pandemic is not gender neutral, women are affected more than men by the social and economic effects of infectious – disease outbreaks. (Ebola and Zika outbreaks). They carry greater responsibility for caring duties when schools close and family members fall ill. They are at greater risk of domestic violence and are disproportionately disadvantaged by reduced access to sexual-and reproductive health services. Because more women are in insecure employments than Men, they are more affected by job losses in times of economic instability. The policies Government implemented and still continue to implement must not fly blind they must measure and take into account that outbreaks and resultant action affect groups differently. Those who were most risk at catching the virus in their line of work, were our healthcare workers, the majority are women. The longer-term effects of burnout and long covid are becoming evident must be addressed supports and measures to rehabilitate must be provided free of charge.

We need to begin work on a gender-impact assessment of COVID-19. The lived experiences of women on the frontline and supports they needed but were not available to them needs to inform our public policy decisions. This unfortunately is not over and probably won't be the last such crisis we will face. There are many lessons to be learned, particularly around representation of women at senior decision-making forums, policies on childcare, sick pay and

the effects on the gender pay and pension gap that this period had will need to be examined. Policies will now need to be introduced to repair and promote better practices for the future and support the needs of those suffering from burnout and with long covid.

Conclusion

The resilience and strength of Irish women never fails to surprise me. However, that resilience and strength continue to be tested.

Unless the State radically changes the way, it deals with women on the frontline, I worry about the future. We cannot expect to send our exhausted nurses and midwives out year on year, pandemic or no pandemic, into over-crowded, unsafe environments. Unless we provide the agreed reduced working week, improved salaries, provide more opportunities to expand nursing led services, (many which became really important during the pandemic), and safe staffing levels I fear we won't have a thriving profession ahead of us because young student nurses are watching.

We need governments and senior decision makers to fund and set implementation targets for the important public health policies discussed earlier. Nurses and midwives as the largest professional group of working women don't need to be put on a pedestal, they need to be where they deserve, in senior decision-making roles, deciding on policy and strategy as well as delivering clinical care. This is required to ensure focus on allowing them do their important work without constant fear of personal risk.

I want to end on a positive note and talk about the bravery and persistence our young student nurses and midwives showed during the pandemic. These are young people, mostly women, who gave up their part-time jobs, worked above and beyond what was needed, donned PPE, fought to get vaccinated and have been in a long fight to get their pay and conditions improved.

These are young people who are fighting for the future of their profession.

The energy, passion and love these young people have for their work on the wards is simply inspiring. However, unless we make the necessary changes in terms of safe staffing, retaining our nurses, tackling overcrowding and so much more, these young nurses will continue to flock to Australia, New Zealand, London and Canada.

They have worked unpaid in our health service when it has been at its worst. They have had to fight and protest for fairness and still they went to very dangerous workplaces and paid for

accommodation away from their families to do so. They've seen their older colleagues and the pressure they are under. They look at the struggles required for every advance, and they ask why it is so.

The commitment of the trade union I am proud to be General Secretary of, is that we owe it to them and the future women on the frontline to continue the struggle against what is unreasonable and unjust.

Thank you for listening.

Go raibh maith agaibh as bhur gcomhludar inniu agus as ucht éisteacht liom. Táim sásta aon cheist atá agaibh a thógaint agus a fhreagairt más feidir liom!!

I will now share a few pictures of our work of work as it has become and captions from our members of their lived experience. I hope it describes for you this lived experience in their own words.

As we go marching, marching we bring the greater days for the rising of the race,

no more the drudge and idler

ten that toil where one reposes

but the sharing of life's glories,

bread and roses, bread and roses.

(James Oppenheim, The American Magazine, December 1911)

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