United Nations A/HRC/59/48

General Assembly

Distr.: General
22 April 2025

Original: English

Human Rights Council
Fifty-ninth session
16 June–11 July 2025
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Health and care workers as defenders of the right to health

Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng

Summary

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, focuses on health and care workers as key protectors of the right to health, and thus human rights defenders.

The Special Rapporteur explores their ability to support the enjoyment of the right to health and related human rights. She elaborates on their health, mental well-being, safety, remuneration and fairness in the workplace so that they can deliver quality healthcare services.

She examines health and care workers both as rights holders and as protectors of the rights of health seekers, since both aspects are interlinked. She highlights specific situations in which health and care workers protect their patients' rights to health and all rights, including sexual and reproductive health rights, as well the right of patients facing violence, whether in their private lives or State-inflicted, and those in conflict and crisis situations.

The Special Rapporteur asserts that the practice of medicine is a tool for the promotion of human rights. Health and care workers are key to a human rights-based healthcare system that ensures health facilities, goods and services without discrimination.

I. Introduction

1. Health and care workers are critical to realize and defend the right to health. Deeply embedded within the social fabric, health and care workers serve as the backbone of health systems, delivering preventive, curative and palliative services and responding to the needs of individuals and communities. They are uniquely positioned to act as catalysts for health equity. As such, the realization of the right to health of all individuals can be achieved only when the rights of health and care workers themselves are upheld, ensuring that they are enabled and empowered to carry out their vital work.

2. Health and care workers face challenges that undermine their well-being and their ability to deliver quality care. These challenges are interconnected and structural. They often result in unfair, unhealthy and unsafe working conditions, unmanageable workloads, occupational hazards, unequal opportunities in career advancement and experiences of harassment and violence.

3. Health and care workers' challenges reflect and exacerbate health inequities, compounding forms of discrimination that have a disproportionate impact on certain workers who have historically been made vulnerable, such as Black people, women, LGBTQIA+ people and foreign-born/qualified professionals, as they experience and participate in the workplace. In this context, discrimination can take the form of isolation, intimidation, career advancement barriers, unfair labour practices, unequal pay, limited leadership opportunities and direct aggressions. In turn, the lack of diversity among health and care workers contributes to disparities in care and biased treatment for individuals from marginalized populations.

4. Health and care workers are intertwined with the larger social system. As the primary interface between patients and the health system, they influence and are influenced by systemic issues such as access to resources, funding and administrative support. As market-driven health systems increasingly perceive healthcare as a commodity, cutting losses and enhancing profits are sometimes favoured over individuals' well-being. In this context, health and care workers may be treated as commodities themselves.

5. For the purposes of the present report, the Special Rapporteur defines health and care workers as encompassing all individuals engaged in activities whose primary intent is to enhance and deliver healthcare. This comprises a wide range of professionals, including doctors, nurses, midwives, pharmacists and allied workers, such as direct care workers in home- and community-based settings. They operate across diverse sectors, including public, private, non-governmental, rural, intercultural and faith-based settings.

6. In the present report, the Special Rapporteur explores the role of health and care workers as defenders of the right to health. Due to the nature of violations that may occur related to the right to health, health and care workers must be understood as human rights defenders who ensure the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable standard of health. In discharging their responsibilities, the Special Rapporteur asserts that health and care workers are uniquely positioned to flourish as human rights defenders, and must be supported and protected, especially in the face of threats in the pursuit of justice. Success hinges on the protection, promotion and realization of their own enjoyment of the right to health.

II. Methodology

7. Within the framework of Human Rights Council resolution 51/21, pursuant to which the present report is submitted to the Council, the Special Rapporteur identified health and care workers as a strategic priority for the realization of the right of everyone to the enjoyment of the right to health.[1]

[1] A/HRC/47/28.

8. In the present report, the Special Rapporteur builds on the work of her predecessors, who have analysed occupational health as an integral component of the right to health,[2] and medical education as a factor that influences the ability of health and care workers to fulfil States' obligations to provide healthcare that is available, accessible, acceptable and of good quality.[3]

9. In preparing the present report, the Special Rapporteur issued a call for inputs, inviting stakeholders to share their lived experiences and knowledge, with a substantive equality lens, including an intersectional, anti-racist and anti-colonial approach.[4] The Special Rapporteur expresses her appreciation to all who contributed.

III. Legal framework

A. International human rights law

10. The right to health is enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights, which provides that everyone has the right to enjoy the highest attainable standard of physical and mental health. It is upheld in other international human rights instruments, including the Universal Declaration of Human Rights (art. 25), the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5 (e) (iv)), the Convention on the Elimination of All Forms of Discrimination against Women (arts. 11 (1) (f) and 12), the Convention on the Rights of the Child (art. 24), the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (arts. 28 and 43) and the Convention on the Rights of Persons with Disabilities (art. 25). Furthermore, the right to health has been acknowledged in several regional human rights instruments, either through direct adjudication or in association with other rights. Those instruments include the African Charter on Human and Peoples' Rights (art. 16), the American Convention on Human Rights (art. 26) and its Additional Protocol in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (art. 10), among others.

11. In its general comment No. 14 (2000), the Committee on Economic, Social and Cultural Rights emphasized that the right to health requires all States to have public health and healthcare facilities available in sufficient quantity, which includes trained medical and professional personnel receiving domestically competitive salaries. It also found that health facilities, goods and services must also be accessible to everyone, without discrimination, especially to vulnerable or marginalized groups, and that such accessibility is not constrained to physical accessibility, but also comprises other dimensions, such as affordability information accessibility. Furthermore, health facilities, goods and services must be culturally appropriate and respectful of medical ethics, including the protection of confidentiality. In addition, they must be scientifically and medically appropriate, which encompasses the requirement of skilled medical personnel.[5]

12. In its general comments, the Committee on Economic, Social and Cultural Rights has confirmed that all economic, social and cultural rights, including the right to health, entail obligations of progressive realization and of immediate effect. States must guarantee that all rights are exercised without discrimination, including incitement to discrimination and harassment. In addition, States must immediately take deliberate, concrete and targeted steps towards the realization of rights. Those steps unfold, for instance, into the obligation to adopt legislative measures or to provide judicial remedies.[6]

13. Upholding and defending the right to health for all also means safeguarding health and care workers' rights in the realization of their right to just and favourable conditions of

[2] A/HRC/20/15.
[3] A/74/174.
[4] OHCHR | Call for input: health and care workers as key protectors of the right to health.
[5] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 4–17.
[6] Committee on Economic, Social and Cultural Rights, general comments No. 3 (1990) and No. 20 (2009).

work. That is both an underlying determinant of health and a stand-alone right under the International Covenant on Economic, Social and Cultural Rights (art. 7) and other international and regional human rights instruments.

14. Article 7 of the International Covenant on Economic, Social and Cultural Rights delineates four specific State obligations regarding the right to just and favourable conditions of work. First, States must ensure remuneration sufficient to provide all workers with fair wages and equal pay for work of equal value, free from discrimination of any kind, enabling them to have an adequate standard of living. Furthermore, remuneration should be sufficient to enable the enjoyment of other rights, such as the right to social security, health and education, which highlights the interdependence and indivisibility of the rights protected by the Covenant. Second, States must guarantee safe and healthy working conditions. Third, hiring, promotion and termination must not be discriminatory, and States must provide equal opportunities for promotion based solely on considerations of seniority and competence. This element imposes an obligation to issue non-discrimination legislation to guarantee equal treatment, including temporary special measures to accelerate de facto equality, as well as monitoring mechanisms. Fourth, States must ensure that workers have access to adequate rest, leisure and a reasonable limitation of working hours. This recognizes the need for a balance between the different dimensions of the individual's professional, family and personal lives to avoid work-related stress, accidents and disease.[7]

15. Just and favourable conditions of work cannot be achieved without guaranteeing freedom from physical and mental harassment, including sexual harassment. The right to liberty and security of person is enshrined in article 9 of the International Covenant on Civil and Political Rights and recognized in several other international instruments. The Human Rights Committee has indicated that "security of person concerns freedom from injury to the body and the mind, or bodily and mental integrity", and that States Parties to that Covenant must take appropriate measures to address patterns of violence against vulnerable groups.[8] Similarly, health and care workers should be able to perform their jobs in defence of the right to health in optimal conditions, free from violence.[9]

16. Medical confidentiality must be understood to be protected by the right to privacy, as health data refer to an individual's sensitive information. Any limitation must comply with the principle of legality and meet the requirements to justify it.[10]

17. A basic element of both the right to health and the right to access information is the right to informed consent to treatment, linked to autonomy, confidentiality and privacy, as all people have the freedom to control their own health and body. Informed consent is a condition sine qua non for medical practice and the obligation to comply with it is of an immediate nature. Therefore, health and care workers must be trained on informed consent, for the protection of both the patients and themselves.

18. The right to equality and non-discrimination is enshrined in various human rights instruments, including the International Covenant on Civil and Political Rights (art. 26) and the International Covenant on Economic, Social and Cultural Rights (art. 2). It is a cross-cutting principle underscoring all rights, including the right to health.[11] Non-discrimination and equality are fundamental to the exercise and enjoyment of other human rights. States have the obligation to eliminate both formal and substantive discrimination.

19. Guaranteeing health and care workers' rights requires the elimination of barriers based on prohibited grounds within the workplace to also tackle substantive discrimination. Historically, those barriers have had a negative impact on, inter alia, women and Black

[7] Committee on Economic, Social and Cultural Rights, general comment No. 23 (2016), paras. 32–34.
[8] Human Rights Committee, general comment No. 35 (2014), paras. 3–9.
[9] A/HRC/50/28, paras. 76 and 77.
[10] Inter-American Court of Human Rights, *Manuela et al. v. El Salvador*, Judgment, 2 November 2021, paras. 204 and 216.
[11] Committee on Economic, Social and Cultural Rights, general comment No.14 (2000), para. 18.

people. They require action such as the implementation of positive measures to redress de facto discrimination.[12]

20. Importantly, in health systems, discrimination impacts not only health and care workers, but also the people with whom they interact. Health inequities persist even when coverage is expanded or universal health coverage is achieved, meaning that structural factors, such as racism, sexism, gender-based violence and citizenship status, contribute to the prevalence of those inequities.

B. International labour law

21. States have additional obligations to protect the rights of health and care workers under international labour law. The International Labour Organization Declaration on Fundamental Principles and Rights at Work of 1998 affirms that member States of the International Labour Organization (ILO) have obligations that arise from their membership of the organization, even if they have not ratified the ILO conventions in which those obligations are expressed.[13] The original Declaration outlined four fundamental principles: (a) freedom of association and the effective recognition of the right to collective bargaining; (b) the elimination of all forms of forced and compulsory labour; (c) the effective abolition of child labour; and (d) the elimination of discrimination in respect of employment and occupation. In June 2022, ILO added the right to a safe and healthy work environment as a fifth fundamental principle, in response to the coronavirus disease (COVID-19) pandemic.[14]

22. The Discrimination (Employment and Occupation) Convention, 1958 (No. 111) is one of the most widely ratified ILO conventions, ratified by 175 member States, obligating States to prohibit discrimination (art. 1).

23. The Equal Remuneration Convention, 1951 (No. 100), ratified by 174 member States, provides that men and women must receive equal remuneration for work of equal value. This Convention is particularly important for health and care workers, as women make up at least 67 per cent of the global health workforce.[15]

24. The Nursing Personnel Convention, 1977 (No. 149) is binding on the 41 member States who have ratified it.

C. International humanitarian law

25. While international human rights law covers settings including war, international humanitarian law is strictly restricted to those situations which meet the threshold of an armed conflict.[16] These can be international armed conflicts or non-international armed conflicts. In both situations, international humanitarian law applies and complements international human rights law to regulate the parties to the armed conflict.[17]

26. International humanitarian law is primarily enshrined in the four Geneva Conventions of 12 August 1949 and the Protocols Additional thereto and hinges on the fundamental principles of humanity, distinction, proportionality and military necessity. The principle of

[12] Committee on Economic, Social and Cultural Rights, general comment No. 23 (2016), paras. 9 and 47.

[13] ILO Declaration on Fundamental Principles and Rights at Work and its Follow-Up, adopted at the 86th Session of the International Labour Conference (1998) and amended at the 110th Session (2022), available at https://www.ilo.org/resource/conference-paper/ilo-1998-declaration-fundamental-principles-and-rights-work-and-its-follow.

[14] Ibid., p. 9.

[15] See https://www.who.int/activities/value-gender-and-equity-in-the-global-health-workforce#:~:text=Women%20account%20for%2067%25%20of,around%205%20billion%20people%20worldwide.

[16] Common article 2 of the Geneva Conventions of 12 August 1949.

[17] United Nations, Office of the United Nations High Commissioner for Human Rights, *International Legal Protection of Human Rights in Armed Conflict* (United Nations publication, Sales No. E.11.XIV.3, p. 1.

distinction requires parties to an armed conflict never to attack civilian objects, including hospitals, health facilities and civilian health and care workers.

27. Under international humanitarian law, all parties to a conflict must fulfil the obligations applicable to them with respect to health and care work.[18] All parties must ensure the respect and protection of all medical personnel and humanitarian personnel engaged in medical duties,[19] their means of transport and equipment, hospitals and other medical facilities, as well as other civilians engaged in the provision of health and care services.[20]

28. International humanitarian law requires the parties to an armed conflict to adopt practical measures to prevent and end violence against medical personnel and facilities and ensure accountability for violations,[21] and to develop effective measures that reinforce the duty to protect and respect medical personnel, hospitals, medical facilities and transportation, including in domestic legislation.[22]

29. Parties are also encouraged to collect and report data on obstruction, threats and physical attacks on medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and medical facilities, and to share challenges and good practice in this regard.[23] It is also important that victims of violations of international humanitarian law, including medical personnel, are fairly and adequately compensated.

30. States, along with relevant non-State actors, should aim to provide specific and appropriate educational measures for health and care workers, State employees and the public on humanitarian law and the provision of health services in conflict. Increasing awareness of the principles of humanity, impartiality, neutrality and independence may improve public perceptions of medical personnel in conflict areas.

IV. Definition of care workers

31. The care economy accounts for 11.5 per cent of total employment globally and has a critical role in ensuring the health and well-being of individuals and communities.[24] However, definitions of care workers vary in international instruments, national legislation and academic research. According to the World Health Organization (WHO), strictly speaking, health and care workers include unpaid care providers and any person "whose primary intent is to enhance health", such as those who provide direct personal care services at home, including parents tending to their sick children.[25] Complex classifications for paid workers further complicate the definition of care workers and their role within health systems.

32. The Special Rapporteur recognizes the importance of addressing the challenge of defining care workers and the impact that challenge has on the development of policies and legal frameworks. However, in the present report, she does not build on that debate or intend to provide a lasting definition of health and care workers.

[18] Security Council resolution 2286 (2016).

[19] Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (Geneva Convention I), art. 24; Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I); Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II).

[20] Security Council resolution 2286 (2016); Geneva Convention I, art. 24; Protocol I Additional to the Geneva Conventions of 1949. See also Security Council resolution 2439 (2018).

[21] Security Council resolution 2286 (2016).

[22] Geneva Convention I, art. 24; Protocol I Additional to the Geneva Conventions of 1949; Protocol II Additional to the Geneva Conventions of 1949.

[23] Security Council resolution 2286 (2016).

[24] ILO, "Migrant workers in the care economy" (Geneva, 2024), p. 1.

[25] WHO, *The world health report 2006: working together for health* (Geneva, 2006).

V. Determinants of health and their impact on health and care workers

33. The ability of health and care workers to defend the right to health and other health-related rights is determined by more than just personal choices or expertise. It is also shaped by the social determinants of health. These determinants can facilitate or constrain the ability of health and care workers to provide healthcare, reflecting disparities based on socioeconomic status, ethnicity, race, gender, migration status and other factors.[26]

34. Health and care workers assigned to areas of low socioeconomic status may be subjected to hazardous housing, food insecurity and unrealistic workloads due to a lack of proper healthcare resources in the area. In turn, this puts these health and care workers at a greater risk of developing conditions such as hypertension and of suffering strokes, increases their exposure to infectious disease and physical injuries, and can drastically worsen their mental health and well-being. These social determinants of health vary greatly depending on social group and status, affecting who is able to deliver care and how such care is delivered.

35. The political determinants of health, or norms, policies and practices, also drive how health and care workers enjoy and defend the right to health and other health-related rights. For example, the use of vaccines and healthcare in general as a political tool during the COVID-19 pandemic had widespread effects on the health outcomes of doctors and nurses globally. Some officials declared that COVID-19 was a hoax, ridiculed mitigation efforts and promoted unproven therapies to reduce the spread of the disease. This political influence, the proponents of which faced no consequences, deterred patients from taking proper precautionary measures, which increased the number of hospitalizations due to COVID-19 infection and greatly increased the workload for many health workers.[27]

36. The commercial determinants of health, or the private sector activities that affect people's health, directly or indirectly, and the enabling political economic systems and norms also affect health and care workers' enjoyment of the right to health.[28] Personal protective equipment for health and care workers is often designed for men, even though women make up 67 per cent of the health workforce.[29] The stress that comes with the increased risk of infection – sometimes resulting from ill-fitting personal protective equipment – and infection itself is detrimental to both the physical and mental health outcomes of women health and care workers.

37. Health and care workers have reported experiencing moral conflict over insurance policies and have reported refusing or limiting patients' access to treatment due to insurance coverage.[30] Having to constantly make decisions to strike a balance between the health and financial needs of patients is another source of stress.

38. Legal strategies can help ensure that health and care workers have access to proper health services, housing, food sources, social support systems and protective equipment.

VI. Equity: health and care workers

39. In order to realize the right to health, the systemic factors that perpetuate and exacerbate inequities within the health field must be addressed. In this context, health and care workers are crucial for the development and implementation of strategies to promote health equity, as they both observe and manage the impacts on people of the social determinants of health.

[26] See https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

[27] Christine A. Sinsky and others, "Politicization of medical care, burnout, and professionally conflicting emotions among physicians during COVID-19", *Mayo Clinic Proceedings*, vol. 98, No. 11 (November 2023), pp. 1613–1628.

[28] See https://www.who.int/health-topics/commercial-determinants-of-health#tab=tab_1.

[29] See https://www.who.int/activities/value-gender-and-equity-in-the-global-health-workforce.

[30] See https://www.ama-assn.org/practice-management/prior-authorization/health-insurance-denials-delayed-care-and-medication-access.

40. Health and care workers are often exposed to discriminatory practices. Certain groups of health and care workers, including Black and brown individuals, women, LGBTQIA+ persons and migrants, among other population groups, are made particularly vulnerable in the challenging, underresourced and at times dangerous contexts in which they work, and thus face a double jeopardy of abuse.[31] Stigma and discrimination towards LGBTQIA+ workers and patients contribute to inadequate services and even denial of services, and health and care workers do not receive sufficient education and training on the needs of LGBTQIA+ persons, whether fellow health and care workers or patients.[32]

41. The system of privilege and disadvantage affects health and care workers in multiple and intersecting ways, integrated through their daily personal and professional lives. For instance, health and care workers are targets of patient bias, which manifests as "behavior or use of language that demeans clinicians based on their social identity traits".[33] While such bias can be overt, such as patient refusal of care, it may also be more subtle, such as questioning the role of the clinician, non-verbal disrespect, professional undermining, ethnic stereotyping, enquiring about the worker's background and making flirtatious remarks.[34]

42. Racial and ethnic minorities face greater entry barriers and significant obstacles during their career development, including limited access to leadership positions. For instance, in the United States of America, studies have found that only 5.7 per cent of physicians identify as Black or African American,[35] which can leave them feeling isolated, invisible and treated like outsiders. According to one survey conducted in early 2022, nurses reported facing discrimination from both patients and colleagues.[36] In turn, the lack of diversity among health and care workers can negatively impact the quality of care received by patients from marginalized groups, as cultural competency and understanding of diverse health experiences are crucial for effective patient care.

43. Equity gaps in the health and care workforce cannot be closed without also addressing gender dynamics. Women make up 67 per cent of the health and care workforce, globally. However, they hold only around a quarter of leadership positions.[37] Across the world, women, especially women from disadvantaged backgrounds, are paid less than their male counterparts.[38] A factor contributing to the gender pay gap is prescribed roles in society, pushing unpaid caregiving and domestic labour on women, limiting or restricting their participation in the workforce.

44. In addition to confronting the root causes of migration, such as limited educational and professional opportunities and political instability, migrant health and care workers face challenges in adapting to their workplaces and encounter stigma, discrimination, poor treatment and harsh working conditions. This, coupled with a general 12.6 per cent pay gap for migrant workers and a 19.6 per cent pay gap in the care sector, exacerbates their economic vulnerability.[39] Indeed, there is growing concern about the rise in cases of intimidation of and violence against migrant workers, especially discriminatory and xenophobic rhetoric against

[31] A/HRC/42/41, para. 25.

[32] See https://www.who.int/activities/improving-lgbtqi-health-and-well--being-with-consideration-for-sogiesc.

[33] Kimani Paul-Emile and others, "Addressing patient bias toward health care workers: recommendations for medical centers", *Annals of Internal Medicine*, vol. 173, No. 6 (September 2020), pp. 468–473.

[34] Margaret Wheeler and others, "Physician and trainee experiences with patient bias", JAMA Internal Medicine, vol. 179, No. 12 (October 2019), pp. 1678–1685.

[35] See https://www.aamc.org/news/what-s-your-specialty-new-data-show-choices-america-s-doctors-gender-race-and-age.

[36] See https://statnews.com/wp-content/uploads/2023/05/rwjf473632.pdf.

[37] See https://www.who.int/publications/i/item/9789240025905.

[38] See https://www.un.org/en/observances/equal-pay-day.

[39] See https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_protect/@protrav/@migrant/documents/publication/wcms_763803.pdf.

migrants, and the lack of long-term solutions for integrating individuals to enable them to transition to stable forms of legal status, such as long-term residence or citizenship.[40]

45. Despite being home to more than 3 billion people worldwide,[41] rural and remote communities experience shortages of health and care workers that are more than twice as high as those experienced in urban settings.[42] Furthermore, those workers practising in rural and remote communities often experience challenges such as limited access to training and longer working hours.

46. Health disparities between Indigenous and non-Indigenous populations continue to be significant. Indigenous health and care workers alleviate health inequities by improving access, ensuring services are culturally appropriate and assisting non-Indigenous personnel in delivering culturally appropriate care.

47. Key drivers of workforce migration in the health sector include unfavourable working conditions caused by a country's broader social, economic and political climate. Some of these push factors include a shortage of medical supplies and equipment, a lack of properly trained medical specialists and insufficient medical infrastructure.[43] Understaffing in hospitals and clinics can lead to extremely long working hours, medical specialists having to take on patients with ailments that they are not properly trained to treat, and a low number of experienced staff available to train new doctors and nurses.

48. Achieving health equity goes beyond expanding coverage or reaching universal health coverage. It also requires that the underlying power imbalances that shape the health sector be addressed and contemplation of the social fabric that underpins formal and substantive inequality and the different ways in which discrimination manifests itself in the daily lives of health and care workers, including direct, indirect, explicit, implicit, overt and covert forms of discrimination, as exemplified in this section.

VII. Communicable and non-communicable diseases

49. Health and care workers face increased exposure to pathogens and diseases themselves, being at a heightened risk of contracting infections.

50. During the COVID-19 pandemic, WHO estimated that between 80,000 and 180,000 health workers died from the disease between January 2020 and May 2021.[44] Occupational exposure also places health and care workers at a greater risk of contracting viral infections and diseases such as hepatitis B and C and HIV/AIDS and respiratory infections such as coronaviruses and influenza.[45]

51. Outbreaks and emergencies, including pandemics, significantly increase mental health concerns for health and care workers. In particular, the lack of pre-established, rights-based guidelines to inform decision-making regarding prioritization on the part of health and care workers places on them the emotional burden of making decisions themselves without clear parameters.

52. Health and care workers have increasingly experienced mental health stressors due to burnout, workplace harassment, extreme fatigue and the emotional toll of experiencing death and illness on a daily basis,[46] leading to compassion fatigue. These circumstances can be immensely stressful, both physically and mentally, leading to an increased risk of depression,

[40] United Nations Network on Migration, "Guidance note: regular pathways for admission and stay for migrants in situations of vulnerability", July 2021.

[41] See https://wdi.worldbank.org/table/3.1.

[42] WHO, "Retention of the health workforce in rural and remote areas: a systematic review", Human Resources for Health Observer Series No. 25 (Geneva, 2020), p. 4.

[43] See https://www.who.int/teams/health-workforce/migration#:~:text=International%20health%20worker%20migration%20is,during%20the%20COVID%2D19%20pandemic.

[44] See https://www.who.int/news/item/20-10-2021-health-and-care-worker-deaths-during-covid-19.

[45] See https://www.who.int/tools/occupational-hazards-in-health-sector/occupational-infections.

[46] See https://www.cdc.gov/vitalsigns/health-worker-mental-health/index.html.

anxiety, sleeping disorders and other mental illnesses, compounded by higher risks of substance abuse disorder.[47]

53. Data on health and care workers' mental health underestimates the prevalence of mental health issues, as workers are often hesitant to report their mental health challenges due to stigma and the perception that doctors must be self-resilient.

54. During the COVID-19 pandemic, the prevalence of existing mental health disorders was exacerbated. By the end of 2022, some 76 per cent of health workers reported that their mental health had worsened since the first quarter of 2020.[48]

55. Burnout has been linked to nearly double the risk of medical error, increased odds of being involved in a medical malpractice suit, increased turnover of medical staff, feeling absent or distanced from patients and work, and greater levels of patient-reported dissatisfaction.[49] Therefore, improving mental health outcomes for health and care workers is essential, not just for the well-being of health and care workers, but also for the well-being of those they treat.

56. Many health practitioners have expressed the fear of having their medical licence revoked or being ostracized by co-workers. These fears can lead to an overreliance on self-treatment, low peer support and an increased risk of suicide in the health workforce as a population.

57. Suicide is a prominent issue for resident physicians globally who take on a heavy physical and mental workload, amid notoriously challenging conditions.

58. Accurate reporting and data collection is also essential to address the mental health challenges of health and care workers. However, larger-scale policy interventions are still needed to improve the stigmatized culture surrounding mental health in health and care workplaces.

59. Health and care workers often experience exposure to toxic chemicals, harmful radiation and other carcinogens due to the use of these substances in medical tests and procedures. Some of these substances include cleaning and disinfecting sterilant, mercury, toxic drugs, pesticides, latex and laboratory reagents. Health and care workers are at greater risk of developing cancer due to this exposure.[50]

60. Sleep disorders, which interfere with health and care workers' alertness and mood, can have a large impact on health and care workers' cognitive function. Furthermore, feeling unwell due to the physical discomfort that comes with non-communicable diseases and their symptoms, or physical injury, can also have a significant impact on health and care workers' mood.

VIII. Sexual and reproductive health rights

61. Effective sexual and reproductive healthcare relies heavily on health and care workers. They have a direct relationship with the public and as such are key players in the implementation of reproductive policies. However, their ability to discharge their responsibilities is often undermined by various factors, including health system hierarchy, inadequate resources, poor working conditions and persistent inequities, which affect the enjoyment of their own rights and their ability to provide quality and effective care for others.

62. Comprehensive counselling and sexual and reproductive education delivered by them can have a positive impact on family planning and individuals' decision-making regarding their reproductive health.

[47] Samuel B. Harvey and others, "Mental illness and suicide among physicians", *The Lancet*, vol. 398, No. 10303 (September 2021), pp. 920–930, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9618683/.

[48] Hanan F. Abdul Rahim and others, *Our duty of care: A global call to action to protect the mental health of health and care workers* (Doha, World Innovation Summit for Health, 2022), p. 14.

[49] Ibid., pp. 11, 12 and 16; and see https://pmc.ncbi.nlm.nih.gov/articles/PMC8137852/.

[50] See https://www.who.int/tools/occupational-hazards-in-health-sector.

63. In her previous report, the Special Rapporteur exposed the risks of States' responses to alleged harm, particularly in the context of abortion, where it is criminalization itself that causes harm.[51] Criminalization in the context of abortion involves the application of criminal law to "any persons who seek, access, provide [including through providing abortion-related medication], aid, assist with, provide evidence-based information on, or are aware of someone having accessed abortion".[52]

64. Health and care workers fear being criminalized, prosecuted or having other sanctions imposed on them, such as the revocation of their medical licences. Restrictive legal frameworks tied to contraception, emergency contraception, abortion or third-party authorizations become barriers to accessing sexual and reproductive health.

65. In addition, health and care workers must often overcome direct attacks and harassment to provide reproductive care. In the context of sexual and reproductive services, health and care workers providing abortion care have been targets of harassment and violence, leading to intimidation and isolation from their communities.

66. Conscientious objection frameworks, individual or institutional, can obstruct access to sexual and reproductive healthcare, and may lead to violations of the right to health.

67. Obstetric violence is a form of gender-based violence consisting of inhumane, abusive or negligent treatment during childbirth carried out by health and care workers, as well as over-bureaucratization and forced medical procedures.[53] States should implement human rights-based training and awareness plans for health and care workers, addressing the behaviours that constitute obstetric violence during pregnancy and labour. Furthermore, States should create monitoring and accountability mechanisms for redress in case of mistreatment or violence, in line with the WHO recommendations on intrapartum care for a positive childbirth experience.[54] This could both reduce instances of obstetric violence and empower health and care workers to protect sexual and reproductive rights.

IX. Confidentiality

68. Confidentiality of medical data derives from the right to privacy and the right to health, as rights of all individuals and of health and care workers themselves, who can prevent or challenge the disclosure of certain information to third parties.[55] It also becomes an obligation for health and care workers by virtue of their profession. Guaranteeing confidentiality is crucial to providing acceptable and accessible health goods and services, given that individuals need assurance that their information will remain confidential in order for them to access health services. Therefore, health services must be "designed to respect confidentiality and improve the health status of those concerned".[56]

69. Health and care workers require clear safeguards and protections to be able to realize their right and fulfil their obligation to confidentiality. Legal and regulatory frameworks that on the one hand protect confidentiality and on the other hand require reporting on patients in various contexts – such as obstetric emergencies, abortion, migration, drug use and mental healthcare – can create unnecessary tensions for health and care workers, and can result in systemic challenges that have a negative impact on health outcomes for all.

70. Confidentiality is crucial for sexual and reproductive health. Legal frameworks can compel healthcare providers to breach confidentiality by requesting parental or spousal consent or by imposing the duty to report obstetric incidents within contexts where abortion is criminalized, colliding with their duty to maintain medical secrecy and confidentiality. In such situations, the risk of prosecution may lead health and care workers to report any

[51] A/79/177, para. 1.
[52] Ibid., para. 35.
[53] Inter-American Court of Human Rights, *Beatriz et al. v. El Salvador*, Judgment, 22 November 2024, paras. 148 and 149.
[54] WHO, *WHO recommendations: intrapartum care for a positive childbirth experience* (Geneva, 2018).
[55] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 12 (c).
[56] Ibid.

obstetric occurrence to the authorities, even when the duty to report does not apply, or to deny access to health services.

71. People living with HIV may fear that their health information may be used against them in a legal action. Potential violation of confidentiality can therefore discourage people from getting tested and disclosing their HIV status, acting as a barrier to HIV/AIDS prevention, diagnosis and treatment.[57]

72. Fear of deportation can lead migrants to avoid healthcare and to wait until health issues become critical to seek services because of their concerns about being reported to the authorities. In order to realize the right to health and health-related rights, health facilities ought to be areas where all individuals can seek healthcare without fear of law enforcement or immigration-related consequences.

X. Harassment and violence against health and care workers

73. Harassment refers to any behaviour that degrades, humiliates, irritates, alarms or verbally insults another person, including abusive words, bullying, gestures and intimidation. Harassment and verbal abuse, sexual violence and physical assault are among the most prevalent types of violence against health and care workers.

74. A staggering 62 per cent of health and care workers have reported violence in the workplace, with 58 per cent of cases constituting verbal abuse and 12 per cent sexual harassment.[58] It is estimated that workplace violence in the health sector constitutes approximately a quarter of all workplace violence.[59] The Special Rapporteur has previously advocated for violence-free environments in healthcare and has underscored the importance of protecting the physical and mental health of health and care workers, as they are key in the "delivery of acceptable, accessible, affordable and quality care".[60]

75. Sexual harassment persists among health and care workers. Sexual harassment is multifaceted, covering a range of physically inappropriate sex-related behaviours, both verbal and non-verbal, including unwelcome advances or sexual coercion and sexualized gestures or comments, among others. Health and care workers commonly experience sexually suggestive, offensive or humiliating remarks, requests for inappropriate contact, non-consensual touching, cybersexual harassment and the displaying of sexual symbols and acts.[61]

XI. Health and care workers in conflict

76. Health and care workers in situations of fragility and conflict display courage and commitment to ensure that individuals in the most vulnerable situations continue to receive healthcare, but do so at great personal risk. In humanitarian emergencies, hospitals, facilities and transport are sometimes bombed, looted, occupied, raided and vandalized, and medical workers are sometimes threatened, kidnapped, injured or killed.

77. In 2024, the World Health Organization reported 1,637 attacks on healthcare, with 937 deaths and 1,774 injuries of health workers across ongoing conflicts.[62]

[57] A/79/177, para. 33.

[58] See https://www.who.int/tools/occupational-hazards-in-health-sector/violence-harassment.

[59] Mei Ching Lim and others, "Workplace violence in healthcare settings: the risk factors, implications and collaborative preventive measures", *Annals of Medicine and Surgery*, vol. 78 (June 2022).

[60] A/HRC/50/28, para. 76.

[61] Blanca Paniello-Castillo and others, "'Enough is enough': tackling sexism, sexual harassment, and power abuse in Spain's academia and healthcare sector", *The Lancet Regional Health – Europe*, vol. 34 (October 2023).

[62] World Health Organization, Surveillance system for attacks on health care, available at https://extranet.who.int/ssa/Index.aspx.

78. The destruction and closing of hospitals and other medical facilities create fear and broader insecurities among civilians, especially patients suffering from chronic disease or illness.

79. In the Occupied Palestinian Territory, more than 1,450 attacks have been recorded on health workers, patients, hospitals and other medical infrastructure since 7 October 2023.[63] The Safeguarding Health in Conflict Coalition (a group of international non-governmental organizations working to protect health workers, services and infrastructure) identified 761 incidents of violence against or the obstruction of healthcare, with over 100 incidents specifically affecting healthcare facilities in the Gaza Strip in 2023.[64]

80. The sustained violence by Israeli forces, which may amount to genocide, has had a significant impact on medical infrastructure. It was reported that, by the end of June 2024, 22 out of the 28 hospitals in the Gaza Strip had been rendered non-functional as a result of severe damage from attacks.[65] The Turkish-Palestinian Friendship Hospital, the only specialized cancer centre in the Gaza Strip, stopped operating due to damage from Israeli military strikes, leaving the estimated 10,000 cancer patients in the Gaza Strip without care.[66]

81. By October 2024, the conflict between the Sudanese Armed Forces and the Rapid Support Forces had displaced over 11 million people.[67] WHO has documented over 140 attacks on healthcare in the Sudan since the outbreak of the conflict in April 2023,[68] leaving the healthcare system in serious peril.

82. In 2023, there were reports of over 440 health workers being arrested or detained in 12 different countries and territories.[69] Health professionals were detained during mass arrest campaigns of civilians, hospital raids and when following approved routes. Independent human rights organizations have documented the arbitrary detention of at least 310 health and care workers by Israeli forces in the Gaza Strip, further contributing to the degradation of the territory's healthcare system.[70] Drawing upon documented testimonials of international health and care workers, medical personnel were targeted along with hospital infrastructure, and healthcare workers have reportedly been direct targets of the Israeli military, as opposed to being indirect casualties of attacks.[71]

83. A pattern of attacks on medical infrastructure and health and care workers has been observed in conflicts in recent years, including in the Syrian Arab Republic, Ukraine and Yemen, and in the Gaza Strip.[72] After such attacks, health services often remain disrupted and access to healthcare further limited during a crisis, as was the case when eight polio workers were killed in Afghanistan in 2022, leading to the suspension of the national polio vaccination campaign.[73] Attacks on healthcare in the Syrian Arab Republic between 2017 and 2019 resulted, on average, in a 51 per cent reduction in outpatient consultations the day after an attack, with significant reductions continuing for 37 days afterwards.[74]

[63] Ibid.

[64] Ibid.

[65] OHCHR, "Thematic report: attacks on hospitals during the escalation of hostilities in Gaza (7 October 2023–30 June 2024)" (31 December 2024).

[66] Ru'a Rimawi, Bram Wispelwey and Navid Madani, "Roadblocks to cancer care in the Occupied Palestinian Territories", *Health and Human Rights Journal*, vol. 26, No. 2 (December 2024), pp. 39–44.

[67] International Organization for Migration, "Displacement in Sudan crosses 11 million as devastating crisis reaches new heights", statement by IOM Chief, 29 October 2024.

[68] World Health Organization, Surveillance system for attacks on health care, available at https://extranet.who.int/ssa/Index.aspx.

[69] Safeguarding Health in Conflict Coalition and Insecurity Insight, *Critical Condition: Violence Against Health Care in Conflict – 2023* (Baltimore, 2024), p 11.

[70] Submission by Human Rights Watch.

[71] Submission by Doctors Against Genocide.

[72] Ibid., pp. 8 and 9.

[73] Submission by WHO, p. 5.

[74] Submission by Physicians for Human Rights, p. 7.

XII. Stewardship

84. Importantly, strategies and action plans must be based on accurate and disaggregated workforce data, which enable evidence-based policymaking by highlighting gaps and guiding interventions.

85. In order to meet their obligations under international law, States must implement intersectoral policies that safeguard health and care workers and reduce abrasive interactions at the point of care.

86. High-quality education and lifelong learning for health and care workers is essential to ensure that they possess the skills required to meet the evolving health needs of populations. Medical schools shape students' views and attitudes towards patients and colleagues. Medical professional bodies are also key for human rights-based curricula and approaches, to cultivate an environment that upholds patients' rights and enables individuals to speak up in the face of injustice affecting all health and care workers.

87. Women health and care workers are at heightened risk of sexual- and gender-based violence and harassment due to persistent power imbalances and gender discrimination. Fear of retaliation, stigma and inadequate reporting mechanisms further enable a culture of silence, allowing harassment and abuse to persist without accountability.

XIII. Good practices

88. The Special Rapporteur extends her appreciation for the responses to her call for input on good practices.[75]

89. In Kazakhstan, anti-discrimination laws extend to employment, ensuring individuals are not denied opportunities to work due to their HIV status.[76]

90. In India, there is a framework agreement between the Government of India and the Government of the United Kingdom of Great Britain and Northern Ireland for collaboration on healthcare workforce. It facilitates skill development, building capacity and highlighting the balance between meeting global health workforce demands and ensuring the sustainability of domestic health systems, in line with the WHO Global Code of Practice.[77]

91. In Colombia, the Ten-year Public Health Plan 2022–2031 outlines management strategies, aims and policies to improve public health, with a strong focus on addressing systemic challenges and ensuring the well-being of public health personnel and communities. Notably, the Plan incorporates climate change adaptation as a guiding element in the management of primary healthcare.[78]

92. In Saudi Arabia, to address the surge in demand during Hajj season, the Ministry of Health has implemented an initiative allowing specialized medical and technical staff from within Saudi Arabia and abroad to enhance the capacity of healthcare facilities to respond to the unique and intensified needs during Hajj, including increased mitigated epidemiological risks.[79]

93. In Spain, instruction No. 3/2017 of the Secretary of State for Security establishes a protocol for action by the State Security Forces and Corps in response to aggression against health workers. This is a significant step toward safeguarding the physical and emotional well-being of health and care staff, ensuring that they can perform their duties without fear of violence or harassment.[80]

[75] See https://www.ohchr.org/en/calls-for-input/2025/call-input-health-and-care-workers-key-protectors-right-health, question 10. The submissions will be posted on the Special Rapporteur's web page.
[76] Submission by Eurasian Coalition for Health, Rights, Gender and Sexual Diversity.
[77] Submission by Centre for Health, Equity, Law & Policy. See also submission by India.
[78] Submission by Colombia.
[79] Submission by Saudi Arabia.
[80] Submission by Spain.

94. In Iraq, the law on the protection of physicians (Law No. 26 of 2013) targets physical assault, improper tribal claims and illegal demands on physicians, creating a foundation for their safety and enabling them to perform their duties without fear of violence or undue pressure.[81]

95. In Uruguay, Law No. 19,529 of 2017 establishes mental health as a fundamental human right for both patients and healthcare professionals. Recognizing the challenging working conditions that often compromise the emotional well-being of health professionals, the law seeks to create a more supportive environment for those delivering mental healthcare.[82]

96. The Buenos Aires Commitment, adopted in 2022 during the Regional Conference on Women in Latin America and the Caribbean, organized by the Economic Commission for Latin America and the Caribbean, marks a transformative step toward recognizing care as a right.

97. In the Philippines, legislation provides a robust legal framework to protect the rights and welfare of its health and care workers.[83]

XIV. Conclusions and recommendations

98. **The Special Rapporteur on the right to the highest attainable standard of physical and mental health underscores the importance of recognizing the crucial role of health and care workers for the realization of the right to health and other health-related rights. Thus, upholding their own rights, adopting an intersectoral, evidence- and rights-based approach must be a priority.**

99. **The Special Rapporteur reaffirms that medical practice itself is a tool for human rights promotion, and that health and care workers are crucial in transforming patriarchal and paternalistic medical systems.**[84]

100. **The Special Rapporteur recommends that States and other stakeholders:**

(a) **Ensure adequate and sustainable resources to strengthen health systems, guarantee fair and just labour practices, including fair remuneration of health and care workers and provision of the tools of trade, especially for population groups that have historically been marginalized and excluded;**

(b) **Bound by their obligations under international law, act to ensure fair recruitment, distribution and retention mechanisms for a sustainable and equitable health and care workforce;**

(c) **Expand protections for health and care workers who expose politically or commercially driven interference in health systems, research and healthcare delivery, including cases of pharmaceutical or insurance industry influence over patient care;**

(d) **Strengthen oversight of commercial influence in healthcare, including pharmaceutical funding, private insurance, medical policies and medical research, to protect health and care workers from ethical conflicts and undue pressures that compromise patient care;**

(e) **Prioritize recruitment and retention of health and care workers from rural, Indigenous and underserved communities, ensuring professional development opportunities and support systems;**

(f) **Ensure access for health and care workers to comprehensive medical services, including surveillance, prevention, vaccinations, counselling, treatment,**

[81] Submission by Iraq.
[82] Submission by Uruguay.
[83] See https://www.studocu.com/ph/document/liceo-de-cagayan-university/fundamentals-of-nursing/republic-act-no-7305-the-magna-carta-of-public-health-workers-supreme-court-e-library/108876039.
[84] A/76/172, para. 80.

rehabilitation and support for work-related diseases, injuries and mental health conditions at no cost to the employee;

(g) **Enact or amend legal frameworks and policies to protect health and care workers' parental rights, including adequate parental leave, reasonable breastfeeding time and appropriate facilities and other appropriate accommodations;**

(h) **Implement and fully comply with the ILO obligations and recommendations on safe and fair work conditions, including limits on working hours, leisure, workload, support systems and risk assessment tools on violence and harassment;**

(i) **Strengthen protections for migrant health and care workers, including fair labour contracts, recognition of foreign credentials and transparent pathways to transition to stable forms of legal status, such as long-term residency or citizenship, to reduce precarity and vulnerability to exploitation;**

(j) **Eliminate barriers to accessing sexual and reproductive health, as related to confidentiality and conscious objection, revise legal and regulatory frameworks, ensure the decriminalization of abortion and ensure that there are no barriers to access to sexual and reproductive rights;**

(k) **Explore ethical and rights-based bilateral agreements for migrant health and care workers to ensure fair wages, working conditions and career advancement opportunities for migrant workers while preventing workforce depletion in their countries of origin;**

(l) **Strengthen legal frameworks that protect, promote and respect international legal protections under international human rights law and international humanitarian law for health and care workers in situations of conflict, genocide and violence. Post-conflict policies should be detailed and time-bound, and include the participation of health and care workers, civilians and other stakeholders;**

(m) **Update medical pedagogy and curricula through a human rights, community-based approach that embodies ethical practices and empowers both providers and patients;**

(n) **Establish committees of diverse health and care workers to advise on accountability for redress in cases of mistreatment of or violence against workers and to prevent potential violations of individuals' rights by health and care workers;**

(o) **Ensure that mental healthcare is both accessible and confidential and that it includes medical prevention, detection, treatment and rehabilitation for mental disorders resulting from work.**

101. **Health and care workers are human rights defenders. In a world where the full enjoyment of the right to the highest attainable standard of physical and mental health remains a distant goal, health and care workers are key to guaranteeing human rights in their practice, particularly with regard to, but not limited to, the rights to non-discrimination, substantive equality, autonomy and privacy.**

102. **There is an urgent need for a paradigm shift to reimagine health systems that are sustainable and equitable and provide for dignified and compassionate ways in which humans – crucial for the functioning of health systems – are valued and cared for.**