



EXPOSED, SILENCED, ATTACKED:

FAILURES TO PROTECT HEALTH AND ESSENTIAL WORKERS DURING THE COVID-19 PANDEMIC

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THE COVID-19 PANDEMIC

CONTENTS

1. EXECUTIVE SUMMARY	5
2. INTRODUCTION	9
3. METHODOLOGY	11
4. UNSAFE AND UNFAIR WORKING CONDITIONS	14
4.1 Deaths and infections due to Covid-19	14
4.2 Lack of adequate personal protective equipment (PPE)	19
4.3 Workload and mental health concerns	23
4.4 Pay and compensation	25
5. RIGHTS TO FREEDOM OF EXPRESSION AND PEACEFUL ASSEMBLY	29
6. STIGMA AND VIOLENCE	36
7. BROADER STRUCTURAL PROBLEMS	40
8. INTERNATIONAL LAW AND STANDARDS	45
8.1 Right to health	47
8.2 The right of everyone to the enjoyment of just and favourable conditions of work	47
8.3 Protection against stigma, discrimination and violence	50
8.4 Freedom of expression	50
8.5 International cooperation and assistance	52
9. CONCLUSIONS AND RECOMMENDATIONS	53

1. EXECUTIVE SUMMARY

In March 2020, the WHO declared COVID-19 to be a pandemic. At the time of writing this report, 11,125,245 people had contracted the illness and 528,204 people had died as a result. Most countries had imposed some form of restrictions on people's movement and other human rights to control the spread of the virus. And several countries are yet to see the worst of the pandemic. At this difficult time, health and essential workers have played an extraordinary role in the response to the pandemic. Across countries, they have put their health and well-being at risk, often in very difficult circumstances and with very little support, to ensure that people are able to access the essential services they need, including health care, food and other nutritional supplies, and emergency public services.

Despite this, health and essential workers across the world have faced enormous challenges in doing their jobs and governments have not adequately protected them. Amnesty International's analysis has shown that over 3000 health workers have lost their lives due to COVID-19 during the pandemic – a figure that is likely to be a major underestimate given a lack of reporting - and many others have worked in unsafe environments due to shortages in personal protective equipment (PPE). They have further faced reprisals from the authorities and their employers for raising safety concerns, including arrests and dismissals, and even in some cases been subjected to violence and stigma from members of the public.

This report looks at these challenges and also flags some broader structural issues in health and social support systems across the world that have exacerbated these challenges and must be urgently addressed. It is largely based on information from the following sources: (i) monitoring by Amnesty International researchers on the rights of health and essential workers in 63 countries and territories, including interviews with health and essential workers; (ii) a literature review of media reports, academic articles, and reporting by unions and other civil society actors on the challenges faced by health and essential workers during the pandemic; and (iii) a collation of data from multiple sources, including the media and lists compiled by national medical associations, on the numbers of health and essential workers who have contracted COVID-19 and who have died as a result. While much of the analysis focuses on health workers, due to the better availability of information, the analysis and need for protection extends to a much wider range of workers who are exposed to COVID-19 through their work.

“In terms of what it's like at the moment, every day is like running on a treadmill with the speed set on high and you trying to keep pace, everyone is tired and anxious.”

Nurse, UK

Health and many other essential workers often face greater exposure to COVID-19 as a result of their work than the general population, and are therefore at greater risk of infection, serious illness, and even death if not adequately protected. While in many countries there is currently no systematic tracking of how many health and essential workers have contracted COVID-19 and died as a result, some estimates do exist. According to the International Council of Nurses, “more than 230,000 HCWs

[health care workers] have contracted the disease, and more than 600 nurses have now died from the virus". Amnesty International has collated and analysed a wide range of available data that shows that at least 3,000 health workers are known to have died after contracting COVID-19 in 79 countries around the world. In the UK data has shown "elevated rates [of death] among some of the individual health care professions" as compared with the general working population, including male and female nurses, male nursing auxiliaries and assistants, male and female social care workers and male health care workers. Other occupations with raised death rates for men included taxi drivers and chauffeurs, bus and coach drivers, workers in factories, and security guards.

Data and analysis from some countries in this report are beginning to show that certain groups of health and essential workers have been disproportionately affected by the pandemic and have experienced higher levels of infection and death. Examples include BAME health workers (that is, health workers who identify as black, Asian, or minority ethnic) in the UK, sanitation workers who are also often from the *dalit* community in India, and the Somali-speaking community in Finland (Some analysis has indicated that members of the Somali-speaking community are more likely to be employed as essential workers, which may have contributed to this incidence rate).

Shortages of PPE for health and essential workers were reported in almost all of the 63 countries and territories from which Amnesty International collected information, and according to a survey published in May 2020 by Public Services International in 62 countries, less than a quarter of trade unions reported having adequate equipment. Health and essential workers have had to rely on a variety of means to protect themselves in these circumstances, which put their health and safety at risk. In some countries, health workers reported having to procure PPE and pay for it themselves, since this was not being provided to them. Others have reported having to improvise and re-purpose items in an attempt to protect themselves, include garbage bags and raincoats. Since the start of the pandemic, several countries have changed their import and export regulations around essential commodities, which include PPE, which may have exacerbated the situation for some countries struggling to purchase PPE on the international market.

Furthermore, as health workers face increased workloads and additional occupational risks, health workers in some countries have also said that they are not being paid fairly and are not being compensated in cases of occupational illness or even death. Increased workloads and the possible increase in work related anxiety and stress, particularly in these difficult circumstances, can have adverse consequences on the mental health of health workers. A survey of health workers in Portugal published in April 2020 following the onset of the COVID-19 pandemic noted that almost 75% of health professionals surveyed considered their levels of anxiety as "high" or "very high" and 14.6% reported having moderate or significant levels of depression. A health worker in South Africa explained this to Amnesty International, saying "The big issue for me is how tired we all are rushing from one patient to the next, which results in many of us accidentally touching our faces and exposing ourselves to the virus. We also sweat a lot and the visor steams up. I have been off work with COVID-19 and I am a locum doctor, which means I am only paid when I work, so I'm feeling even more stressed than before".

In response to these conditions, workers have often spoken out and in many cases faced reprisals including dismissals or even arrest. Amnesty International noted reports in at least 31 countries where health and essential workers had publicly protested their working conditions, had gone on strike or threatened to do so. Amnesty International found that in some countries, governments or particular employers had imposed restrictions or instructions to prevent health and essential workers from speaking out about their concerns. In others, however, even though no official restrictions were placed on health and essential workers, many were operating in contexts where criticising the authorities is often met with repression and were at risk of reprisals.

For example, in Russia, authorities have opened an administrative investigation into endocrinologist Yulia Volkova, accusing her of disseminating 'knowingly false' information about COVID-19, after she published a video on Twitter on 25 March in which she asked that physicians be provided with PPE.

“Who did I scare with my video? It does not say about my hospital, the name of the head physician is not called. I just said that we demand that we be provided with modern protective equipment”, Yulia Volkova told Amnesty International.

In Malaysia, police dispersed a peaceful gathering of workers and activists who were in a picket against a hospital cleaning services company. The workers’ complaints centred around what they said was the unfair treatment of union members by the company as well as a lack of sufficient PPE for hospital cleaners. Police arrested, detained overnight and charged five activists who were protesting for “unauthorised gathering” in violation of their rights to freedom of association and assembly. Similarly, in Egypt, the authorities have arrested and arbitrarily detained nine health workers, for expressing their health-related concerns or criticizing the government’s handling of the pandemic.

“I feel so let down. The government and the local government officials are just not doing their best to safeguard doctors ... We are completely hopeless and can only protest. We’re then told we cannot even protest. That they are shutting our mouths.”

Health worker, Pakistan

Moreover, while health workers have seen an unprecedented outpouring of public support and solidarity in many countries, in some, health and essential workers have also experienced stigma – and even in some cases violence - because of the job they perform in the context of the COVID-19 pandemic. Reports have also emerged of health workers being denied access to essential services, such as housing, because people fear they are carrying COVID-19 and would spread the infection. There have been reports in at least ten countries of health workers being evicted from where they live, there being attempts to evict them, them finding it hard to find a place to live or facing stigma where they reside.

Amnesty International recorded instances in at least eleven countries, where health and essential workers have even been attacked or subjected to violence on the way to work, in their workplaces, as well as by their community or neighbours, and in their homes. Further, in May 2020, 13 medical and humanitarian organisations representing 30 million healthcare professionals issued a declaration condemning “over 200 incidents of COVID-19 related attacks [against health workers] – a trend that endangers these vital frontline responders and the communities they serve”.

For example, in Mexico, as of 28 April the Ministry of Interior had documented at least 47 cases of aggressions against health workers, with 70% of the attacks being against women. A nurse was reportedly drenched with chlorine while walking on the street. The National Council to Prevent Discrimination (CONAPRED) reported that, from 19 March to 8 May, they received 265 complaints concerning discrimination on the basis of COVID-19 among health workers, including 17 from doctors, eight from nurses and 31 from administrative or support staff.

States have clear human rights obligations to protect health and essential workers in the context of COVID-19, including their right to health; just and favourable conditions of work; freedom of expression and peaceful assembly; freedom from discrimination and violence; and the obligation of all states to provide international cooperation and assistance for the realization of human rights. Protecting health and essential workers’ rights is crucial to ensure a stronger and more rights-respecting response to the pandemic. Health workers are valuable sources of information about the spread and scale of the COVID-19 pandemic and government responses to it. Ensuring health and essential workers are protected is a significant step towards ensuring that everyone is protected.

“When a health worker is provided with adequate personal protective equipment, we will not be scared of attending to any patient, regardless of the symptoms they exhibit, and lives would be saved.”

Health worker, Nigeria

This report is released at a time when the pandemic seems to be waning in some countries and becoming more intense in others. However, the lessons and recommendations contained in this document are universal. Countries who are experiencing the worst of the pandemic right now must urgently implement the recommendations contained in this report to protect the rights of health and essential workers. Countries who may experience it intensely in the future, and are as yet not severely affected, should use the time available to ensure that health systems are prepared and that they have the infrastructure to fully protect the rights of health and essential workers if and when the pandemic hits. And countries who have just seen the worst of the pandemic should prepare themselves for potential second waves, as well as follow up on the concerns raised by health and essential workers to ensure accountability in situations where their rights were not fully protected.

Amnesty International is making a comprehensive set of recommendations to governments across the world to ensure that health and essential workers are adequately protected during the COVID-19 pandemic. These include:

- States should ensure that employers – whether the employer is public or private - provide all health and essential workers with adequate PPE to protect themselves during the COVID-19 pandemic, in line with international standards.
- States should recognise COVID-19 as an occupational disease, and workers who contract COVID-19 as a result of work-related activities should be entitled to cash compensation and medical and other necessary care. This should include all health and essential workers irrespective of the nature of their contract, including workers belonging to groups who have faced structural discrimination.
- Health and essential workers' safety concerns must be listened to and addressed in an appropriate manner. There must be no retaliation against workers for raising concerns or lodging a complaint related to health and safety. Where health and essential workers have faced reprisals or disciplinary action at their workplace for raising health and safety concerns, or have lost their jobs as a result, the action against them should be properly investigated by competent authorities, and where relevant, they should be granted adequate reparations, including the possibility of being reinstated.
- Any attacks or acts of violence against health and essential workers must be promptly investigated in a thorough, independent and impartial manner by state authorities, and perpetrators must be brought to account. In doing so, states should acknowledge that some health and essential workers may be at additional or specific risk due to their multiple and intersecting identities, and this should be factored into the state's response.
- Comprehensive, effective and independent reviews should be carried out regarding states' and other actors' preparedness for and responses to the pandemic. Where there is cause to believe that government agencies did not adequately protect human rights – including the rights of health and essential workers - in the context of the pandemic, states should provide effective and accessible remedies, including through thorough, credible, transparent, independent and impartial investigations into these allegations.
- States should collect and publish data by occupation, including categories of health and other essential workers who have been infected by COVID-19, and how many have died as a result, in order to ensure effective protection in the future. This data should be disaggregated on the basis of prohibited grounds of discrimination, including but not limited to gender, caste, ethnicity, and nationality wherever possible, as well as place of work.

A full list of recommendations can be found at the end of the report.

2. INTRODUCTION

“We are physically and mentally exhausted. Our personal lives are completely upside down, and the main source of our stress is the attitude of the government and the lack of awareness people have about the disease”

Health worker, Pakistan¹



Doctors and health workers of the Young Doctors Association protesting the lack of PPE, resources and working conditions in Pakistan, April/May 2020. © Young Doctors Association

In December 2019, reports of a new illness began to emerge, which was later named COVID-19. By March 2020, the World Health Organization (WHO) had declared COVID-19 to be a pandemic. At the time of writing this report, 11,125,245 people had contracted the illness and 528,204 people had died as a result.² Most countries had imposed some form of restrictions on people’s movement and other

1. Interview with doctor, 22 May 2020, Lahore, Pakistan
2. WHO Coronavirus Disease (COVID-19) Dashboard, <https://covid19.who.int/>

human rights to control the spread of the virus. Several countries are probably yet to see the worst of the pandemic. There is no doubt that the COVID-19 pandemic has had an unprecedented physical, social and economic impact on people all over the world. People have fallen ill, lost family members and loved ones, and had their livelihoods disrupted. The present situation is uncertain, and the future more so, with people experiencing anxiety and serious concerns about what lies ahead.

At this difficult time, health and essential workers have played an extraordinary role in the response to the pandemic. Across countries, they have risked their health, wellbeing and lives, and often worked in very difficult circumstances and with very little support, to ensure that people are able to access the essential services they need, including health care, food and other essential supplies, and emergency public services. Despite this, health and essential workers across the world have faced enormous challenges in doing their jobs, while governments have not adequately protected them. Shortages in personal protective equipment (PPE) in several countries have meant that health and essential workers have often had to perform their jobs without adequate protection and in unsafe environments. In some cases, they have not received fair remuneration and compensation and have often experienced high workloads and increasing anxiety and stress as a result. When they have tried to speak out about these concerns, many have faced repression and other forms of reprisals from the state and from their employers. Health and essential workers have also been subject to physical attacks and have faced stigma due to the jobs they do in several countries, which has made it harder for them to access essential services such as housing.

This report looks at concerns around occupational health and safety, repression and other forms of reprisals, and violence and stigma for health and essential workers. It also flags some broader structural issues in health and social support systems across the world that have exacerbated these challenges and must be urgently addressed as well.

3. METHODOLOGY

Since the start of the COVID-19 pandemic, the challenges faced by health and essential workers have been in sharp focus. Amnesty International has been highlighting the need to protect the rights of health and essential workers in the context of several countries and regions.³ This report is a continuation of that work and attempts to present a broader picture of the challenges that health and essential workers face in their work during the COVID-19 pandemic in countries across the world. This report is based on information from the following sources:

- Amnesty International collected information relating to the rights of health and essential workers in 63 countries and territories across the world,⁴ including 18 in Europe, four in the Middle East and North Africa region, 10 in Asia, 10 in the Americas, and 21 in Africa.
- Issues covered include health and safety in the workplace; reprisals and retaliation for raising concerns around workplace safety and pandemic response more generally; and violence and stigma from state and non-state actors. In some cases, information is based on secondary sources and media reporting, while in others, Amnesty International was able to conduct interviews with health and essential workers and their representatives.
- Amnesty International conducted a thorough literature review of media reports, academic articles, and reporting by unions and other civil society actors on the challenges faced by health and essential workers during the pandemic to track the concerns being raised. Wherever possible, information obtained through the monitoring mentioned above was verified and corroborated through this secondary research.
- Amnesty International spoke with international organizations, experts, and civil society organizations working on similar issues to confirm the information emerging from the monitoring and the literature review. Where relevant, their observations are also reflected in the findings and conclusions.

3. See for example: Amnesty International India, Abandoned At The Frontline: India's Sanitation Workers Seek Immediate Help From The Government Amidst COVID-19, <https://amnesty.org.in/abandoned-at-the-frontline-indias-sanitation-workers-seek-immediate-help-from-the-government-amidst-covid-19/>; Amnesty International, Nigeria: Authorities must protect health workers on the frontline of COVID-19 response, (Index: AFR 44/2264/2020); Amnesty International, The Cost of Curing: Health Workers' rights in the Americas during COVID-19 and beyond, (Index: AMR 01/2311/2020); Amnesty International, COVID-19 and its human rights impact in Indonesia, (Index: ASA 21/2238/2020)

4. Argentina, Austria, Belarus, Brazil, Burkina Faso, Burundi, Cameroon, Chile, Democratic Republic of Congo, Denmark, Egypt, El Salvador, Eritrea, Ethiopia, Finland, France, Ghana, Greece, Guatemala, Guinea, Honduras, Hong Kong, India, Indonesia, Italy, Ivory Coast, Japan, Kuwait, Lesotho, Libya, Malaysia, Mali, Mexico, Moldova, Mongolia, Namibia, Nepal, Nicaragua, Nigeria, Pakistan, Papua New Guinea, Paraguay, Philippines, Poland, Portugal, Republic of Congo, Russia, Sierra Leone, Slovenia, Somalia, South Africa, South Sudan, Spain, Sudan, Sweden, Tajikistan, Togo, Tunisia, Turkey, Ukraine, United Kingdom, USA and Zimbabwe.

- Amnesty International reviewed and collated data related to deaths among health care workers from multiple sources and created a dataset of over 1500 names of health care workers who died of COVID-19 in 79 countries. The data sources included memorial pages dedicated to medical professionals who died of COVID-19 or related causes, such as the one curated by Medscape, lists compiled by national medical associations including Brazil's Federal Nursing Council and Italy's National Federation of Orders of Surgeons and Dentists, and lists and obituaries published in local, regional or national media around the world. To compile the dataset, we worked with a data scientist who extracted data from HTML pages, PDF reports and other documents, processed and cleaned the data by collating multiple sources and eliminating duplicates. The data was then analysed and contextualised using additional information such as overall levels of deaths from COVID-19 and levels of testing for each country. More information about the data collection and processing methodology, including the list of sources and the full dataset can be found here: <https://public.flourish.studio/visualisation/3015800/>

Given the rapidly evolving situation with regards to the COVID-19 pandemic and the significant difficulties in accessing and verifying information during this time including travel restrictions, there are some limitations to the information reflected in this report, and some caution is needed regarding how it should be interpreted.

First, every country is not covered, and nor is every country uniformly covered in terms of depth and spread of information. Monitoring depended on the scale of the pandemic in the country in question, the amount of data being collected and disseminated, ease of access and capacity of Amnesty International staff members in specific locations, and whether health and essential workers and their representative organizations were able to operate freely and share information with Amnesty International. Some countries do not collect or disseminate information on key aspects of health and essential workers' well-being (such as COVID-19 related infections and deaths), while circumstances in other countries make it dangerous for health and essential workers to protest or speak out about the challenges they face. In a number of countries, where information has not been collected, health and essential workers may face similar – or even more severe – threats and challenges. As a result, this report contains a snapshot of information, that in some parts may be anecdotal but is still a powerful reminder of the common risks and challenges health and essential workers face as they do their jobs and highlights the need for further data and research.

Second, information in this report is relevant for the period between January 2020 and June 2020, and the pandemic has affected countries differently over this period. Some countries experienced the most severe phases earlier in the year while others are possibly still to feel the worst impact. The severity of health and essential workers' concerns is linked to the intensity of the pandemic, and this report often documents what it was like for them during the most severe phases. Therefore, certain countries may not feature prominently because they are yet to experience the worst phase, while the situation may have improved in some of the countries mentioned in the report, if the intensity of the pandemic has reduced.

Third, there is no global or uniformly agreed definition for who constitutes a health worker or an essential worker. For the purposes of this report, "health worker" refers to everyone working in the health care sector and involved in the delivery of health care in any capacity, which includes but is not limited to doctors, nurses, hospital cleaners, ambulance drivers, administrative staff at hospitals, and any health and social care workers working in the community or other settings. "Essential worker" refers to anyone who has been working and providing essential public services during the COVID-19 pandemic, including people working in public services (such as emergency response, public transport workers, refuse collectors) as well those working in businesses allowed to remain open during the

COVID-19 pandemic (such as grocery stores and people providing delivery services). In many countries, concerns faced by health workers have received more prominence and there is in general more data available around health workers when compared with essential workers. For this reason, health workers find more mentions in this report. However, Amnesty International emphasises that all persons at an equivalent level of risk - in the workplace and otherwise – are entitled to the same levels of protection. In particular, health and essential workers should have equal access to protection, and therefore, this report refers consistently to both categories of workers.

4. UNSAFE AND UNFAIR WORKING CONDITIONS

The obligation to protect the health and safety of health and essential workers stems from the right to health and the right to the enjoyment of just and favourable conditions of work. The right to health includes “The right to healthy natural and workplace environments”, which includes “preventive measures in respect of occupational accidents and diseases” and “safe and hygienic working conditions”.⁵ The UN Committee on Economic, Social and Cultural Rights’ (ESCR Committee) General Comment 14 notes that “States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data ... States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services”.⁶ This would apply to the working conditions of health workers and essential workers. Moreover, as per Article 7 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), “States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular ... (a) (i) Fair wages and equal remuneration for work of equal value without distinction of any kind ... (b) Safe and healthy working conditions ... (d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay”. Details of what this entails are discussed in more detail in a later chapter of this report.

4.1 DEATHS AND INFECTIONS DUE TO COVID-19

Health workers and many other essential workers often face greater exposure to COVID-19 as a result of their occupations, and may therefore be at greater risk of infection, serious illness, and even death if not adequately protected. There is currently no systematic tracking of how many health and essential workers have contracted COVID-19 and died as a result. However, some estimates exist. According to the International Council of Nurses, “more than 230,000 HCWs [health care workers] have contracted the disease, and more than 600 nurses have now died from the virus”.⁷ According to data collected by Amnesty International as of 5 July 2020, over 3000 health workers have died from COVID-19 and related causes in 79 countries around the world.

5. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000, para 15

6. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, para 36

7. International Council of Nurses, “More than 600 nurses die from COVID-19 worldwide”, 3 June 2020, <https://www.icn.ch/news/more-600-nurses-die-covid-19-worldwide>



Nursing professionals perform an act in honour of the nurses victims of coronavirus (COVID-19) in Brazil amidst the coronavirus pandemic at the Museu da República on May 12, 2020 in Brasilia. © 2020 Getty Images

While a lack of comprehensive data makes definitive conclusions difficult at present, data available from some countries gives cause for concern that protecting the health of health and essential workers has not always been a priority for governments and employers.

Some countries have published some data on the number of health workers who have been confirmed as having COVID-19, which indicate that large numbers of health workers have been affected by COVID-19 in many settings. For example:

- In the **UK**, as of 26 June 2020, 268 deaths involving COVID-19 had been registered among social care workers, and 272 deaths amongst health workers, in England and Wales.⁸
- Weekly bulletins published in **Spain** reported that as of 29 May 2020, health workers made up 24.1% of all confirmed COVID-19 cases and at least 63 had died.⁹
- In **Ukraine**, as of 9 June 2020, the Ministry of Health stated that around 18% of confirmed COVID-19 cases were among health workers.¹⁰
- As of 22 June 2020, the Ministry of Health in **Argentina** stated that medical and non-medical personnel working in health centres accounted for almost 14% of all confirmed COVID-19 cases in the country.¹¹

8. Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020, <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020#deaths-involving-covid-19-among-men-and-women-health-and-social-care-workers>

9. In a press conference on 29 May, the government said 63 health workers had died after contracting COVID-19. However, a government report released on the same day put the number at 52. The report is available here: <https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/Paginas/InformesCOVID-19.aspx>

10. A Tokhmakhchi, "Two thousand doctors are infected with coronavirus. Why can't the medical system protect its own?" Hromadske, 30 April 2020, <https://hromadske.ua/posts/dvi-tisyachi-medikiv-infikovani-koronavirusom-chomu-medichna-sistema-ne-mozhe-zahistiti-svoyih>

11. E Vexler, "Coronavirus in Argentina: amid the claims of health personnel, City and Province modify the distribution of personal protective equipment", *Clarín* 17 April 2020, https://www.clarin.com/sociedad/coronavirus-argentina-medio-reclamos-personal-salud-ciudad-provincia-modifican-distribucion-equipos-proteccion-personal_0_NljkuITD.html

- In **Denmark**, 6% of all tested health personnel – and 8.4% of nurses in hospitals - were reported to have had COVID-19 at the beginning of May, compared with 3.8% of the general population.¹²
- In June, the Ministry of Health in **Brazil** reported that 83,118 cases of health workers with COVID-19 were confirmed, and 189,788 were still waiting for a result.¹³ As of 5 July, there had been 238 COVID-19 related deaths among nursing personnel,¹⁴ and as of 21 May 113 doctors had died.¹⁵
- On 13 May, health authorities in **Mexico** confirmed 36,327 COVID-19 cases and 3,573 deaths in the country. Of these, 8,544 cases and 111 deaths were of health workers. Of the health workers, 41% were nurses, 37% doctors, 19% other medical staff, 2% laboratory workers and 1% were dentists.¹⁶

Again, the top-line figures will not tell the full story. In the UK, a survey by the Office for National Statistics found “elevated rates [of death] among some of the individual health care professions”, including male and female nurses and male nursing auxiliaries and assistants.¹⁷ Similarly, the survey found that social care workers and male health care workers had an elevated rate of death involving COVID-19. Other occupations with raised death rates for men included taxi drivers and chauffeurs, bus and coach drivers, workers in factories, and security guards.¹⁸

Furthermore, these figures are likely to be underestimates, with under-reporting a common feature in some countries, whether due to a lack of testing, counting or transparency. For example:

- In the **USA**, the Centers for Disease Control and Prevention (CDC) has provided several updates on how many health workers have contracted COVID-19 and those who have died. As of 5 July, according to the CDC, 92,572 ‘healthcare personnel’ had contracted COVID-19 and 507 had died as a result.¹⁹ However, the CDC has clarified that of the total number of people surveyed, “healthcare personnel status” was only available for 21.5% of people, and amongst COVID-19 cases within health workers, “death status” was only available for 65.6%.²⁰ In other words, the counting was limited because it was not clear whether all people surveyed were or were not “healthcare personnel” and what their “death status” was. Therefore, it is likely that these figures are under-estimates. Data from the Guardian and Kaiser Health News noted that nearly 600 frontline health workers had died of COVID-19 in the US.²¹

12. “COVID-19 and employees in the social and health services” 6 May 2020, <https://files.ssi.dk/COVID-19-ansatte-social-og-sundhedsvaesenet-uge19-as23>

13. Folha de São Paulo, “Number of coronavirus cases in healthcare professionals more than doubles in a month”, 12 June 2020, <https://www1.folha.uol.com.br/equilibrioesaude/2020/06/numero-de-casos-do-coronavirus-em-profissionais-de-saude-mais-do-que-dobra-em-um-mes.shtml>

14. Federal Nursing Council, observatoriodaenfermagem.cofen.gov.br

15. PEBMED, Covid-19: Brazil surpasses the mark of one hundred doctors killed due to the virus, 27 May 2020, <https://pebmed.com.br/covid-19-brasil-ultrapassa-a-marca-de-cem-medicos-mortos-por-conta-do-virus/>

16. Government of Mexico, Press Conference #COVID19, (2020). Retrieved from <https://www.youtube.com/watch?v=h4pceSA8Xbl>

17. Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020, <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020#deaths-involving-covid-19-among-men-and-women-health-and-social-care-workers>

18. Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020, <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020#deaths-involving-covid-19-among-men-and-women-health-and-social-care-workers>

19. CDC, Cases in the U.S., <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html> [last updated 5 July 2020]

20. CDC, Cases in the U.S., <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

21. “Exclusive: nearly 600 US health workers died of Covid-19 – and the toll is rising”, The Guardian, 6 June 2020, <https://www.theguardian.com/us-news/2020/jun/06/us-health-workers-dying-coronavirus-stats-data>

- In **Russia**, an association of health professionals has collected the names of health workers who have died during the COVID-19 pandemic,²² and a media house who verified their data has said that 186 health care workers had died of COVID-19 in Russia as of 18 May.²³ On 18 June, the head of Roszdravnadzor (Russia's healthcare watchdog) announced that 489 doctors had died due to COVID-19.²⁴ However, a few hours later they retracted this statement, saying "the figures were not official but taken from the Internet".²⁵ Amnesty International has written to the government requesting clarity on these numbers.
- **France** only started recording deaths of health workers at the end of April, with the Director General of Health, Jerome Salomon, having previously described calls to do so as 'a bit macabre'.²⁶ As a result, available information is currently incomplete, but information from 35% of hospitals surveyed has recorded over 30,000 cases and 16 deaths in those locations.²⁷ Once other establishments are surveyed, the national figure is likely to be much higher. Additionally, a survey from CARMF (Caisse Autonome de Retraite des Médecins de France) has counted the deaths of 26 independent doctors who had been working during the pandemic, while SOS Médecins reported that 16% of its health professionals had been infected with COVID-19.²⁸ The impact of COVID-19 on social care workers remain unclear.

According to Amnesty International's monitoring, the countries with the highest numbers of known health worker deaths thus far include the USA (507), Russia (545), UK (540, including 262 social care workers), Brazil (351), Mexico (248), Italy (188), Egypt (111), Iran (91), Ecuador (82), and Spain (63). This data is regularly updated, and the most recent figures are available here: <https://public.flourish.studio/visualisation/3015800/>²⁹

22. Memory List, <https://sites.google.com/view/covid-memory/home>

23. M Litavrin et al, "In Russia, at least 186 physicians died from coronavirus - mortality among them is 16 times higher than in other countries", 19 May 2020, <https://zona.media/article/2020/05/19/martyrology>. On 26 May, the Russian Ministry of Health reported figures of health workers who had died due to COVID-19, and as of Friday, 22 May, there were 101 names on the list. See "The list of deaths due to the coronavirus of doctors, which is maintained by the Ministry of Health, includes 101 people", TACC, 26 May 2020, <https://tass.ru/obschestvo/8567201>

24. Russia revises sharply higher coronavirus death toll among medics, *Reuters*, 18 June 2020, <https://uk.reuters.com/article/uk-health-coronavirus-russia-medics/russia-revises-sharply-higher-coronavirus-death-toll-among-medics-idUKKBN23P1WU>

25. See https://web.telegram.org/#/im?p=@roszdravnadzor_official; Also: "Roszdravnadzor called unofficial data on nearly 500 physicians who died from COVID-19", *Interfax*, 18 June 2020, <https://www.interfax.ru/russia/713731>

26. L Guedj, "Authorities begin to discern contaminated and deceased health professionals, discreetly", *France Inter* 19 May 2020, <https://www.franceinter.fr/societe/les-autorites-commencent-a-recenser-les-professionnels-de-sante-contamines-et-decedes-en-toute-discretion>

27. Infection with the new Coronavirus (SARS-CoV-2), COVID-19, <https://www.santepubliquefrance.fr/maladies-et-traumatismes/maladies-et-infections-respiratoires/infection-a-coronavirus/articles/infection-au-nouveau-coronavirus-sars-cov-2-covid-19-france-et-monde>

28. See L Chereil et al, "Mourners for Covid-19, general practitioners believe they have been betrayed by the state", *France Inter*, 5 June 2020, <https://www.franceinter.fr/endeuilles-par-le-covid-19-des-medecins-generalistes-estiment-avoir-ete-trahis-par-l-etat>; CARMF, "29 doctors who died from COVID-19", 4 May 2020, <http://carmf.fr/actualites/communiqués/2020/covid/cp-med-dcd-covid.pdf>

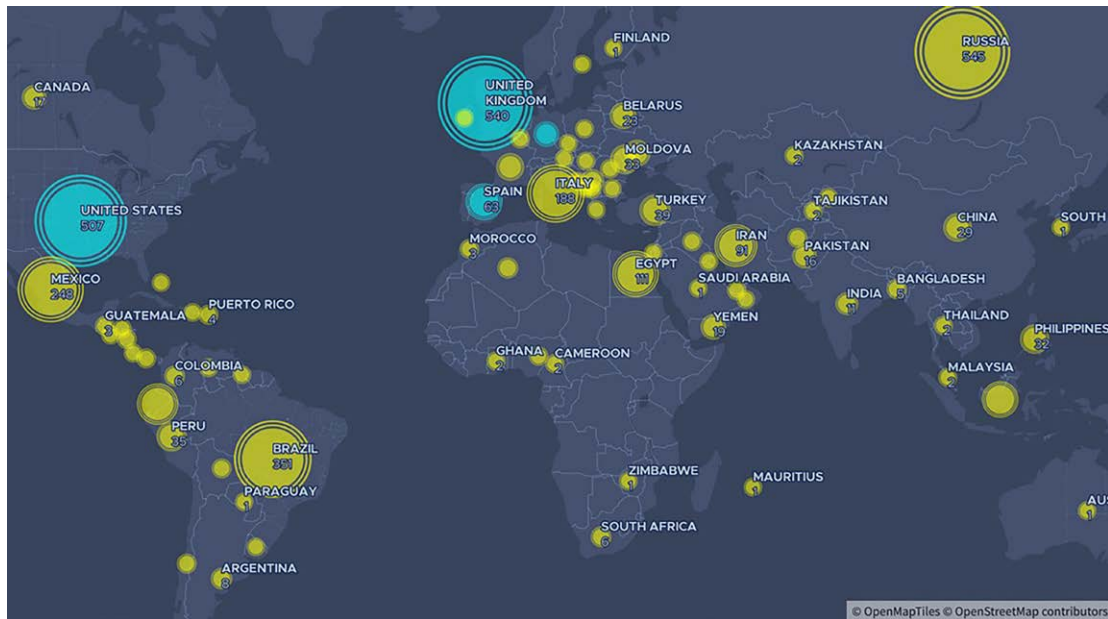
29. Given the lack of official and comprehensive data about COVID-19 related health workers deaths in many countries, this map was compiled using different sources across countries. The data presented here give a snapshot of available information but must be interpreted and compared across countries with caution. First, the understanding of who constitutes a "health worker" is not consistent across all countries, and in many countries, essential workers are not reflected in these statistics at all. Second, the sources of data are not comparable in all countries. Some governments have instituted a reasonably comprehensive tracking of health and essential workers' infections and deaths, and where this is the case, the map uses this data. In other countries, Amnesty International has relied on non-governmental sources, such as civil society monitoring, because government data is either non-existent or inadequate. Finally, even where credible data exists, it is hard to extrapolate why the numbers look the way they do without further analysis. The data can depend, for example, on whether testing for health workers was readily available, and whether states were recording which health and essential worker deaths were related to COVID-19. In some countries, the numbers of COVID-19 related deaths and infections for health and essential workers may be high because the scale of the pandemic was severe. In other countries, this may be high because adequate PPE was not available, or the statistics may only reflect the fact that a greater proportion of health workers were tested as compared to the general population. The overall figure is likely to be a significant underestimate due to under-reporting, while accurate comparisons across countries are difficult due to differences in counting. For example, as mentioned previously, the US figure is based on incomplete data, while France has collected data from just some of its hospitals and health centres. The UK is one of the few countries to count deaths of both health and social care workers. A list of deceased health workers provided by a health association in Russia are contested by the government.

EXPOSED, SILENCED, ATTACKED:

FAILURES TO PROTECT HEALTH AND ESSENTIAL WORKERS DURING THE COVID-19 PANDEMIC

Amnesty International

Health workers deaths due to Covid-19



Data and analysis from some countries is also beginning to show that certain categories of health and essential workers may have been more affected by the pandemic and have experienced higher levels of infection and death.

- Globally, several studies have shown that women form a significantly greater proportion of the health workforce: a 2019 study by the WHO found that women account for 70% of the health and social care workforce.³⁰ More specifically, in **Spain**, for example, 76.5% of the total health worker COVID-19 cases are of women, and women also form a greater proportion of the health workforce than men do.³¹
- In the **UK**, early studies have indicated that BAME health workers (that is, health workers who identify as black, Asian, or minority ethnic), appear to be significantly over-represented in the total number of COVID-19 related health worker deaths, with some reporting that up to 60% of health workers who died identified as BAME.³² Studies also indicate that, in general, people who identify

30. Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce, Human Resources for Health Observer Series No. 24, <https://apps.who.int/iris/bitstream/handle/10665/311322/9789241515467-eng.pdf>

31. See: <https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/Documents/INFORMES/Informes%20COVID-19/COVID-19%20en%20personal%20sanitario%2029%20de%20mayo%20de%202020.pdf>. As per data from the Ministry of Health as of 2018, women represent a majority in the health sector, especially among primary care nurses (78.7%), emergency nurses (71.23%), midwives (93.05% are women), nursing assistants (94.43%), paediatric nurses (73.11%) and administrative staff of health centres (82.44%). They are also in the majority, although to a lesser extent, in primary care (55.9%) and emergency medicine (54.71%). See: <https://pestadistico.inteligenciadegestion.mscbs.es/publicoSNS/comun/Informe.aspx?IdNodo=23646>

32. S March et al, "Six in 10 UK health workers killed by Covid-19 are BAME", *The Guardian*, 25 May 2020, <https://www.theguardian.com/world/2020/may/25/six-in-10-uk-health-workers-killed-by-covid-19-are-bame>; T Cook et al, "Exclusive: deaths of NHS staff from covid-19 analysed", *HSJ*, 22 April 2020, <https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article>. As per data, 79.2% of the NHS workforce identify as 'white' and 20.7% of the workforce identify as 'asian', 'black', 'chinese', 'mixed', or 'other', see "NHS Workforce: Ethnicity Facts and Figures", 6 January 2020, <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#by-ethnicity>

33. Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, June 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

as BAME have been more severely affected by COVID-19.³³ This was the subject of an official investigation which confirmed this trend.³⁴

- In **India**, certain essential jobs are closely associated with caste groups that have faced historic discrimination. For example, sanitation workers (workers involved in cleaning public spaces, including cleaning sewers and toilets and collecting garbage) are also often from the *dalit* community. Sanitation workers in India have been advocating for better workplace protections and working conditions in the context of the COVID-19 pandemic (this will be discussed in more detail later).³⁵ A lack of adequate protection for sanitation workers in these circumstances disproportionately impacts certain caste groups who have been historically marginalised and discriminated against.
- In **Finland**, early data from the City of Helsinki indicated that the Somali-speaking community was disproportionately affected by COVID-19, with 2.4% of the Somali-speaking community reportedly affected, as opposed to a 0.4% incidence rate among the general population. Some analysis has indicated that members of the Somali-speaking community are more likely to be employed as essential workers, which may have contributed to this incidence rate.³⁶

In some of the countries mentioned above, the data clearly raises concern that health and essential workers may have been disproportionately impacted, which must be urgently investigated. The reliability and comparability of data in this area is limited, however, by the different ways that states collect and report information, making definitive conclusions difficult at this stage in the pandemic. Higher prevalence levels of infection amongst health workers could, for example, be due to higher testing rates for these workers than other groups of the population. Furthermore, states define health workers and other essential workers in different ways, and essential workers may not be included in this data.

Methodological challenges are also significant when trying to estimate how many health and essential workers have died of COVID-19 in different countries, and even more so when trying to draw conclusions about the causes of these deaths. In some countries, the numbers of COVID-19 related deaths and infections for health and essential workers may be high because the scale of the pandemic was severe. In other countries, this may be high because adequate PPE was not available. In others, the data may simply not exist either because it is not counted, or it is hidden.

Data on the scale of COVID-19 related infections and deaths of health and essential workers is extremely valuable. It serves as a crucial reminder of the human costs of this pandemic, particularly of those who were on the frontlines, and their families. It is an important tool to understand what risks health and essential workers faced, so health systems and countries can be better prepared in the future. This data can also lead to further enquiries about what caused these particular risks, and how they could be potentially prevented in the future. Ensuring that this data is disaggregated based on prohibited grounds of discrimination, place of work and occupation will allow States to better assess the impact of the pandemic and what specific strategies may be necessary to protect particular groups in the future.

34. Public Health England, Disparities in the risk and outcomes of COVID-19, June 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

35. Amnesty International India, Abandoned At The Frontline: India's Sanitation Workers Seek Immediate Help From The Government Amidst COVID-19, 24 April 2020, <https://amnesty.org.in/abandoned-at-the-frontline-indias-sanitation-workers-seek-immediate-help-from-the-government-amidst-covid-19/>

36. According to a report commissioned by the City of Helsinki ('Getting integrated in the city – a comprehensive picture of residents with a foreign background in Helsinki in 2020'), in 2017, about half of employed women with a Somali background were working in health care and social services, and nearly 40% of employed men with a Somali background were working in transportation and logistics. However, other reasons for the difference in rates of impact include lack of information on the epidemic in Somali language and the fact that many members of the Somali-speaking community live in smaller housing.

4.2 LACK OF ADEQUATE PERSONAL PROTECTIVE EQUIPMENT (PPE)

Shortages of PPE for health and essential workers were reported in almost all of the 63 countries and territories from which Amnesty International collected information. In at least 31 of these countries, Amnesty International researchers recorded reports of strikes, threatened strikes, or protests, by health and essential workers as a result.³⁷ For the purpose of this report, PPE includes all equipment and materials that health and essential workers are advised to use to protect themselves from COVID-19, including gloves, medical/surgical face masks, goggles, face shields, gowns, respirators, and aprons.³⁸ While a lot of the data in this section pertains to the working conditions of health workers, and not specifically essential workers, this is only because health workers' concerns have been raised more prominently of late. Shortages of PPE likely affect health and essential workers equally. Amnesty International emphasizes at the outset that the standards of protection for health and essential workers at equivalent levels of risk should be the same.



An emergency nurse (ICU) dressed in garbage bags and a protective mask loaned altruistically by a private company at the emergency entrance door of the San Jorge hospital on March 31, 2020 in Huesca, Spain. © 2020 Getty Images

“We go every day and ask questions to people whether they have any symptoms. But we are totally exposed without any mask, gloves etc. The shawl I tie across my face is just something for my solace. It won’t really protect me, I know.”

ASHA worker (community health worker), India³⁹

37. See for example: L Togiba, “Papua New Guinea is not prepared’: 4,000 nurses to strike over Covid-19 readiness” *The Guardian*, 30 March 2020, <https://www.theguardian.com/world/2020/mar/30/papua-new-guinea-is-not-prepared-4000-nurses-to-strike-over-covid-19-readiness>; “Nurses in South Africa protest demanding PPE, income tax breaks and Danger Allowance”, *Peoples Dispatch*, 1 May 2020, <https://peoplesdispatch.org/2020/05/01/nurses-in-south-africa-protest-demanding-ppe-income-tax-breaks-and-danger-allowance/>

38. WHO, Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages, *Interim Guidance*, 6 April 2020, [https://www.who.int/publications/item/rational-use-of-personal-protective-equipment-for-coronavirus-disease-\(covid-19\)-and-considerations-during-severe-shortages](https://www.who.int/publications/item/rational-use-of-personal-protective-equipment-for-coronavirus-disease-(covid-19)-and-considerations-during-severe-shortages)

39. Interview with ASHA worker, India, April-May 2020

Public Services International (PSI), a global union federation of 700 trade unions and 30 million workers from around the world, published a survey on 11 May 2020, conducted with their members on the challenges health and essential workers faced during the COVID-19 pandemic. The results are based on responses from 62 countries. Only 23.8% of the unions who responded reported that health workers had been issued with “full and replenished PPE” (57% said they had not been) and only 14.1% of unions who responded reported that workers delivering public services had been issued with adequate PPE (64.1% reported they had not).⁴⁰ There were significant variations at the regional level. For example, in the Inter-Americas, 69.7% of respondents said health workers did not have adequate PPE and 76.1% said workers delivering public services who could come into contact with infected people did not have adequate PPE.⁴¹ In Asia, the equivalent figures were 50% and 51.4% respectively.⁴² The International Trade Union Confederation (ITUC) conducted a similar study amongst their members. According to the study, published on 28 April 2020, “shortages of personal protective equipment (PPE) for health and care workers is a serious issue in the majority of countries”. Around 51% of countries said that “PPE supplies are sometimes, rarely or never adequate”.⁴³

Health and essential workers have had to rely on a variety of means to protect themselves in these circumstances, which put their health and safety at risk. In some countries, health workers reported having to procure PPE and pay for it themselves, since this was not being provided to them. Others have reported having to improvise and re-purpose items, such as garbage bags and raincoats, in an attempt to protect themselves. A doctor working in **Mexico** City told Amnesty International, “Each of us doctors, we had to invest approximately 12% of our monthly wage to buy proper protective gowns, face shields, glasses and goggles.”⁴⁴

The British Medical Association (BMA) carried out a survey with over 16,000 doctors in the **UK** on the question of adequate PPE in April 2020. About 48% of the respondents, which included doctors in the health and social care sector, reported buying PPE for their own use, or that of their department, or using donated PPE, due to the lack of supplies where they worked and 65% of doctors said they felt either “partly or not at all protected”.⁴⁵ In a survey with health workers in **Sweden** by the union *Kommunal*, 42% of home care workers said that there had been situations where they had to work without proper PPE, 84% were worried over the lack of PPE and 48% reported shortages of PPE.⁴⁶ In the US, National Nurses United (NNU) conducted a survey of nearly 23,000 nurses and found that 87% of respondents reported having to reuse a single-use disposable respirator or mask with a COVID-19 patient; 27% of nurses providing care to confirmed COVID-19 patients reported having been exposed without the appropriate PPE and having worked within 14 days of exposure; and 84% of nurses said they had not yet been tested.⁴⁷

40. PSI, COVID-19 Union Response Survey, Global Narrative Summary, 11 May 2020, https://pop-umbrella.s3.amazonaws.com/uploads/3abccd99c-219b-4b9e-af1e-fa3ac2c398b7_COVIDSurvey_GlobalSummaryIntro.pdf?key=

41. PSI, COVID-19 Response – Union Survey Results [Inter-America summary], https://data.surveymizmo.com/r/310559_5eb95355d438c6.40111487

42. PSI, COVID-19 Response – Union Survey Results [Asia-Pacific summary], https://data.surveymizmo.com/r/310559_5eb40d60a27e33.72816889

43. ITUC Global COVID-19 Survey – Key findings, https://www.ituc-csi.org/IMG/pdf/200428_ituc_covid-19_globalsurveyreport_en.pdf

44. Interview with doctor, Mexico City, Mexico, 24 April 2020

45. BMA survey reveals almost half of doctors have relied upon donated or self-bought PPE and two thirds still don't feel fully protected, 3 May 2020, <https://www.bma.org.uk/news-and-opinion/bma-survey-reveals-almost-half-of-doctors-have-relied-upon-donated-or-self-bought-ppe-and-two-thirds-still-don-t-feel-fully-protected>

46. Kommunal, “Quick survey on protective equipment”, Week 14: 1-2, April 2020

47. National Nurses United, New survey of nurses provides frontline proof of widespread employer, government disregard for nurse and patient safety, mainly through lack of optimal PPE, 20 May 2020, <https://www.nationalnursesunited.org/press/new-survey-results>

A doctor in **Nigeria** told Amnesty International, “Surgical masks are not adequately available in the hospital where I work. Authorities contracted tailors to sew unsafe masks with local fabrics. Doctors and nurses had to protest before they were given N95 masks.⁴⁸ These masks are not adequately available. We have to wash the masks for repeated usage. Health workers are in danger. We work under deplorable conditions.”⁴⁹

A health worker in **South Sudan**, which recorded its first case of COVID-19 on 5 April, told Amnesty International that, “last month in May there were around 4000 [units of] PPE. But perhaps half or three-quarters have been used by staff on the frontline and also used by people spraying surfaces and by burial teams. Four thousand is not what we expect, we need at least 10,000 but the government is financially constrained and reliant on donations.”⁵⁰

Surveys in **Finland**, including by the Finnish Nurses Association found that health workers in Finland were sometimes using raincoats instead of disposable gowns and were sometimes instructed to craft facemasks from tissue paper.⁵¹

Health and essential workers have also approached courts or other administrative agencies for relief regarding lack of adequate PPE. Amnesty International is aware of planned, on-going or completed litigation or equivalent proceedings before administrative bodies in at least **the UK, South Africa, Sweden, India, Zimbabwe, Pakistan, Spain, and France** on this issue. In some instances, the courts have ruled in their favour. For example, after being approached by health workers’ unions, the Supreme Court in Spain asked the Ministry of Health to “adopt all the measures at its disposal to achieve the best distribution of the means of protection for health personnel” and to inform the Court of the measures adopted to this end every 15 days.⁵²

However, a petition at the Lahore High Court in **Pakistan**, asking the Court to direct the government to provide “Personal Protective Equipment (PPE) Kits to all the health professionals performing their duties to combat COVID-19” (amongst other things) ruled against the health workers and dismissed their claims.⁵³ In addition, the Court criticised the petitioners saying, “the instant writ petition on the face of it appears to be a mala fide move and an attempt to get easy social media projection for no solid and sound basis ... Consequently, the [petition] is dismissed with costs ... [I]t is observed that if the departmental authority considers that the conduct of the petitioners is against the norms of civil service, they have violated the relevant law or by moving such writ petition they have tried to bring bad name to the institution, the authority will be at liberty to proceed against them”.

There are many reasons why health and essential workers across the world have been finding it hard to access PPE, not least the fact that there is a genuine global shortage due to a massive simultaneous increase in demand. However, policies in some countries have made it harder for health and essential workers to access the necessary protection. In **Nicaragua**, for example, at the start of the pandemic

48. There have been several protests on this issue in Nigeria, see for example: Nigerian doctors strike over lack of PPE, welfare concerns, *Al Jazeera*, 15 June 2020, <https://www.aljazeera.com/news/2020/06/nigerian-doctors-strike-lack-ppe-welfare-concerns-200615084342885.html>; Nigerian Doctors End Strike as Virus Cases Spike, VOA, 21 June 2020, <https://www.voanews.com/africa/nigerian-doctors-end-strike-virus-cases-spike>

49. Interview with doctor, 27 April 2020 [on the telephone]

50. Interview with health worker, South Sudan, 11 June 2020.

51. See for example: “Nurses instructed to protect themselves from raincoat and kitchen towels - Corona survey reveals barren everyday life”, 17 April 2020, <https://sairaanhoitajat.fi/sairaanhoitajia-ohjeistettu-suojautumaan-sadetakkiin-ja-talouspaperiin-koronakysely-paljastaa-karun-arjen/>; “The shortage of protective equipment continues - now in short protective jackets”, 22 April 2020, <https://www.tehy.fi/fi/mediatiedote/tehyn-kysely-pula-suojavarusteista-jatkuu-nyt-vahissa-suojatakit>

52. <http://www.poderjudicial.es/cgpj/es/Poder-Judicial/Tribunal-Supremo/Sala-de-prensa/Notas-de-prensa/El-Tribunal-Supremo-requiere-a-Sanidad--todas-las-medidas-a-su-alcance--para-distribuir-medios-de-proteccion-al-personal-sanitario>

53. Court order on file with Amnesty International

when the government was trying to understate the risk of COVID-19 in the country, it prohibited health workers from using the necessary PPE.⁵⁴

The lack of available data in many countries has made it difficult to know the extent of PPE shortages, and there still seems to be no global estimate of how much is needed to adequately cover all health and essential workers. Early on in the pandemic, the WHO had warned that “shortages [of PPE] are leaving doctors, nurses and other frontline workers dangerously ill-equipped to care for COVID-19 patients, due to limited access to supplies such as gloves, medical masks, respirators, goggles, face shields, gowns, and aprons”, and estimated that the manufacture of PPE needed to be increased by 40% to meet rising demand.⁵⁵

National estimates provide some indication of the extent of PPE shortages. In the **USA**, GetUsPPE, a web-based platform, published data in April 2020 based on the experience of 632 health care facilities in the country. According to their data, the majority of surveyed institutions had less than two weeks of PPE supply remaining. At the time, 36% had no remaining supply of face shields, 22% had no N95 respirators, and 20% had no gowns.⁵⁶ In May 2020, **Pakistan’s** National Command and Operation Centre said there was a shortage of 19,960 disposable gloves, 1.6 million latex gloves, 963,638 goggles, 84,327 face shields, 166,633 disposable caps, 178,323 shoe covers, 13,501 gum boots and 5 million surgical masks.⁵⁷ In **Russia**, the newspaper Vedomosti assessed that only 26% of masks, 27% of respirators, 17% of gloves and 30% of protective suits necessary were available as of 1 May.⁵⁸

Trade restrictions may have exacerbated the situation for some countries struggling to purchase PPE on the international market. Since the start of the pandemic, several countries have changed their import and export regulations around essential commodities, which include PPE. The World Trade Organization (WTO) has tracked the trade measures states have introduced in the context of COVID-19.⁵⁹ According to their data, as of 5 June 2020, 56 countries and two trade blocs (the **European Union** and the **Eurasian Economic Union**) had put in place measures to either ban or to restrict the export of some, or all, forms of PPE or the raw materials to produce PPE. For example, **Colombia** and **Bangladesh** put in place temporary export bans on some types of PPE. Several countries had also liberalized import rules for the same products, including by reducing tariffs and increasing import quotas. States may have valid reasons for the protectionism described above not least because of the need to ensure that there is sufficient PPE for health and essential workers within their territory. However, there is no doubt that these measures risk exacerbating shortages in countries that do not produce PPE and do not have adequate stocks of PPE currently, and are therefore dependent on imports. The ESCR Committee also noted that “States parties have extraterritorial obligations related to global efforts to combat COVID-19. In particular, developed States should avoid taking decisions, such as imposing limits on the export of medical equipment, that result in obstructing access to vital equipment for the world’s poorest victims of the pandemic”.⁶⁰

54. Amnesty International, The Cost of Curing: Health workers’ rights in the Americas during COVID-19 and beyond, (Index: AMR 01/2311/2020)

55. WHO, Shortage of personal protective equipment endangering health workers worldwide, 3 March 2020, <https://www.who.int/news-room/detail/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide>

56. For more details, see: <https://getusppe.org/>

57. “Government predicts surge”, *Dawn*, 1 May 2020, https://epaper.dawn.com/print-textview.php?StoryImage=01_05_2020_001_009

58. A Sokolov, “Why in Russia there are not enough means of protection against a coronavirus”, *Vedomosti* 1 May 2020, <https://www.vedomosti.ru/society/articles/2020/05/01/829484-ne-hvataet-sredstv-zaschiti>

59. WTO, COVID-19: Trade and trade-related measures, https://www.wto.org/english/tratop_e/covid19_e/trade_related_goods_measure_e.htm

60. Committee on Economic, Social and Cultural Rights, Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, E/C.12/2020/1, 17 April 2020, para 20, <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1AVC1NkPsgUedPIF1vfPMKXidSV%2fGyVFSAvr6nizxSIX6zd%2bu5KD26NraabijKaWMnkFhhMb4MahybE5I%2foU5sQSh6PCbcepqzI0iCYklyq>

4.3 WORKLOAD AND MENTAL HEALTH CONCERNS

“In terms of what it's like at the moment, every day is like running on a treadmill with the speed set on high and you trying to keep pace, everyone is tired and anxious. As ICU [intensive care unit] nurses we've gone from having one patient to having 3-5. We've got amazing colleagues from other parts of the hospital coming to help us, but they're anxious being in this environment and need a lot of support and guidance that we can't give. It's emotionally exhausting; I've heard a son say goodbye to his mother over the phone, admitted a nurse from one of the wards and held her hand as she was put to sleep to be put on the ventilator and comforted a woman who lost her husband at the age of 40 leaving her to bring up two kids alone. I've cried a lot.”

Nurse, UK⁶¹

In several countries, health and essential workers have experienced an increase in their workload, often in contexts where workloads were already high to start with. It is important to acknowledge the toll that increased working hours and changes in terms of employment (such as when annual leave may be taken) have on the levels of tiredness, stress and anxiety these workers face at this difficult time. Sometimes, this has happened through the adoption of legal measures that revise their working hours and other terms and conditions, and at other times, it has happened simply because the pace of work has accelerated so much more due to the pandemic. Amnesty International noted examples of countries where formal measures to extend health workers' working hours or modify their terms of service have been passed.⁶²

With an increase in patients, health workers report that their workloads have increased significantly. In some settings – such as in intensive care units – the nature of the work has also become more taxing. A health worker in **Paraguay** similarly told Amnesty International, “Before COVID-19, we used to have breaks. But with COVID, it's not possible to have breaks [at work]”.⁶³ A health worker in **South Africa** explained the range of concerns they had, saying “The big issue for me is how tired we all are rushing from one patient to the next, which results in many of us accidentally touching our faces and exposing ourselves to the virus. We also sweat a lot and the visor steams up. I have been off work with COVID-19 and I am a locum doctor, which means I am only paid when I work, so I'm feeling even more stressed than before”.⁶⁴ In **Egypt**, a representative of the Doctors Syndicate (a union of doctors) described their

61. Interview with health worker, England, 14 April 2020 [on the telephone]

62. For example, in **Finland**, under the Emergency Powers Act, the government can introduce the “obligation to work in the healthcare sector” and has done so through a decree. Under this decree, “A person who is covered by the obligation to work in the healthcare sector and has been issued with an order to work must carry out necessary work in the healthcare sector. A work order may be issued for a maximum of two weeks at a time, and it may be renewed once”. No work orders were however issued under this decree during its validity 19 March - 13 May. Another decree under the Emergency Powers Act enabled health care worker employers to extend resignation periods, postpone or freeze annual leaves and order overtime work. Employers have commonly utilized this to modify terms of service. Similarly, in **Turkey**, a decree was issued that limited the ability of health workers to resign, saying “For three months following this decree, healthcare workers in the private or public sector who are already working or appointed in any healthcare institutions are not allowed to leave their jobs until a second announcement within the scope of the pandemic. This decision is taken to fight effectively against the pandemic and not to disrupt the healthcare service”. Copy on file with Amnesty International. It is permissible to officially revise health workers' working conditions to some extent during a pandemic. Article 2 of the Forced Labour Convention excludes “any work or service exacted in cases of emergency, that is to say, in the event of war or of a calamity or threatened calamity, such as fire, flood, famine, earthquake, violent epidemic or epizootic diseases, invasion by animal, insect or vegetable pests, and in general any circumstance that would endanger the existence or the well-being of the whole or part of the population” from the definition of forced or compulsory labour. As per the 2014 protocol to the Forced Labour Convention, 1930, “The measures taken to apply the provisions of this Protocol and of the Convention shall be determined by national laws or regulations or by the competent authority, after consultation with the organizations of employers and workers concerned”. Amnesty International has not analysed the specific circumstances in which different countries introduced official changes to health workers' working conditions. However, it is crucial that this is done after consultation with the organizations of employers and workers concerned.

63. Interview with health worker, Paraguay, 29 April 2020 [on the telephone]

64. Interview with health worker, Western Cape, South Africa, 10 June 2020 [on the telephone]

working hours to Amnesty International: "Some doctors are working for up to 14 hours in their full PPE kit and without breaks, causing severe fatigue and poor concentration which also affect their ability to protect themselves and use the PPE properly".⁶⁵

In **South Sudan**, which only has one testing lab to serve the country and one mobile testing lab along the southern border,⁶⁶ media report that lab technicians are working up to 16 hours a day to work through the backlog of 5000 samples.⁶⁷ There are related pressures in their personal lives as well. An ASHA worker (community health worker) in **India** told Amnesty International, "I have been sleeping on the veranda outside at night. I have a two-year old child, I am terrified about her being infected."⁶⁸ Furthermore, increased workloads at work may often have been matched with increased workloads at home, such as increased care responsibilities, especially because schools and creches were closed during this period, and health and essential workers may not have been able to access support from others (such as help with cleaning and cooking) as they previously had.

Increased workloads, and the possible increase in work related anxiety and stress, can have adverse consequences on the mental health of health workers. Two surveys of health workers in **Portugal** published in April 2020 following the onset of the COVID-19 pandemic noted that almost 75% of health professionals surveyed considered their levels of anxiety as "high" or "very high" and 14.6% reported having moderate or significant levels of depression.⁶⁹ Another study in Portugal found that the nurses surveyed felt a total of 40% increase in their anxiety levels during this period, likely linked to increased working hours.⁷⁰ 57% of nurses classified their sleep as "bad" or "very bad", and 48% of nurses classified their quality of life as "bad" or "very bad". Only 1.4% of nurses interviewed had sought mental health support.⁷¹

A recent paper in the British Medical Journal also noted that "healthcare workers in **China** reported depression (in 50.3%), anxiety (44.6%), and insomnia (34.0%)".⁷² A study on frontline and second line health workers in **Italy** found "a substantial proportion of mental health issues, particularly among young women and frontline HCWs [health care workers]".⁷³ Data from other pandemics and epidemics support this.⁷⁴

Some countries - not all - have been taking active measures to increase staffing levels for the pandemic response. These include measures to hire more health workers and invite volunteers to work in the public health system for short periods of time.⁷⁵ However, a broader approach is essential to ensure that health and essential workers have the psychosocial support they need in the workplace. The WHO has published guidance on mental health and psychosocial considerations during the

65. Interview with health worker, Egypt, 10 June 2020 [on the telephone]

66. Ministry of Health of the Republic of South Sudan, COVID-19 Weekly Situation Report 22-28 June 2020. On file with Amnesty International.

67. Maura Ajak and Cara Anna "Virus outbreak could spin 'out of control' in South Sudan", *Associated Press*, 22 June 2020, <https://apnews.com/265a7d7cbb6eb6ec29f4bcb1c69e739d>. Interview with health workers, South Sudan, 11 June 2020.

68. Interview with ASHA worker, India, April-May 2020

69. Universidade Nova de Lisboa, Results of Questionnaire 2: Risks for Health Professionals go well beyond the virus, <https://barometro-covid-19.ensp.unl.pt/resultados-do-questionario-2-os-riscos-para-os-profissionais-de-saude-vaio-muito-para-alem-do-virus/>

70. Cintesis, Cintesis Study Reveals: COVID-19 is Affecting Nurses' Mental Health, <http://cintesis.eu/en/cintesis-study-reveals-covid-19-is-affecting-nurses-mental-health/>

71. Cintesis, Cintesis Study Reveals: COVID-19 is Affecting Nurses' Mental Health.

72. J Gold, "Covid-19: adverse mental health outcomes for healthcare workers", *British Medical Journal*, 369, 2020, <https://www.bmj.com/content/369/bmj.m1815>

73. R Rossi et al, « Mental Health Outcomes Among Frontline and Second-Line Health Care Workers During the Coronavirus Disease 2019 (COVID-19) Pandemic in Italy », 3(5) *JAMA Network Open*, 2020 <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766378>

74. S Dutta, "Supporting mental health and resilience in frontline COVID-19 (coronavirus) health care workers", *World Bank Blogs*, 28 May 2020, <https://blogs.worldbank.org/health/supporting-mental-health-and-resilience-frontline-covid-19-coronavirus-health-care-workers>

75. Examples include Greece and the UK.

COVID-19 outbreak, with specific observations on the needs of health workers. This included several practical recommendations for managers of health care facilities, including ensuring that good quality communication and accurate information updates are provided to all staff; rotating workers from higher-stress to lower-stress functions; partnering inexperienced workers with their more experienced colleagues; initiating, encouraging and monitoring work breaks; implementing flexible schedules for workers who are directly impacted or have a family member affected by a stressful event; and ensuring that staff are aware of where and how they can access mental health and psychosocial support services and facilitate access to such services.⁷⁶

4.4 PAY AND COMPENSATION

As health workers face increased workloads and additional occupational risks, concerns have been raised in several countries that they are not being paid fair wages and are not being compensated in cases of occupational illness or even death. In many contexts, this builds on longstanding and broader issues of inadequate pay and challenging working conditions, especially for certain workers. For example, according to the WHO, there is an average gender pay gap of around 28% in the health workforce.⁷⁷

At the start of the crisis, at least one provincial government in **Pakistan** reduced health worker wages (and the wages of some other public sector workers) by 10% to support a government-led COVID-19 fund.⁷⁸ According to reports, in **Indonesia**, the Secretary of the Legal Aid Agency of the Indonesian Nurses Association said that there had been 330 reports that nurses in government-owned or private-owned hospitals experienced pay cuts and did not receive any holiday bonus, as of 25 May 2020. 65% of them were temporary workers. In **South Sudan** doctors on the government's payroll have not received salaries since February and do not receive welfare packages and medical cover. Doctors went on strike for one day after which the government offered them the equivalent of USD 40 in local currency as a lump sum to cover part of the salary arrears. "Doctors refused saying it was not what they are supposed to get. The government offered SSP 10,000 last month. Then, earlier this month [June] some were threatened: if you don't take this month, your contract will be terminated," a doctor told Amnesty International.⁷⁹

In **Guatemala**, the government set up a specific hospital to handle COVID-19 cases and hired additional health workers on temporary contracts to work at the facility. Amnesty International spoke with one staff member working at this hospital in early May.⁸⁰ They had been working there for 40 days at the time and had not been paid at all for the work they were doing. Representatives of the Office of the Human Rights Ombudsperson of Guatemala verified this, saying half the doctors at the facility did not have formal contracts, and none of them had been paid.⁸¹

76. WHO, Mental health and psychosocial considerations during the COVID-19 outbreak, 18 March 2020, https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af_2

77. M Boniol et al, "Gender equity in the health workforce: Analysis of 104 countries", WHO Health Workforce Working paper 1, March 2019, p 3 <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?sequence=1&isAllowed=y>

78. M Bhatti, "Doctors feel wronged as govt deducts 10pc of their salaries for COVID-19 fund", *The News*, 4 April 2020, <https://www.thenews.com.pk/print/639038-doctors-feel-wronged-as-govt-deducts-10pc-of-their-salaries-for-covid-19-fund>

79. Interview with health workers, South Sudan, 11 June 2020. See also P Akol, "One health-care worker dies of COVID-19, first front-line fatality in S. Sudan", *Eye Radio*, 29 May 2020, <https://eyeradio.org/one-health-care-worker-dies-of-covid-19-first-front-line-fatality-in-s-sudan>; M Ajak and C Anna "Virus outbreak could spin 'out of control' in South Sudan", *Associated Press*, 22 June 2020, <https://apnews.com/m/265a7d7cbb6eb6ec29f4bcb1c69e739d>

80. Interview with health worker, 12 to 14 May 2020 [on the telephone]

81. Interview with inspector from the Human Rights Ombudsman's Office of Guatemala (Procuraduría para los Derechos Humanos – PDH), Guatemala, 13 May 2020



HOSPITAL FACILITIES AND CLEANING STAFF FIRED AND NOT PAID IN GUATEMALA⁸²

On 21 March, the Government of Guatemala opened a temporary hospital in the “Parque de la Industria” [Industrial Park] in Guatemala City to receive and treat patients with COVID-19, with an initial capacity of 319 beds. At the beginning of May, medical staff publicly denounced the lack of contracts, salaries and safe working conditions at the hospital. According to information reported in the press based on information from the Public Accounting Office, this hospital had used less than 2% of the public budget that was assigned to it by the Congress, due to a lack of operative capacity and personnel to be able to carry out the functions of the hospital.

On 5 June, 46 facilities and cleaning staff working at this hospital were fired. The only reason for dismissal given by the Ministry of Health is that administrative requirements meant they needed to present a high school or university degree to keep their job. Many of these workers only have a basic education and did not have these papers. Furthermore, they had not been paid since they began work on 24 March (just as several other health workers at the hospital). They have also not been given any unemployment compensation. Amnesty International has called on the Minister of Public Health and Social Assistance to protect the 46 staff fired on 5 June, by urgently paying them their due salaries and carrying out an independent investigation on the circumstances of their termination.

Even where they are being paid according to their contracts, health and essential workers have raised concerns about how much they are paid, noting that their remuneration is low or does not adequately account for the additional tasks they now have or the risks they face in their jobs during a pandemic. One ASHA worker (community health worker) in **India** told Amnesty International, “On regular months, besides the INR 3000 (approximately USD 40) we get, we earn extra by doing other work like delivery [labour] assistance and vaccination. But now because we are only involved in the COVID-19 [response], we are not able to go for such work which is greatly affecting our already little income.”⁸³ Her colleague added, “What will we get out of this? For a paltry amount of INR 3000, we are putting the whole family in danger. My husband blames me every day”.⁸⁴ These amounts are lower than the minimum wage in many states in India.

In **Egypt**, the Ministry of Health promised doctors a remuneration of EGP 20,000 (approximately USD 1200 per month) if they worked with COVID-19 cases for 14 days and quarantined themselves for another 14 days. However, most doctors found themselves getting paid about a quarter of the promised amount (around USD 300 per month). Prior to the outbreak of the pandemic, many doctors supplemented their incomes by working in private clinics and hospitals.⁸⁵ According to an official letter seen by Amnesty International, the Ministry of Health required them to stop working in private clinics

82. Amnesty International, Guatemala: COVID-19 Hospital Workers fired; not paid, (Index: AMR 34/2465/2020)

83. Interview with ASHA worker, India, April-May 2020

84. Interview with ASHA worker, India, April-May 2020. ASHA (Accredited Social Health Activist) workers are community health workers are women who are “trained to work as an interface between the community and the public health system” in India. In general, they perform a range of health functions, listed here: <https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=150&lid=226>. ASHA workers are considered volunteers and do not get a fixed salary. Instead, they are paid based on “incentives” depending on the tasks they perform, in addition to a minimum amount of INR 2000 to INR 4000 per month depending on the state they work in. The pandemic has expanded their tasks, and the additional remuneration offered is INR 1000. This is cumulatively lower than the minimum wage in many states, see for details: https://www.indiabudget.gov.in/budget2019-20/economicsurvey/doc/vol1chapter/echap11_Vol1.pdf

85. Interview with health worker, Egypt, 9 June 2020 [on the telephone]

and hospitals and join the "COVID-19 battle", which could significantly impact their earnings and their livelihoods.

Many governments have introduced benefits or specific measures of support for health workers during the COVID-19 pandemic, to supplement their usual income. Amnesty International noted reports of this being the case in at least 29 countries. While this is a welcome move, workers have raised concerns in some countries that they have not been actually paid these benefits, or that these benefits do not extend to categories of health and essential workers who are at equal or additional risk during the COVID-19 pandemic.

In **Ghana**, for example, the government introduced certain benefits for "frontline workers",⁸⁶ such as a salary increase, free transport and an exemption from paying taxes for three months. However, certain workers involved in the COVID-19 response were not covered, including workers involved in the disinfection, isolation and burial of the bodies of persons who died because of COVID-19.⁸⁷ In **India**, the government introduced the Pradhan Mantri Garib Kalyan Package (the Insurance Scheme for Health Workers Fighting COVID-19) which provides for COVID-19 related death insurance of INR 50 lakh (approximately USD 66,150) for 90 days starting from 30 March 2020 to health care workers, including sanitation staff working at hospitals.⁸⁸ The scheme, however, does not clarify whether it extends to contract workers in hospitals. It also leaves out any benefits for those who collect solid waste from cities and towns, including quarantine areas.⁸⁹ In the **UK**, porters, cleaners and social care staff were initially left out of a scheme under which families of health workers who died of COVID-19 were granted indefinite leave to remain in the UK (the equivalent of residency) free of charge. This was later amended to include them.⁹⁰

COVID-19: AN OCCUPATIONAL ILLNESS

A related issue is linked to access to compensation if health and essential workers become sick or die as a result of contracting COVID-19 in the workplace. The ILO Employment Injury Benefits Recommendation, 1964 understands an occupational disease to be a "disease known to arise out of the exposure to substances or dangerous conditions in processes, trades or occupations as occupational diseases". It further states that "there should be a presumption of the occupational origin of such diseases where the employee (a) was exposed for at least a specified period; and (b)

86. Government of Ghana defined "frontline workers" as doctors, nurses and other health workers who have direct contact with COVID 19 patients

87. K Darko, "Environmental health workers unhappy with exclusion from Covid-19 stimulus package", *MyJoy Online*, 11 May 2020, <https://www.myjoyonline.com/news/national/environmental-health-workers-unhappy-with-exclusion-from-covid-19-stimulus-package/>

88. Pradhan Mantri Garib Kalyan Package: Insurance Scheme for Health Workers Fighting COVID-19, FAQs, <https://www.mohfw.gov.in/pdf/FAQPradhanMantriGaribKalyanPackageInsuranceSchemeForHealthWorkersFightingCOVID19.pdf>

89. Amnesty International India, Abandoned At The Frontline: India's Sanitation Workers Seek Immediate Help From The Government Amidst COVID-19, 24 April 2020, <https://amnesty.org.in/abandoned-at-the-frontline-indias-sanitation-workers-seek-immediate-help-from-the-government-amidst-covid-19/>

90. A Woodcock, "Coronavirus: Bereaved families of migrant NHS cleaners and porters locked out of leave-to-remain scheme", *The Independent*, 19 May 2020 <https://www.independent.co.uk/news/uk/politics/coronavirus-nhs-cleaners-leave-to-remain-scheme-home-office-a9523111.html#gsc.tab=0>; Coronavirus (COVID-19): bereavement scheme for family members of NHS and health and social care workers, 20 May 2020, <https://www.gov.uk/guidance/coronavirus-covid-19-bereavement-scheme-for-family-members-of-nhs-and-health-and-social-care-workers>

91. ILO, ILO Standards and COVID-19 (coronavirus), 29 May 2020, https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---normes/documents/genericdocument/wcms_739937.pdf

92. For details of which countries have done so, see: https://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_ent/documents/publication/wcms_741360.pdf

93. See for example, "Council of Global Unions Statement on Recognition of COVID-19 as an Occupational Disease", 28 April 2020, https://www.ituc-csi.org/IMG/pdf/cgu_statement_iwmd2020_en.pdf

has developed symptoms of the disease within a specified period following termination of the last employment involving exposure”. If COVID-19 is recognised as an occupational illness, health and essential workers who have contracted COVID-19 during their work would have access to a range of benefits and entitlements, including adequate medical care, cash benefits and compensation to the extent that they are incapacitated from working, compensation in case of death, and a funeral grant / benefit.⁹¹

While some countries have explicitly recognised COVID-19 to be an occupational disease,⁹² others have not done so, and this is a central ask of many organizations representing health and essential workers.⁹³ Data from the ILO suggests that at least 13 countries have categorised COVID-19 to be an occupational illness for some professions, and eight others have said they would consider it to be so if it was shown that it was contracted at work (the ILO monitoring is not exhaustive).⁹⁴ As per WHO guidance, “Health worker rights include that employers and managers in health facilities [...] honour the right to compensation, [and provide] rehabilitation and curative services if infected with COVID-19 following exposure in the workplace. This would be considered occupational exposure and resulting illness would be considered an occupational disease”.⁹⁵ The ILO has further stated that “infection by COVID-19, if contracted as a result of work, could be considered as a work or employment injury”.⁹⁶

Linked to the issue of COVID-19 being an occupational disease for health and essential workers, is the question of testing for COVID-19. Testing is essential for ensuring the benefits and entitlements that accrue to health and essential workers from COVID-19 being classified as an occupational disease would apply. For example, if health and essential workers were not tested for COVID-19, they would not be deemed eligible for claiming the medical care and treatment they were entitled to when COVID-19 was recognized as an occupational illness, and nor could they claim the compensation and other allied benefits.

At present, whether health and essential workers are tested for COVID-19 depends on the individual testing strategies employed in each country. Several health and essential workers’ organizations have asked to be priority groups for testing, both because of the enhanced risk they face of contracting COVID-19, and because of the high likelihood that they might pass this on to others while they do their jobs. States should consider COVID-19 an occupational illness, and as a part of this, ensure that health and essential workers form a part of the priority groups for COVID-19 testing in their jurisdictions.

94. For details of which countries have done so, see: https://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_ent/documents/publication/wcms_741360.pdf

95. WHO, Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health, Interim Guidance, 18 March 2020, https://www.who.int/docs/default-source/coronaviruse/who-rights-roles-respon-hw-covid-19.pdf?sfvrsn=bcabd401_0

96. ILO, ILO Standards and COVID-19 (coronavirus), 29 May 2020, https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---normes/documents/genericdocument/wcms_739937.pdf

5. RIGHTS TO FREEDOM OF EXPRESSION AND PEACEFUL ASSEMBLY

As a result of the threats and pressures mentioned above related to COVID-19, health and essential workers in several countries have spoken out and protested, in particular demanding more PPE and better working conditions. Amnesty International noted reports in at least 31 countries where health and essential workers had publicly protested about their working conditions and / or gone on strike, or threatened to go on strike, on these grounds. In other contexts, they have raised concerns privately with their managers and employers about similar issues. Amnesty International found that in some countries there were governmental restrictions or instructions in place to prevent health and essential workers from speaking out about their concerns. In others, however, even though no official restrictions were placed on health and essential workers, as discussed below, many were operating in already closed or closing environments for dissent or civil society space, where criticising the authorities is often met with repression, and many were worried about reprisals if they made their concerns public.

Under article 19 of the International Covenant on Civil and Political Rights (ICCPR), everyone – including health and essential workers - has the right to “freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds”.⁹⁷ While this right may be subject to certain restrictions for the protection of national security, public health or public order, or for the protection of the rights of others, these restrictions must be provided by law, be necessary and proportionate specifically aimed at a relevant legitimate purpose, and not be discriminatory.⁹⁸ In many contexts, many health and essential workers are human rights defenders today as their actions promote and defend people’s rights to health and to information. The UN Declaration on Human Rights Defenders outlines the main protections all people are entitled to when acting up for human rights.⁹⁹ These protections should apply to health and essential workers where relevant as well. Furthermore, under the right to freedom of expression, states have an obligation to protect whistle-blowers who may

97. Article 19, ICCPR

98. Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1984/4 (1984); CESCR General Comment No. 14, para. 29 states that any limitations “... must be proportional, i.e., the least restrictive alternative must be adopted...” and “...they should be of limited duration and subject to review.” See also, Human Rights Committee, General comment No. 34, CCPR/C/GC/34, 12 September 2011.

99. Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms, A/RES/53/144, 8 March 1999, <https://www.ohchr.org/Documents/Issues/Defenders/Declaration/declaration.pdf>

face retaliation because of having reported wrongdoing, and to put in place the necessary mechanisms to enable whistle-blowers to disclose the relevant information safely and without fear of reprisals.¹⁰⁰ Furthermore, these rights are also crucial from the perspective of people’s access to information, with health workers being valuable sources of information about the spread and scale of the COVID-19 pandemic and government responses to it.

Despite this, however, there have been many reports of governments and employers seeking to silence workers and repress those who dare to speak up. In certain countries, protests have been banned, or met with force or other forms of reprisals. In some countries, measures have been put in place by governments to dissuade workers from making their concerns public. In others, workers have faced reprisals in the workplace by employers for raising health and safety concerns.

Some governments have issued warnings to health workers about speaking publicly about ‘government policy’, which could include decisions around PPE and how the pandemic was handled. In **Honduras**, health workers – particularly those on short-term and precarious contracts – have been asked to sign non-disclosure agreements (NDA) in several hospitals, prohibiting them from speaking publicly about what happens at work, including concerns around health and safety in the workplace. One health worker in Honduras told Amnesty International, “In more than one hospital, during the pandemic, they have made medics sign confidentiality agreements. They have been threatened that if they give information, they will be fired”.¹⁰¹ The President and Vice President of the of the Medical College of Honduras told Amnesty International that some health workers had been fired for speaking out about health and safety concerns in the workplace.¹⁰² In **Poland**, the Deputy Minister of Health reportedly notified some epidemiologists and hospitals that they were not to speak about the COVID-19 pandemic to the public.¹⁰³ In **Malaysia**, the Ministry of Health issued a reminder to civil servants, which includes health workers employed by the government, of existing disciplinary rules on criticising government policy, in particular on social media:



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Translation: Do you like making public statements or commenting on government policy on social media? Be careful. You could be subject to disciplinary action under rules 19(1) and 19(2), PU(A) 395/1993 [Public Officers (Conduct and Discipline) Regulations 1993]

100. Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, A/70/361, 8 September 2015, https://www.un.org/en/ga/search/view_doc.asp?symbol=A/70/361. As per the Special Rapporteur, a whistle-blower “is a person who exposes information that he or she reasonably believes, at the time of disclosure, to be true and to constitute a threat or harm to a specified public interest, such as a violation of national or international law, abuse of authority, waste, fraud, or harm to the environment, public health or public safety”.

101. Amnesty International saw a copy of a letter from a hospital to all employees, dated 3 April 2020, asking them to come to the director’s offices, to sign a letter of confidentiality, but has not yet seen the actual NDA. This was also confirmed by Amnesty International interviews with the President and Vice President of the Honduras medical college.

102. Interview with the President and Vice-President, 20 April 2020

103. K Nowosielska, “The Ministry prohibits doctors from talking about problems”, Prawo.pl 27 March 2020, <https://www.prawo.pl/zdrowie/zakaz-publicznego-wypowiedzenia-sie-lekarzy-na-temat-epidemi,499036.html> - According to the Deputy Minister of Health, such opinions can be expressed only by a national consultant in consultation with the Ministry of Health or the Chief Sanitary Inspector.

In other countries, health and essential workers who have shared concerns about the pandemic, gone on strike or publicly protested have faced adverse consequences. Perhaps the most prominent case of this nature was that of Li Wenliang in **China**, the whistle-blower doctor who died after contracting the virus.

Li Wenliang was an ophthalmologist working in Wuhan, China. He sent out a warning to fellow medics in late December 2019 about patients with symptoms similar to those of the severe acute respiratory syndrome (SARS) outbreak that began in southern China in 2002. He was immediately silenced by the local authorities for “spreading rumours”.¹⁰⁴ He also received a ‘reprimand letter’ from the police.

Li Wenliang contracted COVID-19 in early 2020 while working at Wuhan Central Hospital. He later died of the illness in February 2020. The National Supervisory Commission commissioned an investigation into how Li Wenliang was treated after he raised the alarm and spoke up. The investigators found that the reprimand letter was “inappropriate and failed to respect relevant law enforcement procedures” and recommended that the police revoke it.¹⁰⁵



HOSPITAL WORKERS CHARGED FOR HOLDING A PEACEFUL PROTEST IN MALAYSIA

On 2 June 2020, Malaysian police dispersed a peaceful gathering of workers and activists who were in a picket against a hospital cleaning services company. The workers’ complaints centred around what they said was the unfair treatment of union members by the company as well as a lack of sufficient PPE for hospital cleaners. Police arrested, detained overnight and charged five activists who were protesting for “unauthorised gathering” in violation of their rights to freedom of association and assembly. Amnesty International is calling on the Malaysian Minister of Home Affairs to drop all charges against them.¹⁰⁶

In Pakistan, health workers protested their working conditions and lack of PPE in April 2020. In the same month, the Young Doctors Association also announced a hunger strike.¹⁰⁷ On 6 April, security forces used excessive force against protesting doctors in Quetta, beat them with batons and detained 53 health workers for at least 24 hours.¹⁰⁸ In **Hong Kong**, 9,000 medical workers of the Hospital

104. Amnesty International, China: Doctor’s death highlights human rights failings in coronavirus outbreak, 7 February 2020, <https://www.amnesty.org/en/latest/news/2020/02/china-doctor-death-highlights-human-rights-failings-in-coronavirus-outbreak/>

105. “China releases investigation report on issues concerning Dr. Li Wenliang”, Xinhuanet 19 March 2020, http://www.xinhuanet.com/english/2020-03/19/c_138896212.htm

106. According to the union, since the start of the COVID-19 pandemic, cleaners do not have access to adequate personal protective equipment when they clean COVID-19 wards and facilities, and the company - Edgenta UEMS - has provided them with an inadequate supply of masks and gloves. The union has also accused Edgenta UEMS of particularly targeting cleaners active in the union. On June 3, the company released a statement denying the allegations put forth by the union. However, legal representatives of the union stand by their original allegations. In a letter to Amnesty International Malaysia on June 19, UEM Edgenta once again denied the allegations. They also stated that they had taken multiple actions since the incident. These include forming an internal taskforce to review the allegations by the union; a roadshow at selected hospitals in Northern Peninsular Malaysia that included an audit of PPE and engagement sessions with healthcare support services employees; and the development of PrihatinLine, an online channel for HSS employees to share feedback and concerns with top management and the new taskforce

107. “Pakistan doctors on hunger strike”, *The Hindu*, 25 April 2020, <https://www.thehindu.com/news/international/pakistan-doctors-on-hunger-strike/article31434755.ece>

108. S Khan “COVID-19 in Pakistan: Why the government and doctors are at odds”, *Deutsche Welle*, 16 April 2020, <https://www.dw.com/en/covid-19-in-pakistan-why-the-government-and-doctors-are-at-odds/a-53149990>

Authority Employees Alliance voted to strike against the government's failure to close the border with the mainland to prevent a coronavirus outbreak in the city. Later, even though the right to strike is protected under the law in Hong Kong, a legislator suggested that doctors who went on strike should be penalised, including by being banned from obtaining specializations in different medical areas in the future.¹⁰⁹ While this never materialised in law, it sent a chilling message to doctors not to organize and go on strike for fear of reprisals. In **India**, a doctor was interrogated by the police and his phone was seized after he “made several Facebook posts concerning the allegedly deficient protective gear supplied by the government to its doctors attending COVID-19 virus affected patients in its hospitals”.¹¹⁰ The Calcutta High Court ordered the authorities to return his mobile phone and directed that “there shall be no further interrogation of the writ petitioner [the doctor] without the leave of a proper court”.

“I feel so let down. The government and the local government officials are just not doing their best to safeguard doctors ... We are completely hopeless and can only protest. We’re then told we cannot even protest. That they are shutting our mouths.”

Health worker, Pakistan¹¹¹

There have been reports in several countries about health and essential workers being fired or facing disciplinary action for speaking out about their concerns regarding health and safety in the workplace and how their governments are handling the pandemic. The Inter-American Commission on Human Rights expressed concern over healthcare personnel fired from their jobs for speaking up in **Nicaragua**, for example.¹¹² In **Brazil**, a representative from an association of health workers told Amnesty International: “Repression takes the form of threats of firing”.¹¹³ In **Russia**, authorities have opened an administrative investigation into endocrinologist Yulia Volkova, accusing her of disseminating ‘knowingly false’ information about COVID-19, after she published a video on Twitter on 25 March in which she asked that physicians be provided with PPE. “Who did I scare with my video? It does not say about my hospital, the name of the head physician is not called. I just said that we demand that we be provided with modern protective equipment”, Yulia Volkova told Amnesty International.¹¹⁴

109. “Ban strike doctors from specialisations: Regina Ip”, RTHK 8 April 2020, <https://news.rthk.hk/rthk/en/component/k2/1519571-20200408.htm>

110. Dr. Indranil Khan v State of West Bengal and others, WP 5326 (W) of 2020, https://www.scribd.com/document/454566448/Calcutta-HC-Indranil-Khan-writ-petition-order#fullscreen&from_embed

111. Interview with doctor, 22 May 2020, Lahore, Pakistan

112. The IACHR statement is available here: <https://twitter.com/cidh/status/1255149895335292928?s=21>

113. Interview with doctor, 20 May 2020 [on the telephone]

114. See Amnesty International demands termination of fake news case against doctor Yulia Volkova, 8 May 2020, <https://eurasia.amnesty.org/2020/05/08/amnesty-international-trebu-et-prekrashheniya-dela-o-fake-news-v-otnoshenii-vracha-yulii-volkovoj/>



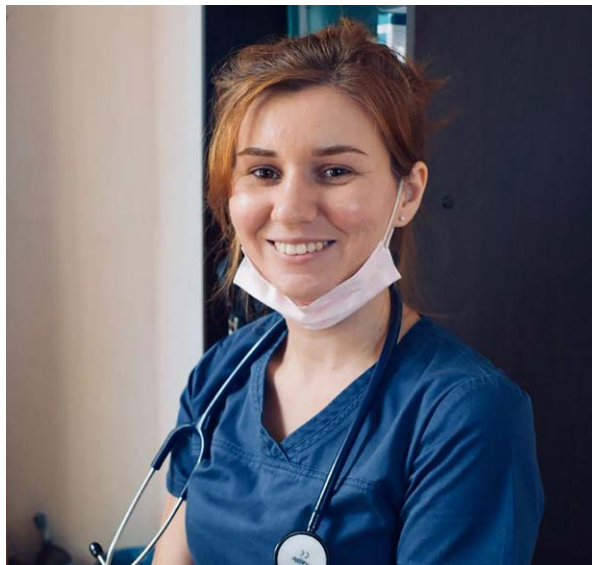
TATYANA REVVA¹¹⁵

INTENSIVE CARE DOCTOR FACING REPRISALS IN RUSSIA

Dr. Tatyana Revva, an intensive care unit doctor from Kalach-on-Don, has faced reprisals and potential dismissal after she repeatedly complained to the hospital's management about the shortage of PPE for medical workers in the context of the COVID-19 pandemic, as well as other work-related issues.

In early March, she reported her concerns to an independent trade union, Doctors' Alliance, and recorded a video describing the issues confronted by staff in her hospital. Her letter to the union and her video have since been made public. She told Amnesty International that, as a result, within a month she received two formal reprimands and one written warning from the hospital's management, and on six occasions had to give written explanations about alleged irregularities in her work.

The ongoing disciplinary proceedings against Tatyana Revva have been launched for her purported violation of patient confidentiality. The patient in question is her father who had been admitted to the hospital's emergency department with a suspected heart attack. Tatyana Revva received an official reprimand after visiting him, on the grounds that she should have allegedly filled in the patient's record forms even though she was not a consulting doctor, and this was not her area of expertise. Tatyana Revva mentioned this incident in a letter to the trade union and in an interview with a journalist but did not disclose her father's personal details or diagnosis, and thus did not breach patient confidentiality. Nonetheless, this has become the grounds for the disciplinary proceedings against her that may lead to her dismissal, which appears to be intended to punish her for having raised concerns about lack of PPE.



*Doctor Tatyana Revva
at the Central District
Hospital, Kalach-on-Don,
Volgograd region, Russia,
April 2020. © Private*

115. Amnesty International, Russian Federation: Whistleblower doctors facing reprisals: Tatyana Revva, 11 May 2020, EUR 46/2301/2020, <https://www.amnesty.org/en/documents/eur46/2301/2020/en/>

In **Egypt**, Amnesty International has documented how Egyptian authorities have used vague and overly broad charges of "spreading false news" and "terrorism" to arbitrarily arrest and detain health care workers who speak out and have subjected them to threats, harassment and punitive administrative measures.¹¹⁶ The concerns raised by health workers have included unsafe working conditions, lack of adequate PPE, insufficient infection control training, limited testing of health care workers, and lack of access to vital health care. Amnesty International documented the cases of nine health care workers, including seven doctors and two pharmacists, who were arbitrarily detained between March and June by the National Security Agency (NSA) for expressing their health-related concerns including in social media posts. Amnesty International also spoke to seven doctors who witnessed security and administrative threats against their health worker colleagues for raising similar concerns. On 27 June, security forces in Egypt barred members of the Doctors' Syndicate from organizing a press conference to respond to the Prime Minister, who publicly held doctors responsible for the increasing COVID-19 death toll in the country. According to a syndicate member present during the incident, security forces surrounded the syndicate to force the organizers to postpone the conference.¹¹⁷ According to the Doctors Syndicate, two doctors were detained for having criticized the Prime Minister's statements or promoted the event on their social media platforms. A source from the Doctors Syndicate confirmed that doctors are being subjected to threats, interrogations by the NSA, administrative questioning, and penalties. He said: "We are receiving a lot of complaints in that regard, while many others are preferring to pay for their own personal equipment to avoid this exhausting back and forth. They are forcing doctors to choose between death and jail."¹¹⁸

While health and essential workers have been able to protest about COVID-related concerns in the **USA**, there have been several reports of employers who stopped their health workers from speaking out with a range of reprisals, including harassment, disciplinary procedures, and unfair dismissal. The American Nurses Association – an organization representing the interests of 4 million registered nurses in the US - issued a statement saying it was "disturbed about reports of employers retaliating against nurses and other health care workers for raising legitimate concerns about their personal safety while caring for patients with COVID-19. Reports of intimidation, firing, ostracizing and more are unacceptable".¹¹⁹



TAINIKA SOMERVILLE¹²⁰
NURSING HOME ASSISTANT IN THE USA

On 2 April, Tainika Somerville was fired from her role as a nursing assistant in a Bridgeview Healthcare Centre in Cook County, Illinois, after having filmed a Facebook live video stream two days earlier that shows her reading out a petition at her workplace from her and other workers about the lack of PPE in the facilities.

116. Amnesty International, Egypt: Health care workers forced to make impossible choice between 'death or jail', 18 June 2020, <https://www.amnesty.org/en/latest/news/2020/06/egypt-health-care-workers-forced-to-make-impossible-choice-between-death-or-jail/>

117. Interview with health worker, Egypt, 29 June 2020 [on the telephone]

118. Interview with health worker, Egypt, 10 June 2020 [on the telephone]

119. "ANA Disturbed by Reports of Retaliation Against Nurses for Raising Concerns About COVID-19 Safety", 9 April 2020, <https://www.nursingworld.org/news/news-releases/2020/ana-disturbed-by-reports-of-retaliation-against-nurses-for-raising-concerns-about-covid-19-safety/>

120. Amnesty International, The Cost of Curing: Health Workers' rights in the Americas during COVID-19 and beyond, (Index: AMR 01/2311/2020)

A nursing assistant for over 20 years, she was employed in a private nursing home to feed, bathe, check vital signs and provide emotional support to older residents. Tainika Somerville told Amnesty International that she was angry about how the company had hidden the presence of COVID-19 in the nursing home. “The way we found out [that COVID-19 was in the facilities] ... was a slap in the face. The whole time they were telling us that it wasn’t in the building, they were lies. In the end, we found out through a newspaper article.”

Tainika Somerville told Amnesty International that she was accused by letter of verbal abuse and refusing to follow instructions. She believes she was fired because she spoke out about the lack of PPE and working conditions in her workplace. Amnesty International sent a letter to Dynamic Health Care Consultants, Inc, the parent company of Somerville’s employers, asking for more information about these concerns, but has yet to receive a reply. Tainika Somerville told Amnesty International that all she wants right now is to get her job back.



*Tainika Somerville,
a nursing assistant
in Illinois, USA. ©
Private*

6. STIGMA AND VIOLENCE

In many countries, health workers have seen an unprecedented outpouring of public support and solidarity. There have been public displays of gratitude for health and essential workers, and tributes in their honour. Unfortunately, in some countries, health and essential workers have experienced stigma and violence because of the job they perform in the context of the COVID-19 pandemic. States should ensure that health and essential workers are not subject to such stigma and violence, condemn such stigmatization, and, where appropriate, investigate and prosecute any incidents of violence against them. All employers, including those in the private sector, should take all steps necessary to protect their staff from stigma and violence linked to their employment, including through the measures discussed in more detail below.

Several international human rights treaties guarantee the right to equality and non-discrimination.¹²¹ The right to non-discrimination is an immediate and cross-cutting obligation and applies to the exercise of each and every human right guaranteed under international law. The ESCR Committee has said that state parties must “immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination” on any of the prohibited grounds.¹²² The ESCR Committee has also said that state parties must “adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds”.¹²³

Stigma has taken the form of health and essential workers finding it harder to access essential services like transport and housing or experiencing negative attitudes from members of the public. Rose [name withheld], a nurse at one of the largest public hospitals in Manila, **Philippines** told Amnesty International:

“I have personally experienced discrimination, back when buses were still allowed to operate. I was of course wearing my uniform and it’s clear I am a medical worker. A lot of times the buses won’t stop in front of me. If I do get on a bus, the people inside would avoid me. Sometimes I think of going to work without a uniform on; I don’t care if I get penalized for it”.¹²⁴

Similarly, a doctor in **Nigeria** told Amnesty International that she was denied entry into a supermarket because she was in her medical uniform.¹²⁵

121. These include the ICESCR; the ICCPR, the Convention on the Elimination of All Forms of Discrimination against Women; the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities

122. CESCR, General Comment No. 20: Non-discrimination in economic, social and cultural rights, E/C.12/GC/20, 2 July 2009, para 8(b)

123. CESCR, General Comment No. 20: Non-discrimination in economic, social and cultural rights, E/C.12/GC/20, 2 July 2009, para 11

124. Interview with health worker, 27 May 2020

125. Interview with doctor, 13 May 2020 [on the telephone]

Reports have also emerged of health workers being denied access to essential services, such as housing, because people fear they are carrying COVID-19 and would spread the infection. There have been reports in at least ten countries of health workers being evicted from where they live, there being attempts to evict them, them finding it hard to find a place to live or facing stigma where they live.¹²⁶

“During the past three months, there is a noticeable increase in the number of attacks on the medical staff. COVID-19 related stress, anxiety, and panic among the population could be significant factors. If there is a shortage of ventilators, doctors were to blame. If the patient is suspected of having COVID-19, doctors were to blame. Relatives of the patients usually attribute any mistakes and shortages by the MoH [Ministry of Health] directly to the doctors and physically and verbally attack them”.

Doctor, Sudan¹²⁷

Furthermore, an extremely concerning trend during the COVID-19 pandemic has been the apparent increased number of attacks against health and essential workers. Health and essential workers have been attacked or otherwise subjected to violence on the way to work, in their workplaces, as well as in their homes. In May 2020, 13 medical and humanitarian global organizations representing more than 30 million healthcare professionals issued a declaration condemning increasing incidents of attacks against health workers. The declaration noted that there had been “over 200 incidents of COVID-19 related attacks [against health workers] – a trend that endangers these vital frontline responders and the communities they serve”.¹²⁸ The violence faced by health and essential workers has also been widely covered by local and international media, and incidents have been reported in a wide range of countries.¹²⁹

For example, attacks have been reported against health workers in **Mexico**, including one nurse who was reportedly drenched with chlorine while walking on the street.¹³⁰ As of 28 April, the Ministry of the Interior in Mexico has documented at least 47 cases of aggressions against health workers in 22 states in the country, with 70% of the attacks being against women.¹³¹ The National Council to Prevent Discrimination (CONAPRED) reported that, from 19 March to 8 May, they received 265 complaints concerning discrimination on the basis of COVID-19 among health workers, including 17 from doctors, eight from nurses and 31 from administrative or support staff.¹³² In the **Philippines**, a hospital utility worker was attacked on the street and his attackers poured bleach on his face.¹³³ People in the **Indian**

126. These countries include Ethiopia, Nepal, El Salvador, Honduras, India, Indonesia, Chile, Argentina, and Italy.

127. Interview with health worker, Khartoum State, Sudan, 26 May 2020, via WhatsApp.

128. Declaration by the Health Care in Danger Community of Concern about the current situation of violence against health care, <https://healthcareindanger.org/resource-centre/declaration-by-the-health-care-in-danger-community-of-concern-about-the-current-situation-of-violence-against-health-care/>

129. D McKay et al, “Attacks against health-care personnel must stop, especially as the world fights COVID-19”, 395 Lancet, p 1743, 2020 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31191-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31191-0/fulltext); “Health workers become unexpected targets during Covid-19”, *The Economist*, 11 May 2020, <https://www.economist.com/international/2020/05/11/health-workers-become-unexpected-targets-during-covid-19>

130. K Semple, “‘Afraid to Be a Nurse’: Health Workers Under Attack”, *New York Times*, 27 April 2020, <https://www.nytimes.com/2020/04/27/world/americas/coronavirus-health-workers-attacked.html>

131. Ministry of the Interior “Observations on human rights violations during the health contingency by COVID-19”, 28 April 2020. Retrieved May 12, 2020, from <https://www.gob.mx/segob/documentos/observaciones-sobre-violaciones-a-derechos-humanos-durante-la-contingencia-sanitaria-por-covid-19>

132. J Xantomitola, “Health workers, the third group with the most complaints presented to Conapred” Retrieved from: <https://www.jornada.com.mx/2020/05/11/politica/005n2pol>

133. K Semple, “‘Afraid to Be a Nurse’: Health Workers Under Attack”, *New York Times*, 27 April 2020, <https://www.nytimes.com/2020/04/27/world/americas/coronavirus-health-workers-attacked.html>

city of Indore threw stones at health workers who had come to their localities to conduct COVID-19 testing.¹³⁴ In **Russia**, a mob reportedly attacked ambulance workers, and demanded to be told “where the infected people were”.¹³⁵ In **France**, there were reported incidents of robberies and break-ins of health workers’ houses, and PPE was often stolen.¹³⁶ Amnesty International has also recorded several instances of violence against health workers across **Pakistan** since April. Hospitals have been vandalized, many doctors have been attacked, and one was even shot by a member of the Counter Terrorism Force. The Young Doctors Association says health workers are being attacked on a daily basis and that the exact number is “beyond count”.¹³⁷

Amnesty International has heard worrying stories and reports about the violence health and essential workers have experienced in the course of producing this report. A representative from an association of health workers told Amnesty International in **Brazil** told Amnesty International that he was aware of recent instances where health workers were attacked inside hospitals by the families of people coming in for treatment.¹³⁸ In **Sudan**, the Central Committee of Sudanese Doctors (CCSD) reported that they had recorded 28 attacks on health workers across the country between March and May 2020. One doctor told Amnesty International, “I was witness to an incident ... during the COVID 19 measures. The hospital staff ordered the patient’s companion to not enter the hospital because of the virus. The companion is a member of security force, attacked the medical doctor and injured him”.¹³⁹

Whatever the reason or motivation for these attacks, violence against health and essential workers should not be tolerated. Ensuring that health and essential workers can do their jobs safely is essential not just for their safety, but for the safety of everyone they care for.

In certain countries, security forces and law enforcement have been responsible for the attacks against health and essential workers. For example, in **Nigeria**, the President issued an exemption for health and essential workers from the ongoing lockdown and curfew. However, these workers continue to face restrictions on movement, harassment and intimidation by security agents.¹⁴⁰ On 20 May 2020, the Lagos State branch of the Nigerian Medical Association directed its members to stay at home following the harassment of healthcare workers in Lagos by security agents. In April, doctors at the Federal Medical Centre, Asaba, Delta State, went on a strike over the harassment of health workers by security agents.¹⁴¹ As one health worker in Nigeria told Amnesty International, “I am one of the frontline workers working in one of the COVID-19 isolation centers ... On the issue of security, we are highly disappointed that our members across the country face a lot of harassment from security agents despite showing their identity cards, sometimes even when they are in their uniforms. They are denied

134. “Covid-19: Health workers attacked in cities, 7 held in Indore for pelting stones” *Hindustan Times*, 3 April 2020, <https://www.hindustantimes.com/india-news/covid-19-health-workers-attacked-in-cities-7-held-in-indore-for-pelting-stones/story-Z1bAixXRhH7aFQyLZb8wmN.html>

135. “In Kostroma a team of doctors attacked because of tests for coronavirus”, *K1News*, 16 April 2020, <https://k1news.ru/news/koronavirus/v-kostrome-napali-na-brigadu-vrachej-iz-za-analizov-na-koronavirus/>. See also, “The Russians beat a doctor who came to take a test for coronavirus and got into the video”, *Lenta*, 18 April 2020, <https://lenta.ru/news/2020/04/18/skoraya/>

136. R Noel et al, “Coronavirus: stolen masks, caregiver assaulted, when the shortage increases incivility”, *France Bleu*, 22 March 2020, <https://www.francebleu.fr/infos/faits-divers-justice/coronavirus-masques-voles-soignants-agresses-quand-la-penurie-renforce-les-inciviles-1584893642>

137. For more details see: Amnesty International, Open Letter: Protection of health workers in Pakistan. TGA ASA 33.2020.005, 1 July 2020, <https://www.amnesty.org/download/Documents/ASA3326332020ENGLISH.pdf>

138. Interview with doctor, 20 May 2020 [on the telephone]

139. Interview with health worker, Khartoum State, Sudan, 27 May 2020, via WhatsApp.

140. “Curfew: Lagos NMA Directs Doctors, Health Workers To Stay At Home From 6pm Today,” Channels Television, 20 May 2020, <https://www.channelstv.com/2020/05/20/curfew-lagos-nma-directs-doctors-health-workers-to-stay-at-home-from-6pm-today/>

141. “Lockdown: Doctors in Delta embark on indefinite strike over police brutality,” *MSN News*, 10 April 2020, <https://www.msn.com/en-za/news/other/lockdown-doctors-in-delta-embark-on-indefinite-strike-over-police-brutality/ar-BB12qXpA>

movement, embarrassed and assaulted”¹⁴². In **Nepal**, there were two incidents where police resorted to excessive use of force against health workers allegedly for “violating the lock-down”. The police issued an apology and said disciplinary measures were taken against the officials responsible.¹⁴³

“WHO calls upon governments, employers and workers organizations to institute measures for zero-tolerance to violence against health workers at the workplace and at the way to and from their workplace, and for intensifying social support and respect for health workers and their families”.

WHO statement¹⁴⁴

Governments in some of the countries where these attacks are happening are taking steps to respond. In some cases where health workers have been attacked, the authorities have arrested those responsible, and governments in a few countries have issued official statements clarifying the role of health workers and making it clear that violence against health workers should not and will not be tolerated. In **Mexico**, for example, the government made public statements in support of health and essential workers, and took steps to increase security for them.¹⁴⁵ Legislation has been tabled and even passed in some countries – such as **Italy**,¹⁴⁶ the **Philippines**, and **Argentina**¹⁴⁷ – prescribing penalties for harassing or discriminating against health and / or essential workers.

There are several steps that managers of health facilities and governments should take to better protect health workers from acts of violence. For example, the International Committee of the Red Cross (ICRC) has developed a “Checklist for health care services” which contains key recommendations on how to respond to violence against health workers during the COVID-19 response. This includes specific guidance on how to support health-care workers with high exposure to stress and violence; how to assess the risks and implement preparedness measures; how to promote the rights and responsibilities of staff; the importance of communicating with the public; ensuring coordination with security forces; and the need to document acts of violence against health workers.¹⁴⁸ Ensuring that people have credible and evidence based information about the pandemic is key to addressing the stigma health and essential workers face. Professionals and professional associations have made additional recommendations, including: providing dedicated transport to healthcare staff to reduce their risk of violence and stigmatization on the way to and from work;¹⁴⁹ ensuring adequate PPE so fears about health workers spreading COVID-19 will be alleviated;¹⁵⁰ and ensuring accountability for violence against health workers.¹⁵¹

142. Interview with nurse, Nigeria, 29 May 2020 [on the telephone]

143. “Police Take Action Against DSP Lamsal For ‘Beating’ Doctors”, Rising Nepal, 16 April 2020, <https://risingnepaldaily.com/mustread/police-take-action-against-dsp-lamsal-for-beating-doctors>

144. WHO, “WHO calls for healthy, safe and decent working conditions for all health workers, amidst COVID-19 pandemic”, 28 April 2020, <https://www.who.int/news-room/detail/28-04-2020-who-calls-for-healthy-safe-and-decent-working-conditions-for-all-health-workers-amidst-covid-19-pandemic>

145. “Government of Mexico (2020, April 23). “IMSS head of nursing calls for an end to attacks against health personnel”. From <http://www.imss.gob.mx/prensa/archivo/202004/211>

146. Legislature 18^a - Bill n. 867-B, available here: http://www.senato.it/japp/bgt/showdoc/18/DDLPRES/0/1152754/index.html?part=ddlpres_ddlpres1-articolato_articolato1; S di Santo, “Okay by the House to the bill against aggression”, Nurse24, 21 May 2020, <https://www.nurse24.it/infermiere/leggi-normative/ddl-contro-aggressioni-sanitari-ok-camera.html>

147. In Argentina, this was a local law passed in the city of Buenos Aires, not the whole country. For more details, see: <https://www.telam.com.ar/notas/202005/469413-legislatura-portena-multas-discriminar-personal-salud.html>

148. ICRC, COVID-19 and Violence Against Health Care, Safer COVID-19 Response: Checklist for Health-Care Services, https://healthcareindanger.org/wp-content/uploads/2020/05/4469_002_Safer_COVID-19_Response-Checklist_for_Health-care_Services-Lr_1.pdf

149. P. Forgione, “New patterns of violence against healthcare in the covid-19 pandemic”, 15 May 2020, *The BMJ Opinion*, <https://blogs.bmj.com/bmj/2020/05/15/new-patterns-of-violence-against-healthcare-in-the-covid-19-pandemic/>

150. P. Forgione, “New patterns of violence against healthcare in the covid-19 pandemic”, 15 May 2020, *The BMJ Opinion*, <https://blogs.bmj.com/bmj/2020/05/15/new-patterns-of-violence-against-healthcare-in-the-covid-19-pandemic/>

151. D McKay et al, “Attacks against health-care personnel must stop, especially as the world fights COVID-19”, 395 *Lancet*, p 1743, 2020 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31191-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31191-0/fulltext)

7. BROADER STRUCTURAL PROBLEMS

Several challenges health and essential workers face today – including many of those detailed in this report - are symptoms of broader structural issues with health care and social support systems, which have been brought into sharp focus as a result of the pandemic. While this report cannot adequately explore all these underlying concerns, this section flags four main concerns that emerged repeatedly in the research for this report.



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Officials from the National Union of Workers in Hospital Support and Allied Services' (NUWHSAS) after their release from overnight remand. Location: Ipoh, Perak, June 3, 2020. © Private

HISTORIC UNDER-INVESTMENT, CRUMBLING PUBLIC INSTITUTIONS AND UNDER-PRIORITIZATION OF HEALTH AND SOCIAL CARE SYSTEMS

There has been significant under-investment in and under-prioritization of health and social care systems across the world, because of which these systems were more vulnerable when an unexpected event like the COVID-19 pandemic happened. This manifested itself in different ways in different contexts, including poor infrastructure, inadequate equipment and under staffing. A study in the *British Medical Journal* investigated trends in global health financing, according to which “annual costs of an “essential package” of 218 interventions to achieve universal health coverage would be about \$100 (£78; €90) per head, while a more basic package of 108 “highest priority interventions” would cost \$50 per head”. Based on 2016 data (the latest available at the time), 24 of 49 ‘lower middle income’ countries couldn’t cover either package of care mentioned above; and no ‘low income country’ could. Ultimately, the study concluded that “Absolute levels of health spending are rising—but they remain too low in many countries to finance universal health coverage, and health is still not given enough priority by governments”.¹⁵²

Because of this, health care facilities in some countries suffered from infrastructural shortages that made health workers more vulnerable during the pandemic and put their health and well-being at greater risk. For example, a nurse in **Paraguay** told Amnesty International, “We had two whole weeks without proper running water in our hospital. The infrastructure in the hospital just simply does not work properly”.¹⁵³ Similarly, a nurse in **Nigeria** told Amnesty International, “In the government hospital where I work, there is no running water for health workers to wash their hands. Doctors and nurses have to fetch water in a bowl, which is not sanitary”.¹⁵⁴ In **Venezuela**, a recent survey of health service providers on the capacity of the Venezuelan health system to deal with COVID-19 showed that 31.8% of hospital workers reported they did not have access to potable water and 64.2% reported intermittent access to potable water between 27 February and 1 March. On 16 May, another national survey on the impact of COVID-19 reported a shortage of gloves in 57.14% of the health sector, of masks in 61.9%, of soap in 76.19% and of disinfectant alcohol in 90.48%.¹⁵⁵

In other countries, under-investment in the public health sector was a result of specific governmental policies, such as austerity measures, which resulted in significant reductions in public health spending and impacted people’s access to health care.¹⁵⁶ For example, austerity measures have eroded the accessibility and affordability of health care in Greece, with many people finding it harder to afford health care and access the public health system when they need to and has also increased the burden on health workers.¹⁵⁷ A health worker in Greece told Amnesty International, “During the financial crisis when there were cuts in the health sector this resulted in most hospitals operating with half the personnel required and ...it is nearly impossible to cope...[W]e are not at all protected as far as the provision of health care and the security of staff is concerned. [In our hospital] we work with half the

152. M Schäferhoff et al, “Trends in global health financing”, *BMJ* 2019; 365:l2185, <https://www.bmj.com/content/365/bmj.l2185>

153. Interview with nurse, 29 April 2020

154. Interview with nurse, 27 April 2020 [on the phone]

155. HRW, “Venezuela: Urgent Aid Needed to Combat Covid-19”, <https://www.hrw.org/news/2020/05/26/venezuela-urgent-aid-needed-combat-covid-19>; See also: <https://sfo2.digitaloceanspaces.com/estaticos/var/www/html/wp-content/uploads/2020/03/ENCUESTA-MUV-COVID-19.pdf>

156. See Amnesty International, *Resuscitation Required: The Greek Health System after a decade of austerity*, (Index: EUR 25/2176/2020); Amnesty International, *Wrong Prescription: The Impact of Austerity Measures on the Right to Health in Spain*, (Index: EUR 41/8136/2018)

157. Amnesty International, *Resuscitation Required: The Greek Health System after a decade of austerity*, (Index: EUR 25/2176/2020)

required staff and if [COVID-19] cases increase it would be impossible”.¹⁵⁸ Similarly, a health worker in **Spain** said, “We have insufficient personnel, far below what is expected from a country like Spain, insufficient resources and a shrinking budget. This is the context in which the pandemic appears.”¹⁵⁹

In the words of the Committee on Economic, Social and Cultural rights, “Health-care systems and social programmes have been weakened by decades of underinvestment in public health services and other social programmes, accelerated by the global financial crisis of 2007–2008. Consequently, they are ill equipped to respond effectively and expeditiously to cope with the intensity of the current pandemic.”¹⁶⁰ It is crucial that plans to recover from the COVID-19 pandemic not be based on austerity measures introduced without adequate safeguards and due regard for human rights.

Furthermore, there has been a growing role of the private sector in health care delivery in many contexts. According to the UN Special Rapporteur on extreme poverty and human rights, the widespread privatisation of public goods in many societies has systematically eliminated human rights protections and further marginalised those living in poverty.¹⁶¹ States must act in accordance with their human rights obligations while designing any collaboration with the private sector, including putting in place a regulatory framework that ensures health care is accessible and affordable to all, keeping in mind the needs of marginalized groups; and establishing standards for public and private actors involved with privatization to ensure that data on human rights impacts are collected and published.¹⁶²

INADEQUATE PREPAREDNESS FOR THE PANDEMIC

Concerns have also been raised, including by several health workers, that some countries were not adequately prepared for the onset of the pandemic. For example, in an interview with Amnesty International, a doctor in **Sudan** explained how she felt that health workers were not adequately trained in infection prevention and control prior to the pandemic, which she felt could impact their ability to protect themselves during a pandemic, in addition to other issues. “There are few IPC (infection prevention and control) training courses organized by MoH (Ministry of Health) and for a limited number of health workers ... Furthermore, most hospitals face severe shortages in medical staff”¹⁶³ she said. “Why did we find ourselves working overnight with COVID-19 patients in triage hospitals? Why the government did not provide us with proper training for more three months since the COVID-19 outbreak in Egypt?”, said another doctor in **Egypt**.¹⁶⁴

Amnesty International spoke with a doctor in **Argentina**, who worked in a health centre that had not yet seen any cases of COVID-19. At the time of the interview, there were 47 confirmed cases in the province where this hospital is located. While she felt staff had been adequately trained to respond to the COVID-19 crisis, she was concerned that they did not have adequate PPE. She told Amnesty International that most doctors had bought in their own PPE for fear of getting infected. For the first

158. Interview with health worker, Greece, 1 April 2020 [on the phone]

159. Interview with health worker, Madrid, 14 April 2020

160. Committee on Economic, Social and Cultural Rights, Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, E/C.12/2020/1, 17 April 2020, <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1AVC1NkPsgUedPIF1vfPmKXidSV%2fGyVFSAvr6nizxSIX6zd%2bu5KD26NraabiJKaWMnkFhhMb4MahybE51%2foU5sQSh6PCbcepqzI0iCYklyq>

161. Report of the Special Rapporteur on extreme poverty and human rights, A/73/396, 26 September 2018, <https://undocs.org/A/73/396>

162. Report of the Special Rapporteur on extreme poverty and human rights, A/73/396, 26 September 2018, <https://undocs.org/A/73/396>

163. Interview with health worker, Khartoum State, Sudan, 27 May 2020, via WhatsApp.

164. Interview with health worker, Egypt, 9 June 2020 [on the telephone]

few weeks, the authorities had “given them scraps of fabric to make their own chinstraps”.¹⁶⁵ In the survey by Public Services International described in chapters above, 33.2% of respondents noted that relevant workers had not been given Occupational Health and Safety training.¹⁶⁶

In April 2020, a nurse in the **UK** told Amnesty International, “Questions about supply of PPE dominate most days here, with no guarantee of ongoing supply. Currently ICU is prioritised, but we know that other areas of our hospital are going without adequate supplies. It feels very much like our Trust was ill-prepared: this crisis started in January, and we only ramped up orders in March”.¹⁶⁷

These concerns are also echoed in secondary literature on this issue.¹⁶⁸ While Amnesty International has not conducted a review of the level of preparedness of countries prior to the pandemic, and compared these with the guidelines and best practice, states should put in place systems to assess how prepared their health and social systems were for such an event, and what needed to be improved or changed. Assessing the preparedness of countries to this pandemic is an important way to ensure that countries are in a better position to respond to an event like this in the future.

TRANSPARENCY AND ACCOUNTABILITY

The principles of transparency and accountability are extremely important. Health and essential workers should have access to information about the pandemic and decision making and be able to freely share relevant information about it. Furthermore, any victim of a violation of the right to health should have access to effective judicial or other appropriate remedies.¹⁶⁹ The concerns raised in the previous chapter around the reprisals and repression against health and essential workers raising concerns about their working conditions reinforce the need to ensure that health systems incorporate the principles of participation, transparency and accountability in their design. Accountability would also include the need to independently and impartially investigate all allegations of state wrongdoing in the context of the pandemic, across various issues.

INTERNATIONAL CO-OPERATION AND ASSISTANCE

The COVID-19 pandemic has also highlighted the need for all states to work together and support the full realization of human rights globally through fulfilling their obligations around providing international cooperation and assistance. The world is facing a global problem that needs a global solution, and several countries in the world do not have the resources or capacity to respond to the health and social consequences of the pandemic without assistance. While several states have worked to provide materials and resources to others where possible, other troubling developments indicate that this may not be the norm. For example, when states withdraw support from multilateral bodies responding to the crisis (such as the USA has with the WHO), they risk weakening the international response to the pandemic. Similarly, trade protectionism around PPE (as described in the chapter above) undermines the ability of some states to ensure protections for health and essential workers.

165. Interview with doctor, Province of Tucuman, Argentina, 22 May 2020. There have been broader concerns regarding PPE and shortages in Argentina since, see here: “Coronavirus: ‘If we are infected, who will take care of the patients?’”, The doctors’ claim for the lack of supplies”, *La Nacion*, 23 April 2020, <https://www.lanacion.com.ar/sociedad/coronavirus-miedo-contagiarse-enfermeros-medicos-denuncian-falta-nid2355345>; “Coronavirus in Argentina: in two videos, doctors warn about the precariousness of protection kits”, *Infobae*, 24 April 2020, <https://www.infobae.com/coronavirus/2020/04/24/coronavirus-en-argentina-dos-videos-alertan-sobre-la-precariedad-de-los-kits-de-proteccion-para-los-medicos/>

166. PSI, COVID-19 Union Response Survey, Global Narrative Summary, 11 May 2020, https://pop-umbrella.s3.amazonaws.com/uploads/3abcd99c-219b-4b9e-af1e-fa3ac2c398b7_COVIDSurvey_GlobalSummaryIntro.pdf?key=

167. Interview with health worker, England, 13 April 2020 [on the telephone]

168. See for example: P Chetterje, “Gaps in India’s preparedness for COVID-19 control”, *The Lancet*, 20 (5), 2020, [https://www.thelancet.com/journals/lanpub/article/PIIS1473-3099\(20\)30300-5/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS1473-3099(20)30300-5/fulltext); M Gilbert et al, “Preparedness and vulnerability of African countries against importations of COVID-19: a modelling study”, *The Lancet*, 395 (10227), 2020, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30411-6/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30411-6/fulltext)

169. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000

The obligation to engage in international cooperation and assistance also requires states who have the resources to provide financial assistance to those who need this to protect people's rights and health during the COVID-19 pandemic.¹⁷⁰ There is an urgent need for states to treat the COVID-19 pandemic as the global emergency it is, and collaborate and cooperate with each other to provide financial assistance where necessary, share information about best practices in how to respond to the virus, scientific information about the virus, technical information on producing medical equipment and PPE domestically, and of course, ensuring that all persons across the world have equal access to a vaccine when this becomes available.

170. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000, para 40

8. INTERNATIONAL LAW AND STANDARDS

“No worker is expendable. Every worker is essential, no matter what category is applied to them by States or businesses. Every worker has the right to be protected from exposure to hazards in the workplace, including the coronavirus ... Our message today is simple, but crucial: every worker must be protected, no matter what.”

Statement by Special Rapporteurs¹⁷¹



Health workers screen motorists and people visiting a public hospital in Harare, Zimbabwe, after Zimbabwe announced its first case of coronavirus, in one of Africa's most visited tourist spots. The pandemic now threatens a national health system that has nearly collapsed amid an economic crisis, 21 March 2020. © Tsvangirayi Mukwazhi/AP/Shutterstock

171. “Every worker is essential and must be protected from COVID-19, no matter what” – UN rights experts, 18 May 2020, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25892&LangID=E>

Several human rights monitoring bodies have recently issued statements regarding human rights concerns in the context of the COVID-19 pandemic. These have included concerns around the rights of health and essential workers. For example, the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes stated that “The brave doctors, nurses, emergency first-responders and other medical professionals working on the frontlines of the global fight against the coronavirus pandemic are heroes. Their tireless work and self-sacrifice show the best of humanity. They must be protected ... Yet, unacceptable shortages in critical protective equipment continue to be a grave concern in nearly all countries battling the coronavirus”.¹⁷²

The ESCR Committee said, “Many health-care workers, who are performing heroic work on the front lines, responding to the pandemic, are being infected as a result of inadequacies in or shortages of personal protective equipment and clothing ... As the frontline responders to this crisis, all health-care workers must be provided with proper protective clothing and equipment against contagion. It is also essential that they are consulted by decision-makers, and that due regard is paid to their advice. Health-care workers play a critical role in providing early warning of the spread of diseases such as COVID-19 and in recommending effective measures of prevention and treatment”.¹⁷³ Similarly, the European Committee of Social Rights stated that “All possible measures must be taken to ensure that an adequate number of healthcare professionals are deployed and that their working conditions are healthy and safe (see also Article 3 of the Charter). This includes the provision of necessary personal protective equipment”.¹⁷⁴ The Working Group on Economic, Social and Cultural Rights (the Working Group) of the African Commission on Human and Peoples’ Rights called on States parties to “ensure that all frontline medical personnel are protected from infection and receive adequate remuneration for their services in a timely manner”.¹⁷⁵ Similarly, the Inter-American Commission on Human Rights and the Office of the Special Rapporteur on Economic, Social, Cultural, and Environmental Rights noted that states “must prioritize the integrity and well-being of healthcare professionals during the pandemic and deemed it fundamental that states take specific measures to protect and acknowledge people who are carrying out formal or informal care work” and stressed the importance of “special measures for protecting and training health workers, including the provision of protective clothing and disinfecting equipment, as well as duly guaranteeing their labour and social security rights”.¹⁷⁶

This section details states’ obligations around protecting health and essential workers’ human rights in the context of COVID-19, including their right to health; just and favourable conditions of work; freedom of expression and peaceful assembly; freedom from discrimination and violence; and the obligation of all states to provide international cooperation and assistance for the realization of human rights.

172. OHCHR, COVID-19: Health care heroes need protection – UN expert, 27 March 2020, <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25754&LangID=E>

173. Committee on Economic, Social and Cultural Rights, Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, E/C.12/2020/1, 17 April 2020, <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1AVC1NkPsgUedPIF1vIPMKIdSV%2fGyVFSAvr6nizxSIX6zd%2bu5KD26NraabiJKaWMnkFhhMb4MahybE5l%2foU5sQSh6PCbcepqz10iCYklyq>

174. European Committee of Social Rights, Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020, <https://rm.coe.int/statement-of-interpretation-on-the-right-to-protection-of-health-in-ti/16809e3640>

175. African Commission on Human and Peoples’ Rights, Press release on the impact of the COVID-19 pandemic on economic, social and cultural rights in Africa, 4 June 2020, <https://www.achpr.org/pressrelease/detail?id=510>

176. OAS, IACHR and OSRESCER Urge States to Guarantee Comprehensive Protection for Human Rights and Public Health during the COVID-19 Pandemic, 20 March 2020, http://www.oas.org/en/iachr/media_center/PReleases/2020/060.asp

8.1 RIGHT TO HEALTH

Several international human rights treaties protect the right to health.¹⁷⁷ As per Article 12 of the ICESCR: “(1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for ... (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases”. The components of this right are elaborated on in the ESCR Committee's General Comment 14. As per the General Comment, Article 12 protects “the right to healthy natural and workplace environments”, which includes “preventive measures in respect of occupational accidents and diseases” and “safe and hygienic working conditions”.¹⁷⁸ The General Comment also notes that “States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data ... States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services”.¹⁷⁹ This would apply to the working conditions of health workers and essential workers.

8.2 THE RIGHT OF EVERYONE TO THE ENJOYMENT OF JUST AND FAVOURABLE CONDITIONS OF WORK

As per Article 7 of the ICESCR, “States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular ... (a) (i) Fair wages and equal remuneration for work of equal value without distinction of any kind ... (b) Safe and healthy working conditions ... (d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay”. In its General comment 23, the ESCR Committee has provided more detail on what this right entails.¹⁸⁰

- All workers have the right to a fair wage. As per General Comment 23, “The notion of a fair wage is not static, since it depends on a range of non-exhaustive objective criteria, reflecting ... the impact of the work on the health and safety of the worker, specific hardships related to the work and the impact on the worker’s personal and family life”.¹⁸¹
- Preventing occupational accidents and disease is a fundamental aspect of the right to just and favourable conditions of work. As per General Comment 23, States should “adopt a national policy for the prevention of accidents and work-related health injury by minimizing hazards in the working environment”.¹⁸² Workers affected by a preventable occupational accident or disease should have the right to a remedy, and “workers suffering from an accident or disease and, where relevant, the dependants of those workers, receive adequate compensation, including for costs of

177. These include the ICESCR and the Optional Protocol to the ICESCR; the Convention on the Elimination of All Forms of Discrimination against Women; the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities.

178. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000, para 15

179. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000, para 36

180. CESCR, General Comment No. 23 on the right to just and favourable conditions of work, E/C.12/GC/23, 4 March 2016

181. CESCR, General Comment No. 23 on the right to just and favourable conditions of work, E/C.12/GC/23, 4 March 2016, para 10

182. CESCR, General Comment No. 23 on the right to just and favourable conditions of work, E/C.12/GC/23, 4 March 2016, para 25

treatment, loss of earnings and other costs, as well as access to rehabilitation services”.¹⁸³ Workers should be able to monitor working conditions without fear of reprisal.¹⁸⁴ Paid sick leave is critical for sick workers to receive treatment for acute and chronic illnesses and to reduce infection of co-workers.¹⁸⁵

- As per the General Comment, daily working hours should generally be limited to eight hours,¹⁸⁶ and the number of hours of work per week should also be limited through legislation.¹⁸⁷ Exceptions should be strictly limited and subject to consultation with workers and their representative organizations. Legislation should also identify daily and weekly rest periods.¹⁸⁸

These should apply to the working conditions of all health workers and essential workers, including in the informal sector.¹⁸⁹ States should also take measures to ensure that third parties, such as private sector employers, do not interfere with the enjoyment of the right to just and favourable conditions of work and respect international occupational health standards.¹⁹⁰

In the context of the COVID-19 pandemic, the ESCR Committee noted that “all workers should be protected from the risks of contagion at work, and States parties should adopt appropriate regulatory measures to ensure that employers minimize the risks of contagion according to best practice public health standards. Until such measures are adopted, workers cannot be obliged to work and should be protected from disciplinary or other penalties for refusing to work without adequate protection”.¹⁹¹

There are several ILO Conventions that also protect aspects of the right to just and favourable conditions of work; some of these instruments are specific to health workers, and include:

Occupational Safety and Health Convention, 1981 (No. 155):¹⁹²

This Convention contains several protections similar to those contained in the ESCR Committee’s General Comment 23. It requires member states to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. As per Article 13, “A worker who has removed himself from a work situation which he has reasonable justification to believe presents an imminent and serious danger to his life or health shall be protected from undue consequences in accordance with national conditions and practice”. Furthermore, Article 16 (3) states that “Employers shall be required to provide, where necessary, adequate protective clothing and protective equipment to prevent, so far as is reasonably practicable, risk of accidents or of adverse effects on health”.

183. CESCR, General Comment No. 23 on the right to just and favourable conditions of work, E/C.12/GC/23, 4 March 2016, para 29

184. CESCR, General Comment No. 23, para 26

185. CESCR, General Comment No. 23, para 30

186. CESCR, General Comment No. 23, para 35

187. CESCR, General Comment No. 23, para 37

188. CESCR, General Comment No. 23, paras 38 and 39

189. CESCR, General Comment No. 23, para 5

190. CESCR, General Comment No. 23, para 59

191. Committee on Economic, Social and Cultural Rights, Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, E/C.12/2020/1, 17 April 2020, para 16 <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuWIAVC1NkPsgUedPIF1vfPMKXidSV%2fGyVFSAvr6nizxSIX6zd%2bu5KD26NraabiJKaWMnkFhhMb4MahybE5I%2foU5sQSh6PCbcepqzI0iCYklyq>

192. The convention has been ratified by 69 states; the text is available here https://www.ilo.org/dyn/normlex/en/f?p=1000:11300:0::NO:11300:P11300_INSTRUMENT_ID:312300

The Occupational Safety and Health Recommendation, 1981 provides further detail into what these obligations entail. Paragraph 3 recommends that states take measures regarding “design, manufacture, supply, use, maintenance and testing of personal protective equipment and protective clothing”, “prevention of harmful physical or mental stress due to conditions of work”, and “supervision of the health of workers”.¹⁹³ As per Paragraph 10, the responsibilities of employers might include “to provide, without any cost to the worker, adequate personal protective clothing and equipment which are reasonably necessary when hazards cannot be otherwise prevented or controlled” and “to ensure that work organisation, particularly with respect to hours of work and rest breaks, does not adversely affect occupational safety and health”.

Employment Injury Benefits Convention, 1964 (No. 121):¹⁹⁴

The Employment Injury Benefits Convention requires state parties to prescribe a definition of ‘industrial accident’ and ‘occupational diseases’ and publish a list of what diseases would qualify. Workers who have experienced “a morbid condition; incapacity for work resulting from that condition and involving suspension of earnings; total loss of earning capacity or partial loss thereof in excess of a prescribed degree, likely to be permanent, or corresponding loss of faculty; and loss of support suffered as the result of the death of the breadwinner by prescribed categories of beneficiaries” are entitled to a range of benefits, including compensation, medical care, and a funeral benefit where applicable. According to Paragraph 6 of the Employment Injury Benefits Recommendation, 1964, “there should be a presumption of the occupational origin of such diseases where the employee (a) was exposed for at least a specified period; and (b) has developed symptoms of the disease within a specified period following termination of the last employment involving exposure”. The WHO has already stated that the employers of health workers must honour the right to compensation, rehabilitation, and curative services for health workers infected with COVID-19 following exposure in the workplace should be “considered as an occupational disease arising from occupational exposure”.¹⁹⁵

Nursing Personnel Convention, 1977 (No. 149):¹⁹⁶

This Convention applies specifically to “all categories of persons providing nursing care and nursing services” and states, amongst other things, that “nursing personnel shall enjoy conditions at least equivalent to those of other workers in the country concerned in the following fields”: hours of work, including regulation and compensation of overtime, inconvenient hours and shift work; weekly rest; paid annual holidays; educational leave; maternity leave; sick leave; and social security. It also asks states to endeavour to improve existing laws and regulations on occupational health and safety by adapting them to the special nature of nursing work and of the environment in which it is carried out.

193. Occupational Safety and Health Recommendation, 1981 (No. 164), text available here: https://www.ilo.org/dyn/normlex/en/f?p=NORML EXPUB:12100:0::NO::P12100_ILO_CODE:R164

194. The convention has been ratified by 24 states; the text is available here - https://www.ilo.org/dyn/normlex/en/f?p=1000:11300:0::NO:11300:P11300_INSTRUMENT_ID:312266

195. WHO, Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health, Interim Guidance, 18 March 2020, [https://www.who.int/publications-detail/coronavirus-disease-\(covid-19\)-outbreak-rights-roles-and-responsibilities-of-health-workers-including-key-considerations-for-occupational-safety-and-health](https://www.who.int/publications-detail/coronavirus-disease-(covid-19)-outbreak-rights-roles-and-responsibilities-of-health-workers-including-key-considerations-for-occupational-safety-and-health)

196. The convention has been ratified by 41 states; the text is available here - https://www.ilo.org/dyn/normlex/en/f?p=1000:11300:0::NO:11300:P11300_INSTRUMENT_ID:312294

8.3 PROTECTION AGAINST STIGMA, DISCRIMINATION AND VIOLENCE

Several international human rights treaties guarantee the right to equality and non-discrimination.¹⁹⁷ The right to non-discrimination is an immediate and cross-cutting obligation and applies to the exercise of each and every human right guaranteed under international law. The ESCR Committee has said that State Parties must “immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination” on any of the prohibited grounds.¹⁹⁸ The ESCR Committee has also said that State Parties must “adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds”.¹⁹⁹

8.4 FREEDOM OF EXPRESSION

Under article 19 of the ICCPR, everyone has the right to “freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds”.²⁰⁰ While this right may be subject to certain restrictions for the protection of national security, public health or public order, or for the protection of the rights of others, these restrictions must be provided by law, be necessary and proportionate specifically aimed at a relevant legitimate purpose, and not be discriminatory.²⁰¹ The burden of justifying a limitation upon a right guaranteed under the ICCPR lies with the state.

In the present instance, it is unclear how limiting health and essential workers’ rights to the freedom of expression around their working conditions and health and safety at work meets the strict criteria for what would constitute a valid restriction on article 19 rights. This is essential to ensure access to timely, meaningful and accurate information concerning the nature and level of the health threat and the measures taken by state authorities. The UN Human Rights Committee has also stated that “The obligation also requires States parties to ensure that persons are protected from any acts by private persons or entities that would impair the enjoyment of the freedoms of opinion and expression to the extent that these Covenant rights are amenable to application between private persons or entities”.²⁰²

HEALTH AND ESSENTIAL WORKERS AS HUMAN RIGHTS DEFENDERS

In many contexts, many health and essential workers are human rights defenders today as their actions promote and defend people’s rights to health and to information. The UN Declaration on Human Rights Defenders outlines the main protections all people are entitled to when acting up for

197. These include the ICESCR; the ICCPR, the Convention on the Elimination of All Forms of Discrimination against Women; the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities

198. CESCR, General Comment No. 20: Non-discrimination in economic, social and cultural rights, E/C.12/GC/20, 2 July 2009, para 8(b)

199. CESCR, General Comment No. 20: Non-discrimination in economic, social and cultural rights, E/C.12/GC/20, 2 July 2009, para 11

200. Article 19, ICCPR

201. Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1984/4 (1984); CESCR General Comment No. 14, para. 29 states that any limitations “... must be proportional, i.e., the least restrictive alternative must be adopted...” and “...they should be of limited duration and subject to review.” See also, Human Rights Committee, General comment No. 34, CCPR/C/GC/34, 12 September 2011.

202. Human Rights Committee, General comment No. 34, CCPR/C/GC/34, 12 September 2011, para 7

human rights.²⁰³ These protections should apply to health and essential workers where relevant as well. The Special Rapporteur on the situation of human rights defenders has recommended that states “enact legislative and policy frameworks with a view to establishing national protection programmes for defenders, in consultation with defenders and civil society” and “develop a mechanism to investigate complaints of threats or violations against defenders in a prompt and effective manner, and initiate appropriate disciplinary, civil and criminal proceedings against perpetrators as part of systemic measures to prevent impunity for such acts”.²⁰⁴

Human rights defenders are crucial in the struggle to overcome the COVID-19 pandemic and ensure that no one is left behind in the response. Health and essential workers who are defending human rights have been key in informing the public about the challenges posed by COVID-19 at all stages, ensuring governments provide accessible and reliable information in a clear and transparent manner, and raising the alarm when measures are damaging, inadequate or disproportionate. States bear the ultimate responsibility to protect human rights defenders, to prevent and effectively address allegations of human rights violations and abuses committed against them and related to their human rights work, and to ensure that they can carry out their work in a safe and enabling environment.²⁰⁵

HEALTH AND ESSENTIAL WORKERS AS WHISTLE-BLOWERS

In some contexts, health and essential workers have also blown the whistle to raise the alarm and expose wrongdoing that threatens human rights or to disclose other information in the public interest that they have acquired in the context of their work-based relationship. Since the outbreak of COVID-19, several health and essential workers have reported through internal channels or to independent bodies information regarding the unsafe conditions in their workplace or have sometimes felt compelled to speak publicly about the government’s response to the COVID-19 pandemic.

Under the right to freedom of expression, states have an obligation to protect whistle-blowers who may face retaliation because of having reported wrongdoing, and to put in place the necessary mechanisms to enable whistle-blowers to disclose the relevant information safely and without fear of reprisals.²⁰⁶ The Special Rapporteur on the promotion and the protection of the right to freedom of opinion and expression has said that states laws should “protect any person who discloses information that he or she reasonably believes, at the time of disclosure, to be true and to constitute a threat or harm to a specified public interest ... Upon disclosure, authorities should investigate and redress the alleged wrongdoing”. Furthermore, the Special Rapporteur clarifies that “protections against retaliation should apply in all public institutions ... Acts of reprisals and other attacks against whistle-blowers and the disclosure of confidential sources must be thoroughly investigated and those responsible for those acts held accountable”.²⁰⁷

203. Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms, A/RES/53/144, 8 March 1999, <https://www.ohchr.org/Documents/Issues/Defenders/Declaration/declaration.pdf>

204. Report of the Special Rapporteur on the situation of human rights defenders, A/HRC/31/55, 1 February 2016, https://www.ohchr.org/Documents/Issues/Defenders/A-HRC-31-55_en.pdf

205. Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms, A/RES/53/144, 8 March 1999, Art. 2.

206. Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, A/70/361, 8 September 2015, https://www.un.org/en/ga/search/view_doc.asp?symbol=A/70/361. As per the Special Rapporteur on , a whistle-blower “is a person who exposes information that he or she reasonably believes, at the time of disclosure, to be true and to constitute a threat or harm to a specified public interest, such as a violation of national or international law, abuse of authority, waste, fraud, or harm to the environment, public health or public safety”.

207. Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, A/70/361, 8 September 2015, https://www.un.org/en/ga/search/view_doc.asp?symbol=A/70/361.

8.5 INTERNATIONAL CO-OPERATION AND ASSISTANCE

The vast majority of the world's states are party to human rights treaties that include the obligation of international cooperation and assistance.²⁰⁸ The ESCR Committee's General Comment 14 states clearly that "given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing states in this regard".²⁰⁹ In addition to financial assistance, states also have an obligation to cooperate and share information wherever possible to achieve common human rights goals and protections. In the words of the ESCR Committee, "Pandemics are a crucial example of the need for scientific international cooperation to face transnational threats. Viruses and other pathogens do not respect borders ... Combating pandemics effectively requires stronger commitments from States to international co-operation, as national solutions are insufficient".²¹⁰

208. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000, paras 38 and 45.

209. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000, para. 40; CESCR, General Comment No. 19: The right to social security, E/C.12/GC/19, 4 February 2008, para 41.

210. Committee on Economic, Social and Cultural Rights, Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, E/C.12/2020/1, 17 April 2020, para 23, <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1AVC1NkPsgUedPIF1vfPMKXidSV%2fGyVFSAvr6nizxSIX6zd%2bu5KD26NraabiJKaWMnkFhhMb4MahybE5l%2foU5sQSh6PCbcepqzIoiCYklyq>

9. CONCLUSIONS AND RECOMMENDATIONS

“When a health worker is provided with adequate personal protective equipment, we will not be scared of attending to any patient, regardless of the symptoms they exhibit, and lives would be saved.”

Health worker, Nigeria²¹¹

“We have worked tirelessly and are ready to work more. But we cannot sustain ourselves without proper support.”

ASHA worker, India²¹²

This report has outlined the grave concerns health and essential workers experience today, and the many ways in which governments are failing to adequately protect the full range of their human rights. In the context of their occupational health and safety, health and essential workers face shortages and difficulties accessing PPE in several countries; they also experience challenges around remuneration and compensation, high workloads and associated anxiety and stress. In several countries, instead of being supported, health and essential workers are facing reprisals from the state and from their employers for speaking out about their working conditions or for criticising the authorities’ response. And finally, health and essential workers are also subjected to social stigma and acts of violence from members of society because of the jobs they perform. While many of these concerns have been thrown into sharp focus in the context of the pandemic, they often reflect long-standing structural issues that have affected health and social systems for years, including a systematic lack of investment and preparedness, poor infrastructure, and the inadequate mainstreaming of human rights in health system design. Whatever the reason, the time to ensure that health and essential workers are

211. Amnesty International Nigeria Public Statement, Nigeria: Authorities must protect health workers on the frontline of COVID-19 response, 1 May 2020, AFR 44/2264/2020, <https://www.amnesty.org/download/Documents/AFR4422642020ENGLISH.pdf>

212. Interview with ASHA worker, India, April-May 2020

adequately protected is now, and all states have an obligation to make this happen. Not doing so carries a high cost that everyone will have to bear.

This report is released at a time when the pandemic seems to be waning in some countries and becoming more intense in others. Amnesty International has been monitoring the situation in several countries, and the lessons and recommendations contained in this document are universal. Countries who are experiencing the worst of the pandemic right now must urgently implement the recommendations to protect the rights of health and essential workers mentioned below. Countries who are as yet not severely affected, should use the time available to ensure that health systems are prepared and that they have the infrastructure to fully protect the rights of health and essential workers if and when the pandemic hits. And countries who have just seen the worst of the pandemic should prepare themselves for potential “second waves”, as well as follow up on the concerns raised by health and essential workers to ensure accountability in situations where their rights were not fully protected.

Based on the information above, Amnesty International make the following recommendations to ensure that health and essential workers are adequately protected during the COVID-19 pandemic:

- States should provide clear and reasoned public guidance on which workers are considered “essential” or “key” for the duration of the pandemic, and what their entitlements are, including where relevant, that they can travel despite any quarantines or curfews in place. This should include all persons working in the delivery of health care in any capacity, as well as workers in sectors that continue to operate and provide essential services during this period;
- Non-State actors, such as private employers, also have a responsibility to respect the human rights and to secure just and favourable conditions at work. States must effectively regulate and enforce this right and sanction non-compliance by public and private employers;
- Health and safety protections at the workplace, and benefits associated with being part of the COVID-19 response, should be equally available to all health and essential workers engaged in the response, irrespective of the terms of their contract (permanent or temporary), whether they work in the formal or informal sector, and how long they have been in post.

JUST AND FAVOURABLE CONDITIONS OF WORK

a. Deaths and infections due to COVID-19

- States should collect and publish data by occupation, including categories of health and other essential workers who have been infected by COVID-19, and how many have died as a result, in order to ensure effective protection in the future. This data should be disaggregated on the basis of prohibited grounds of discrimination, including but not limited to gender, caste, ethnicity, and nationality wherever possible, as well as place of work.

b. Lack of adequate PPE

- States should ensure that employers – whether the employer is public or private - provide all health and essential workers with adequate PPE to protect themselves during the COVID-19 pandemic, in line with international standards. Where health and essential workers have had to pay for and procure PPE privately because of shortages, they should be reimbursed;
- States should ensure that employers – whether the employer is public or private – take all practicable steps to make the workplace safe for workers, including putting in place rules around physical distancing, and adapting working protocols to ensure protection against the current health

risks. Where employers require workers to commute to and from a workplace, they should ensure protections against the risks to workers arising due to the pandemic.

- States should protect workers' right to remove themselves from a work situation that they have reasonable justification to believe presents an imminent and serious danger to their life or health, including because they feel they do not have adequate PPE, and protect them from any undue consequences as a result of this removal;
- States should collect and publish data on whether all health and essential workers have access to PPE, what the PPE gap for health and essential workers is, what types of PPE there is a shortage of, and where the shortages are, to allow for a more comprehensive assessment of needs and a more equitable distribution of PPE;
- Where shortages persist, states should consider all available measures to increase the availability and dissemination of quality PPE to health and essential workers, including by:
 - Prioritizing the delivery of existing PPE stocks to health and essential workers experiencing shortages, before allowing access to other industries that are not as key now,
 - Taking steps to prevent the hoarding of these supplies;
 - Encouraging domestic production and manufacture through granting incentives and support to businesses to do so;
- States should assess and ease trade and pricing practices that put the availability, affordability and quality of essential commodities such as PPE at risk within their country or in other countries.

c. Workload and mental health concerns

- Where relevant, states should ensure that changes to health and essential workers' working hours, leisure time, annual leave, and other terms of employment are only modified in line with international human rights law and standards, and in consultation with workers and their representatives. Any such modifications must be temporary, necessary and proportionate, and must ensure that workers have adequate opportunities to rest and recuperate;
- States should take active steps to protect the mental health of health and essential workers, including by
 - Ensuring that employers design and implement an occupational health strategy that recognises the need for psychosocial support for health and essential workers, including by encouraging employers to take measures to reduce stress in the workplace by managing work shifts appropriately;
 - Ensuring that workers are aware of where and how they can access mental health and psychosocial support services, and states and employers should facilitate access to such services;
- States must ensure that all health and essential workers who have contracted COVID-19 or are asked to quarantine because they are suspected of having COVID-19, are entitled to paid sick leave as long as they are unable to work;
- States must ensure that health systems and other essential services are adequately staffed, and that where necessary, sufficient numbers of health workers and essential workers are recruited to account for the increased workload, during the COVID-19 pandemic;

d. Work and compensation

- States must ensure that all health workers and essential workers are paid fair wages, which reflect the impact of their work on the health and safety of the worker, specific hardships related to the work and the impact on the worker's personal and family life, in line with international human rights law and standards. Where the circumstances of the pandemic affect any of the factors listed above – such as, where hardships or the impact of the work on the health of the worker are significantly increased - states should consider revising their wages, or supplementing them even if temporarily, to reflect these changed circumstances;
- Where States have already put in place measures to provide additional compensation or benefits for some health and essential workers who are facing additional hardship due to the COVID-19 pandemic, they must ensure that (i) these measures are equally available to all workers in equivalent circumstances; and (ii) that all health and essential workers receive the additional compensation or benefits in a prompt and timely manner. In doing this, States should acknowledge that some health and essential workers may face greater risks due to the nature of their jobs and underlying socio-economic factors that may result in poorer health outcomes for them;
- States must continue to make efforts to close the gender pay gap including in the healthcare and social care sectors and create decent working conditions for paid care workers;
- States should recognise COVID-19 as an occupational disease, and workers who contract COVID-19 as a result of work-related activities should be entitled to cash compensation and medical and other necessary care. This should include all health and essential workers. If health and essential workers die as a result of contracting COVID-19 at work, their family and dependants should receive compensation and other forms of support.
- States should ensure that health and essential workers have timely access to testing services for COVID-19, and form part of the priority groups for COVID-19 testing in their jurisdictions;

REPRISALS

- States must ensure that all health and essential workers can exercise their right to freedom of expression without fear of reprisals and ensure that employers put in place systems that allow health and essential workers to report on health and safety risks.
- Health and essential workers' safety concerns must be listened to and addressed in an appropriate manner. There must be no retaliation against workers for raising concerns or lodging a complaint related to health and safety.
- Where health and essential workers have faced reprisals or disciplinary action at their workplace for raising health and safety concerns, or have lost their jobs as a result, the action against them should be properly investigated by competent authorities and where relevant, they should be granted with adequate reparations, including the possibility of being reinstated.
- States should publicly recognise the role of health and essential workers in defending human rights during the pandemic and provide a safe and enabling environment in which they can exercise their work free from reprisals, intimidation or threats.
- States should protect all health and essential workers who defend human rights and ensure that any limitation on the rights to freedom of expression, association, peaceful assembly, movement, and privacy are strictly necessary and proportionate for the protection of public health or in

pursuance of another legitimate purpose under international human rights law.

- States must ensure that health and essential workers can exercise their rights to freedom of peaceful assembly and of association, without fear of reprisals. This includes refraining from violating workers' rights, taking positive measures to fulfil the rights and protecting against violations by third parties, and respecting the rights of all workers to engage in collective bargaining and other collective action, including the right to strike.

STIGMA AND VIOLENCE


- To counter stigma against health and essential workers, states should disseminate accurate and evidence-based information about
 - The COVID-19 illness, how it is spread, and how it can be prevented, so people act on evidence and not misinformation;
 - Their support for health and essential workers, including the crucial role they are performing during the pandemic.
- Where necessary, states should facilitate health and essential workers' access to essential services, including housing, so they are at less risk of being denied the same due to social stigma.
- States should ensure that health and essential workers have a safe mode of transport to and from work (for example, providing them with transport where they are unable to take public transport because of lock down measures), and that this is accessible and affordable to all of them. This should take into account the specific needs of different types of health and essential workers, including their personal circumstances, where they live, what time their shift is, etc.
- States must put in place protocols to ensure that managers of all facilities where health and essential workers work conduct an analysis of what risks their staff face regarding violence and stigma and put in place adequate security measures to address these threats.
- States must inform all security personnel and others responsible for overseeing lockdowns, curfews or quarantines where these are in place, that health and essential workers are entitled to go to and from work, and any complaints of harassment or violence by security personnel must be immediately investigated.
- Any attacks or acts of violence against health and essential workers must be promptly investigated in a thorough, independent and impartial manner by state authorities, and perpetrators must be brought to account. States must have a zero-tolerance attitude to violence and discrimination against health and essential workers. In doing so, states should acknowledge that some health and essential workers may be at additional or specific risk due to their multiple and intersecting identities, and this should be factored into the state's response.
- States must set up systems to document any violent incidents, discrimination and/or stigmatization faced by health and essential workers during the COVID-19 pandemic and encourage workers to report such incidents promptly.

GENERAL

- Accountability should be a crucial part of recovery from the pandemic. Comprehensive, effective and independent reviews should be carried out regarding states' and other actors' preparedness for and responses to the pandemic. Where there is cause to believe that government agencies

did not adequately protect human rights – including the rights of health and essential workers - in the context of the pandemic, states should provide effective and accessible remedies, including through thorough, credible, transparent, independent and impartial investigations into these allegations, ensure accountability, and learn lessons to ensure that any failure to adequately uphold human rights in their responses is not repeated in any future waves of the COVID-19 pandemic, or any other mass disease outbreaks.


- States should ensure the participation of health and essential workers in the development and implementation of all policies that affect them, and that future health and social sector reforms are based on principles of accountability and transparency and are fully consistent with human rights obligations.
- States should increase budgetary allocations to the public health sector; and develop a plan to ensure that the public health system is adequately funded and staffed. This should include a detailed assessment of the amount of public health spending necessary to ensure that all persons can enjoy the right to health, and options to finance increased public health spending.
- States who have the resources to provide financial support to states unable to effectively respond to the COVID-19 pandemic and its fallout have an obligation to do as a matter of urgency, including by encouraging international financial institutions to extend greater support, in their capacities as members of these organizations.
- Where they have not done so, states should ensure that the rights to health, to and at work, to social security, and to an adequate standard of living are recognized and protected in their domestic legal systems.
- Where they have not done so, states should sign and ratify the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Occupational Safety and Health Convention, 1981; the Employment Injury Benefits Convention, 1964; and the Nursing Personnel Convention, 1977.



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EXPOSED, SILENCED, ATTACKED:

FAILURES TO PROTECT HEALTH AND ESSENTIAL WORKERS THE DURING COVID-19 PANDEMIC

Health and essential workers have played an extraordinary role in the global response to the COVID-19 pandemic. Across countries, they have put their health and wellbeing at risk, often in very difficult circumstances and with very little support, to ensure that people are able to access the essential services they need. Based on information from 63 countries and territories, this report highlights the challenges health and essential workers have faced during this period. Amnesty International's analysis has shown that over 3000 health workers have lost their lives due to COVID-19 during the pandemic – a figure that is likely to be a major underestimate - and many others have worked in unsafe environments due to shortages in personal protective equipment (PPE). They have faced reprisals from the authorities and their employers for raising safety concerns, including arrests and dismissals, and in some cases have been subject to violence and stigma from members of the public. This report makes concrete recommendations for what governments across the world need to do to comply with their human rights obligations and adequately protect the rights of health and essential workers.

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