SHORT TERM SCIENTIFIC MISSION (STSM)
SCIENTIFIC REPORT

This report is submitted for approval by the STSM applicant to the STSM coordinator

Action number: CA18211
STSM title: Comparing Iceland's to Ireland's response to Covid-19. What can we learn?
STSM start and end date: 13/09/2021 to 17/09/2021
Grantee name: Julika Hudson

PURPOSE OF THE STSM:

Rights-based approaches to organising and managing health systems are seen as central to facilitating respectful, quality care in childbirth. However, the World Health Organisation (WHO 2015) has drawn attention to the fact that there is increasing evidence of human rights violations in childbirth. This has been further highlighted during the pandemic and measures appear incoherent and infringe on the woman's rights and are not embedded in evidence (Sadler et al 2020). While the goal of protecting families and healthcare workers is widely accepted, a proportionate response has been called for.
One issue identified in research during the past year is the discrepancy between guidelines published and how they have been adapted by the different European countries. A recent study by Lalor et al (2021) has shown that Iceland was most closely aligned with WHO guidance. In Ireland restrictions remain incoherent and not based on best available evidence (MAI 2021).
The tentative aims of this STSM were to:

- Investigate why Iceland adhered to WHO guidance more closely than Ireland, e.g. learn more about Iceland's maternity system and legal rights of women
- Investigate how midwives' morale has been affected by the restrictions in Iceland and what we can learn from Iceland's response.

DESCRIPTION OF WORK CARRIED OUT DURING THE STSMS

For the duration of the STSM, I met with Prof Inga Karlsdottir daily to discuss how maternity care is arranged in Iceland and how this is supported by legal and governmental structures as well as education. Inga had kindly put together some reading, so I was able to attend our meetings prepared and feel, I really got the most out of my five-day STSM. I also had free time to browse the literature and follow up on points we established during our conversations.
Hildur Kristjansdottir, midwife, Associate professor University of Iceland was unfortunately unable to attend the scheduled meeting, but I learned more about her work and about autonomy in midwifery from Inga and read up on relevant publications. It was interesting to see how strongly the education system has been influenced by visits from inspirational midwives from the UK that further encouraged to create a third level education programme that adhered to the core principles of midwifery and strengthened midwifery's voice in Iceland.
Sigridur Sia Jonsdottir, midwife, Dean of School of Health Sciences and Associate professor University of Iceland was able to contribute through her wealth of experience to our discussion of topics related to childbirth, parent relationship, stress, and working conditions in Iceland. It is also important to say that Iceland is not free of the power struggles symptomatically underlying maternity care, and I did hear of midwifery units being closed for no apparent reason other than that it was gaining too much popularity/power. However,

there were also great stories of success where midwives had implemented evidence-based guidelines and of units where there was effective collaboration of the multidisciplinary team in support of the woman. Education was again the main point that we all felt had contributed to this.
I very much enjoyed a presentation from Katrín Björg Ríkharðsdóttir, Head of Directorate of Equality, Icaland that Inga had organised about equality in Iceland and gender-based violence. Barriers to equality included financial crisis and indeed the Covid-19 pandemic, but overall, Iceland is very progressive compared to Ireland and both Inga and Katrín think Icelandic women have been influenced by seeing their mothers and grandmothers go on strike for equality in 1970.
While it is clear that Iceland is struggling with increased interventions like most other high-income countries, it overall appeared that midwifery had gained momentum through a motivated group of midwives, the right investments, and maybe a little luck. As a result the focus of maternity care in many instances is on the mother-midwife relationship. Midwives are recognised and accepted practitioners in different models of care and therefore they were able to attend to the needs of their clients during this pandemic.

DESCRIPTION OF THE MAIN RESULTS OBTAINED

It appears that there was no blanket ban in Iceland, but through established relationships between women and midwives, an individual estimation of the situation was undertaken, and continued support and care was guaranteed during the pandemic. Continuity of care instead of the fragmented structure in Ireland seem to have contributed to this.
Based on my conversations with the Icelandic midwives and researchers, I wonder if Iceland adhered more closely to the WHO guidelines regarding continuous support in maternity care because of their stronger midwifery voice.
During the STSM, we explored how this is strongly connected to education. Their midwifery education programme is consistent with best available evidence and students are exposed to different models of care, where they can practice what they learn.
The greatest surprise to me was, that midwives in Iceland must have a dual nursing training, something that in Ireland has been suggested by some to be a prohibitor of a unified midwifery voice. In Iceland it is geographically necessary as in the smaller units with only occasional births, no full midwife position would be available. It does not stop Icelandic midwives to be very clear about their role as midwives though and to promote a salutogenic model of pregnancy and birth.
The woman's strike for equality in 1970 seems to have encouraged women in Iceland to voice their needs. The effect this single event has had on generations to come is remarkable and gives hope for the future of Irish midwifery services and women's rights in Ireland considering recent events (Repeal/coroner inquests into maternal deaths/march for maternity).
Collaboration of the multidisciplinary team to provide the woman with a satisfactory birth experience appears also to have been key to a functioning maternity system in Ireland. Understanding the need for reflection and openness to learning might have made the maternity units in Iceland more adaptable when balancing the pressures of the pandemic and the needs of the birthing women
The learning outcomes have strengthened my belief in the need for my PhD study on how women approach the moral ethical space of decision-making to contribute to the discussion around maternal autonomy after the replacement of 40.3.3 here in Ireland and the subsequent change to the HSE Consent Policy. I think it is important to have respectful maternity where women can vindicate their rights and avoid trauma for all parties involved.

FUTURE COLLABORATIONS (if applicable)

I have drafted a commentary article about my learning from this STSM and I hope I will be able to publish it. No further collaboration is planned at this point, but I really enjoyed this experience and hope that I will stay in touch and continue to learn from Inga and her colleagues.