Contribution to HRC 59 report — Special Rapporteur right to health

In this report, the International Council of Nurses (ICN), the global voice of nursing representing over 28 million nurses through 130+ National Nurses Associations (NNAs), responds to selected questions posed by the Special Rapporteur, highlighting:

(i) nurses' fundamental role in defending the right to health, and

(ii) severe barriers faced by nurses and other health care workers (HCWs) in realizing their full potential to protect health, including:

lack of investment in nursing workforces and health; lack of respect for HCWs' rights, decent work and practice environments; lack of effective policy frameworks or implementation; and increasing attacks in violation of International Humanitarian Law (IHL) including the Geneva Conventions.

2. Other groups/individuals providing health and care that are not governed by said frameworks

The World Health Professions Alliance (WHPA), including ICN, recently issued statements reiterating the need for a regulated professional health workforce and noting the detrimental effects of over-reliance on unregulated HCWs such as community health workers (CHWs), which can significantly impact patient safety and strain health systems and health professionals.

See Appendix II for firsthand testimony provided to ICN on harmful effects of excessive reliance on unregulated HCWs who may lack formal training (e.g. in South Sudan and Kenya).

3. Adequacy and effectiveness of laws/policies in relation to protections, fair treatment and labour experience of HCWs

The 2020 State of the World's Nursing Report (SOWN) indicates that legal protections, including working hours, conditions, minimum wage and social protection, exist in most countries, but are inequitable across regions (with weaker levels of regulations reported in South-East Asia and Western Pacific regions and African and South America regions).

Furthermore, as outlined in ICN's The Economic Power of Care report (2024), despite existing laws/policies, nurses and health care workers (HCWs) around the world continue to face low pay, overwork and long working hours, inadequate protections and threats to their physical and psychological safety, suggesting policies are not adequately enforced or funded. ICN has continually warned that nurses are systematically inadequately compensated, valued and protected which has led to a grave shortage of nurses that constitutes a global health emergency, with alarmingly high levels of nurses leaving the profession. This harms HCWs and deprives populations of care. ICN's Recover to Rebuild report (2023) documents country-level examples including Ghanaian nurses facing workplace hazards and overwork/exhaustion-driven symptoms of depression, anxiety, or PTSD in Polish, USA, and Mexican nursing workforces.

ICN has also raised the alarm that increasing strikes or industrial action by nurses and HCWs (e.g. in Spain, Finland, USA, France, Denmark, Mexico, New Zealand,

Uganda, Sweden) further indicate unfair working conditions, treatment and compensation.

Inadequate protections/unfair treatment during COVID-19

As per ICN's report with WHPA on COVID-19 and the health professions, extensive surveys of NNAs indicate that nurses faced pathogen exposure risks, excessive working hours, psychological distress, burnout, stigma, and violence during and following the pandemic. An average of ~10% of confirmed infections were among HCWs with nurses comprising the most affected HCW group in many countries. Only 14 of 31 NNAs surveyed reported access to compensation for HCWs contracting COVID-19 at work. Almost 80% of responding NNAs received reports of mental health distress among nurses.

Inadequate protections/unfair treatment in conflict or crisis zones

ICN has continually warned that attacks on HCWs are becoming increasingly normalized in conflicts, with IHL — which should protect health personnel and facilities — violated with seeming impunity (see Q8).

ICN's #NursesforPeace campaign and humanitarian work highlights further threats to nurses in conflicts and crises including psychological trauma, displacement and extreme economic insecurity.

See Appendix I for examples reported by NNAs to ICN including:

Nigeria: Poor conditions with nurses forcibly deployed to unsafe regions.

West Bank, Palestine: Nurses receiving minimal salary and army harassment and checkpoints impeding nurses' transit to work.

Gaza, Palestine: Nurses receiving no salary and facing extreme food insecurity.

Tanzania: NGOs providing insecure nursing contracts with short-notice termination.

Inadequate protections/unfair treatment in international recruitment

Current non-binding international policy, the WHO Global Code of Practice, is falling short in protecting nurses and populations from inequitable recruitment/migration patterns and ICN calls for a strengthened Code.

While ICN supports individual nurses' rights to move abroad, ICN's report to WHO and consistent calls to decision-makers (which were reflected in the G20 Health Ministers' Declarations) warn of escalating unethical recruitment practices by high-income countries, including the "poaching" of nurses from fragile health systems with workforce shortages, which deprives vulnerable populations of the right to health and puts additional pressure on remaining HCWs.

ICN has further condemned appalling accounts of abusive, exploitative treatment of migrant nurses including misleading information, debt bondage, and poor

working/living conditions (examples: UK, USA, Ireland, Belgium).

4. Human rights and right to health in nursing education and curricula

ICN believes that all nursing education, including Continuous Professional Development, must strongly incorporate human rights and the right to health.

As outlined in Position Statements, ICN calls for nursing education to integrate training in:

i. Health inequities and discrimination, social determinants of health (SDOH), and global rights and justice frameworks.

ii. Effective PHC including accessible preventive and community-based care.

iii. Advanced practice nursing.

iv. Delivering culturally-competent care and making care accessible to underserved groups including migrants, refugees and displaced persons.

v. Capacitating nursing workforces to defend health in crises through Core Competencies in Disaster Nursing.

vi. Climate action practice, research, and advocacy.

vii. Leadership including paths for nurses to defend the right to health at organizational, governmental, and international levels.

5. Situation of women, gender-diverse persons, older persons, Indigenous Peoples, Black people, and racial/gender parity in education, employment and leadership roles

ICN's Gender Equity in the Nursing and Health Workforce Position Statement (2024) highlights that women, gender-diverse persons, and nurses in the health workforce receive less pay, lower status jobs, fewer leadership roles, and face workplace violence and harassment. Women and gender-diverse persons from groups marginalized due to race/class/caste/age/ability/social status/ethnicity/sexual orientation face even greater intersectional barriers within the sector (1, 2). As women comprise 90% of the nursing workforce, chronically undervaluing nurses' contributions and leadership exacerbates gender inequality, while investing in nurses is a pathway to gender parity.

ICN further condemns gender-discriminatory practices, such as recent bans on women pursuing nursing and midwifery education in Afghanistan, which deprive populations of care and women of rights to an education and profession.

In nursing education, SOWN indicates that certain race, ethnic or other vulnerable groups, e.g. Indigenous peoples, may be underrepresented.

In terms of older persons, ICN's report on supporting older nurses at work notes that globally, one in six nurses is aged 55+ (17%). ICN Workforce Forums data shows a shorter than optimal average working life reported in several countries (e.g. Ireland, China, Korea), indicating a potential need for improved supports to allow older nurses to maintain employment.

6. Laws/policies impacting HCWs' ability to provide accessible, high- quality care, including for underserved populations

Nurses provide essential care to diverse populations, including vulnerable and marginalized groups, often under extremely challenging conditions. However, short-sighted laws, policies and systemic barriers frequently hinder nurses from realizing their full potential to support the right to health for all, including:

i. Chronic under-resourcing or underfunding of health systems and nursing workforces.

ii. Restrictive laws/policies violating gender equity by limiting access to re-productive health services, including abortion.

iii. Exclusion of refugees and migrants from health services due to lack of legal status.

iv. Legal frameworks that fail to enable the independent or advanced nurse practice roles critical to filling service gaps and defending populations' right to health.

See Appendix II for firsthand testimony reported to ICN detailing country-level barriers to HCWs delivering accessible health care in conflicts and crises, including:

Sudan and South Sudan: Grave lack of essential medical supplies, medications and PPE with numerous health facilities, including specialist facilities, destroyed by the war.

Turkey: Unregistered migrant workers excluded from health care and sanitation systems.

Afghanistan: Legal restrictions on women showing their body to male health workers prevent care delivery; severe financing obstacles including international freezes on funding with health services dependent on donors.

Mauritania: Severely under-resourced facilities for persons displaced by the climate crisis.

Jordan/Gaza: Visa restrictions preventing Jordanian nurses from entering Gaza to provide care on humanitarian missions.

7. Nurses defending the right to health in their daily work and in conflicts or crises

As outlined in nursing's Code of Ethics, nurses defend the right to health by providing health and mental health care; by identifying and addressing SDOH; by advocating for health-promoting policies; and by working to eliminate barriers to care.

ICN's Primary Health Care (PHC) report highlights case studies submitted by NNAs showing nurses upholding the right to health and supporting progress towards UHC, including:

New Zealand: Following Cyclone Gabriel, the 'Maranga Mai!' plan enabled nurses as policy and primary health leaders. Nurses are taking leading health equity roles addressing disparities faced by Māori and Pacifica communities and building disaster preparedness.

Costa Rica: Nurses have played a central role in systemic reform towards multidisciplinary community-oriented PHC teams, contributing to the 8% reduction in infant mortality and 2% in adult mortality evident in the first decade of this reform.

India: Through strengthened health and nursing education policies, graduate nurses now serve as community health officers, staffing 150,000 health and wellness centers each serving 5,000-10,000 people.

In conflicts and crises, nurses play an especially critical role as first responders,

defenders of health, coordinators of crisis care and advocates for vulnerable populations.

See Annex III for testimony reported to ICN by NNAs, showing nurses bravely defending the right to health during conflicts and crises, including:

Gaza, Palestine: Nurses working long hours unpaid and facing extreme financial hardship to protect populations' right to health.

Gaza; Puntland border region of Somaliland; areas of Sudan: Nurses volunteering to work in dangerous conflict zones with urgent health needs.

Lebanon: Nurses leaving their families to live inside hospitals and continue providing emergency care to conflict-affected populations.

Ukraine: Nurses risking their safety to provide lifesaving care amidst the ongoing war.

8. Reprisals and acts committed against health and care workers

ICN estimates that over 1,000 nurses and HCWs have been killed in conflict zones in the last 2–3 years. There was a record high of over 2,500 horrific incidents against healthcare in 2023, including kidnappings, killings, and arrests of HCWs and bombing, looting, and attacks on health facilities, medical supplies and convoys.

Through #NursesforPeace and other advocacy, ICN continually calls for an urgent

end to these abhorrent attacks and for HCWs to receive the protection owed to them under IHL, and reports direct testimony from NNAs.

Firsthand testimony from nurses includes:

Lebanon: Accounts of Lebanon's hospitals and HCWs being directly targeted with nurses risking death and injury and losing faith in international law to protect them.

Gaza: Reports of unprecedented nurse fatalities and injuries and the arrest and detention of ~200 nurses and doctors without trial and with no news of their safety or whereabouts.

Ukraine: Reports of over 1,800 medical facilities attacked in Ukraine over the past two years, with 214 destroyed beyond repair.

Afghanistan: Reports of kidnappings, killings and arrests of HCWs and arrests/kidnapping of HCWs' families.

Violence against healthcare personnel also includes interpersonal violence and harassment, which, as ICN has reported, is believed to have increased following the COVID-19 pandemic.

10. Good practices/examples of investments in professional and personal development and wellbeing of HCWs

The examples outlined in Q6 show that there is a strong positive impact for populations when nurses are enabled with professional development including

degree-level training; advanced practice certifications and pathways; and training in PHC, emergency preparedness and culturally-competent care.

ICN provides development programmes, such as Leadership for Change, Global Nursing Leadership Institute (GNLI), and Organizational Development of National Nursing Associations (ODENNA), including ODENNA Africa, and, through its Humanitarian Fund, supports training for nurses in crisis-affected countries, including in mental health and disaster response.

NNAs do crucial work supporting nurses' personal and professional development and the protection of their well-being even in extremely challenging conditions. As ICN reported, during the ongoing conflict, Lebanon's NNA has worked to ensure emergency nursing training and to connect nurses with psychological support.

However, nurses' development and wellbeing is threatened by persistent underinvestment in the global nursing workforce coupled with inadequate protections and frequent violations of IHL. This severely compromises both nurses' own rights and their ability to defend populations' right to health.

Based on the information outlined in this report, ICN urges the SR and HRC to prioritize protecting and investing in nurses and HCWs to safeguard the right to health for all.

Appendices

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Appendix I

Reports from National Nursing Associations on inadequate protections and unfair treatment in conflict- or crisis-affected zones, drawn from conversations with ICN undertaken between September 2024—December 2024.

Nigeria: Many nurses report experiencing unsafe working conditions, including nurses sent without their choosing to the more dangerous regions in the north where there are security and protection issues for civilians.

Tanzania: Nurses working in NGOs describe facing unfair HR treatment with insecure jobs that can be terminated at short notice. Public sector nurses report being underpaid, overworked, and expected to perform duties outside their training.

Palestine: Nurses in the West Bank report harassment by the Israeli army who enter into hospitals and disrupt their work. They have been paid only 10–15% of their salaries over the past 2 years because of administrative blocks due to the occupation. They face significant delays getting to work due to army roadblocks, turning a 15-minute journey into a 2-hour ordeal.

The Palestinian Nursing and Midwifery Association report that in Gaza, unprecedented numbers of nurses have been killed and injured on duty. Gazan nurses continue to work though they have received no salary payments and face extreme food insecurity.

Lebanon: Nurses in red zones report poor working and living conditions and living on-site, away from their families, due to dangerous transport conditions. There is high nurse unemployment due to hospital destructions and resource constraints and HCWs have been displaced.

Ethiopia: HCWs in the Tigray region were not paid during the 2-year war, leading to extreme food insecurity. Nurses in Addis Ababa face difficult working conditions and are routinely expected to do 24-hour shifts.

Somaliland: Nurses describe salaries not covering living costs, leaving them reliant on community food donations, especially in rural areas.

Appendix II

Reports from National Nursing Associations on policies and barriers impacting healthcare access and nurses' ability to provide care in conflict- or crisis-affected zones, drawn from conversations with ICN undertaken between September 2024—December 2024.

Mauritania: Nurses expressed concern that persons in a large rural camp (Borat camp) for individuals displaced by the climate crisis are unable to access healthcare, with no NGO or government response to the growth of this population of internally displaced persons (IDPs) and the only MoH health centre nearby overrun and understocked. Mauritiana's NNA also expressed concern about migrants who pass through Mauritania en route to Europe: the EU has an agreement with them that they should send these migrants back to their countries of origin, but they often become stuck in Mauritania as they have no official documents, and are a very vulnerable group with no service provision as they are neither registered refugees nor IDPs.

Somaliland: Nurses describe a concerning lack of access to health services in the conflict-affected border regions with Puntland/Somalia and reported that nurses in these regions are overextended and under-resourced. There have been increased cases of sexual and gender-based violence (SGBV) in these regions which has led to a higher rate of female genital mutilation (FGM) as a perceived protective measure against rape.

Tanzania: Nurses report that investment policies favouring urban areas mean that rural areas face disadvantages. They also highlighted that there is a lack of adequate access to health services for disabled people.

Turkey: Nurses report that whole families from the east of Turkey move for work each summer and the migrant workers do not have access to healthcare or adequate hygiene or sanitation when outside of their region because of the

complexities of the health system and payment/ insurance structure, meaning they can only access emergency services. Turkish nurses also describe many unregistered migrants and refugees who cannot access existing health services due to their lack of legal status.

Sudan: Nurses describe witnessing the destruction of their once well-functioning health system during the war, with numerous facilities, including specialist facilities, destroyed and the health care infrastructure in a state of collapse with no electricity supplies and a desperate need for generators to power hospitals, affecting specialist equipment such as haemodialysis and oncology and impeding or stopping the delivery of care. Many health care workers have been displaced. Many individuals lack access to essential medical services amid an extensive humanitarian crisis. Nurses expressed concern around the cholera outbreak and urgent need for intravenous fluids, oral rehydration solutions (ORS), personal protective equipment (PPE), and other consumables necessary for infection prevention and control. Poor water, sanitation, and hygiene further impede the populations' right to health.

South Sudan: Nurses report harsh conditions, a lack of equipment, minimal resources, and shortages of essential medical supplies and medications all of which impede delivery of health care. At Al Saba Children's Hospital, the nation's only paediatric facility, resource gaps are especially acute. Families must often buy basic medical items themselves, leaving many children untreated if they cannot afford them.

There are also reports of over-reliance on unregistered health care assistants,

especially in rural health settings. There is a lack of legal framework to establish the differences in responsibilities between HCAs and nurses. Though unregistered health workers can play a supportive role, over-reliance on these workers in place of health professionals can place addition burdens on nursing workforces in their efforts to provide safe, effective, accessible care, as nurses may end up supervising large teams of unregulated workers.

Kenya: Nurses highlight barriers to care imposed by a new government insurance scheme that now requires individual payments instead of family payments, including for children, making it difficult for students, elderly people and poor families to afford healthcare. The elderly often share their resources with grandchildren, leading to poor nutrition and health, and Many cannot afford insurance and lack access to treatment and do not seek treatment for complex comorbidities.
There are also reports of excessive use of Community Health Assistants without formal training which leads to risks of misdiagnosis/inappropriate treatment (e.g. treating potential malaria cases with simple fever medication).

Afghanistan: Nurses report a lack of female health workers, especially in more rural areas. Women are not allowed to show any part of their body or face to a male health worker and therefore cannot access healthcare from a male provider that requires assessment, especially for any issue related to women's health and pregnancy, thus depriving them of access to care. Women are also not able to travel to a health facility without a male guardian, further restricting their right to health.

Afghanistan also faces severe financing obstacles to health care, including international freezes on funding, and health services are reported to be dependent on donors.

Jordan: Nurses from Jordan report that they have sought to enter Gaza on humanitarian missions to provide care to the civilians in their neighbouring country and protect access to healthcare, at risk to their personal safety, but only one such mission has managed to gain entry into Gaza as others have not been granted visas.

Appendix III

Reports from National Nursing Associations on nurses defending the right to health in conflict- or crisis-affected zones, drawn from conversations with ICN undertaken between September 2024—December 2024.

Ethiopia: Nurses report that though health workers were not paid during the recent civil war in Tigray, nurses and medics continued to work to protect the right of the Tigray population to access care while facing extreme food insecurity themselves.

Somaliland: Nurses are volunteering their time to work in the Puntland border region where there is conflict and women face increased SGBV. There is decreased access to healthcare in that area and nurses are overstretched.

Palestine: It is reported that Gaza's nurses continue to work long hours in extremely dangerous conditions to provide civilians with healthcare. They have not received any pay at all since the beginning of the war, meaning they struggle to meet their own and their families' basic needs including water and food.

Nurses in the West Bank have been impeded from receiving more than 10–15% of their salaries but continue to work with little pay in order to protect the rights of the Palestinian people to care.

Sudan: Many nurses have chosen to remain in more dangerous areas working in demanding roles in order to serve the population who need them during the war and ensure the continued running of the health service.

Lebanon: Many nurses in conflict zones have moved to live inside hospitals even while their families have fled to safety so that they can continue providing emergency care to populations affected by the conflict.

Jordan: Nurses report volunteering to enter Gaza on humanitarian missions to provide care to civilians, though only one such mission has managed to gain entry as others have not been granted visas.