Briefing paper: Review of the Nursing Personnel Convention, 1977 (C149) and Nursing Personnel Recommendation, 1977 (R157)

Contents

Overview of C149 and R157

The Nursing Personnel Convention, 1977 (C149) is a Technical Convention, an instrument that is relevant to a specific category of workers and legally binding to the states that ratify it. The Convention is accompanied by the Nursing Personnel Recommendation, 1977 (R157), a more comprehensive document which also includes an Annex of Suggestions for Practical Application. Recommendations are not legally-binding, and governments that ratify the Convention are not obligated to implement them, only to report on the provisions of the Recommendation.

There is currently no ILO instrument that covers health services in general. However, C149 is an important sectoral instrument due to its broad definition of nursing personnel, the growth of the health sector over the last four decades and the expansion of nursing work in sectors such as aged care since the Convention was adopted.

The premise for why the Convention is needed, set out in its preamble, continues to be as relevant in 2021 as it was in 1977:

- There is a lack of development in effective provision of health services in many countries. Shortages of qualified nursing personnel and poor utilisation of existing workers are some of the main reasons for this.
- The work of nursing personnel is vital for public health and for the welfare of the population.
- The public sector is a major employer of nursing personnel and should play an active role in the improvement of conditions of employment and work of nursing personnel.

C149 addresses 'special conditions' under which nursing work is carried out; these specific standards for nursing personnel are to supplement general ILO standards that apply to all workers (the general standards being discrimination, freedom of association and the right to bargain collectively, voluntary conciliation and arbitration, hours of work, holidays with pay and paid educational leave, social security and welfare facilities, and maternity protection and the protection of workers' health).

The Convention focuses on recognising the work of nursing personnel, defining them as a distinct occupational group and incorporating them into the health policy framework. The specific standards that are set out in C149 comprise of only seven substantial articles which focus on governments recognising the work of nurses, establishing a regulatory framework for nursing and recognising their right to representation and to bargain. They cover general principles and are open to a large degree of interpretation. Governments that ratify C149 essentially commit to the following:

- **Adopt a definition of nursing personnel which encompasses 'nursing personnel' in the broad sense**: C149 it applies to all 'nursing personnel', wherever they work, which is defined to include 'all categories of persons providing nursing care and nursing services' (art. 1.1 and 1.2). In principle, this extended definition of nursing personnel should apply not only to professional nurses in the hospitals sector, but also to nursing assistants, aides, trainees and students, including workers undertaking nursing services across all sectors.
- **Adopt and apply policy on nursing services and nursing personnel within the framework of general healthcare policy:** With the objective to further the health of the population and to attract and retain the nursing personnel workforce, C149 obliges governments to pursue 'within the resources available for health care as a whole' and 'in a manner appropriate to national conditions' necessary policy measures that provide education and training, employment and working conditions, career prospects and remuneration to nursing personnel (art. 2.1 and 2.2).

- **Establish requirements for education and training of nursing personnel and limit practice to those who meet the requirements:** Nursing education and training should be co-ordinated with education and training of other workers in the field of health, and requirements laid down through national laws and regulations or competent professional bodies or authorities (art. 3 and 4).
- **Commit to ensuring that nursing personnel enjoy 'at least equivalent' conditions to other workers in the country:** this applies in relation to hours of work, overtime, shift work, weekly rest, paid holidays, education leave, maternity leave, sick leave and social security (art. 6); it is critical to note here that this article of the Convention does not create any legally-binding standards specific to nursing personnel, and instead asserts that existing provisions should be extended to nurses under national law and regulations.
- **Establish a preference for determining conditions of employment and work through negotiation; Include employers' and workers' organisations in consultation in relation to health policy formulation and involve nursing personnel in participatory processes in decisions concerning them**: This applies both in relation to national policy relating to nursing services and nursing personnel and co-ordination with broader health policies (art. 2.3 and 2.4); as well as to planning of nursing services and decisions affecting nursing personnel (art. 5.1) and the settlement of disputes relating to terms and conditions of employment (art. 5.3); C149 establishes a 'preference' that conditions of employment and work be determined through negotiation between employer and workers' organisation (art. 5.2).
- **'If necessary, endeavour to improve' existing OHS laws and regulations**: This requires making adaptations that recognise the 'special nature of nursing work and the environment in which it is carried out'. However, it does not define this necessity and it is not specific about OHS obligations (article 7).
- **Allow for loopholes on nursing labour carried out on a volunteer basis**: There is an allowance made for competent authorities to establishing special rules in relation to volunteer nursing labour, which are not bound to the convention except for articles that relate to education, training and OHS provision; decisions on this are supposed to be made 'after consultation with the employers' and workers' organisations concerned, where such organisations exist' (article 1.3).

The accompanying Recommendations (R157) add substantial detail to the above, outlining policy guidance and proposals for practical application. However, unlike the Convention, this constitutes guidance and is not legally-binding. The key points addressed in these recommendations are:

- **Expansive definition of nursing personnel which encompasses all categories of work across all sectors recommending three-tiered classification structure.**
- **OHS and provisions for preventing and compensating 'special risks' faced by nursing personnel.**
- **Organisation of working time and schedules, including shift work and on-call duty, and provisions for**
    - **Rest time**
    - **Annual leave**
    - **Sick leave**
    - **Maternity leave**
    - **Compensation for particularly arduous or unpleasant conditions**
- **Principle for determining remuneration by collective bargaining as a preference, to reflect both the value of the work, be commensurate with other professions requiring**

comparable qualifications, skill, and levels of responsibility, and take into account the difficult conditions of nursing work and the need to attract and retain workers.

- **Provisions for 'special employment arrangements', including making provisions for part-time and temporary work as a means of attracting and retaining workers – *note this is highly problematic as it amounts to a promotion of insecure work.***
- **Participation of nursing personnel in social dialogue in the context of:**
  - **Developing a holistic healthcare policy.**
  - **Workers' participation in decision making in the workplace.**
  - **Averting recourse to industrial action among nurses through negotiation and arbitration.**
  - **Nursing personnel should have a say in shaping and adjudicating disciplinary rules relevant to them.**
  - **Right to claim exemption on grounds of conviction.**
- **Recommended organisation of professional practice, education and training for nursing personnel, with two streams of education proposed and provisions for continuing education and return to the workforce.**
- **Principles for international cooperation and migrant nursing personnel.**

See Appendix B for a detailed outline of the above points.

Current Status and Implementation of C149

- C149 was adopted at Geneva on 21 Jun 1977. It has since been ratified by only 41 countries, with only 5 new ratifications in the last 20 years.

Decade	Ratifications	Countries
1970s	8	Sweden, Ecuador, Bangladesh, Belarus, Russian Federation, Ukraine, Finland, Philippines
1980s	20	Iraq, Uruguay, Zambia, Poland, Denmark, Guinea, Egypt, Guyana, United Republic of Tanzania, Venezuela, Jamaica, France, Italy, Portugal, Ghana, Congo, Malawi, Greece, Belgium, Norway
1990s	8	Malta, Kenya, Kyrgyzstan, Azerbaijan, Latvia, Seychelles, Tajikistan, Guatemala
2000s	4	Slovenia, Lithuania, Luxembourg, Fiji
2010s	1	El Salvador

- Among many countries that have ratified C149, application of the Convention is problematic. A substantial proportion of countries are failing to meet even minimal reporting obligations. Under Article 22 of the ILO Constitution, specific reports are periodically requested from States which have ratified ILO Conventions. The Committee of Experts on the Application of Conventions and Recommendations (CEACR) makes direct requests of government to provide information and reports observations. A survey of the CEACR comments gathered for all countries that ratified the convention shows that many governments are not providing full responses to the ILO's questions and not providing relevant documents that had been requested. 11 out of 41 Governments that ratified the Convention have not met their most recent reporting obligations and have a history of not meeting their routine minimal reporting obligations: Congo, France, Ghana, Guinea, Guyana, Jamaica, Kyrgyzstan, Malawi, Malta, Russian Federation and Tajikistan (see Appendix A).

- OHS is central to the ILO's mandate: 'protection of workers against sickness, disease and injury arising out of employment is among the objectives of the International Labour Organization as set out in its Constitution' and 'promotion of occupational safety and health is part of the International Labour Organization's agenda of decent work for all'. New ILO Conventions concerning occupational health have been adopted since C149 was adopted, including:
    - the Occupational Safety and Health Convention of 1981 (No. 155) – 69 ratifications; it is worth noting however that C155 contains a provision for exclusion of particular branches of economic activity, e.g., maritime shipping or fishing
    - List of Occupational Diseases Recommendation, 2002 (No. 194) – the recommendation calls for a competent authority to establish a 'national list of occupational diseases for the purposes of prevention, recording, notification and, if applicable, compensation'; it includes an annex list of occupational diseases which is meant to be regularly reviewed; it was last revised in 2010 and should be done so soon, to include COVID-19
    - Occupational Health Services Convention, 1985 (No. 161) (ratified by only 33 countries)
    - ILO/WHO: Occupational safety and health in public health emergencies: A manual for protecting health workers and responders, 2018
    - ILO Violence and Harassment Convention, 2019 (C190)

- In addition to the Equal Remuneration Convention, 1951 (No. 100), which is not adequately reflected in C149, there have been a number of ILO Conventions relevant to gender equity developed since the adoption of this Convention, which should be reflected in any review. These include:
    - Workers with Family Responsibilities Convention, 1981 (No. 156).
    - Maternity Protection Convention, 2000 (No. 183)

- See Appendix C for a summary of 13 relevant ILO Conventions that had been adopted since C149; it is worth noting that the majority of these conventions have even fewer ratifying countries than C149, but there is a substantial degree of cross-over with countries that have ratified C149.

The General Survey in the context of COVID-19 pandemic and earlier developments

- Member States of ILO are required to report under Article 19 of the ILO Constitution on non-ratified Conventions and on Recommendations, indicating in their reports the extent to which effect has been given or is proposed to be given to those instruments. The ILO's *General Survey 2022 (Decent work for care economy workers in a changing economy)* combines four ILO instruments as part of a one reporting process: the Nursing Personnel Convention, 1977 (C149), the Domestic Workers Convention, 2011 (C189), the Nursing Personnel Recommendation, 1977 (R157) and the Domestic Workers Recommendation,

2011 (R201). The *General Survey* takes the form of 56 detailed questions relevant to all four instruments.

- The *General Survey* was launched on 25 June 2019, thus preceding the COVID-19 pandemic and the urgency that a major health emergency and crisis in the global economy entails for this review. Taking this into account, in June 2020, the deadline for government submissions was extended to 28 February 2021, to give an opportunity for Member States to report on recent developments. Trade unions and other social partners are encouraged to submit reports by June 2021. The ILO's Bureau for Workers' Activities (ACTRAV) released a general guidance to assist trade unions to answer questions on the four instruments. PSI will be providing a more detailed guidance for affiliates, specifically on Convention, 1977 (C149) and the Nursing Personnel Recommendation, 1977 (R157).

- The health sector is big business and a significant area of global economic growth; in the five years prior to the COVID-19 pandemic, the global health market grew at an average rate of 7.3% per year, far exceeding growth in other sectors and attracting record levels of private financing due to a high return on investment. At the same time, it relies heavily on public funding, and the vast majority of the world's people depend on public health. The commercialised health sector was projected to be worth $11.9 trillion in 2022, close to 10% of global GDP (with 42% of value concentrated in North America). While the Asia-Pacific region has seen the highest rates of growth, an increased demand for care services due to an ageing population trend in many mid- and high-income countries has also seen transformation in the composition of the health sector as multinational nursing home companies in Europe, North America and increasingly Latin America now dominate aged care. This is proving a significant liability on all of society, undermining health as a public good and creating the conditions for profiting from the pandemic.

  In 44 years since C149 was adopted, nursing occupations have undergone significant changes due to technological innovation in the health sector. Automation, Artificial Intelligence (AI) and Information & Communication Technology (ICT) continue to deliver benefits such as new treatments, telehealth, faster and more precise diagnostic tools, and real-time integration of patient data. However, the digital turn in the health sector has also given rise to new threats in the form of erosion of privacy, the introduction of new forms of workforce surveillance and changes in the organisation of work towards more insecure forms of employment. The so-called 'gig economy' or 'digital platform work' has already become established in nursing occupations in some countries, especially the United States. The deployment of app-based platforms and algorithms to organise work is especially advanced in the homecare sector but is increasingly also entering into hospitals. Given the right conditions, many of these innovations could be utilised to ease the burdens on workers through saving time, making difficult jobs easier and more fulfilling, and facilitating better work-life balance, prevent burnout through more flexible arrangements. However, when guided by priorities of profit-seeking, cost-cutting and privatisation, the deployment of digital health platforms as employment vehicles threatens to erode public services, undermine job security thus reducing workforce retention, preventing workforce skilling, and compromising the quality of patient care. These implications of digital platforms – especially for job security – cannot be ignored; job security is a necessity for decent nursing jobs, and it needs to be a central issue in the General Survey.

- The COVID-19 pandemic has exposed failures in health systems facing underinvestment in public health and exposed to the profit motive, widening inequality and furthering private profits from the commercialisation of health at the expense of the workforce and public. The crisis has been most acute in aged care facilities, with COVID-19 related deaths among nursing home residents accounting for approximately 40% of total deaths across OECD countries. It has also led to millions of nursing personnel around the world infected, and thousands of deaths. Confronting an escalating emergency, health workers have seen their working conditions deteriorate, with high numbers of nursing personnel infected due to a lack of protective equipment and adequate OHS. Absences due to sickness have placed further pressure on the workforce, leading to greater risks for workers and patients. The lasting impact is not yet clear, however – especially with emerging evidence of 'long COVID' it is beyond reasonable doubt that it will exacerbate the difficulties in attracting and retaining nursing personnel. For health systems to be viable in the future, this makes the widely recognised goal of reducing a global shortage of nurses all the more urgent.

- Gender-equity needs to be central to the review process. Women make up approximately 67% of employment in the health and social sectors (compared with 41% of total employment).

- A persistent crisis in the health workforce is not new; workforce shortages and inequality in access to health across the majority world have persisted for decades. This was indeed a key premise for C149 when it was adopted in 1977, underscoring the shortage in nursing personnel and the dimension of global inequity. In 2016, the United Nations High-Level Commission on Health Employment and Economic Growth noted that across OECD countries, health sector employment grew by 48% between 2000 and 2014. Despite a projected 40 million new health sector jobs worldwide by 2030, these will be mostly concentrated in high- and middle-income countries. There will be a shortfall of 18 million health workers by 2030 if decisive and immediate actions are not taken to invest in the health workforce. This inequality is also evident in education capacity, as three quarters of capacity for educating health workers is concentrated in high- and upper-middle-income countries. According to the WHO State of World Nursing 2020 report, there was a shortfall of 5.9 million nurses globally, of which 5.3 million (89%) is concentrated in low- and lower middle-income countries.

- 2017 World Health Assembly resolution on "Working for Health: A Five-Year Action Plan (2017-2021) has been hailed as a paradigm shift on recognising the economic value of investment in the health sector – it calls for investment in the health workforce recognising that decent working conditions are key to attracting and retaining the workforce, strengthening quality of health services, and combating gender inequality. The Action Plan puts forward a plan for forward collaboration between ILO, OECD and WHO for tripartite social dialogue between governments, employers, and trade unions, strengthening or producing national health workforce strategies, improving data and monitoring, aligning domestic resources and development assistance with workforce strategies and scaling up professional and vocation education programs for the health workforce.

- The GS process can be expected to expose in granular detail the structural inadequacies of health systems, the failure of existing arrangements to meet global healthcare needs, the inequality between wealthy countries and the majority world, the lack of action taken to

ensure investment in decent conditions for nursing personnel, and the inadequacy of measure to protect health workers from harm in the midst of a global health emergency. Critically, it is important for PSI and affiliates to use this process to propose solutions.

Key recommendations

RELEVANCE

- The core premises of the Convention remain highly relevant. As the sole ILO instrument covering the health sector, these provisions are unique to C149 and not captured in any other ILO instrument.
    - A professional classifications structure for nursing personnel determined in relation to education and training, level of functions and authorisation to practice.
    - Specific standards relevant to working time, shift work, on-call duty, etc including limitation and compensation.
    - An approach to dispute settlement that recognises the central role of unions in shaping sectoral policy and determining workplace conditions through negotiation, especially in relation to OHS, policies on special risks, determining emergency exemptions and the organisation of working time with the consent and participation of unions.
- ➔ To this end, critical elements of the instruments should be retained and where necessary, updated and strengthened:

SCOPE AND COVERAGE OF THE CONVENTION

- The Convention adopts a broad definition of nursing personnel. In principle, it extends coverage to all workers at both advanced and basic qualification levels who are engaged in nursing work across both the public and private health sectors, including not only hospitals but also nursing homes, homecare and community health services. Key questions in the General Survey concern whether national laws actually match this definition of nursing personnel set out by the Convention.
- ➔ Identify inconsistencies and assess which groups of health workers are included and excluded within national laws from the definition of 'nursing personnel' set out in C149.
- ➔ Develop a case for strengthening the Convention. The focus needs to be on the substantial changes that have occurred in the health sector since 1977:
    - Changes in composition of the health sector, especially the growth employment of nursing personnel outside hospital settings (nursing homes and home-based care),
    - Changes in work organisation, especially growth in insecure and temporary work
    - Changes in professional classification structures and programmes for skills and training
    - Expansion of a globalised migrant nursing personnel workforce including the phenomenon of 'chain migration',
- ➔ Encourage the ILO to issue clear guidance that makes explicit reference to all sectors covered by the Conventions, to remove any scope for ambiguity.
- ➔ Call for the Convention to stress the need for job security and income security in the nursing (to roll back precarity and wage cuts/freezes, that have become generalised over the last decade). This is especially relevant in light of trends in digitalisation of health care and expansion of the so-called 'gig economy' and the expansion of platform work into nursing occupations that threatens public services, job security and rights to privacy.

OCCUPATIONAL HEALTH

- The issue of health and safety of nursing personnel is of critical importance, with the pandemic placing increasing pressure and risk on the workforce. This has been particularly evident in the disparity between hospitals and long-term care settings in many countries.

➔ Provisions concerning OHS in C149 (article 7) and R157 (paras 24-26) need to be strengthened to include prevention and compensation for injury, illness and special risks, including exposure to infectious diseases.

➔ There have been a number of instruments adopted since C149 that relate to occupational health and safety, occupational health services, and occupational diseases which should be reflected in a revised Convention.

WORKING CONDITIONS

- *Detailed recommendations for working conditions are set out in R157 (paras. 21-61). For a detailed summary, see Appendix B.*
- These standards should be protected, retained and strengthened in any revised instrument; crucially, they need to be applicable to the entire nursing personnel workforce. Ideally, they would be part of the Convention as legally binding standards rather than recommendations and suggestions for implementation.
- In their current form, the R157 provides a framework for sectoral collective agreements. However, as they were developed over 40 years ago and many modern collective agreements exceed these standards, these provisions should be updated.
  - ➔ standards set out in R157 should be compared to a sample of best-practice collective agreements drawn from three sections: a) public hospitals, b) private hospitals and c) nursing homes. This sample should be tested against R157 to assess where the agreements meet, exceed or contradict the provisions set out in R157. For example, a comparison with the Public Health System Nurses' & Midwives' (State) Award 2019, a sectoral industrial instrument that covers all nursing personnel employed in public health organisations in New South Wales, Australia:
    1. Reflected in R157:
       - Classification structure reflecting education and responsibility
       - Limits on working time
       - Annual leave
       - Sick leave
       - Maternity leave
       - Restrictions and compensation for on-call duty
       - organisation of shift work
       - Minimum rest periods
       - Hazard pay
       - Right to union representation in disciplinary processes
       - Inclusion of union in health service planning
       - Consultation with union when introducing significant changes that has effect on nursing personnel
       - Exemptions in cases of emergency
    2. Exceeding R157
       - Reasonable workloads and minimum staff to patient ratios
       - Maximum proportion of enrolled nurses or assistants to registered nurses
       - Subsidised accommodation and board for live-in nursing personnel and excluding them for carrying out domestic work
       - Staff facilities such as toilets, change rooms and lockers
       - Personal and carers leave
       - Domestic and family violence leave
       - Long service leave

- Career break scheme
- Travel allowance
- Continuing education allowance
- Remote living allowance
- Car allowance
- Communication device allowance
- Uniform and laundry allowance
- Other special allowances
- Facilities time for on-duty trade union activities and leave for trade union conferences and courses

3. Contradicting R157
   - Limit placed on how long workers can be employed on temporary contracts
   - Conversion of casual workers to permanent

➔ Regarding minimum nurse-to-patient ratios it is important that these are stressed as a floor that should be established, not as a limit.

'SPECIAL EMPLOYMENT ARRANGEMENTS': TEMPORARY WORKERS VULUNTEER NURSES

- The most problematic aspects of C149 and R157 relate to provisions for 'special employment arrangements', which including making provisions for part-time and temporary work as a means of attracting and retaining workers, as well as allowing volunteer nurses, who are exempt from most of the provisions under the Convention.
- There is a broader issue with the ILO instruments – with only one convention that deals with security of employment, the Termination of Employment Convention, 1982 (No. 158). The ILO has developed policy in relation to 'non-standard forms of employment' (NSFE) and its Committee of Experts released the most recent conclusions in 2015; however, while this shows sensitivity to many relevant issues including job precarity raised by trade unions, a key problem with NSFE is that it is an inadequate umbrella term; it encompasses all kinds of employment that are not permanent and full-time, i.e.. 'fixed-term work, temporary and agency work, dependent self-employment, and part-time work'. There are however no Conventions addressing job security itself, a particular weakness given the growth in the gig economy / platform work. It is important to note that platform work is also an increasing trend in the health sector, with nursing personnel increasingly affected, especially among workers in nursing homes and homecare.
  - ➔ Provision for temporary work in 'special employment arrangements' (para 57 and 58 of R157) should be removed.
  - ➔ Provision for volunteer nurses and their exemption from the Convention should also be removed (Article 1.3 of C149); consideration should be given to the ILO's *Guidelines on decent work in public emergency services* (2018) which contains provisions for persons in volunteer work participating in crisis response. Key provisions are to carefully consider what specific activities should be designated for unpaid volunteers, and that 'the use of volunteers should not impair the coordination of [Public Emergency Services (PES)], substitute PES workers, or undermine the wages or working conditions of other PES workers or be used to justify the understaffing or underfunding of PES'.

SOCIAL DIALOGE AND DISPUTE RESOLUTION

- The Convention contains significant provisions for consultation with social partners relating to national health policy as well as to decisions that affect nursing personnel at the workplace level, including collective bargaining and dispute resolution.

- Neither the convention nor the recommendation prohibits workers exercising the right of industrial action. However, given that nursing personnel are essential workers whose withdrawal of labour can be life threatening, governments are meant to ensure that mechanisms are in place to resolve disputes through social dialogue and arbitration mechanisms before industrial action becomes necessary. There is a danger here that this provision can be used to restrict nursing personnel from engaging in industrial action on the spurious basis of 'essential services'.
  - ➔ Provisions within C149 and R157 for social dialogue with workers representatives, including at the level of national health policy and in workplace decision making, should be pursued as rights and contested in all cases that they are being denied.
  - ➔ Article 5.3 of C149 and Para 19.2.c of R157 needs to be strengthened to remove any ambiguity that could give governments license to exclude nursing personnel from the right to strike.

COMPLIANCE WITH THE CONVENTION

- The Convention is ratified by only 41 countries; ILO reports suggest that a substantial number of countries that have ratified it are not complying with it.
  - ➔ Review the history of (non)compliance with C149 among government that have ratified C149, identify key issues that are preventing some governments from applying the provisions,
  - ➔ Identify barriers that are discouraging governments from ratifying the Convention.

Appendix A: Summary of reporting process for ILO Member States that have ratified C149

Under Article 22 of the ILO Constitution, reports are periodically requested from States which have ratified ILO Conventions. A reporting form (dating from 1986) is used by countries that ratify the C149 to make an annual report to the ILO on the measures taken to give effect to the Convention.[1] Governments are asked to:

- describe the national policy concerning nursing services and nursing personnel and indicate the bodies responsible for formulating and implementing policy
- indicate special rules established concerning nursing personnel who give nursing care and services on a voluntary basis and how employers' and workers' organisations were consulted
- indicate measures with regard to education and training, and employment and working conditions, including career prospects and remuneration and indicate how coordination and consultation is carried out
- Indicate the manner in which basic requirements regarding education and training are laid out, how it is supervised and how cooperation is ensured.
- Indicate legislative or other provisions which specify the requirements for practice of nursing.
- Provide information on both private and public sectors regarding:
    - Participation of nursing personnel in planning of nursing services and consultation on decisions
    - How conditions of employment and work of nursing personnel are determined
    - How disputes applicable to nursing personnel are settled
    - What are the procedures other than negotiation, and whether parties concerned were consulted
- Indicate whether nursing personnel enjoy conditions at least equivalent to other workers in regards to hours of work, overtime, shift work, weekly rest, paid holidays, education leave, maternity leave, sick leave and social security.
- Indicate any measures that give effect to adaptations to OHS for nursing personnel.
- State to what authorities the application of the provisions under the convention are entrusted and how they are supervised and enforced.
- State whether courts or tribunals have given decisions relevant to the application of the convention and provide text of those decisions.
- Provide general data on nursing personnel including numbers of workers by sectors and activity, by level of training and functions, relation to population, number of patients, and the number of people leaving the profession. Provide general information on how the convention is applied in practice and any practical difficulties encountered in implementing it.
- Indicate the representative organisations of employers and workers which have been included in the reporting, or else explain why they have not been included. Communicate the observations that were received from representative organisations relating to legislation or the practical application of provisions in the convention.

[1] https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:14002:0::NO:::

A survey of the CEACR comments gathered for all countries indicates that 11 out of 41 Governments that ratified the Convention have not met their most recent reporting obligations. In all cases these states have a history of not meeting minimal reporting obligations. These countries are:

- **Congo**: ignored request to report in 2018 and 2019; partial reporting in 2014; did not report in 2013; reported in 2011; ignored requests to report in 2010, 2009, 2008, 2007 and 2006; reported in 2005 but only information that they had already provided; ignored request to report in 2003; partially reported in 1999 and 1995, but did not send requested information; ignored request to report in 1994; partial report in 1993; ignored request to report in 1992 after making a first report in 1991.
- **France**: ignored request to report in 2018; reported in 2014 and 2011; ignored request to report in 2010, 2009 and 2008; reported in 2005; did not supply requested information for 10 years.
- **Ghana**: ignored requests to report in 2019 and 2018; reported in 2015; ignored requests to report in 2013; reported in 2009 and 2005; ignored requests to report in 2004 and 2003; reported in 2002; ignored requests to report in 2000 and 1999; reported in 1996; ignored requests to report in 1995 and 1994; reported in 1992; ignored request to report in 1991; made first report in 1990.
- **Guinea**: ignored requests to report in 2019 and 2018; reported in 2015; ignored requests to report in 2014; reported in 2013; ignored requests to report in 2012, 2011, 2010, 2009, 2006, 2002, 2001, 2000, 1999; reported in 1995; ignored requests to report in 1994; reported in 1992 and 1991.
- **Guyana**: ignored requests to report in 2019 and 2018; reported in 2015; ignored requests to report in 2013, 2012, 2011, 2010, 2009, 2008; reported in 2005; partial reports in 2000, 1995, 1994, 1993; reported but did not respond to comments in 1992; partially reported in 1991 and 1990.
- **Jamaica**: ignored requests to report in 2018; reported in 2013 and 2009; reported in 2004 but reproduced previous information; reported in 2002 but did not respond to comments; ignored requests to report in 2001, 2000, 1999; reported in 1995 and 1992; initial detailed report in 1990.
- **Kyrgyzstan**: ignored requests to report in 2018; briefly reported in 2017; reported in 2013; ignored requests for thirteen consecutive years to report in 2011, 2010, 2009, 2008, 2007, 2006, 2005, 2004, 2003, 2002, 2001, 2000, 1999; initial report in 1995.
- **Malawi**: ignored requests to report in 2018, reported in 2015; ignored requests to report in 2014 and 2013; reported in 2009; ignored requests to report in 2008; reported in 2005; ignored requests to report in 2003; reported in 2001, 1999, 1995; ignored requests to report in 1994, 1993, 1992; initial report in 1990.
- **Malta**: ignored requests to report in 2018; briefly reported in 2014 without responding to comments; ignored requests to report in 2013; reported in 2009; ignored requests to report in 2008; reported in 2004 and 2001; ignored request to report in 1999; reported in 1996; ignored request to report in 1995.
- **Russian Federation**: last provided substantive information on the implementation of the Convention in 2003 and had previously sent detailed reports; very brief report in 2010; ignored requests to report in 2008.
- **Tajikistan**: ignored requests to report in 2019 and 2018; reported in 2017; ignored requests to report in 2014 and 2013; reported in 2010.

A number of CEACR reports refer to Article 5 paragraph 3 of C149 when there are cases of major collective labour disputes: *"The settlement of disputes arising in connection with the determination of terms and conditions of employment shall be sought through negotiations between the parties or, in such a manner as to ensure the confidence of the parties involved, through independent and impartial machinery such as mediation, conciliation and voluntary arbitration."* This provision is also linked to Paragraph 19.2.c of R157: *"the settlement of disputes arising in connection with the determination of terms and conditions of employment should be sought through negotiation between the parties or through independent and impartial machinery, such as mediation, conciliation and voluntary arbitration, with a view to making it unnecessary for the organisations representing nursing personnel to have recourse to such other steps as are normally open to organisations of other workers in defence of their legitimate interests"*. When citing these provisions, CEACR points out the underlying issues behind the dispute and questions the government about what they are doing to ensure a negotiated settlement and to resolve underlying issues. Examples include:

- Azerbaijan: noting that industrial action is prohibited in hospitals, and CEARC wanted an explanation about the arrangements for settling disputes through compulsory arbitration.
- Jamaica: CEARC observed in light of the government putting an injunction against industrial action, that the government failed to negotiate on working conditions, and this has led to staff shortages, and resulted in civil disobedience among the workforce, which is escalating from wearing black armbands and sickout action. CEARC demanded to know what the government was doing to negotiate.
- Malta: escalating disputes, ILO offered to mediate to avert industrial action
- Poland: protests over chronic low wages, workload, restructuring and commercialisation of hospitals. CEARC wants to know what the government is doing to strengthen social dialogue.
- Finland, 2009: "Article 5, paragraph 3, of the Convention. Settlement of disputes. The Committee notes the observations made by the Commission of Local Authority Employers (KT) concerning the industrial action taken by the Union of Health Professionals (TEHY) during the collective negotiations held in autumn 2007. According to these observations, the TEHY attempted to force a 25 per cent pay increase by undertaking a mass resignation that directly and critically threatened the life and health of patients. TEHY action allegedly affected emergency units and operations in complete disregard of ministerial directives and established labour practices. The Committee requests the Government to transmit any comments it may wish to make in reaction to the observations of KT, especially in light of Article 5(3) of the Convention which requires the settlement of collective labour disputes through independent and impartial procedures such as mediation, conciliation and voluntary arbitration with a view to making it unnecessary for the organizations of nursing personnel to have recourse to industrial action which may be disruptive of sensitive health-care operations. "

Appendix B: Outline of the Nursing Personnel Recommendation, 1977 (R157)

Expansive definition of nursing personnel which encompasses all categories of work across all sectors that recommends a three-tiered classification structure: A modern classification system is recommended for nursing personnel which should be applied across all establishments and sectors employing nursing personnel (Para. 6.2). Classifications should be based on the level of judgement, responsibility, authority, and technical skill required (Para. 6.1). A proposed three-tier structure is put forward (5.2):

> *(a) professional nurses, having the education and training recognised as necessary for assuming highly complex and responsible functions, and authorised to perform them;*
>
> *(b) auxiliary nurses, having at least the education and training recognised as necessary for assuming less complex functions, under the supervision of a professional nurse as appropriate, and authorised to perform them;*
>
> *(c) nursing aides, having prior education and/or on-the-job training enabling them to perform specified tasks under the supervision of a professional or auxiliary nurse.*
>
> NOTE: The Convention applies to 'all nursing personnel, wherever they work' however it does not explicitly define the service settings. The structure set out above should be equally applicable to nursing aides in hospitals as well as community-based health workers (CHWs), long-term care and all other health settings.

The implementation suggestions call for consulting with employers' and workers' organisations in classifying these categories (Annex. 5), and to develop four functions of nursing personnel: direct and supportive nursing care; administration of services; nursing education; research and development (Annex. 3). The implementation suggestions further advise that the classification system should be linked with scales of remuneration and be sufficiently open, allowing passing from one level to another, providing incentives for equitable promotion (Annex. 12).

Functions that involve direct relations with patients and the public must be recognised, (Para. 21.2), but there should also be a range of possibilities for professional advancement for nursing personnel in the areas of leadership positions, administration, education, research and development; the remuneration structure should reflect this. (Para. 22.1).

Participation of nursing personnel in social dialogue in the context of developing a holistic healthcare policy: Nursing personnel should be included 'in planning and in decisions concerning national health policy in general and concerning their profession in particular at all levels, in a manner appropriate to national conditions' (Para. 19.1). Healthcare policy recommended to be formulated in consultation with employer and workers' organisation and to include measures to (Para. 4.2.c):

> *(i) to facilitate the effective utilisation of nursing personnel in the country as a whole; and*
>
> *(ii) to promote the fullest use of the qualifications of nursing personnel in the various establishments, areas and sectors employing them*

There should be representation of nursing personnel at levels of 'elaboration and application of policies and general principles regarding the nursing profession, including those regarding education and training and the practice of the profession' (Para. 19.2.a)

Workers' participation in decision making in the workplace: There should be representation of nursing personnel through workers' organisation to determine conditions of employment and work in negotiation with employers. (Para. 19.2.b). At the level of the employing establishment, nursing personnel or their representatives should be associated with decisions relating to their professional life (Para. 19.2.d). This includes decisions concerning organisation of work, working time and rest periods, which should be taken in agreement or consultation with freely chosen representatives of nursing personnel or with organisations representing them. This includes matters such as: working schedules; what hours are to be considered as inconvenient; conditions to be considered particularly arduous or unpleasant; conditions in which on-call duty will be counted as working time; length of meal and rest breaks; the form and amount of compensation for overtime, shift work and work in inconvenient hours; circumstances under which emergency exemptions can be made (43).

Relevant instrument for protecting representatives of nursing personnel: Workers' Representatives Convention and Recommendation, 1971. (Para. 20)

Levels of remuneration should be preferably determined by collective bargaining, and should reflect both the value of the work, be commensurate with other professions requiring comparable qualifications, skill and levels of responsibility, and take into account the difficult conditions of nursing work and the need to attract and retain workers: The recommendations put forward several principles for raising the pay of nursing personnel: pay levels should be commensurate with 'socio-economic needs, qualifications, responsibilities, duties and experience, which take account of the constraints and hazards inherent in the profession, and which are likely to attract persons to the profession and retain them in it' (Para. 25.1); should reflect other professions requiring similar or equivalent qualifications or responsibilities (Para. 25.2); should be comparable across different establishments and sectors where nursing personnel work (Para. 25.3); should be adjusted over time (Para. 25.4); and should preferably be fixed by collective agreement (Para. 25.5). The implementation suggestions however offer somewhat weakened guidance and advise that pending the raising of pay levels for nursing personnel to levels commensurate with other professions, they should be raised to sufficient levels to attract and retain workers (Annex. 16). The implementation suggestions further advise that increases in remuneration should be provided at every level in reference to development of experience and ability (Annex, 13).

Remuneration should be entirely payable in money (Para. 28.1) and deduction should not be made unless allowed under national laws or fixed by collective agreements or arbitration (Para. 28.2). Nursing personnel should have a free choice to use the services provided by the employers (Para. 28.3) and should not be charged for work clothing, medical equipment and supplies and transport, which should be provided and maintained free of charge by the employer (Para. 29).

The Practical Application Suggestions call for sufficient budgetary provision (Annex. 1), and for appropriate technical and material resources for nursing personnel to be able to properly carry out their tasks (Annex. 4).

Insecure work - temporary work and part-time work are treated the same for the purpose of 'special employment arrangements': There should be temporary and part-time employment measures introduced to make most effective use of available nursing personnel labour and to

prevent their withdrawal from the profession (Para. 57). Conditions should be equivalent to permanent and full-time staff, with entitlements calculated on a pro rata basis (Para. 58).

Standards for professional practice, education and training for nursing personnel: The practice of the nursing profession should be limited to authorised persons who attain the required education and training or who are licensed by a certification body (Para. 13). Workers in a lower classification should not be used as substitutes for those in higher categories except for cases of emergency (Para. 6.3 and 15.1). Conditions for such an emergency exemption should be taken in agreement or consultation with freely chosen representatives of nursing personnel or with organisations representing them. (Para. 43.c).

Two tiers of education and training are recommended, one advanced and one less advanced (Para. 9.2):

> *(a) an advanced level, designed to train professional nurses having sufficiently wide and thorough skills to enable them to provide the most complex nursing care and to organise and evaluate nursing care, in hospitals and other health-related community services; as far as possible, students accepted for education and training at this level should have the background of general education required for entry to university;*
>
> *(b) a less advanced level, designed to train auxiliary nurses able to provide general nursing care which is less complex hut which requires technical skills and aptitude for personal relations; students accepted for education and training at this level should have attained as advanced a level as possible of secondary education.*

Practical work of students should be organised for their training needs and it should in no case be used as a means of meeting normal staffing needs (Para. 60.1); students should only be given tasks for which they are prepared (Para. 60.2). They should be given the same health protection as nursing personnel (60.3) and should have appropriate legal protections (Para. 60.4). Students should receive detailed information on employment, working conditions and career prospects of nursing personnel (Para. 61).

Nurses undergoing advanced level of higher nursing education should be prepared for the highest responsibilities 'in direct and supportive nursing care, in the administration of nursing services, in nursing education and in research and development in the field of nursing' (Para. 10), whereas nursing aides should be 'given theoretical and practical training appropriate to their functions' (Para. 11). Where workers are already employed on work for which they are not qualified, they should have their training facilitated as quickly as possible to obtain the necessary qualifications (Para. 15).

Education and training should be carried out 'where appropriate', within framework of the general education system at the same level as comparable professions (Para. 7.2); it should contain elements of both theory and practice (Para. 8.1), with the practical elements 'given in approved preventive, curative and rehabilitation services, under the supervision of qualified nurses' (Para. 8.2); it should be organised according to community needs and integrated with education and training of other healthcare workers (Para. 7.4); Additionally, the Practical Application Suggestions call for using nursing education and training programmes to supplement general education where it is lacking (Annex. 6).

Nursing education and training programmes should include provisions for continuing education and training to ensure knowledge and skills are kept current (Para. 12.1); provisions should be made for

the promotion and advancement of nursing aides and auxiliary nurses (Para. 12.2); where possible, nurses who wish to undertake continuing education and training should be granted paid leave in accordance with the Paid Educational Leave Convention 1974 (Para. 24.2); other forms of support could consist of grants of paid or unpaid education leave, adaptation of hours of work, payment of study or training costs (Para. 24.1). The Practical Application Suggestions further advise that paid educational leave should be included as work for the purpose of entitlements to social benefits and other employment rights and that where possible, unpaid educational leave should be taken into account for seniority in regard to remuneration and pension rights (Annex. 15).

Education and training should also facilitate re-entry of nurses into the workforce after periods of interruption (Para. 12.3 and 22) taking into account previous experience and duration of interruption (Para. 23). The Practical Application Suggestions advise that verification of qualifications may be necessary in some circumstances, and that conditions for renewal of authorisation to practice may be conditional on a requirement for undertaking continuing education (Annex. 8). Re-entry could be facilitated by methods such as employing the worker alongside another person before verification takes place (Annex. 9).

Nursing personnel should have a say in shaping and adjudicating disciplinary rules relevant to them: Disciplinary rules applicable to nursing personnel should be determined with the participation of representatives of nursing personnel. Those subjected to disciplinary proceedings should receive fair judgement and have recourse to appeal procedures, with a right to be represented by persons of their choice at all levels of the proceeding (Para. 17). The Practical Application Suggestions further advise that any disciplinary rules applicable to nursing personnel should include a clear definition of the breach of professional conduct, an indication of sanctions applicable, and should be proportional to the gravity of the fault, and within the framework of rules applicable to health personnel as a whole (Annex. 10).

Right to claim exemption on grounds of conviction: Nursing personnel should have the right to claim exemption, without being penalised, from specific duties which conflict with their 'religious, moral or ethical convictions' as long as they raise this objection with their supervisor in good time to avoid compromising quality of care (Para. 18).

Averting recourse to industrial action among nurses through negotiation and arbitration: Without explicitly exempting nursing personnel from the right to take industrial action, the recommendations say: 'the settlement of disputes arising in connection with the determination of terms and conditions of employment should be sought through negotiation between the parties or through independent and impartial machinery, such as mediation, conciliation and voluntary arbitration, with a view to making it unnecessary for the organisations representing nursing personnel to have recourse to such other steps as are normally open to organisations of other workers in defence of their legitimate interests' (Para. 19.2.c)

Organisation of working time and schedules, including shift work and on-call duty: There should be as little recourse to work in overtime, on-call duty, and at inconvenient hours as possible; compensation should be received for overtime and work on public holidays through either time off, higher pay than normal, or both; inconvenient hours should also be compensated with higher pay (Para. 37). The Practical Application Suggestions advise that overtime should be worked on a voluntary basis except where volunteers are not available, and it is necessary for patient care (Annex. 19.2). The Practical Application Suggestions further advise that the need for work in overtime, on-call hours and inconvenient hours should be limited as much as possible, and that

planning should take into account staff leave and absences as to not overburden others (Annex. 19.1).

Working time should be counted as all the time that workers are at the disposal of the employer, 'subject to possible special provisions concerning on-call duty' (Para. 31). The Practical Application Suggestions however also advise that any period of on-call time spent in the workplace or when services are actually used should be regarded as working time and remunerated as such (Annex. 21).

Normal hours should not be higher than those concerning workers in general; in cases where they are above 40 hours, they should be reduced progressively but rapidly without any reduction in pay (Para. 32). Normal daily hours should be continuous and not be higher than 8 hours per day; the working day including overtime should not exceed 12 hours. Exemptions however can be established by laws, regulations, collective agreements, work rules or arbitration awards, or a temporary exemption in case of a special emergency (Para. 33). Conditions for such an emergency exemption should be taken in agreement or consultation with freely chosen representatives of nursing personnel or with organisations representing them (Para. 43.c).

The Practical Application Suggestions advise that all effort should be made for fairly allocating hours of work across the workforce, taking into account individual circumstances and preferences, and that the organisation of hours of work should be based on the need for nursing services rather than being subordinated to work patterns of other health service personnel (Annex. 18)

Sufficient notice should be given to workers about changes in schedule, with the exemption of a special emergency (Para. 35). The Practical Application Suggestions advise that at least two weeks advance notice should be given (Annex. 20).

Shift work should be compensated with increased pay on same basis as shift work in other employment; shift workers should have a rest period of 12 hours minimum; split shifts should be avoided (Para. 38). Decisions about the form and amount of compensation should be taken in agreement or consultation with freely chosen representatives of nursing personnel or with organisations representing them (Para. 43.e).

Rest time: Weekly rest time should in no case be less than an uninterrupted 36 hours, and where it is less than a continuous 48 hours, it should be reduced to that level. (Para. 36). Workers should have reasonable meal breaks, and reasonable rest breaks – the latter included in normal hours of work (Para. 34). Decisions over the length of breaks should be taken in agreement or consultation with freely chosen representatives of nursing personnel or with organisations representing them (Para. 43.d). The Practical Application Suggestions advise that workers should be free to take meals and rest breaks in a place of their choice, other than their workplace (Annex. 22).

Annual leave: Workers should receive – *and be required to take (!)* – a paid annual holiday of same length as other workers; where it is less than 4 weeks per year, it should be raised progressively but as rapidly as possible to 4 weeks (Para. 39). The Practical Application Suggestions advise that the time that annual holidays are taken should be decided equitably, taking into account individual preferences, family obligations and the requirements of the service (Annex. 23).

Sick leave: Workers who are absent due to illness or injury should be entitled to maintenance of the employment relationship and income security in a manner determined by laws or regulations or collective agreements; there should be three categories distinguished: injury or illness incurred at work, where absence is necessary for health of others, and cases that are unrelated to work (Para. 41).

Maternity leave: Workers should be entitled to it; it should not be considered as sick leave and there should be no discrimination made between married and unmarried persons. Relevant instruments should be applied: Maternity Protection Convention (Revised), 1952, and the Maternity Protection Recommendation, 1952, Employment (Women with Family Responsibilities) Recommendation, 1965 (Para. 42).

Compensation for particularly arduous or unpleasant conditions: Financial compensation should be given to nursing personnel who work in 'particularly arduous or unpleasant conditions' (Para. 27). This should be compensated with reduction of working hours, increase in rest periods, or both, without loss in pay (Para. 40). Decisions about the conditions to be considered particularly arduous or unpleasant should be taken in agreement or consultation with freely chosen representatives of nursing personnel or with organisations representing them (Para. 43.g).

OHS and provisions for preventing and compensating 'special risks' faced by nursing personnel: Illnesses contracted by nursing personnel as a result of their work should be compensated as an occupational disease under national laws or regulations (Para. 56). The Practical Application Suggestions further advise that these national laws or regulations should 'prescribe a list establishing a presumption of occupational origin in respect of certain diseases when they are contracted by nursing personnel, and revise the list periodically in the light of scientific and technical developments affecting nursing personnel'; such a list should also be complemented by general definitions of occupational diseases, enabling nursing personnel to establish the occupational origin of diseases that are not presumed (Annex. 28).

Special risks to nursing personnel need to be eliminated, and where not possible, minimised. (Para. 49.1). This should happen in collaboration with nursing personnel and organisations representing them (Para. 51). Nursing personnel should have access to occupational health services; these should be established where they do not exist (Para. 45). OHS studies should be carried out to assess special risks to nursing personnel may be exposed to should be undertaken and kept up to date, to prevent risks and to compensate as appropriate (Para. 48.1).

Nursing personnel exposed to special risks should receive financial compensation (Para. 49.3). The Practical Application Suggestions provide the clarification that at risk groups encompass personnel who are 'regularly exposed to ionising radiations or to anaesthetic substances and personnel in contact with infectious diseases or mental illness' (Annex. 24). Measures to reduce exposure to special risks include PPE, immunisation, shorter hours, more rest breaks, temporary removal from the risks, longer holidays (Para. 49.2). Nursing personnel exposed to special risks should undergo medical examinations at commencement and termination of employment, and at regular intervals, according to circumstances of risk to their health or to others; medical examinations should be confidential and should not be carried out by doctors with whom the nurses have a close working relationship (Para. 47).

Risks for pregnant women and parents of young children should be mitigated through transferring nursing personnel to appropriate work for their situation without loss of entitlements (Para. 50). The Practical Application Suggestions further clarify that this relates specifically to work involving exposure to ionising radiation, anaesthetic substances and infectious diseases (Annex. 26).

Relevant instruments: Occupational Health Services Recommendation, 1959; Protection of Workers' Health Recommendation, 1953; Radiation Protection Convention and Recommendation, 1960; Maternity Protection Recommendation, 1952

International cooperation and migrant nursing personnel: There should be a preference for educating, training and recruiting nurses within their own country (Para. 63). Recruitment of foreign nursing personnel should be authorised in cases where there is a lack of qualified personnel in the country of employment and if there is no shortage of nursing personnel in the country of origin (Para. 67). Migrant nursing personnel should receive equal conditions of employment as those of national personnel at equivalent qualifications (Para. 66.3). Whether working or training they should receive equality of treatment in regards to social security (Para. 69.a). They should be supported if they wish to be repatriated (68). Employing countries should participate in bilateral and multilateral agreements to ensure maintenance of rights pertaining to migrant nursing personnel (Para. 69.b).

Multilateral or bilateral agreements should be developed to promote exchanges of personnel, ideas and knowledge to improve nursing care. These should organise exchange programs, lay down conditions for mutual recognition of qualifications acquired abroad, and harmonise education and training and requirements to practice, without lowering standards (Para. 62).

Nursing personnel undertaking training and education abroad should have access to appropriate financial aid (Para. 64.1), which may be dependent on returning to their country and working in a job using their new qualifications for a specified minimum period (Para. 64.2). The Practical Application Suggestions further propose that such financial aid could include payment of travel expenses, study costs, scholarships and continuation of full or partial remuneration for nursing personnel already employed (Annex. 29).

Relevant instruments: Migration for Employment Convention and Recommendation (Revised), 1949

Appendix C: Summary of other relevant ILO Instruments

Labour Relations (Public Service) Convention, 1978 (No. 151)

- Ratified by 57 countries, including 20 who also ratified C149 (Belarus, Belgium, Denmark, Finland, Ghana, Greece, Guinea, Guyana, Italy, Latvia, Luxembourg, Philippines, Poland, Portugal, Russian Federation, Seychelles, Slovenia, Sweden, Uruguay, Zambia)
- Applies to public employees - all people employed by public authorities - unless more favourable provisions in other Conventions are applicable to them (article 1).
- Protection for public employees against anti-union discrimination; preventing employers from requiring joining or resigning from a public employees association; preventing employers dismissing or otherwise prejudicing on basis of union membership (article 4)
- Independence of unions, protection against interference by public authorities, including through establishing state-controlled or financed unions (article 5)
- Facilities to be provided to representatives of recognised public employees organisations, to carry out functions during and outside hours of work (article 6)
- Measures to allow for negotiation to be carried out on terms and conditions of employment between public authorities and unions, or other methods that allow representatives to participate in determining (article 7)
- Settlement of disputes to be sought through negotiation or independent and impartial mechanisms, like mediation, conciliation, arbitration (article 8)
- Civil and political rights or public employees for normal exercise of freedom of association, 'subject only to the obligations arising from their status and nature of their functions' (article 9)

Night Work Convention, 1990 (No. 171)

- Only 17 ratifications, but six of those are ones that also ratified C149 (Uruguay, Portugal, Belgium, Slovenia, Lithuania, Luxembourg)
- Covers healthcare by default (excludes workers in agriculture, stock raising, fishing, maritime transport and inland navigation) but other limited categories of workers can also be excluded (article 2)
- Measures are to be taken to protect health and safety, assist meeting family and social responsibilities, maternity protection, provide opportunities for career advancement, and appropriate compensation (article 3)
- Night workers have rights to undergo free health assessments and receive advice (article 4)
- Suitable first aid needs to be provided (article 5)
- Night workers unable to work due to health reasons to be transferred to alternative employment or granted same benefits as other workers who are unable to work; temporary unfit to work at night need to be given same protections against dismissal as any worker on grounds of health (article 6)
- Protection for women night workers to receive alternative to night work for sixteen weeks before and after childbirth, can be extended with medical certificate (article 7)
- Compensation for night workers in the form of working time, pay or similar benefits to recognise the nature of night work (article 8)
- Appropriate social services (article 9)

- Employer needs to consult worker representatives before introducing schedules that include night work, and should do so regularly, on details such as schedules, form of organisation, OHS and social services required (article 10)

Termination of Employment Convention, 1982 (No. 158)

- Ratified by 36 countries, including 11 that also ratified C149 (Finland, France, Latvia, Luxembourg, Malawi, Portugal, Slovenia, Sweden, Ukraine, Venezuela, Zambia)
- Termination only permitted for valid reasons or based on operational requirements (article 4)
- Cannot terminate employees due to union membership, being a union rep, making complaints against the employer, race, colour, sex, marital status, family responsibilities, pregnancy, religion, political opinion, national extraction or social origin, absence from work during maternity leave (article 5)
- Cannot terminate employees due to absence from work due to injury or illness (article 6)
- In cases relating to termination due to conduct, employee has right to defend himself against allegations (article 7)
- Provisions for unfair dismissal appeals to courts etc (article 8)
- Except for cases of serious misconduct, minimum notice or compensation in lieu must be offered (article 11)
- Severance allowances (article 12)
- Consultation with workers representatives in cases of terminations or economic or structural reasons (article 13)

Part-Time Work Convention, 1994 (No. 175)

- Ratified by only 18 countries, but including 10 that ratified C149 (Belgium, Finland, Guatemala, Guyana, Italy, Luxembourg, Portugal, Russian Federation, Slovenia, Sweden).
- Flexible working arrangements to promote gender equality and allow workers to balance work and family responsibilities.
- Principle of equal treatment of part- and full-time workers in relation to
    - Right to organise, OHS, anti-discrimination (article 4)
    - Remuneration (article 5)
    - Conditions (article 6)
    - Entitlements – maternity, termination, annual leave, sick leave (article 7)
- Allows for excluding workers from the above whose hours of work or hours are below a certain threshold – requires consultation with representative organisations (article 8)
- More access to part-time work, removing laws that prevent or discourage it, including it in employment services placements, with special attention to needs and preferences of specific groups of workers (article 9)
- Ensuring transfer from full-time to part-time work is voluntary

Maintenance of Social Security Rights Convention, 1982 (No. 157)

- Ratified by only 4 countries, including Kyrgyzstan, Philippines and Sweden which ratified C149.

- Revision of the Maintenance of Migrants' Pension Rights Convention, 1935
- Provisions for continuity or transfer of social security rights, benefits and pensions for migrant workers

Workers with Family Responsibilities Convention, 1981 (No. 156)

- Ratified by 45 countries, including 18 which also ratified C149 (Azerbaijan, Belgium, Ecuador, El Salvador, Finland, France, Greece, Guatemala, Guinea, Lithuania, Norway, Portugal, Russian Federation, Slovenia, Sweden, Ukraine, Uruguay, Venezuela)
- Aim to enable the employment for workers with family responsibilities without discrimination and conflict between employment and family responsibilities (article 3)
- Take into account workers family responsibilities in planning, including in the development of community services, such as child-care and family services and facilities (article 5).
- Vocational guidance and training to enable workers to remain in workforce and for re-integration of workers following absence due to family responsibilities (article 7)
- Family responsibilities not a valid reason for termination of employment (article 8)

Maternity Protection Convention, 2000 (No. 183)

- Ratified by 39 countries, including only 8 which also ratified C149 (Azerbaijan, Belarus, Italy, Latvia, Lithuania, Luxembourg, Portugal, Slovenia)
- Convention applies to all women including those in atypical forms of work, although states can exclude certain categories of workers (article 2)
- Provisions for protecting pregnant women (article 3)
- Provisions for maternity leave – minimum period of 14 weeks, and a compulsory period of six weeks (article 4)
- Cash benefits of no less than 2/3 of previous earnings (article 6)
- Unlawful for employer to terminate employment on grounds of pregnancy or absence on leave; guaranteed right to return to employment at the same pay rate at the end of maternity leave (article 8)
- Break or reduction of hours for breastfeeding (article 10)

Occupational Safety and Health Convention of 1981 (No. 155)

- Ratified by 69 countries, including 20 which also ratified C149 (Belarus, Belgium, Denmark, El Salvador, Fiji, Finland, Guyana, Latvia, Malawi, Norway, Portugal, Russian Federation, Seychelles, Slovenia, Sweden, Tajikistan, Ukraine, Uruguay, Venezuela, Zambia)
- Aim to minimise accidents and injury in the working environment (article 4)
- System of inspection (article 9)
- ‘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.’ (article 13)
- Employer responsibilities for safe workplaces (article 16)
- Occupational safety and health measures shall not involve any expenditure for workers (article 21)

Protocol of 2002 to the Occupational Safety and Health Convention, 1981

- Ratified by 14 countries, including six which also ratified C149 (El Salvador, Fiji, Finland, Luxembourg, Portugal, Sweden)
- Establish systems for recording and notifications of occupational accidents and diseases and review in collaboration with employer and worker reps (articles 2-5)
- Collect national statistics (articles 6-7)

Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187)

- Ratified by 49 countries, including 13 who also ratified C149 (Belgium, Denmark, Finland, France, Guinea, Iraq, Malawi, Philippines, Portugal, Russian Federation, Slovenia, Sweden, Zambia)
- Promotion of continuous improvement in occupational safety and health (article 2)
- Formulating a national policy (article 3)
- National system should include: laws and regulations, CAs, other instruments on occupational safety and health; authority responsible for occupational safety and health; inspectorate mechanisms; arrangements to promote cooperation at workplace between workers and managers for workplace-related prevention measures; tripartite advisory body; information services; occupational safety and health training; research on occupational safety and health; data collection and analysis on occupational injuries and diseases; inclusion into social security system; support mechanisms to extend occupational safety and health to micro enterprises, small and medium businesses and informal sector (article 4)
- National programs for occupational safety and health to be formulated, implemented, monitored and evaluated in consultation with representative organisations of workers and employers (article 5)

List of Occupational Diseases Recommendation, 2002 (No. 194)

- the recommendation calls for competent authorities to establish a 'national list of occupational diseases for the purposes of prevention, recording, notification and, if applicable, compensation';
- includes an annex list of occupational diseases which is meant to be regularly reviewed
  ➔ *Note: this list was last revised in 2010; it should be revised to include COVID-19*

Occupational Health Services Convention, 1985 (No. 161)

- ratified by only 33 countries but includes 10 who also ratified C149 (Belgium, Sweden, Finland, Guatemala, Luxembourg, Poland, Seychelles, Slovenia, Sweden, Uruguay)
- establishes a coherent national policy on occupational health services in consultation with representatives (article 2)
- occupational health services to be available to all workers (article 3)
- details the functions of occupational health services, including risk assessment of workplace health hazards, surveillance of risk factors in the working environment, advice on planning and organisation of work, programs for improving practices, testing and evaluating new

equipment, advice on PPE, monitoring health at work, vocational rehabilitation, first aid and emergency treatment, etc (article 4)
- integration with other relevant services (article 9)
- professional independence of personnel providing occupational health services from the control of employers and unions (article 10)

Violence and Harassment Convention, 2019 (No. 190)

- Not yet in force, so far only ratified by three countries, including Fiji and Uruguay which ratified C149
- In consultation with employer and worker representatives, adopt an inclusive, integrated and gender-responsive approach to prevent and eliminate violence and harassment in the workplace, including from third-parties (article 4)
- Protections only extend to violence and harassment in the world of work. Although it frames this in light of gender-based violence and sensitivity to people belonging to vulnerable groups (article 6), and although it calls for recognising the effects of domestic violence (article 10.g), it does not extend to outside the workplace (e.g., provision to domestic violence leave, for example).
- The accompanying recommendation (R206) calls for employers to implement measures to support domestic violence survivors through leave provisions, flexible working arrangements, and protection from dismissal; however, it does not refer to paid leave (para 18).
- Note: According to the WHO, only 37% of countries have measures to address workplace violence against nurses