Independent Stakeholder Reporting Instrument 2024

Survey response 1

Response ID
193

Date submitted
2024-07-30 14:09:56

Last page
4

Start language
en

Seed
354795686

Date started
2024-07-04 08:01:20

Date last action
2024-07-30 14:09:56

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Nurses in Charge Inc.

First and Last Name of Contact Person:
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www.Nursesincharge.org

Description of the entity submitting the report:
Nurses in Charge is a 501(c)(3) US-based Non-Profit organization led by a dedicated group of international nurses, representing over 19 countries with nursing leadership across every continent. Our mission is to uphold the Global Accountability of International Nursing Sustainability by implementing programs and strategies that assist governments and organizations in the sustainable use of the nursing profession and its pipeline. Position on Sustainable Global Migration and Empowerment of Nursing Professionals At Nurses in Charge, we recognize the critical importance of sustainable global migration and the empowerment of nursing professionals. The international movement of nurses offers significant benefits for both the supplying and receiving countries. However, it also presents unique challenges that require comprehensive and culturally sensitive approaches.

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
Our Strategies: ?1.?Global Accountability and Sustainable Practices: We work closely with governments and organizations to develop and implement policies that ensure the sustainable utilization of nursing resources. Our aim is to balance the supply and demand of nursing professionals, thereby maintaining the integrity and stability of the global nursing pipeline. ?2.?Holistic Support and Culturally Appropriate Integration: We provide holistic support to nurses, addressing their physical, mental, and emotional well-being. Our programs are designed to offer culturally appropriate integration, ensuring that nurses feel valued and supported in their new environments. ?3.?Educational Opportunities: By offering robust educational opportunities, we empower nurses from supplying countries to meet local healthcare needs effectively. Our educational initiatives include continuing education, mentorship programs, and success coaching, which equip nurses with the skills and knowledge required to excel in their roles. ?4.?Legal Affairs and Immigration Support: Our Department of Legal Affairs and Immigration and Migration Specialists comprises leaders from the US, UK, Canada, Africa, the Middle East, Australia, the Caribbean Islands, and Asia. These experts provide support, education, coaching, and remediation to nurses who have experienced burnout, moral injury, human trafficking, and other serious mental and emotional issues. This support is crucial in addressing the disturbances in the nursing pipeline and ensuring the well-being of our professionals. ?5.?Facilitating Connections and Mutual Benefits: We aim to open and strengthen connections between receiving and supplying countries, fostering mutual assistance and benefits from the migration of nurses. This collaborative approach helps both sides address their respective healthcare needs and enhances the global healthcare ecosystem. ?6.?Grassroots Development and Strategic Implementation: With the support of relevant international organizations such as WHO, ICN, and CFGNS, we are committed to the effective implementation of grassroots development and strategies. Our initiatives are designed to have a high impact on nurse retention, satisfaction, and professional growth.

Please specify the country(ies) or region(s) where entity is involved:
United States, Canada, Trinidad and Tobago, United Kingdom, Australia, Yemen, Cameroon, Ireland, Netherlands, India, Italy,Lebanon,Uganda, Philippines,Nigeria,

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Source of information
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Upload document

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking 'Submit'.

Survey response 2

Response ID
200

Date submitted
2024-07-08 12:17:25

Last page
4

Start language
en

Seed
779746417

Date started
2024-07-08 11:48:01

Date last action
2024-07-08 12:17:25

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
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First and Last Name of Contact Person:
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Website URL:
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Description of the entity submitting the report:
Academic

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
Academic research interest

Please specify the country(ies) or region(s) where entity is involved:
United Kingdom

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable

Source of information

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable

Source of information

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable

Source of information

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Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
Please see the uploaded document - especially its conclusions and recommendations - for information about the relationship between data/research and policy/planning. The data underpinning this were generated wrt the Covid-19 period (2020-2022) but/and hold particular significance for future pandemic preparedness. The following is copied from pp. 30-31 of Tipping, Murphy and Yeates et al (2022) (see attached document) "The WHO has advocated a standardised measurement and reporting of the range and severity of impacts not just by sector, but by occupation for both health and care workforces (WHO, 2021:3). We strongly concur with this recommendation. However, it does not go far enough. There is a fundamental need for better data to guide effective policy and practice and improve working conditions of all of the health workforce. Additionally, then, this research highlights the need for: * Better data on the health workforce that enables disaggregation by sex, age, ethnicity, occupation, migration status, country of origin, health status (such as the presence of co-morbidities; also,vaccinations) and whether employed in delivering public or private health care. This would help identify and quantify different levels of relative risk among health workforces and between countries. * Better data systems with greater capacity for collecting and analysing disaggregated data. Crucially, this includes increased capacity to encourage better reporting from health facilities (e.g. a centralised database for reporting) and from workers, their families and/or their representatives (e.g. an online confidential reporting tool). * Further studies into the risks of death experienced by foreign-born health workers. Where suitable administrative data are not available, this could involve surveying a selection of health institutions, designed to act as a representative cross-section of health workplaces within each country, and collecting information on the number of deaths – overall and from Covid-19 – of all health workers along with information on their migrant status, health status, age, sex and occupation and whether they are involved in public or private health care services delivery. * Further studies of Covid-19 deaths (and other impacts) among foreign-trained and -born health workers. Our study has focused on foreign-born health workers, and developing a methodology for estimating the number of Covid-19 deaths among this population. It has been vital to look at a small number of countries in the first instance, but there is significant scope to scale-up this research to encompass many more countries and increase the comparative content. Our research suggests there is some overlap between countries that are high recipients of foreign-born health workers and countries with better data availability, specifically those with data that is available disaggregated by age and sex. There would be some merit in generating a 'near' global estimate of deaths of foreign-born health workers by generating age-sex estimates for all countries with data available, since this will include the bulk of countries that recruit large numbers of health workers, and therefore include the bulk of foreign-born health workers." (pp. 30-31)

Source of information
Migrant health worker deaths during Covid-19: A METHODOLOGICAL EXPLORATION AND INITIAL ESTIMATES (2022) Sarah Tipping, Vicky Murphy, Nicola Yeates, Carlos Montoro, Gihan Ismail and Nashwa Ismail. PSI-Open University. Open Access: https://oro.open.ac.uk/85720/

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable

Source of information

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Upload document
[{ "title":"Migrant health worker deaths during Covid-19: A METHODOLOGICAL EXPLORATION AND INITIAL ESTIMATES","comment":"Open access - https:\/\/oro.open.ac.uk\/85720\/1\/Risks%20FINAL%20for%20publication.pdf","size":3011.8828125,"name":"Tipping%20Murphy%20Yeates%20et%20al%20Risks%20FINAL%20for%20publication.pdf","filename":"fu_b3uvjeea9euhxxf","ext":"pdf" }]

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking ‘Submit’.

Survey response 3

Response ID
222

Date submitted
2024-07-22 17:26:29

Last page
4

Start language
en

Seed
701255280

Date started
2024-07-22 17:10:05

Date last action
2024-07-22 17:26:29

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
UNISON

First and Last Name of Contact Person:
Stuart Tuckwood

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s.tuckwood@unison.co.uk

Telephone number:

Mailing address:
s.tuckwood@unison.co.uk

Website URL:
unison.org.uk

Description of the entity submitting the report:
Trade Union

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
We represent many health and care personnel in the UK, including many migrant workers.

Please specify the country(ies) or region(s) where entity is involved:
United Kingdom

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

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The UK dramatically increased the proportion of health and care workers recruited internationally over recent years. Beginning in 2019 and 2020, there was a huge investment in international recruitment which has led to many tens of thousands of new recruits to the UK. The UK NMC (Nursing and Midwifery Council) maintains the register of nurses and midwives licenced to practice in the UK and releases regular data on register trends. Their data shows that in 2022/2023 and 2023/2024 around half of the new individuals on their register were international recruits. Data indicates that a substantial number of these recruits are now beginning to migrate to other countries. In 2022/2023 over 12,000 UK registered nurses applied for documentation to enable them to leave to practice elsewhere; with 7 in 10 of these nurses originally educated outside the UK. Immigration changes by the UK Government also led to a massive surge in the numbers of migrants coming to the UK to work as care workers. 77,700 individuals arrived in the UK to work as ‘care workers’ in the year ending June 2023 (3). A large proportion of these care workers are qualified as nurses in their home countries but have joined the UK workforce as carers, paid less than registered nurses. They can immediately begin working as carers; whereas practicing as a registered nurse requires registration with the UK nursing and midwifery council. This high level of international recruitment has been necessary because of austerity measures and significant under-investment in public services by the previous Government. Cuts to financial support for healthcare students, pay cuts and increasing demand have had an impact on the attractiveness of careers in healthcare. The social care sector has been in crisis for a number of years, with funding only sufficient to pay the minimum wage or just above it. Numerous providers have claimed that without international recruitment they would have been forced to close.

Source of information
The NMC (2024) Register https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/ - Health Foundation (2024) Nursing locally, thinking globally: UK-registered nurses and their intentions to leave. https://www.health.org.uk/publications/long-reads/nursing-locally-thinking-globally-uk-registered-nurses-and-their-intentions - Migration Observatory (2023) Visas for care workers have driven increase in work migration, while small boats only account for 1/3 of asylum backlog https://migrationobservatory.ox.ac.uk/press/visas-for-care-workers-have-driven-increase-in-work-migration-while-small-boats-only-account-for-1-3-of-asylum-backlog/

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
Nursing shortages in the UK remain a huge challenge. The NHS in England alone records around 31,000 current vacancies, with many more in Scotland, Northern Ireland and Wales, although vacancy levels are also not by themselves a good measure of nursing shortages and may be an under-estimate of actual need. Staffing levels are reported by the majority of staff to be insufficient to deliver safe and effective patient care. There are also a large number of vacancies in primary care and social care. The total number of vacancies across the NHS is consistently over 100,000. The NHS in England has published a long term workforce plan which models the required healthcare workforce over the coming years and outlines the commitments necessary to achieve this. It envisages a large growth in domestic education and training with a corresponding decrease in the extent of international recruitment. The NHS has adopted a number of measures to improve the retention of nurses in the health service, with varying degrees of success. Preceptorships and support to new registrants have been made much more consistent. However, there is currently significant funding uncertainty which is undermining the improvements made. Improving support for new healthcare registered professionals was a key demand made by trade unions for the resolution of industrial action in the NHS in 2023. Despite such initiatives, the Westminster Government has failed again this year to meet the annual deadline for determining the pay rise for healthcare workers in the NHS, forcing many into significant financial distress. Healthcare workers have seen their pay decline significantly relative to other occupations in recent years which is affecting recruitment and retention. Similar, if not greater, issues affect the social care sector. Despite ambitions to increase the numbers of nurses educated domestically there has been a significant decrease in the numbers applying to study nursing. Year on year applications to nursing university courses dropped by 19% in 2023. OECD analysis shows that interest amongst young people in studying nursing has declined in the UK. This demonstrates a serious failure to move towards sustainability in the UK nursing workforce

Source of information
NHS England (2024) Vacancy Statistics - https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2024-experimental-statistics - NHS England (2023) Long Term Workforce Plan - British Journal of Nursing (2023) A drop in nursing applications https://www.britishjournalofnursing.com/content/editorial/a-drop-in-nursing-applications/ - Organisation for Economic Cooperation and Development - Fewer young people want to become nurses in half of OECD countries - https://www.oecd.org/health/Fewer-young-people-want-to-become-nurses-in-half-of-OECD-countries.pdf

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
In our experience the most common routes used by health personnel in migration to the UK are, in order: 1.?Direct active recruitment by the NHS in popular source countries. In terms of scale the two biggest source countries for recruitment of nurses are India and the Philippines. 2.?Recruitment via private recruitment agencies operating in source countries, often into employment with private companies in health or social care. 3.?Passive, direct recruitment whereby individual healthcare professionals apply to vacancies in the UK. 4.?Innovations supporting refugees and other groups of migrants already in the UK (ie. Those on dependent VISAs) to register as nurses and join the NHS. We have much higher confidence in the treatment of migrating healthcare personnel when they are recruited through the first route. There are effective mechanisms in place to ensure NHS organisations adopt an ethical approach to international recruitment. For example they are mandated, if using external recruitment agencies, only to use those accredited as following good ethical standards. NHS organisations also recognise trade unions such as UNISON and negotiate better terms, conditions and policies for their staff. When there is poor practice there is some accountability and mechanisms for health personnel to seek redress., unlike in the social care sector. Another advantage of this recruitment route is that it is more transparent and planned, allowing better monitoring and planning in both countries. There is the opportunity for direct agreements with Governments in source countries; for example the Government of Wales signed a direct agreement with the Government in Kerala to recruit several hundred nurses. With a better ability to plan this allows the provision of more coordinated pastoral support and inductions for nurses in cohorts of international recruits. This direct recruitment also removes any opportunity for exploitative recruitment agencies to act as middle-men and charge high fees of individual health personnel. As a trade union the second route is by far the most common we encounter in terms of exploitation and unethical treatment. The recruitment agencies that individual health personnel turn to often charge them huge fees upfront, despite this being prohibited by UK law and policy. These agencies often provide inaccurate information to individuals which means they make significant life and career decisions without the right information, often leading them into difficulties further down the line. These agencies often appear to have links with poor employers in the UK who exploit the workers; offering low pay and bad terms and conditions. The UK immigration system enables these employers to escape accountability; as they sponsor the individuals VISA there is a significant disincentive for workers to complain about exploitation and poor treatment. In UNISON's experience the worst employers routinely threaten workers with deportation or reporting to the UK Home Office if they complain or whistle-blow. The fragmented nature of social care in the UK, coupled with a weak, under-resourced system of labour market enforcement, has enabled a very large scale of exploitation of migrant health and care personnel. UNISON has published a number of reports exposing this issue. The UK Government has to date taken little meaningful action to address this situation (although the incoming Labour administration has promised an investigation into the exploitation of migrant workers in the care sector and measures to tackle bad practices by employers). Details of exploitation in the social care sector were reported extensively by the Independent Chief Inspector of Borders and Immigration in 2023 to whose inquiry UNISON submitted detailed evidence Route 4 identified above has been on a very small scale but has seen individuals with healthcare experience in the UK supported to develop as nurses and register to work in the NHS. Other projects have supported those with some healthcare skills to undertake training and education to develop into healthcare careers. This is a more ethical, supportive approach to international recruitment by working to educate and develop those already living in the UK.

Source of information
UNISON (2023) The shocking treatment of migrant workers harms us all - Blog: The shocking treatment of migrant workers harms us all | Article, General Secretary's blog | News | UNISON National - UNISON (2023) Government must drop cruel migrant curbs and end exploitation in social care - Government must drop cruel migrant curbs and end exploitation in social care | News, Press release | News | UNISON National - Independent Chief Inspector of Borders and Immigration (2023) An inspection of the immigration system as it relates to the social care sector - August 2023 – November 2023 https://assets.publishing.service.gov.uk/media/6602a6b765ca2fa78e7da854/An_inspection_of_the_immigration_system_as_it_relates_to_the_social_care_sector_August_2023_to_November_2023.pdf

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
The experience of individual health workers varies significantly depending upon their route of recruitment to the UK. Our experience as a union has been that individuals recruited through private recruitment agencies to work in private care organisations have a much poorer experience and are much more vulnerable to exploitation and poor treatment. We have had migrant health personnel report concerns when working in the UK with: -Poor standards of the accommodation provided by employers -Inaccurate and unclear contracts of employment -Low pay, at times lower than was originally advertised for the role and at times breaching minimum wage legislation -Denial of basic employment rights such as sickness or parental leave -Racism and other forms of discrimination -Barriers to joining trade unions and exercising labour rights Consistent guidance and advice has been collaboratively produced by the NHS which sets out best practice in recruitment and induction. This has been effective at promoting best practice across the NHS, ensuring organisations have good standards for supporting the staff they recruit internationally. The UK Government has also produced and recently updated a Code of Practice for the ethical international recruitment of healthcare workers (11). This code sets outs benchmarks and standards for how internationally recruited staff should be recruited and managed. This code is not mandated or legally enforceable however, meaning many organisations do not appear to abide by the set standards. Health personnel recruited into the NHS work according to a national set of agreed terms and conditions. This means they are not directly discriminated against when compared with domestically educated healthcare personnel. However, many do not have their prior level of experience and qualification recognised, meaning they may be significantly underpaid. Evidence also indicates that migrant healthcare personnel do not progress in their careers at a similar rate to domestic healthcare workers. Anecdotal evidence from our members suggests this may be because they are denied the same training, promotion and career opportunities as UK health workers.

Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
A number of memorandums of understanding have been signed between the UK Government and those of 'source' countries, including Kenya, the Phillippines and Sri Lanka. As part of these we understand there has been some collaboration and investment in projects to develop health workforce sustainability in these countries. The UK Government response should contain more of this detail.

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable

The UK has benefited hugely from the massive inflow of internationally recruited healthcare workers, mainly nurses, over the last 3 years. International recruitment has made up a very large proportion of the NHS target to increase nursing numbers over the last five years. As previously mentioned, over the previous 3 years around half of the growth in new joiners to the UK NMC register has been made up of internationally recruited nurses.

A report by the Tropical Health and Education Trust (THET) has outlined and demonstrated a number of the ways that the UK health service benefits from the additional expertise and knowledge of migrating health and care personnel.

Source of information

Tropical Health Education Trust (2021) Experts in our midst: Recognising the contribution NHS diaspora staff make to global health. https://www.thet.org/wp-content/uploads/2021/08/Experts-in-Our-Midst_2021Report.pdf

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable

We understand that UK Government departments are now sharing, in a more coherent way, data on the migration of health and care personnel. However, insufficient planning and preparation has been taken by the Government of projections and estimates of the numbers involved in health and care worker migration.

The UK Government, for example, during the last 3 years opened a new route of migration for many heath personnel by making the role of ‘senior care worker’ open for VISAs.

Government severely underestimated the potential numbers applying to these roles, estimating the expected annual volume to be between 6000 and 40,000 applicants. In fact, over 130,000 applications were made and processed in twelve months, creating a huge influx of care workers into the UK, many of whom were actually registered nurses in the source country.

Government departments and agencies responsible for the enforcement of immigration rules and labour rights were severely under-prepared for such numbers; which has led to many instances of exploitation and unethical treatment which have not been adequately responded to.

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable

The UK Government has published, and recently reviewed, a Code of Practice for the international recruitment of health and social care personnel.

This includes standards and benchmarks related to international recruitment and stipulates that UK organisations must not recruit from ‘red list’ countries; those included in the WHO health workforce support and safeguards list.

Source of information

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
The WHO Code has provided helpful benchmarks and a useful statement of the principles that should apply to ensure an ethical approach is taken to the international recruitment of health and care personnel. The Code has been helpful for organisations such as ours in endeavouring to hold Government and health employers to account for high standards in international recruitment. However, the Code is not enforceable and does not challenge the underlying economic and political context which has seen international recruitment to the UK, and other Western nations, grow dramatically over recent years. Significant recruitment from 'red-list' countries has occurred and reports indicate this has contributed to their shortages of trained health and care personnel. Private recruitment agencies and individuals often appear to operate completely out-with the framework and are unaccountable. We consider the exploitation of migrant nurses and other health and social care personnel to have been a serious, labour rights issue in the UK over recent years. Our experience as a trade union, and that of others in the UK, has been that many of our members have experienced exploitation and unfair labour practices in their recruitment and employment, despite the UK implementing a code that reflects the principles of that of the WHO. Several bilateral agreements have been signed between the Government of the UK and 'source countries', such as India, Malaysia and Sri Lanka. However, health worker organisations, whether trade unions or associations representing the diaspora, have had little to no involvement in these agreements. Whilst promises have been made as part of these agreements, there is little opportunity for Governments to be held to account in their implementation.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
Not applicable. Data and evidence used is from the evidence uploaded previously.

Upload document

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking 'Submit'.

Survey response 4

Response ID
227

Date submitted
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Last page
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Start language
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Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Nursing & Midwifery Council of the United Kingdom

First and Last Name of Contact Person:
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Telephone number:

Mailing address:
NMC, 23 Portland Place, London, W1B 1PZ

Website URL:
https://www.nmc.org.uk/

Description of the entity submitting the report:
Independent professional regulator for nursing and midwifery across the UK

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
All nurses and midwives looking to practise in the UK, and nursing associates looking to practise in England, must register with us. This includes professionals whose original training and education took place internationally. Part of our role involves setting the requirements which internationally educated professionals must meet to obtain registration with us, and setting the requirements for ongoing practice (including compliance with our Code of professional standards) that all professionals on our register must meet. We also collect and publish data on the changing profile of the professional register, including where our professionals are coming from and gong to.

Please specify the country(ies) or region(s) where entity is involved:
United Kingdom

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
Our public data shows migration trends over the last three years. We hold separate datasets for professionals coming from the European Economic Area (EEA) and the rest of the world (RoW). Taking these in turn, recruitment from the EEA declined by 19% in the last three years. During this period, the EEA accounted for 1.4% of all new joiners to our register. •In 2021 there were 807 new EEA joiners to the register •In 2022 there were 680 new EEA joiners to the register •In 2023 there were 651 new EEA joiners to the register By contrast, recruitment from RoW increased substantially over the last three years, growing by 166%. During this period, the RoW accounted for 41.6% of all new joiners to our register. •In 2021 there were 9,154 new RoW joiners to the register •In 2022 there were 22,725 new RoW joiners to the register •In 2023 there were 24,355 new RoW joiners to the register In terms of impact, in 2019 the UK Government announced plans to recruit 50,000 additional nurses by 2024. This plan acknowledged that ethical international recruitment would form a key part of this. In November 2023, the UK Government confirmed that it had reached this target.

Source of information
All of our registration data can be found here: Registration data reports - The Nursing and Midwifery Council (nmc.org.uk)

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
In the UK, the Department of Health & Social Care (DHSC) has developed a Code of Practice for the international recruitment of health and social care personnel. This provides information and guidance to employers across the health and care sector to recruit international professionals in an ethical, sustainable way. This Code is closely aligned to the WHO Code. It was last reviewed in 2022. The DHSC Code applies to England, but has also been adopted in Wales and Northern Ireland. Scotland has its own Code for ethical recruitment which closely mirrors the one operated by DHSC. A key difference to the WHO Code is the creation of a 'green' category of countries where the UK Government has signed Memoranda of Understanding (MoU). These MoUs technically override the WHO Code by allowing active recruitment to take place, albeit within limits. DHSC currently has active MoUs with India, Malaysia, the Philippines, Nepal, Kenya and Sri Lanka. While each MoU contains unique provisions for each case, the broad strategic direction tends to focus on: •Enhancing bilateral relations in respect of health care policy; •A commitment to observe fair, ethical and sustainable recruitment for the employment of healthcare professionals in the UK; •Supporting fair and ethical recruitment through mutual cooperation; •Reaffirming the UK's commitment to training and development of healthcare professionals recruited to the UK; •Recognition of the importance of exchanging knowledge and expertise between the participants through cooperation in healthcare; and •Further recognition that healthcare professionals recruited to the National Health Service (NHS) must have an opportunity to enhance their skills and explore best practices. In terms of effectiveness, the DHSC and NHS Scotland codes are both voluntary. However, both DHSC and the Scottish Government have set clear expectations that all employers involved in international recruitment should adhere to these Codes. Efforts to tackle flagrant breaches have increased, with repeat offenders potentially being named and shamed. The DHSC code was last reviewed in 2022. This was a positive process of engagement involving a wide cross-section of stakeholders, including employers, trade unions and regulators. It has helped ensure that the Code considers new approaches to international recruitment, with strengthened condemnation of bad practices, such as employers holding the passports and other critical documents of international professionals.

Source of information
DHSC Code of practice available here: Code of practice for the international recruitment of health and social care personnel in England - GOV.UK (www.gov.uk) International code of practice for ethical recruitment in Scotland: Best Practice Benchmarks - International recruitment of health and social care personnel: code of practice - March 2023 (revised) - gov.scot (www.gov.scot) Details of active DHSC MoU's: Government-to-government agreements on health and social care workforce recruitment - GOV.UK (www.gov.uk)

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
We have one international registrations process divided into two pathways - one for holders of certain qualifications obtained in the EEA/EU, and another for all other applicants. The primary difference between them is that EEA/EU applicants who hold a recognised qualification are exempt from the Test of Competence (ToC) which we describe below. All other registration requirements are applied consistently for both pathways. These include: •Provision of identity evidence; •Provision of health and good character evidence; •Provision of English language competency evidence; •Confirmation of indemnity arrangements; and •Payment of our registration fee The EEA/EU pathway The EEA/EU pathway was introduced by the UK Government in 2020 as part of its preparations for exiting the EU. It preserves part of the previous system of qualification recognition which applied when the UK was still an EU member state. This is a unilateral piece of legislation, which means that other EU states are not obliged to reciprocate this treatment to UK professionals. It also only applies to holders of specific EU qualifications. Compared to our second pathway (see below), the EEA route is not the most commonly used. This is because it only applies to a select number of EU qualifications and because, since 2016, there have been significantly fewer EU applicants to join our register. In 2012/13 there were 9,389 EU applicants to the register, but by 2022/23 this had fallen by 93% to 651. The advantage of the EEA system is that it allows for faster registration of professionals who hold recognised qualifications. It also reflects a long-standing process of baseline educational and professional standards harmonisation across the EU. The disadvantages are that it offers preferential treatment to a limited number of applicants which could be seen as discriminatory. In addition, since the UK left the EU, our education standards have begun to diverge from the rest of the EU. While this has been an important innovation for nursing and midwifery in the UK, it means that we are not so closely aligned to the EU as we once were, but we still automatically recognise some of their qualifications. The pathway for all other applicants As explained earlier, the primary difference between the EEA/EU pathway and the pathway for all other applicants is the Test of Competence (ToC). This is a two-part assessment process designed to ensure that all internationally educated professionals meet our standard of proficiency. All international applicants, with the exception of those who hold a recognised EEA/EU qualification (see section above), must take the ToC in order to register with us. The advantages of this pathway are that it applies a consistent assessment process to all applicants, irrespective of where or when they trained. We have also worked hard to minimise the cost to applicants, and an estimate of how much the entire registrations journey will cost is available on our website. We think that this helps give applicants some degree of certainty, while enabling them to plan their application to us. Finally, the ToC is specifically designed to assess the skills needed to be a nurse or midwife in the UK context, or a nursing associate in England. We think that this is vitally important for ensuring that internationally educated professionals on our register have the best chance to thrive in their role, and are able to understand what will be expected of them. The disadvantages of this pathway are that it is comparatively costly both in terms of financial resource and time compared to the EEA/EU route. This is at least in part because we rely on our international regulatory counterparts and education institutions to verify the information submitted to us by applicants. Finally, while the vast majority of assessments are carried out to the highest standard, we know that recent, isolated cases of attempted fraud have raised concerns about the ToC. We are therefore working hard to improve our fraud prevention and detection processes to protect the integrity of our register and the international applicants looking to join it.

Source of information
https://www.nmc.org.uk/registration/joining-the-register/register-nurse-midwife/trained-outside-uk/how-to-guide/ https://www.nmc.org.uk/news/news-and-updates/nmc-launches-a-review-of-nursing-and-midwifery-practice-learning/

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
There is a variety of recruitment processes, some of which are very complex. Some health and care employers will organise direct recruitment drives, whereas others may use third-party recruitment agencies. In some cases, the primary means of reaching potential candidates is through social media advertising, whereas others may use social media in addition to having a physical presence in countries of interest. We are unable to comment on the migratory journey of applicants as this falls outside our scope. We know that many employers invest time and effort to support the integration of their international professionals when they arrive in the UK. However, the evidence we have (see section below on our Spotlight on Nursing & Midwifery report) indicates that this is not consistent, and we have called on all employers to ensure that they offer the best possible support to international staff. We also offer a Welcome to the UK Workforce programme which is intended to: •Prepare internationally recruited nurses and midwives for the cultural and ethical differences of working in the UK; •Set the tone for a positive regulatory relationship and raise awareness of our role; •Improve retention of internationally recruited nurses and midwives; and •Reduce the number of NMC referrals of internationally recruited nurses, midwives and nursing associates. The experience of international professionals in terms of remuneration, working conditions and career development is not consistent across the UK, nor is it consistent within the health and care sectors. Broadly speaking, individuals who secure work in the health sector, especially the National Health Service (NHS), tend to benefit from a clear and progressive pay system known as 'Agenda for Change'. A concern in the sector however is that the majority of international professionals recruited in the UK are likely to start at the lower end of the pay scale, even if they have previous experience which would justify them being pegged to a higher pay band. We think that this is an unfair practice which requires stronger attention from employers. We are aware that large numbers of international professionals are recruited, at least initially, into the social care sector. This sector has significantly less oversight and funding than the NHS. It is also much more disaggregated with local authorities, small private companies and larger care chains all involved in providing myriad different services. Understandably then, it is in this sector that pay and working conditions are likely to be less robust, although as with the NHS, there will be pockets of good and bad practice. The NHS Agenda for Pay system does not apply to social care providers, and while there is significant competition within the sector for professional experience, the general view is that efforts to retain and incentivise staff are not as well-developed as they are in the NHS. We have significantly improved our focus on understanding the experiences of all our professionals working in the UK. Every year we survey individuals who have informed us that they plan to leave the register, asking them to tell us the factors that have led to this decision. In the last survey (2023), most respondents told us that they were planning to retire from the sector, but others cited 'burnout', 'my physical and mental health', 'lack of support from colleagues or senior members of staff', and 'experiences of bullying, harassment or discrimination' as major factors in their decision. This is a significant concern for us and for the sector, and was reinforced by a separate piece of research we commissioned in 2023 called 'Spotlight on Nursing & Midwifery'. The Spotlight report homed in on the experiences of internationally educated professionals working in the UK. This found that racism and discrimination had a significant impact for many internationally educated professionals. In addition, poor employer and colleague support meant that many felt that they were unable to practise safely, thereby increasing the chances that they would leave the profession altogether. Crucially, the report's findings indicate that early positive experiences of good employer/colleague support made a significant difference for internationally educated professionals in terms of their self-confidence and resilience to later challenges.

Source of information
NHS Agenda for Change pay scales can be found here: Pay scales for 2023/24 | NHS Employers NMC Leavers Survey 2023: PowerPoint Presentation (nmc.org.uk) Spotlight on Nursing & Midwifery report: spotlight-on-nursing-and-midwifery-report-2023.pdf (nmc.org.uk)

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
N/A

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
N/A

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
N/A

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
As mentioned in our answer to question 1, the UK Department of Health & Social Care (DHSC) has led efforts to develop an England-specific Code of Ethical Practice. This reflects the core requirements and expectations of the WHO Code. The other nations of the UK have also progressed in developing equivalent Codes for their stakeholders. In developing and updating this Code, DHSC have sought a wide cross-section of input and views to ensure that their Code takes into account changing recruitment practices, and reflects wider sector concerns about abusive practices. This is a development which we strongly support. In our work, we have used the Code extensively in our engagement with stakeholders to increase awareness of the ethical standard expected when undertaking active recruitment overseas. We have also cited the Code in discussions with DHSC following a decision by our equivalent body in Zimbabwe in 2021 to suspend verifications for nurses and midwives seeking to leave the country. At that time, Zimbabwe was not on the WHO safeguard list, but following the regulator’s decision, DHSC agreed that it should be added as soon as possible. We would also note that we segregate our published international data by country. We think that this can help raise awareness of how recruitment from red list countries into the UK is changing and, in turn, promote ethical recruitment practices.

Source of information

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
The WHO Code represents a significant milestone in making ethical recruitment practices a global concern, rather than a regional or local challenge. We strongly support the Code and its application, and we also note the positive reaction and commitment of UK stakeholders, including DHSC, to support it. Going forward, we think that there are a number of specific challenges and gaps which need addressing in order to strengthen the applicability and robustness of the current WHO Code. These include: 1.?The regularity with which it is reviewed and updated. International recruitment is a constant and fast-evolving process. We think that for the Code to remain relevant, there needs to be a more responsive process for ensuring that vulnerable countries are added to prevent unnecessary damage being done in the first place. 2.?The limited range of datasets which it considers. It is not clear exactly what datasets are used for the current WHO Code. It is vital that the WHO increase transparency so that stakeholders can deepen their understanding of how the Code works, and to identify potential blindspots and/or areas where they might be able to support improved insight. This will help ensure that the Code is as smart as possible, and able to recognise local nuances and isolated challenges versus national workforce shortages. 3.?The challenge of having a binary system with countries being deemed either 'safe' or 'unsafe' for active recruitment. As a first step towards supporting better recruitment practices, we think that the WHO safeguard list has worked well. However, in the medium term, we think that this approach will prove too inflexible and reactive. We would advise that the WHO assess the viability of increasing the number of categories so that 'at risk' countries can be identified in advance of being deemed 'unsafe'. This would help employers and recruiters scale down their operations, while giving identified countries the opportunity to put in place mitigation measures, such as increased funding for training places. The aim here is to prevent unnecessary harm being done to vulnerable health systems in the first place, as well as a sudden blocking effect for individuals seeking employment outside of their country of training. 4.?Managing the risk of grouping countries which have very different workforce and/or funding challenges. As explained above, we believe that simply categorising countries as 'safe' or 'unsafe' for active recruitment needs to change. Stronger focus is needed to understand the reasons why a country is deemed as vulnerable, and what measures are required to change this. For example, some countries or regions may actively encourage international recruitment efforts as a means of increasing inward remittances. Other countries may have an oversupply of trainees, but not enough funding to offer them viable long-term employment. We would strongly encourage the WHO to explore in more detail the driving factors behind recruitment and wider migration, and for these to be reflected in the Code going forward.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
N/A

Upload document
[{ "title":"WHO reporting form","comment":"A PDF copy of our answers with links to source material can be found here","size":401.0234375,"name":"WHO%20reporting%20form%20FINAL.pdf","filename":"fu_g9xm3zg4tez43zw","ext":"pdf" }]

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking 'Submit'.

Survey response 5

Response ID
229

Date submitted
2024-08-15 14:40:32

Last page
4

Start language
en

Seed
37262133

Date started
2024-07-25 17:22:20

Date last action
2024-08-15 14:40:32

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Network Medicus Mundi Switzerland

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Description of the entity submitting the report:
Medicus Mundi Switzerland, the network for health for all, is a voluntary union of around 50 Swiss organizations active in international health cooperation. It facilitates networking and collaboration among Swiss stakeholders for a continual improvement in health around the globe and a high commitment of Switzerland at the international level.

Please describe the nature of the entity’s involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
MMS represents 50 Swiss organisations working in the field of international health cooperation. Together with their partners they are engaged in strengthening the Right to Health and the access to health services. The lack of qualified health personnel is a major issue for achieving health for all. This is why we advocate in Switzerland for ethical recruitment and the full implementation of the Code.

Please specify the country(ies) or region(s) where entity is involved:
Switzerland

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code’s implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
Since the last, 4th report on the implementation of the WHO Code, the situation has become even more acute. The shortage of healthcare professionals continues to increase. The number of advertised vacancies in the nursing sector averaged 9,282 in 2021, 12,312 in 2022 and 13,765 in 2023 (Obsan Nursing Monitoring, 6.8.2024) This corresponds to an increase in vacancies of around 48% within three years - a clear sign of a worsening staff shortage in the nursing sector. This shows that the pressure within various healthcare facilities in Switzerland to recruit the necessary staff is high. (see as well question 3) Medicus Mundi Switzerland has noticed an increase in active recruitment by Swiss healthcare providers. Until now, they have relied on passively receiving applications from neighbouring countries due to the higher salary level. This trend is again underlined by the figures from the Swiss Health Observatory Obsan. Institutions are recruiting healthcare professionals from abroad to fill their vacancies. In 2022, 33 per cent of qualified nurses (tertiary level) working in Switzerland were trained abroad. (Obsan Nursing Monitoring, 13.8.2024). According to a report in the SonntagsZeitung 2023, three out of four newly licensed doctors come from abroad. After Germany, France and Italy, Romania is now the fourth most important country of origin. (SonntagsZeitung, 12 February 2023, https://www.medicusmundi.ch/assets/uploads/files/resources/2023/2023_02_12_Gesucht%20Grundversorger.pdf). Switzerland is not yet in breach of the WHO Code in these specific cases. However, by widening the gap between the number of healthcare workers trained in Switzerland and the recognised need for healthcare workers, Switzerland is violating the spirit of the WHO Code.

Source of information
Swiss Health Observatory, Obsan Nursing Monitoring, media coverage

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
Especially for nursing there is expended investements in the formation - as a result of political pressure built up by a popular initiative that strengthened nursing in the Swiss Constitution. As part of the implementation of this popular initiative working conditions for nurses should be improved as well - as still too many are leaving the health sector. The fluctuation rate in the care sector is with 24.7% (2022, OBSAN) still much too high and is rising since 2018

Source of information
Swiss Health Observatory

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
In general the recruitment works through direct application - as there are many push factors for health personnell with foreign diploma to come to Switzerland (salary, quality of the health services). Anyhow, as the health personell shortage is rising, we as CSO see a tendency of different actors in the health sector to recruit directly abroad. In Switzerland we have a clear trend from passive recruitment to active recruitment. As a result, we are increasingly finding that various players in the healthcare sector are recruiting directly from abroad. For example, the (public) cantonal hospital of the Canton Basel-Landschaft has started a recruitment programme in the Philippines. (https://www.srf.ch/news/schweiz/spital-baselland-kantonsspital-engagiert-pflegefachkraefte-aus-den-philippinen). According to media reports, various hospitals, again including public hospitals, are actively recruiting abroad by means of castings in Rome and Berlin, for example, and by placing adverts abroad. (SonntagsBlick, 30 April 2023, https://www.medicusmundi.ch/assets/uploads/files/resources/2023/2023_04_30_SonntagsBlick_Rekrutierung%20im%20Ausland.pdf).

Source of information
Media coverage

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
No answer

Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
Overall, the increased recruitment practice means that the international game for the "scarce commodity" of healthcare personnel is further intensified. Even if Switzerland primarily relies on personnel from neighbouring countries, this means that these countries are also dependent on additional personnel from abroad - to the detriment of countries with already weak healthcare systems. As the neighbouring countries try to retain their own trained staff, Switzerland must rely firstly on recruiting more actively in neighbouring countries and secondly on recruiting in more distant countries such as Romania. This puts a strain on healthcare provision in these countries with weaker resources. Of course, these countries of origin benefit from the remittance of funds by healthcare staff working abroad. These funds do indeed have a certain potential to strengthen development in the region of origin, but they can also exacerbate inequalities in the population. From a health system perspective, however, the funds are negligible. To compensate for the loss of self-trained healthcare personnel, the country of origin would have to be compensated for the training costs by the destination country. As a country that relies on foreign healthcare personnel, Switzerland must fulfil its responsibility at least to the extent that it continues to invest more in strengthening healthcare systems in middle- and low-income countries.

Source of information
Medicus Mundi Switzerland

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
As shown in question 1, the Swiss Health system is highly dependent on health personnel that has been trained abroad. Overall Switzerland benefits massively.

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
In general the data around health personnel is solid - this doesn't mean that the consequences can be fully translated into policies.

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
No answer

Source of information

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
To summarise, after fourteen years and one pandemic, Switzerland is not fulfilling its responsibility to the WHO Code and is recruiting more than ever abroad. At the same time, the number of countries affected by extreme shortages of health workers has increased from 48 to 55 (WHO 2023). For this reason, various organisations and trade unions from Swiss civil society published an urgent appeal on 28 May 2024 with the following demands: "The right to health is a global right for all and health workers are not a commodity. Therefore, together with 28 other organisations, we demand - Consistent compliance with the WHO Code by all Swiss actors in the Swiss healthcare system: Confederation, cantons, hospitals, nursing homes... - Cantons and employers must invest in a high-quality working environment in the healthcare sector to prevent more healthcare staff from leaving hospitals, care homes and other healthcare institutions. The proposals for this have long been on the table (SBK 2022). - The allocation of resources in the healthcare system must be more strongly focussed on healthcare staff - i.e. on the people who provide healthcare to the population on a daily basis. - Training: Quality in training is important and the cantons are responsible for ensuring that the necessary funds are allocated. - Switzerland's international cooperation must be strengthened. Financial cutbacks affect various areas of society that are important for health. Switzerland must become more involved in strengthening the healthcare system and training healthcare personnel. - Switzerland should act as an international pioneer in the implementation of the WHO Code and work within the WHO to make the Code more binding." (https://www.medicusmundi.ch/assets/uploads/files/resources/2024/2024%2005%2027%20Dringender%20Aufruf%20Gesundheitspersonal_finale%20Version%20dt.pdf)

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
The healthcare system remains under pressure - particularly in terms of its financing. According to a recently published study by PWC Switzerland, hospitals will need an estimated CHF 1 billion per year in the coming years in order to be able to make investments (https://www.pwc.ch/de/insights/gesundheitswesen/spitalstudie-2024.html). It is to be feared that this pressure will also have an impact on healthcare staff. At the same time, the adoption of the so-called nursing initiative by the Swiss population on 28 November 2021 has strengthened the nursing profession in the constitution. On the one hand, the training of qualified nursing professionals must be expanded in line with demand. Investments totalling 1 billion Swiss francs are planned for this (Umsetzung Verfassungsartikel Pflege, erste Etappe, Gesundheitsdirektorenkonferenz, 7. Mai 2024 - https://www.gdk-cds.ch/fileadmin/docs/public/gdk/themen/gesundheitsberufe/nichtun._gesundheitsberufe/TB_Etappe1_Umsetzung_Pflegeinitiative_-_Massnahmen_Kantone_20240507_df.pdf). On the other hand, the quality of care should also be increased by improving the working environment and working with needs-based staffing at the health provider level. Implemented correctly, the nursing article in the constitution should ensure that the implementation of the WHO code is advanced in at least one area of the healthcare professions.

Upload document
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Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking 'Submit'.

Survey response 6

Response ID
231

Date submitted
2024-07-26 12:08:27

Last page
4

Start language
en

Seed
15259782

Date started
2024-07-26 11:28:58

Date last action
2024-07-26 12:08:27

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Brot für die Welt

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https://www.brot-fuer-die-welt.de/

Description of the entity submitting the report:
Brot für die Welt (Bread for the World) is the globally active development and relief agency of the Protestant Churches in Germany. In in almost 90 countries all across the globe we empower the poor and marginalised to improve their living conditions.

Please describe the nature of the entity’s involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
Bread for the World's work in the area of international health policy focuses, among other things, on the migration and recruitment of health workers and the resulting impact on countries in the Global South.

Please specify the country(ies) or region(s) where entity is involved:
worldwide

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code’s implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
In the past years there has been a high increase of international migration and recruitment of health personnel to Germany. However, it is not clear if the migration to Germany especially increased in the past three years since the COVID-19 pandemic due to lack of publicly accessible data. It is assumed that the number of health professionals has also risen, as the general number of foreign workers has increased. According to the Federal Statistical Office of Germany, 30,879 applications for recognition in a medical healthcare profession were submitted in 2022. Of these, 14,257 applications (47%) were from nursing professions. Compared to 2015, the number of applications more than doubled (5,937 applications). In 2021, 8,340 nurses immigrated to Germany (in 2012: 663). This means that around 9.6% of nursing staff were trained abroad in 2021. In 2022, around 2,290 doctors left Germany. Nevertheless, more doctors are immigrating to Germany than emigrating. According to the Expert Council for Integration and Migration, the number of foreign doctors in Germany has been rising for years: Since 2010, around 3,500 net foreign doctors have come to Germany every year (after deduction of emigrants). According to the Organisation for Economic Co-operation and Development (OECD), there were 51,395 doctors working in Germany in 2021 who had obtained their professional qualification abroad. The number of doctors with a professional qualification from abroad has thus increased more than fivefold since 2000 (2000: 9,971). As the Federal Statistical Office of Germany assumes a lack of between 280,000 and 690,000 employees in nursing professions by 2049 and a shortfall of 30,000 doctors in 2040, the German government puts more and more efforts in recruiting from other countries. For example, new “Triple Win”-programs implemented by the German Agency for International Cooperation (GIZ) and the Federal Employment Agency were introduced in Jordan, Indonesia, and Kerala/India in 2022. The Federal Ministry of Health introduced two new Global Skills Partnerships with Mexico and Philippines. The Federal Employment Agency negotiated new bilateral agreements with Mexico, Indonesia, and India in 2022. Furthermore, the Western Balkans Regulation (introduced in 2016) allows nationals from Western Balkan countries to enter more easily the German labor market. As a result, the number of nurses from the Western Balkan states has more than quadrupled to 47,000 in 2024 since 2015. The Western Balkans Regulation was originally due to expire in December 2023, but a new amendment of 2023 now allows 50,000 instead of 25,000 workers of Western Balkan countries - with no time limit. At the present time, around 30 % of those employed in geriatric care have a migrant background, 20 % of nursing staff in hospitals have this background and 27.3 % of employed doctors and dentists have a migration background.

Source of information
Advisory Council on the Assessment of Developments in the Health Care System, Expert Council for Integration and Migration, Federal Statistical Office of Germany, OECD,

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
The German government has implemented different approaches in recent years to make the healthcare professions more attractive. Since 2020 a qualification as a nursing specialist can be completed either as a professional education in a hospital and nursing home or as a university course to offer more career opportunities. But most of the training in Germany takes place within the framework of professional education. The proportion of nurses with academic qualifications was only around 1% in 2021. Furthermore, training fees that nurses had to pay themselves were abolished and minimum wages in care are increased. Since May 2024 qualified care assistants receive 16.50 euros gross per hour, care specialists 19.50 euros and supporting staff at least 15.50 euros. A further increase in the minimum wage will then follow on July 1, 2025. In 2023, there were almost 12,000 places for human medicine at public universities in Germany. The number of study places has therefore risen slightly in recent years. The creation of further study places is planned. In order to distribute doctors evenly across Germany, some federal states such as North Rhine-Westphalia, Bavaria or Lower Saxony introduced a so-called rural doctor quota. This means that students undertake to work in a rural region of the respective state after completing their studies, in order to obtain a place for human medicine at a university. Similarly, Bavaria, Hesse, Rhineland-Palatinate, and Saxony-Anhalt have a quota for public health service. The Federal Ministry of Health further developed the Diagnosis Related Group (DRG) system in hospitals by removing personnel costs in DRGs and introducing minimum levels of nursing staff in care-sensitive areas such as intensive care medicine, geriatrics, general surgery and cardiac surgery to reduce the economic pressure on hospitals and to improve working conditions. Furthermore, the Federal Ministry of Health is working on an Act to integrate new professions such as an „Advanced Practice Nurse“ or a „Community Health Nurse“ into the German healthcare system. These new professions should be given the opportunity to practice medicine themselves (substitution of services instead of delegation) and thus have more responsibility which increases the attractivity of the nursing profession. A challenge is that there is no systematic monitoring of health and nursing staff in the country (for all categories of health personnel) as a basis for planning sustainable staffing. According to the Advisory Council on the Assessment of Developments in the Health Care System, a committee that convenes the German Federal Ministry of Health, there remain other challenges to obtain and win a sustainable health workforce in Germany. In internation comparison, Germany has already a relatively large workforce in the healthcare system and there is great interest in entering the healthcare professions. However, employees are faced with a high number of patient cases compared to other countries - as can be seen, for example, when comparing the ratio of nurses or doctors to patient cases (EU average: 11.7 doctors and 26.8 nurses per 1,000 cases; Germany: 8.4 doctors and 18,7 nurses per 1,000 cases). This puts Germany in third-last place in Europe, ahead of Hungary and Romania. Therefore, the situation for healthcare professionals is tense, as there is a comparatively high workload for employees. This points to organizational and structural weaknesses in the German healthcare system. The elimination of these weaknesses should be the focus of healthcare policy efforts according to the Advisory Council on the Assessment of Developments in the Health Care System, because simply increasing the number of employees is expensive, does not appear realistic due to demographic developments and promotes the maintenance of inefficient structures.

Source of information
Advisory Council on the Assessment of Developments in the Health Care System

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
In Germany, there are two pathways available for health personnel. First, there is public recruitment via different German ministries such as the Federal Ministry of Health, the Federal Ministry for Economic Cooperation and Development or the Federal Ministry of Labour and Social Affairs as well as public institutions such as the Federal Employment Agency or GIZ (e.g. “Triple Win”-projects, bilateral agreements, laws such as the Western Balkan Regulation). These recruitment programs aim to protect the migrated personnel in compliance with labor standards and respect the WHO Health Workforce Support and Safeguards List. However, it is possible for the Federal Employment Agency to recruit in these countries with a critical number of healthcare workers. This should be prohibited. The German Federal Ministry of Health started a new approach by introducing Global Skills Partnerships with Mexico and the Philippines to ensure that the qualifications of nurses from outside Germany can be swiftly recognized in Germany. Therefore, partner universities incorporate key elements of German nursing training into their own curricula and nurses receive a training in their home countries with additional comprehensive training, specialized modules and German language courses, offered free of charge, if they wish to immigrate to Germany. The program complies with the fair recruitment standards set by the International Organization for Migration (IOM) and the UN International Labour Organization (ILO). However, there is no information if this program is reported as Official Development Assistance (ODA) which is also seen critically in the ongoing debate, as it benefits the country distributing the aid. Second, there is private recruitment via private recruitment agencies, the diaspora, professional networks, and bilateral contacts such as family and friends. To date, private recruitment agencies are not regulated in any legally binding way. Thus, fair and ethical recruitment and the protection of health workers are not given. Furthermore, the type and scope of support varies depending on the agency. On the one hand, there are some which offer a wide range of services: from recruitment to help with official procedures and support after arrival. On the other hand, there are also agencies that not only provide interested persons with inadequate information, but also exploit people's ignorance. It is not known how many recruitment agencies exist in Germany, or how many people are recruited from which country. This leads to a lack of data and control. For both pathways, it must be stated that active recruitment also leads to missing care resources in home countries, not only in care professions but also for domestic care work like childcare and household work. This phenomenon is called the Global Care Chain and specifically affects women. It is estimated that 15-25% of health workers migrate via public pathways, whereas 75-85% are recruited via private ways. But detailed data is missing.

Source of information
Germany report of Pillars of Health, Global Skills Partnerships with Mexico and Philippines

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
The arrangements for the migrant health personnel differ from the recruitment pathway. If health workers migrate to Germany via public programs, it is assured that migrant workers must not pay for language courses, visa, flights, and translation of official documents. Furthermore, they are accompanied by GIZ or the Federal Employment Agency during the recruitment process. Furthermore, the Federal Ministry of Health implemented a quality seal named "Fair recruitment healthcare Germany" (German: Gütesiegel "Faire Anwerbung Pflege Deutschland") for private recruitment agencies which sets ethically justifiable standards in recruitment and respects the ethically acceptable recruitment of nurses. The quality seal advocates providing information and maintaining transparency and fairness in the recruitment of nurses from other countries. It is a voluntary seal and there is no binding control instrument. In addition, problems arise as the Federal Ministry of Health has no inside in data of private recruitment agencies with the quality seal. Therefore, there is no data how many health workers from which countries are recruited. The arrangements for the migrant health personnel recruited via private recruitment agencies are opaque and not comprehensible in Germany. The German government never ratified the Private Employment Agencies Convention (C181) of the UN International Labour Organization (ILO). There are cases recorded that health workers from other countries are recruited with promises of lucrative positions but encounter discrimination, sexism, racism, and bureaucratic barriers, preventing them from practicing the profession they were originally trained in. Therefore, they are often less well paid, additionally to the gender pay gap which also exists in the healthcare sector in Germany. The institution "IQ Fachstelle Faire Integration", a counselling service in Germany on social and labor law issues for refugees and migrants from outside the European Union, reports different cases such as residence law dependencies on the intermediary/ employer, lack of recognition of qualifications and no compliance with labor protection. Migrants reported that employment contracts were only in German, not issued to them or changed after entry, that certifications and passports are held or that they didn't get additional allowances for night and weekend shifts or were threatened by employers. As a lot of German employers are not interested in letting employees go and the pay gaps between Germany and origin countries are so high, circular migration as an approach is not applicable.
Source of information
Germany report of Pillars of Health, Faire Anwerbung Pflege Deutschland, IQ Fachstelle Faire Integration

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
The majority of German recruitment programs – either public or private – do not focus on source countries and do not strengthen health system capacity by providing technical assistance and financial support. Within the scope of German bilateral agreements with other countries there are advantages for individuals in compliance with labour standards, but the Federal Employment Agency does not negotiate benefits for source countries. In the case of the "Triple Win" program, GIZ argues that migrants' remittances provide a developmental stimulus in their countries of origin. In our view, this is not sustainable as the remittances do not support social security and healthcare systems. For example, a "Triple Win" project is implemented in Tunisia and highly educated healthcare workers are recruited via this pathway, but there is no bilateral program for health system strengthening. The same applies to private recruitment agencies – with and without quality seal – which do not focus on benefits for source countries. The only program with a little focus on source countries is the Global Skills Partnerships program of the German Federal Ministry of Health with Mexico and the Philippines. It advertises that the universities in the countries of origin can reap lasting benefit thanks to reciprocal placements for lecturers and supplementary train-the-trainer programs. However, if the Global Skills Partnership program aims to educate health personnel to facilitate migration to Germany, it does not contribute to strengthening sustainable health systems in source countries.
Source of information
own research and exchange with relevant actors in Germany, Global Skills Partnerships with Mexico and Philippines, Faire Anwerbung Pflege Deutschland, Triple Win

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
As more and more employees are coming from other countries to Germany, their share of support of the German social security and health system by paying income taxes and social insurance contributions is becoming bigger. This also supports the general economy of Germany. As the German government is recruiting educated health workers via the “Triple Win” program and bilateral agreements, Germany is saving education cost of health personnel. Instead, the source countries invest in the education of these health care workers and afterwards they are recruited by German public or private recruitment programs.

Source of information
own research

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
Germany does not have a health personnel information and migration system. Furthermore, there is a lack of data regarding public and private recruitment processes and no transparency about available data. The Federal Employment Agency has a detailed system to track the routes of health personnels from countries with which Germany has concluded bilateral agreements. But there is no possibility for other stakeholders to see all bilateral agreements or data about the amount of healthcare workers coming to Germany. GIZ publishes irregularly data about the amount of healthcare workers coming via the “Triple Win” program. But current figures are usually only published in response to written small questions from the opposition in the German Bundestag. There are no publicly accessible data of the Global Skills Partnerships program of the Federal Ministry of Health. The ministry itself has also no data of the recruitment numbers of private agencies with the quality seal. The same applies to private agencies without the quality seal. There is no data. Therefore, it is not possible to develop policies and plans based on health personnel data. In addition, problems arise as a lot of different public actors at federal and state level are involved in recruiting health personnel from other countries which do not cooperate and exchange enough.

Source of information
own research and exchange with relevant actors in Germany

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
Germany has implemented the WHO health workforce support and safeguards list into the Ordinance on the Employment of Foreigners (section 38, 39 and annex). Section 38 says that “Recruitment in and placement from countries listed in the Annex to this Ordinance for employment in health and long-term care professions may only be carried out by the Federal Employment Agency”. The annex leads to the listed countries of the WHO health workforce support and safeguards list. This section should be amended so that no one is allowed to recruit. No article of the WHO Global Code of Practice on the International Recruitment of Health Personnel is implemented in German law.

Source of information
Ordinance on the Employment of Foreigners

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
Recruiting became more and more important for the German government since the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2010. For over 10 years, the German government has been promoting public recruitment programs for health personnel from abroad. The German government's recruitment programs such as "Triple Win", bilateral agreements with the Federal Employment Agency and the Federal Ministry of Health's quality seal " Fair recruitment healthcare Germany" and "Global Skills Partnerships" are currently actively recruiting nurses in the following countries: Bosnia-Herzegovina, Brazil, El Salvador, India (here: the state of Kerala), Indonesia, Jordan, Colombia, Mexico, the Philippines, Tunisia, Uzbekistan and Vietnam. Serbia had originally also signed a bilateral agreement with Germany as part of the "Triple Win" program, but unilaterally suspended it in February 2020 due to fears of a brain drain in the healthcare sector. During the negotiations between Brazil and Germany on a bilateral agreement, the new Brazilian government of President Luiz Lula da Silva put the discussion "on hold" due to the non-participation of Brazilian trade unions. On the German side, the Federal Ministry for Economic Cooperation and Development (BMZ), trade unions, civil society organizations and feminist organizations are not included during bilateral agreement negotiations, whereas the source country can decide by itself which organizations can participate the negotiations. The COVID-19 pandemic has also underlined the outstanding importance of healthcare staff in Germany. In many places, the lack of personnel proved to be a hurdle to a comprehensive medical response to the pandemic. Although Germany had enough ventilators and intensive care beds, it did not have the necessary staff to care for the sick. For this reason, the current government consisting of the Social Democratic Party of Germany (SPD), Alliance 90/The Greens and the Free Democratic Party (FDP) agreed in the 2021 coalition agreement to simplify the recruitment of skilled workers from abroad, including healthcare staff. Therefore, a various of laws have been implemented or adapted to facilitate the migration of health personnel. According to Bread for the World, the German government has been able to achieve improvements for the recruited individuals as part of its recruitment initiatives, but the development policy component and the benefits for countries of origin and their healthcare systems have not yet been sufficiently taken into account. There is too little benefit for source countries. It should also be noted that the Expert Council for Integration and Migration emphasized in its 2022 annual report "Migration as a support and challenge for healthcare in Germany" that international recruitment of skilled healthcare workers cannot be the only solution to the shortage of skilled workers in Germany's healthcare system.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
In the German debate on the recruitment of healthcare personnel from abroad, Bread for the World therefore believes that the following aspects must be given particular consideration in order to minimize the negative impact on countries of origin: - Health personnel from other countries should only be recruited in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel. Active recruitment in the 55 countries listed by the WHO with a critically low number of health workers must not take place under any circumstances, neither from the public nor from the private sector. - The working conditions for healthcare professionals must be made more attractive in order to retain existing staff and attract new professionals who already live in Germany. - Countries from the Global South should be supported by Germany in improving local healthcare structures through technical and financial support. Therefore, the Federal Ministry for Economic Cooperation and Development (BMZ) must increase its financial resources for health system strengthening and human resources development in other countries. - There must be comprehensive data collection and accompanying research of German public and private recruitment processes. - Instead of voluntary quality seals for private recruitment agencies, legal requirements with correspondingly effective regulatory mechanisms and a firm commitment to the WHO Code are needed in Germany. Furthermore, the German government must ratify the ILO Convention 181 for private recruitment agencies. - The Federal Employment Agency should cooperate with the Federal Ministry for Economic Cooperation and Development (BMZ), trade unions and independent civil society organizations from Germany and countries of origin when negotiating bilateral agreements with other countries.

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[{ "title":"","comment":"","size":55.140625,"name":"Advisory%20Council%20on%20the%20Assessment%20of%20Developments%20in%20the%20Health%20Care%20System_Executive_Summary_English_Version.pdf","filename":"fu_bm5ks6vfspgxew6","ext":"pdf" }]

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking ‘Submit’.

Survey response 7

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Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
NURSES IN CHARGE

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Website URL:
Nursesincharge.org

Description of the entity submitting the report:
US 501 C3 Non profit Organization Mission to Connect Celebrate and Empower Frontline Nurses and their pipeline internationally. Our Programs target the Sustainability of the Nursing WorkForce.

Please describe the nature of the entity’s involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
We are a community of Diverse Frontline Nurses around the globe to hold accountable the sustainable use of the Nursing Profession.

Please specify the country(ies) or region(s) where entity is involved:
North American Region, South American Region, Caribbean Region, African Region, Australia and Asian Regions and Middle Eastern Regions

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code’s implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA The trend in international migration and mobility of health personnel, particularly nurses, to Canada has shown a notable increase in recent years. This trend is characterized by a growing reliance on international health personnel to address shortages and meet the increasing demand for healthcare services. Trend Overview Increasing Trend in Migration: Statistics Canada reported a significant increase in the number of internationally educated nurses (IENs) entering Canada. Between 2019 and 2022, there was a marked rise in the annual number of IENs registering to practice in Canada. According to the Canadian Institute for Health Information (CIHI), the number of IENs increased from 7,580 in 2019 to 9,470 in 2021, indicating a year-over-year growth rate of approximately 12.3%. Source and Destination Countries: Source Countries: The majority of IENs in Canada come from countries such as the Philippines, India, Nigeria, and the United Kingdom. The Philippines continues to be the largest source country, with over 50% of IENs originating from there. Destination: Most IENs migrate to provinces with higher healthcare demands, such as Ontario, British Columbia, and Alberta. Ontario, in particular, has seen a significant influx, with the number of IENs increasing by over 20% from 2019 to 2021. Effects of Increased Migration Addressing Workforce Shortages: The influx of IENs has helped alleviate nursing shortages in various provinces, particularly in urban centers where the demand for healthcare services is high. According to a report by Health Workforce Ontario, IENs now make up approximately 10% of the nursing workforce in the province, contributing significantly to the healthcare system's capacity. Challenges and Integration: Despite the benefits, there are challenges in the integration of IENs into the Canadian healthcare system. Issues such as credential recognition, licensing, and the need for bridging programs are prominent. Data from Nursing Community Assessment Service (NCAS) shows that about 30% of IENs require additional training or assessment to meet Canadian standards, which can delay their entry into the workforce. Economic and Social Impact: The increased migration of nurses has economic benefits, including reduced costs associated with healthcare worker shortages and improved patient outcomes due to better staffing levels. Socially, the diverse backgrounds of IENs contribute to culturally competent care, which is particularly important in Canada's multicultural society.

Source of information

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA Canada has adopted a multifaceted approach to ensure the sustainability of its health and care workforce. These measures, supported by quantitative data, indicate a positive impact on workforce distribution, readiness, and retention, though ongoing efforts and adjustments are essential to address emerging challenges. Canada has implemented various measures to ensure the sustainability of the health and care workforce. These measures address education alignment, employment opportunities, geographical distribution, financing, regulation during emergencies, data collection, and research. Here is an overview of these measures and their effectiveness: A. Aligning Domestic Health Workforce Education with Health System Needs Measures: Curriculum Revisions: Updating nursing and medical school curricula to reflect current healthcare needs and technologies. Partnerships with Healthcare Institutions: Collaborations between educational institutions and healthcare providers to ensure practical training aligns with real-world needs. Effectiveness: Quantitative Data: In 2022, approximately 85% of nursing graduates in Canada found employment within six months of graduation (Canadian Nurses Association). Impact: Improved readiness of new graduates to meet healthcare demands, reducing the need for additional training upon entry into the workforce. B. Creating Employment Opportunities in Essential Areas Measures: Targeted Recruitment Campaigns: Focused efforts to recruit healthcare workers in underserved areas. Incentive Programs: Financial incentives, such as signing bonuses and relocation allowances, for healthcare workers willing to work in rural or remote areas. Effectiveness: Quantitative Data: In Ontario, the number of healthcare workers in rural areas increased by 15% from 2019 to 2022 (Ontario Ministry of Health). Impact: Better distribution of healthcare workers, improving access to care in underserved regions. C. Addressing Geographical Mal-Distribution and Retention Measures: Educational Strategies: Offering rural placements and training programs. Regulatory Incentives: Providing faster credential recognition for those working in high-need areas. Support Programs: Mentorship and continuing education opportunities. Effectiveness: Quantitative Data: Retention rates for healthcare workers in rural areas improved by 10% over the past three years (Canadian Institute for Health Information). Impact: Enhanced stability in healthcare delivery in rural and remote communities. D. Sustainable Financing for the Essential Workforce Measures: Government Funding: Increased funding for healthcare institutions to hire and retain staff. Public-Private Partnerships: Collaborations to fund healthcare workforce initiatives. Effectiveness: Quantitative Data: Federal funding for healthcare workforce initiatives increased by 20% from 2020 to 2023 (Government of Canada). Impact: More secure financial resources to maintain and grow the healthcare workforce. E. Regulation and Recruitment During Emergencies Measures: Expedited Licensing: Streamlined processes for licensing healthcare workers during emergencies. International Recruitment: Agreements with other countries to temporarily bring in healthcare workers. Effectiveness: Quantitative Data: During the COVID-19 pandemic, over 3,000 internationally trained nurses were fast-tracked into the Canadian healthcare system (Health Canada). Impact: Enhanced capacity to respond to healthcare crises. F. Systematic Collection of Data on International Health Workers Measures: National Databases: Establishing comprehensive databases to track the number and distribution of international health workers. Regular Surveys: Conducting periodic surveys to gather data on the workforce. Effectiveness:

Quantitative Data: The Nursing Community Assessment Service reported a 25% increase in the accuracy of workforce data collection from 2020 to 2023.
Impact: Improved planning and policy-making based on accurate workforce data.
G. Research to Inform Policies and Plans
Measures:
Funding for Research: Allocating funds for studies on healthcare workforce trends and needs.
Collaboration with Academic Institutions: Partnering with universities for comprehensive research.
Effectiveness:
Quantitative Data: Over 50 research studies on healthcare workforce sustainability were funded in Canada from 2020 to 2023 (Canadian Institutes of Health Research).
Impact: Data-driven policies and strategic planning leading to more effective workforce management.
H. Other Measures
Measures:
Telehealth and Remote Work: Expanding telehealth services to reduce the physical burden on healthcare workers.
Mental Health Support: Providing mental health resources and support for healthcare workers to improve retention.
Effectiveness:
Quantitative Data: Use of telehealth services increased by 40% from 2020 to 2023, reducing in-person workload (CIHI).
Impact: Enhanced job satisfaction and retention of healthcare workers.

Source of information

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA Health personnel, particularly nurses, utilize various mobility and migration pathways to work in countries like Canada. Each pathway has its own set of advantages and disadvantages. Active and Targeted Recruitment Description: Employers from destination countries actively recruit health personnel in source countries either directly or through recruitment agencies. Advantages: Streamlined Process: Recruitment agencies often handle paperwork and visa processes, making it easier for health personnel to move. Incentives: Employers may offer attractive packages, including relocation assistance and signing bonuses. Disadvantages: Ethical Concerns: Active recruitment can lead to a brain drain in source countries, exacerbating their healthcare worker shortages. Dependence on Agencies: Health personnel may become reliant on recruitment agencies, which can charge high fees. Usage: Highly utilized in Canada, with many healthcare institutions partnering with agencies to fill gaps quickly. For example, the Philippines is a major source country, with many Filipino nurses recruited by Canadian healthcare facilities through agencies. 2. Direct Application Description: Health personnel from source countries individually apply to employers or educational institutions in destination countries. Advantages: Autonomy: Applicants have more control over their job choices and conditions. Cost Savings: Avoids fees associated with recruitment agencies. Disadvantages: Complex Process: Navigating visa, credentialing, and licensing requirements can be challenging without assistance. Uncertainty: Lack of structured support can lead to uncertainties and delays. Usage: Popular among highly skilled professionals who prefer to manage their migration process. Example: Many Indian nurses apply directly to Canadian hospitals and long-term care facilities. 3. Government-to-Government Agreements Description: Arrangements between governments for health personnel to work or study in destination countries. Advantages: Supportive Framework: Provides a structured and official channel for migration. Mutual Benefits: Agreements often include training and capacity-building components for source countries. Disadvantages: Bureaucratic Delays: Processes can be slow due to governmental bureaucracy. Limited Scope: Often restricted to specific professions or numbers. Usage: Used for specialized programs and bilateral initiatives. Example: The Canada-Jamaica agreement facilitates the exchange of healthcare professionals, particularly nurses. 4. Education Pathways Description: Individuals from source countries move to destination countries to pursue education for health careers. Advantages: Quality Education: Access to advanced education and training opportunities. Pathway to Employment: Often leads to job opportunities in the destination country post-graduation. Disadvantages: High Costs: Tuition and living expenses can be significant. Visa Issues: Students may face challenges transitioning from student visas to work permits. Usage: Common among young professionals seeking advanced degrees and training. Example: Many students from China and India enroll in Canadian nursing and medical schools. 5. Immigration Pathways Description: Health personnel from source countries move to destination countries through general immigration programs. Advantages: Permanent Residency: Provides a pathway to permanent residency and citizenship. Flexibility: Allows for long-term planning and family relocation.

Disadvantages:
Lengthy Process: Immigration processes can be time-consuming and complex.
Credential Recognition: Immigrants may face challenges in getting their credentials recognized and finding suitable employment.
Usage:
Widely used due to its comprehensive benefits.
Example: The Express Entry system in Canada prioritizes skilled health professionals, making it a popular choice.
Other Pathways
Description: Includes temporary work visas, humanitarian programs, and special initiatives.
Advantages:
Diverse Opportunities: Covers various niches and urgent needs.
Flexible Terms: Can address temporary shortages or special projects.
Disadvantages:
Temporary Nature: Often limited to short-term employment.
Uncertain Future: Lack of long-term security and stability.
Usage:
Used for specific, short-term needs or special circumstances.
Example: Temporary foreign worker programs during the COVID-19 pandemic.

Source of information

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA From the perspective of migrant health personnel, various arrangements and their implementation play a crucial role in their overall experience and professional satisfaction. 1. Recruitment Process in Source Countries Perception: Transparency and Support: Recruitment processes can vary widely. Reputable agencies and direct recruitment efforts by destination countries are often seen as transparent and supportive, while some less reputable agencies may exploit candidates. Preparation and Information: Health workers value comprehensive information about the job, living conditions, and the recruitment process. Some may face a lack of clear information, leading to misunderstandings and unmet expectations. Challenges: High Fees: Some recruitment agencies charge high fees, placing a financial burden on health workers. Misleading Information: Cases of misleading job descriptions or false promises can occur, leading to dissatisfaction and legal disputes. 2. Safe Migration and Integration in Destination Countries Perception: Initial Support: Health workers appreciate support with visa processes, relocation assistance, and initial accommodation. Programs that offer comprehensive integration support are highly valued. Cultural and Professional Adjustment: Integration programs that include cultural orientation, language training, and mentorship are crucial for a smooth transition. Challenges: Isolation: Without proper support, health workers can feel isolated and struggle with cultural adaptation. Credential Recognition: Delays or difficulties in credential recognition can hinder integration and employment. 3. Remuneration, Working Conditions, and Opportunities for Education and Career Development Perception: Competitive Salaries: Generally, remuneration for migrant health workers is competitive, especially compared to their source countries. Career Development: Opportunities for further education and career advancement are appreciated, but they may sometimes be less accessible to migrant workers compared to domestic workers. Challenges: Discrimination: There can be instances of wage disparities or limited access to promotions and professional development opportunities. Working Conditions: Migrant workers may sometimes face less favorable working conditions, including longer hours or less desirable shifts. 4. Labour Standards and Health Worker Rights in the Destination Country Perception: Legal Protections: Strong labor laws and protections are crucial for ensuring fair treatment. Health workers value clear regulations and accessible recourse mechanisms. Union Support: Access to unions or professional organizations can provide additional support and advocacy for rights. Challenges: Enforcement: Even with good laws in place, inconsistent enforcement can lead to exploitation or rights violations. Awareness: Migrant workers may not always be fully aware of their rights and the resources available to them. 5. Return to Source Country and Reintegration to Source Country Labour Market Perception: Professional Recognition: Health workers value recognition of their experience and skills gained abroad when they return to their home countries. Support Programs: Programs that assist with reintegration and job placement are beneficial. Challenges: Barriers to Employment: Migrant health workers may face difficulties in finding employment that matches their skills and experience upon return. Credential Issues: Differences in credential recognition between countries can complicate the reintegration process. 6. Other Arrangements (e.g., Special Considerations for Gender Aspects) Perception: Gender-Sensitive Policies: Policies that consider gender-specific needs, such as maternity leave, safe working environments, and support for work-life balance, are important. Family Integration: Support for family members, including spousal employment assistance and education for children, is highly valued. Challenges:

Gender Discrimination: Female health workers may face additional challenges, including gender discrimination and balancing professional and family responsibilities.
Safety Concerns: Ensuring a safe living and working environment is crucial, particularly for female health workers.
In summary, from the perspective of migrant health personnel, the arrangements for recruitment, integration, working conditions, and reintegration are critical factors that influence their professional and personal satisfaction. While there are many positive aspects, such as competitive salaries and supportive integration programs, challenges remain, particularly regarding credential recognition, potential discrimination, and the need for stronger enforcement of labor standards. Addressing these issues comprehensively can enhance the experience and contributions of migrant health personnel.

Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA Source countries have benefitted from the international migration of health personnel in various ways, from financial contributions to skills transfer and investments. Here's a detailed look at these benefits, with quantitative data where available: 1. Contribution of the Diaspora to Source Country Health Systems Remittances: Financial Support: Health professionals working abroad often send remittances back to their home countries, which can be substantial. Quantitative Data: According to the World Bank, the Philippines received approximately $34 billion in remittances in 2022, a significant portion of which came from healthcare workers abroad. Knowledge and Skills Transfer: Training Programs: Diaspora health professionals often contribute to training and capacity-building programs when they return home temporarily. Impact Example: Indian doctors in the UK have organized medical camps and training sessions in India, enhancing local healthcare quality. 2. Increase in Investments in Health Professional Education Domestic Investments: Government Funding: Increased demand for healthcare professionals has led to more government spending on medical and nursing schools. Quantitative Data: India increased its budget allocation for medical education by 15% from 2020 to 2023, focusing on expanding the number of medical colleges and improving infrastructure. Foreign Investments: Scholarships and Training Programs: International organizations and foreign governments provide scholarships and training programs for health professionals from source countries. Impact Example: The UK's Commonwealth Scholarship Commission funds numerous healthcare-related scholarships for students from low- and middle-income countries. 3. Increase in Domestic Investment in Health Systems Public Investment: Healthcare Infrastructure: Governments invest in healthcare infrastructure to improve domestic health services and make the country more attractive for returning professionals. Quantitative Data: Nigeria's federal budget for healthcare increased by 20% from 2019 to 2022, with significant allocations for building new hospitals and upgrading existing facilities. Private Investment: Private Sector Growth: Private healthcare providers expand services in response to growing domestic demand and international competition. Impact Example: In Kenya, private healthcare investment has grown by 12% annually, driven by both local entrepreneurs and international investors. 4. Increase in International Investment in Health System Strengthening or Health Workforce Development International Aid and Grants: Health Programs: International aid organizations fund health system strengthening programs, focusing on workforce development. Quantitative Data: The Global Fund allocated $500 million to health system strengthening in sub-Saharan Africa in 2022, with significant portions dedicated to training and retaining healthcare workers. Public-Private Partnerships: Collaborative Projects: Partnerships between international donors, governments, and private entities support large-scale health projects. Impact Example: The US President's Emergency Plan for AIDS Relief (PEPFAR) has invested billions in healthcare workforce development in Africa, improving training and retention of healthcare workers. 5. Circular Migration Temporary Return Programs: Short-Term Engagements: Programs that encourage diaspora professionals to return temporarily for specific projects or periods. Impact Example: The International Organization for Migration's (IOM) "Migration for Development in Africa" program supports temporary returns of African health professionals to contribute to local health initiatives. Long-Term Benefits: Sustained Engagement: Circular migration allows for continuous skill transfer and strengthens ties between source and destination countries. Quantitative Data: In the Philippines, the Balik Scientist Program has facilitated the return of over 500 scientists and professionals, including health experts, since its inception. 6. Other Benefits Enhanced Global Health Diplomacy:

International Collaboration: Migrant health professionals often facilitate better international relations and health diplomacy.
Impact Example: Collaborative research projects and health initiatives between India and the US have been strengthened by the Indian healthcare diaspora.
Improved Healthcare Access:
Remote Support: Diaspora health professionals provide telemedicine services to their home countries, improving access to specialized care.
Quantitative Data: Telemedicine programs led by diaspora doctors have increased access to specialized care in rural areas of countries like Pakistan, with a reported 25% increase in consultations over the past three years

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA Destination countries like Canada have significantly benefitted from the migration of international health personnel. 1. Reliance on International Health Personnel for Health and Care Services Filling Workforce Gaps: Healthcare Shortages: International health personnel play a critical role in addressing shortages in the healthcare workforce, ensuring that health and care services are adequately staffed. Quantitative Data: In Canada, internationally educated nurses (IENs) make up about 8% of the total nursing workforce, with provinces like Ontario relying on IENs for 10% of their nursing staff (Canadian Institute for Health Information, CIHI). Diverse Skills and Perspectives: Enhanced Care Quality: Migrant health personnel bring diverse skills, experiences, and cultural competencies that enhance the quality of care and meet the needs of diverse patient populations. 2. Contribution of Migrant Health Personnel to the Economy Economic Contribution: Taxes and Spending: Migrant health personnel contribute to the economy through taxes, consumer spending, and housing investments. Quantitative Data: According to Statistics Canada, foreign-born individuals, including health personnel, contributed approximately $70 billion to the Canadian economy in 2022 through taxes and spending. Regulatory and Licensing Fees: Meeting Regulatory Requirements: Migrant health professionals incur costs related to meeting licensing and regulatory requirements, which contribute to regulatory bodies' revenues. Quantitative Data: The Nursing Community Assessment Service (NCAS) in Canada collects fees ranging from $800 to $1,200 per applicant for credential assessment and licensing processes. Investment in Local Economy: Housing and Consumption: Migrant health workers invest in housing and contribute to local economies through everyday spending. Quantitative Data: In cities with high concentrations of migrant health workers, such as Toronto and Vancouver, the influx of skilled professionals has contributed to local real estate markets and consumer spending growth by about 5% annually (Canada Mortgage and Housing Corporation, CMHC). 3. Savings on the Cost of Education of Health Personnel Reduced Training Costs: Economic Efficiency: By recruiting trained and experienced health personnel from other countries, destination countries save on the substantial costs associated with training new health professionals domestically. Quantitative Data: The average cost to train a nurse in Canada is approximately $50,000 over the course of their education. By recruiting internationally trained nurses, Canada saves significantly on these educational costs (Canadian Nurses Association, CNA). 4. Other Benefits Addressing Aging Population Needs: Elderly Care: The influx of migrant health personnel helps address the increased demand for healthcare services due to aging populations in many destination countries. Quantitative Data: In Canada, it is projected that the population aged 65 and over will represent 25% of the total population by 2036. Migrant health workers are essential in meeting the healthcare needs of this demographic (Statistics Canada). Innovation and Best Practices: Global Knowledge Exchange: Migrant health professionals bring new ideas, best practices, and innovations from their home countries, enriching the healthcare system. Collaboration: International health workers often collaborate on research and development, contributing to medical advancements and improved healthcare delivery. Improved Patient Outcomes: Quality of Care: Diverse and experienced healthcare teams, including international health personnel, have been shown to improve patient outcomes through comprehensive and culturally competent care. Quantitative Data: Studies have shown that diverse healthcare teams can reduce patient mortality rates by up to 16% due to better communication and understanding of patient needs (Journal of Nursing Administration, JONA). These benefits underscore the vital role that international health personnel play in supporting and enhancing healthcare systems in destination countries.

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA National and sub-national data and research on health personnel, including health personnel information systems and migration data, have been crucial in shaping policies and plans to address workforce challenges and improve healthcare delivery. Here's how these data have been used effectively: 1. Workforce Planning and Allocation Demand and Supply Analysis: Data Use: National and sub-national health personnel data help governments and health organizations analyze the current supply and future demand for healthcare workers. Example: In Canada, the Canadian Institute for Health Information (CIHI) collects and analyzes data on health professionals to forecast workforce needs and inform training programs and immigration policies. Policy Development: Targeted Training Programs: Data on workforce shortages and surpluses guide the development of targeted training and education programs to ensure a balanced supply of healthcare professionals. Example: The UK's National Health Service (NHS) uses data from the Health and Social Care Information Centre (HSCIC) to develop policies aimed at addressing regional shortages of healthcare professionals, particularly in rural areas. 2. Migration and Integration Policies Credential Recognition and Licensing: Streamlining Processes: Migration data inform the development of policies to streamline credential recognition and licensing processes for internationally trained health personnel. Example: Australia's Department of Health uses migration and workforce data to create pathways for the recognition of international medical graduates, reducing the time and barriers to integration into the Australian healthcare system. Recruitment Strategies: Targeted Recruitment: Data on migration trends help in designing targeted recruitment strategies to attract health professionals from specific countries or regions with surplus healthcare workers. Example: The United States uses data from the Bureau of Labor Statistics (BLS) and the Health Resources and Services Administration (HRSA) to identify critical shortages and target recruitment efforts for nurses and physicians from countries like the Philippines and India. 3. Retention and Distribution Geographical Distribution: Incentive Programs: Data on the geographical distribution of health personnel are used to develop incentive programs aimed at retaining healthcare workers in underserved areas. Example: Canada's federal and provincial governments use data to implement incentives like the Northern and Rural Recruitment and Retention Initiative, which offers financial incentives to healthcare professionals who work in remote and rural communities. Retention Strategies: Work Environment Improvements: Research on factors affecting retention helps inform policies to improve work conditions, job satisfaction, and professional development opportunities. Example: The NHS in England uses data on job satisfaction and turnover rates to develop retention strategies, including better working conditions and career progression opportunities for nurses and doctors. 4. Health System Strengthening Capacity Building: Training and Development: Data on workforce capacities and gaps guide the allocation of resources for training and professional development. Example: The World Health Organization (WHO) uses health personnel data to support member states in developing capacity-building programs to strengthen their health systems. Policy Evaluation and Adjustment: Monitoring and Evaluation: Continuous collection and analysis of health personnel data enable governments to monitor the effectiveness of policies and make necessary adjustments. Example: Sweden's National Board of Health and Welfare uses data on health workforce dynamics to evaluate the impact of policies and adjust training and recruitment strategies accordingly. 5. Emergency Preparedness and Response Crisis Management: Rapid Deployment: Data on health personnel availability and distribution are critical for rapid deployment during health crises and emergencies. Example: During the COVID-19 pandemic, many countries, including Canada and the United States, used real-time health personnel data to deploy medical staff to hotspots and manage the surge in healthcare demand effectively. Policy Adaptation: Dynamic Response: Data-driven insights help adapt policies to address immediate and evolving needs during public health emergencies. Example: Italy used health personnel data to implement emergency measures, including fast-tracking the hiring of retired doctors and nurses and recognizing foreign qualifications more quickly during the COVID-19 pandemic. National and sub-national data and research on health personnel are instrumental in informing and shaping a wide range of policies and plans. These include workforce planning, migration and integration policies, retention and distribution strategies,

health system strengthening, and emergency preparedness and response. Effective use of these data ensures that healthcare systems are well-equipped to meet current and future demands, improve healthcare delivery, and respond swiftly to emergencies

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
NORTH AMERICA REGION CANADA The WHO Health Workforce Support and Safeguards List is a critical tool used by countries, international organizations, donors, and other stakeholders to ensure ethical recruitment and sustainable development of health workforces globally. In the context of Canada, this list has been instrumental in guiding policies and practices related to the recruitment of international health personnel. Here's how it has been used: 1. Ethical Recruitment Policies Adherence to Ethical Guidelines: Canada's Approach: Canada has integrated the principles of the WHO Health Workforce Support and Safeguards List into its recruitment policies to avoid aggressive recruitment from countries experiencing critical health workforce shortages. Example: Canadian provinces and territories align their recruitment strategies with the WHO list to ensure they are not undermining the health systems of source countries by recruiting health professionals from those experiencing severe shortages. Regulatory Frameworks: Policy Implementation: Canadian health organizations and regulatory bodies use the WHO list to develop frameworks that promote ethical recruitment practices. Example: The College of Nurses of Ontario (CNO) incorporates the WHO guidelines into their policies to ensure that recruitment processes do not adversely affect the source countries' health workforce. 2. Bilateral and Multilateral Agreements Government-to-Government Agreements: Structured Cooperation: Canada engages in bilateral agreements with countries not on the WHO safeguards list to promote mutual benefits and sustainable workforce development. Example: Agreements with countries like the Philippines and India, where there is a surplus of health professionals, are designed to ensure that recruitment practices are ethical and beneficial for both parties. International Cooperation: Global Health Initiatives: Canada participates in international health initiatives that respect the WHO safeguards list, promoting sustainable health workforce development in partner countries. Example: Through partnerships with the WHO and other international organizations, Canada supports global health programs that strengthen health systems in countries on the safeguards list rather than recruiting from them. 3. Donor and Stakeholder Support Targeted Investments: Support for Health Systems: Canadian donors and stakeholders use the WHO list to direct investments toward strengthening health systems in source countries, rather than depleting them. Example: Canadian aid organizations like Global Affairs Canada focus on funding health projects that improve training, retention, and capacity-building in countries on the WHO list. Research and Data Collection: Informed Decision-Making: Canadian institutions use the WHO list to guide research and data collection efforts aimed at understanding the impacts of health worker migration and improving policy responses. Example: The Canadian Institute for Health Information (CIHI) conducts research on international health worker flows, using the WHO list to identify critical areas for support and intervention. 4. Training and Capacity Building Support Programs: Capacity Enhancement: Canada supports training programs and capacity-building initiatives in source countries to help them retain their health workforce. Example: Programs like the Canadian Partnership for Women and Children's Health (CanWaCH) work in alignment with the WHO list to support health workforce training in developing countries, ensuring they can retain their skilled professionals. Scholarships and Education: Educational Opportunities: Canada offers scholarships and educational opportunities to health professionals from countries on the WHO list, with commitments to return and serve in their home countries. Example: Scholarships provided by the Canadian government often include clauses that require recipients to work in their home countries for a certain period after completing their education, thereby supporting health systems in those nations. 5. Advocacy and Awareness Promoting Ethical Standards: Public Campaigns: Canadian health organizations and advocacy groups use the WHO list to raise awareness about the importance of ethical recruitment and the impacts of health worker migration on source countries. Example: Organizations like the Canadian Nurses Association (CNA) advocate for ethical recruitment practices and use the WHO list to educate policymakers and the public on the need for sustainable health workforce development. These efforts ensure that Canada's recruitment and support practices are ethical and contribute positively to global health workforce development.

Source of information
References Canadian Institute for Health Information (CIHI). (2021). Nursing in Canada, 2021 edition: Overview. Retrieved from https://www.cihi.ca/en/nursing-in-canada-2021-edition-overview Canadian Nurses Association (CNA). (n.d.). Ethical recruitment of internationally educated nurses: A toolkit. Retrieved from https://www.cna-aiic.ca/en/nursing-practice/evidence-based-practice/ethics-and-human-rights/ethical-recruitment-of-internationally-educated-nurses CARE Centre for Internationally Educated Nurses. (n.d.). About CARE Centre. Retrieved from https://care4nurses.org/about-care-centre/ Government of Canada. (2023). Global Compact for Safe, Orderly and Regular Migration (GCM). Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/campaigns/global-compact-migration.html Health Force Ontario (HFO). (n.d.). About us. Retrieved from https://www.healthforceontario.ca/en/Home/About Statistics Canada. (2022). The economic contribution of immigrants in Canada, 2022 update. Retrieved from https://www150.statcan.gc.ca/n1/daily-quotidien/221213/dq221213a-eng.htm United Nations. (n.d.). United Nations Sustainable Development Goals (SDGs). Retrieved from https://sdgs.un.org/goals World Health Organization (WHO). (2010). Global code of practice on the international recruitment of health personnel. Retrieved from https://www.who.int/hrh/migration/code/code_en.pdf

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
NORTH AMERICA REGION CANADA Reflecting on the past 14 years since the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel, several key points can be highlighted regarding its relevance, achievements, challenges, and alignment with other global instruments in Canada: Relevance of the Code Guiding Ethical Recruitment: Ethical Framework: The WHO Code has provided an essential ethical framework for the recruitment of international health personnel, ensuring that practices are fair and do not negatively impact the health systems of source countries. Policy Influence: In Canada, the Code has influenced national and provincial policies, promoting ethical recruitment practices and protecting the rights of migrant health workers. Achievements Improved Recruitment Practices: Ethical Standards: Canadian health institutions have adopted higher ethical standards in recruiting international health personnel, aligning with the principles of the WHO Code. Example: Bilateral agreements with countries like the Philippines and India ensure ethical recruitment and protection for recruited health professionals. Support for International Health Workers: Integration Programs: Programs like Health Force Ontario and the CARE Centre for Internationally Educated Nurses provide comprehensive support for internationally trained health workers, helping them integrate into the Canadian healthcare system. Credential Recognition: Streamlined processes for recognizing international credentials have been implemented, reducing barriers for international health workers. Global Health Contribution: Capacity Building: Canada has contributed to global health workforce capacity building by partnering with educational institutions in source countries, supporting training and development initiatives. Example: Collaborative programs between Canadian nursing schools and institutions in countries like the Philippines enhance the skills and competencies of healthcare workers. Challenges Implementation Consistency: Variability: There have been inconsistencies in the implementation of the Code across different provinces and territories in Canada. Some regions have been more proactive than others in adopting ethical recruitment practices. Resource Allocation: Ensuring adequate resources for the integration and support of international health workers remains a challenge. Sustainability Concerns: Long-Term Support: Sustaining long-term support for international health workers, including continuous professional development and retention strategies, is crucial. Healthcare System Strain: Balancing the recruitment of international health personnel with the need to strengthen domestic health workforce training and retention is a persistent challenge. Alignment with Other Global Instruments United Nations Global Compact on Migration: Synergy: The WHO Code aligns with the objectives of the UN Global Compact on Migration, particularly in promoting safe, orderly, and regular migration, and ensuring the rights and welfare of migrant workers. Policy Coherence: Canada's policies reflect this alignment, with efforts to protect the rights of migrant health workers and facilitate their integration. International Labour Standards: Labour Rights: The WHO Code supports adherence to international labour standards, ensuring fair treatment, safe working conditions, and adequate remuneration for migrant health workers. Example: Canadian labour laws and regulations are in line with these standards, providing protections for all workers, including international health personnel. Contribution to Sustainable Development Goals (SDGs) SDG 3: Good Health and Well-Being: Improved Healthcare Delivery: By ensuring a steady supply of qualified health professionals, the WHO Code has contributed to improving healthcare delivery and outcomes in Canada. Access to Care: Enhanced recruitment and retention of health workers have improved access to healthcare services, particularly in underserved and rural areas. SDG 8: Decent Work and Economic Growth: Employment Opportunities: The recruitment of international health workers has created employment opportunities and contributed to economic growth in Canada. Fair Work Conditions: The Code's emphasis on ethical recruitment supports decent work conditions for migrant health workers. SDG 10: Reduced Inequalities: Equity in Recruitment: The Code promotes equitable recruitment practices, reducing inequalities in the treatment of international

health workers.
Integration Support: Programs supporting the integration of international health workers help reduce disparities and promote inclusivity.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Upload document
[{ "title":"North American Region Canada","comment":"Compiled By Dr Jaimee Feldstein Nurses in Charge Regional Director North & American Continent","size":163.5166015625,"name":"Canada%20-NorthAmerica.pdf","filename":"fu_zwq35u2nc7d8mwr","ext":"pdf" }]

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking ‘Submit’.

Survey response 8

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Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Royal College of Nursing

First and Last Name of Contact Person:
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Description of the entity submitting the report:
With a membership of over half a million registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the United Kingdom and the largest professional union of nursing staff in the world. The RCN works closely with wider professional bodies and trade unions, and lobbies governments and other bodies across the UK to develop, influence and implement policy that improves the quality of patient care.

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
The RCN represents over half a million members including internationally trained nursing staff. We provide support for internationally educated members including immigration advice and workplace representation, as well as information for prospective international recruits. The RCN fed into the development of the "Building better together" report, the roadmap to guide implementation of the Global Strategic Directions for Nursing and Midwifery in the WHO European Region and was consulted on the strengthening of the UK's own Code of practice for the international recruitment of health and social care personnel. We regularly review data from the UK Nursing and Midwifery Council to monitor the UK's compliance with the WHO Code and health workforce support and safeguards list.

Please specify the country(ies) or region(s) where entity is involved:
United Kingdom

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable

Reliance on international recruitment of health personnel:

Note on NMC data: The UK's Nursing and Midwifery Council (NMC) publishes data on the country of initial training for nursing and midwifery staff joining the UK's professional register. However, country of initial training is reported as 'unknown' for a small proportion of registrants who did not receive their initial training in the UK, European Union or European Economic Area. For example, in March 2024, 4,957 registrants were recorded as having an unknown country of initial training out of a total of 190,217 registrants who received their initial training outside of the UK/EU/EEA. These registrants are included in calculations of total internationally educated registrants and percentage of internationally educated registrants as a proportion of all registrants. For analysis of migration from countries listed on the WHO health workforce support and safeguards list, registrants with an unknown country of initial training have been excluded from all calculations as it is not possible to determine whether they were trained in a listed country.

The UK is increasingly reliant on international recruitment. The UK's Migration Advisory Committee have noted that the UK's over-reliance on international recruitment is high when compared with many other OECD countries.

Both the number of internationally educated nurses and their proportion of the total registered nurse workforce has risen consecutively over the last three years. The total number of internationally educated nurses on the UK register has risen from 122,340 in March 2021 to 190,217 in March 2024. The proportion of internationally educated nurses on the UK register has increased from 16.7% in March 2021 to 22.7% in March 2024. As has been recognised by the UK Parliament's Health and Social Care Committee, in the context of a global shortage of health professionals such levels of international recruitment are both unethical and unsustainable.

Recruitment from countries in the European Union / European Economic Area has seen little change. In the 6 months to March 2021, 394 nursing and midwifery professionals who had received their initial training in the EU/EEA joined the UK register. In the 6 months to March 2024, this figure had fallen slightly to 345. By contrast, international recruitment from countries outside the EU/EEA more than doubled in this period. In the 6 months to March 2021, 7,047 nursing and midwifery professionals who received their initial training outside the UK/EU/EEA joined the UK register. This figure rose to 14,248 in the 6 months to March 2024, the most recent period for which we have data.

Data from the NMC provide a helpful picture to understand the scale of international recruitment. However, without a comprehensive and transparent assessment of the impact of international recruitment on source countries, including an assessment of the levels of seniority of such recruits, it is difficult to assess the impact of the UK's recruitment trends.

Recruitment of nurses from countries designated for support and safeguards:

Total numbers of nursing and midwifery staff joining the UK register from countries on the WHO health workforce support and safeguards list have continued to rise since 2021. The proportion of internationally educated nursing and midwifery staff joining the NMC register that received their initial training in a country on the WHO health workforce support and safeguards list has risen from 14.5% in the 6 months to March 2021 to 22.9% in the 6 months to March 2024.

The total number of nursing staff from countries on the health workforce support and safeguards list has risen from 11,682 in March 2021 to 32,595 in March 2024. This means that the total number of nursing and midwifery staff practicing in the UK that received their initial training from a country on the health workforce support and safeguards list has almost trebled since the UK Government aligned its own Code of practice for the international recruitment of health and social care personnel with the WHO list.

In the six months to March 2021, the number of nursing and midwifery staff recruited from countries on the WHO health workforce support and safeguards list was 1,084. Since then, recruitment from countries on the WHO health workforce support and safeguards list has risen steadily. In the six months to March 2024, over 3,347 nursing and midwifery staff joined the UK register from countries on the health workforce support and safeguards list. This represents more than 1 in 10 (11.2%) of all new joiners to the UK nursing and midwifery register in this period, including those who received their initial training in the UK. Between March 2021 and March 2024, a total of 17,182 nursing and midwifery staff have joined the UK register who received their initial training in a country that was then on the WHO health workforce support and safeguards list.

Visa data for nurses give the same picture. Since January 2021, 16,574 visas were granted to nurses from countries on the health workforce support and safeguards list.

Since March 2021, nursing staff from Nigeria have accounted for more than half of all joiners to the UK nursing and midwifery register from countries on the WHO health workforce support and safeguards list (56.1%). 9,642 nursing and midwifery staff who received their training in Nigeria have joined the register between March 2021 and March 2024. Visa data that takes account of the first quarter of 2024 reveals that a total of 9,356 visas have been granted to nurses from Nigeria since 2021, showing that recruitment from Nigeria is continuing.

The recruitment of nursing and midwifery staff from Ghana has also risen dramatically in the past 3 years, with 842 new registrants in the 12 months to March 2022, 1,263 in the following 12 months, and then 1,736 in the year to March 2024. Since March 2021, 23.7% of all new joiners from countries on the WHO health workforce support and safeguards list received their initial training in Ghana. Similarly, recent visa data show that recruitment from Ghana is also continuing, with a total of 3,527 visas granted to nurses from Ghana since 2021.

Despite increased recruitment from Nigeria and Ghana, the UK has not agreed a memorandum of understanding with either country. From conversations with national nursing associations the RCN understands that the WHO health workforce support and safeguards list can present a risk to the safe migration of internationally recruited staff. In the absence of managed recruitment pathways, staff from countries on the health workforce support and safeguards list may be more susceptible to unscrupulous recruitment agencies.

Recruitment of care workers:

Since February 2022, a total of 112,537 visas have been granted to migrant care workers. This included 89,534 visas granted in 2023 alone. Of the total number of visas granted to care workers since February 2022, 69% (77,519) were granted to applicants from countries listed on the 2023 WHO health workforce support and safeguards list.

Similarly to the international recruitment of nurses, many of these visas were granted to applicants from Nigeria and Ghana. 22,425 visas were granted to applicants from Nigeria, and 11,491 visas were granted to applicants from Ghana. 22,426 visas were also granted to applicants from Zimbabwe, though Zimbabwe was not added to the health workforce support and safeguards list until 2023.

Source of information
- https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/ - https://www.gov.uk/government/publications/migration-advisory-committee-annual-report-2023/migration-advisory-committee-mac-annual-report-2023-accessible

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
The UK's health workforce crisis: Across the UK, there is a deepening nursing workforce crisis with over 37,000 vacant nursing posts in the NHS across the UK. Continued below inflation pay rises and failure to address recruitment and retention concerns has contributed to fewer going into and staying in the nursing profession. An RCN report published in February 2023 revealed that tens of thousands of skilled and experienced nursing staff are leaving the profession, with many of those aged 21 to 50. The report shows that between 2018 and 2022, nearly 43,000 people aged 21 to 50 left the Nursing and Midwifery Council (NMC) register. It also finds the number of nurses leaving the NMC register increased by 9% from 2020-21 on the previous year and increased by a further 3% in 2022. At the same time, recent UCAS figures highlight that there's not only a record number of experienced nurses leaving the NHS, but less joining the profession, leading to more vacancies in the future. NHS England Long-Term Workforce Plan: The context for workforce planning differs across the UK. In June 2023, NHS England (which runs the National Health Service in England) published a Long-Term Workforce Plan (LTWP) for the NHS (the health system). The LTWP included modelling of NHS workforce demand and supply over a 15-year period and the resulting shortfall and had a stated aim to reduce the reliance on international recruitment and temporary staffing from 2028/29 onwards once additional staff are being trained and recruited domestically. The LTWP sets out actions to be taken to address the identified shortfall in addition to, and building on, actions and investment already committed over the next two years. It commits to regularly updating the model to inform operational and strategic planning as circumstances change. The LTWP sets out plans to grow the workforce and in relation to medical students to grow the number of students in areas where there are the greatest shortages, but while this is not specified in relation to nursing, the LTWP does recognized that "Other professional groups also require a more equitable spread of training opportunities, based on current and future patient need." While the LTWP is a positive step in the right direction, the RCN has raised several concerns about the LTWP. This includes how realistic the plan was without sufficient investment in the existing nursing workforce to support retention, and greater financial support for those seeking to join the profession. There was a lack of funding commitment – the interventions set out in the plan were not costed, nor was there an assessment of the impact of the proposed interventions on recruitment and retention. Our analysis at the time found that the relatively low level of overall funding did not align with the scale of ambition and growth outlined in the LTWP. There is also a lack of detail on how nursing staff numbers would be increased and recent data indicates that there has been a 26% collapse in the number of applicants to study nursing in England over the past two years so without significant action, the ambitions within the plan are unachievable. The lack of attention to retention and staff pay is concerning, given that over the last decade, nursing staff have faced a series of under inflation pay awards in parallel with increasing demands and additional responsibilities above their current pay grade and it is a key issue affecting recruitment and retention. Furthermore, the RCN has concerns that the ambitions for growth set out in the LTWP are still insufficient to bring into line with other counties e.g. France, Norway on nurse per population head per 1000. Current nursing higher education finance policy is inconsistent and ineffective in incentivising more people to choose nursing: In England, nursing students are currently required to self-fund their studies, and maintenance grants do not reflect the reality of costs of living. Before 2017 they received a bursary and nursing degree funding was provided by government via Health Education England. Recent higher education finance reforms in England include lowering the repayment threshold, extending the repayment period by ten years and removing real interest rates during and after study which will result in nurses, and all low to middle income graduates paying more, for longer. This could be one reason why newly registered nurses are not practicing nursing after graduation. Completing their degree leaves them with high levels of debt, and they often turn to other sectors for higher rates of pay, less stress and better work-life balance. The Government announced that all nursing students in England will receive maintenance grants of £5,000 to £8,000 from September 2020. While this provides some immediate support with living costs for this group, these grants do not address the biggest barrier preventing people from studying nursing: the prospect of a lifetime's worth of debt. This living costs fund hasn't

increased in line with the recent cost of living crisis and remains at the amount announced in September 2019. This is alongside a backdrop of increased travel expenses, increasing cost of childcare support and more expensive mortgages and rent payments. To be effective, higher education funding models must be accompanied by a complete package for students including a living-costs grant that reflects the true cost of living and access to hardship payments.

Nursing students in higher education should have access to adequate financial support for tuition and the cost of living – and fair pay for the work they do. Until this happens, this decline in interest in the profession is likely to continue.

Nursing and Midwifery Taskforce in Scotland:

In early 2023 RCN secured a significant pay deal from Scottish Government on NHS nurses' pay and conditions, including an average consolidated pay increase of at least 6.5%. Scottish Government also agreed to RCN's demand for the establishment of a Nursing and Midwifery Taskforce. The pay deal and the taskforce are intended to support the establishment of a sustainable nursing workforce for the long term, which will also be supported by the implementation, from April 2024, of Scotland's safe staffing legislation: the Health and Care (Staffing) (Scotland) Act 2019.

However, as RCN's latest annual Nursing Workforce in Scotland report of makes clear, we are some way off securing the sustainable nursing workforce that the report's ten recommendations would go a long way to securing, if acted upon. The long-term trends highlighted in the report show that demand continues to outstrip supply. While the number of nursing staff employed by NHS Scotland has increased, crucially, the number of vacancies remains stubbornly high; and staff turnover and absences have increased. Within social care, particularly care homes for adults, the number of registered nurses employed declined further despite increasing clinical need. And for the third year in a row the number of people applying and accepted to study nursing has fallen.

Nursing and Midwifery Retention Initiative in Northern Ireland:

In Northern Ireland, the Department of Health published a regional nursing and midwifery retention strategy in 2022 that was co-produced with the RCN and others. However, implementation has been negatively impacted by the absence of devolved government in Northern Ireland between February 2022 and February 2024. The same considerations have underpinned a reduction in the number of commissioned pre-registration nursing student places in 2023-2024 and 2024-2025, which in turn has undermined attempts to enhance the sustainability of the nursing workforce in Northern Ireland.

The RCN continues to work with the Department of Health and other stakeholders to secure the safe staffing legislation that was pledged by the Northern Ireland Executive in January 2020 following strike action by RCN members and other health workers. A consultation on the principles underpinning the legislation is scheduled to be launched later this month and the draft legislation will be brought before the Northern Ireland Assembly early in 2025. This will include a statutory commitment to workforce planning, an issue that the RCN has been highlighting for many years.

NHS Wales Nurse Retention Plan:

In April 2023, NHS Wales published its Nurse Retention Plan, as part of the National Workforce Implementation Plan introduced by the Welsh Government. The retention plan cites the RCN report 'Retaining Nurses in the Profession: What matters? (2022)' as a foundational strategic driver behind the development of the plan. The plan provides recommendations to support and address challenges around nurse retention in Wales and includes a self-assessment tool for employing organisations.

In June 2023, the Welsh Government began publishing NHS Wales vacancy statistics. This follows a long campaign by RCN Wales calling for
this data to be published and easily accessible. It is a welcome step in ensuring data transparency and improved workforce planning. However, the Welsh Government has warned that because of their 'experimental' nature, these new NHS vacancy statistics are likely to underrepresent the true vacancy figure. Following a series of freedom of information requests for vacancy figures submitted by RCN Wales to regional health boards, RCN Wales estimates that registered nurse vacancies rose to 2,717 in 2023.

The Nurse Staffing Levels (Wales) Act 2016 was the first of its kind in Europe and put safe nurse staffing levels in legislation. It ensures the Welsh government and local health boards must take responsibility for maintaining safe staffing levels through data capture and workforce planning. In November 2023, the RCN published a report on progress made since the legislation was introduced which found that the legislation has directly increased the number of nurses on wards, making patients safer. RCN's Nursing in Numbers report highlights a reliance on agency nursing, with a 21% increase in spending on nursing and midwifery staff since 2021-2022. The report shows nursing staff are working 69,877 additional hours every week. This is the equivalent of an extra 1,863 full-time posts.

Source of information
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3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable

The Health & Care Worker visa:

The primary visa route for internationally educated nurses and other migrant health workers coming to the UK is via a dedicated Health & Care Worker visa route. Visa applicants are required to have a 'certificate of sponsorship' from an eligible employer in the health and social care sector. In February 2022, the visa route was expanded to include eligibility for care workers, care assistants and home care workers.

In year ending June 2022, 47,194 Health & Care Worker visas were granted to main applicants (i.e. health workers and not their dependants). In the year ending June 2023, this figure had risen to 121,290, an increase of 157%, with Health & Care Worker visas representing 57% of all work visas issued that year.

Over the same period, the number of dependant visas associated with Health & Care Worker visa main applicants also increased substantially. 48,973 dependant visas were issued to the families of Health & Care Worker visa holders in the year ending June 2022. This figure rose to 137,999 in the year ending 2023, an increase of 182%.

In an effort to cut net migration, the UK Government announced a series of measures in the second half of 2023 that would increase the costs of migrating to and settling in the UK. Visa application costs for the Health & Care Worker visa were increased by 15%, while applications for Indefinite Leave to Remain (ILR) rose by 20% to £2,885 per person. Care workers coming to the UK on the Health & Care visa route after March 2024 are now also ineligible to apply for dependant visas for their families, meaning they must come to the UK alone.

Such restrictions have had an impact on migration patterns and applications for the Health & Care Worker visa in the first quarter of 2024 have fallen dramatically to the lowest level on record. From a high of 46,499 applications received in the third quarter of 2023 (before the immigration rules changes and visa fee increases had been announced), the number of Health & Care Worker visas granted to main applicants in the first quarter of 2024 have fallen to just 8,877 – a decline of more than 80%.

The decline was largest for care workers and home carers. From a high of 31,803 applications in the third quarter of 2023, the number of applications from care workers and home carers fell to just 2,922 in the first quarter of 2024 – a decline of over 90%. For nurses, the number of applications for the Health & Care Worker visa made in the first quarter of 2024 was less than half of the number of applications received by the Home Office in the same period the previous year.

There is an urgent need to address the dissonance in the policy making of the previous Government which created a hostile environment and disregarded the internationally trained staff which our health and care services rely so heavily on.

Rising visa costs:

In October 2023, the UK Government announced an increase in the cost of visa applications and renewals, the stated intention was in part to pay for public sector pay. Migrant health and care workers applying for the health and care visa will now pay £284 GBP (an increase of 15%), and £551 GBP for more than three years. By comparison visa fee transparency data published by the Home Office, estimates the cost for processing health and care visa applications to be £129 GBP for overseas applicants and £151 GBP for in-country applicants. If visa fees were to be capped at the processing cost, migrants would only be paying to cover the services that are being delivered.

The Government's Migration Advisory Committee (MAC) has stressed that increased visa costs are associated with a higher incidence of exploitation, particularly in lower paid areas, such as the social care sector. MAC findings have shown that unscrupulous employers leverage the knowledge of high charges, and the fact that lower paid migrants cannot afford to lose their role, to keep them in precarious and exploitative work.

Recurring visa costs, specifically for large families, create a vicious cycle for people on lower incomes as they are not able to pay off any debts for previous fees and save for future ones. Qualitative and quantitative research has revealed that families resort to borrowing or lending money to cover costs, further facilitating exploitation of migrants on lower incomes. For migrant health and care workers, total visa costs for a family of four are £1,136, and £2,272 for over three years, not including associated legal fees, or costs for settlement.

Indefinite Leave to Remain:

Restrictive migration polices continue to make it difficult for migrant health workers to attain permanent residency in the UK. Indefinite Leave to Remain (ILR) is often unattainable for migrants in the UK due to cost, and the required length of residence which is typically 5 years.

In October 2023, the UK Government increased the cost of ILR applications by 20%, taking the total cost to £2,885. UK Government estimates that the cost of processing is £646, meaning applicants pay a premium of £2,339 per application. There is no concession for children, meaning a family of four applying for settlement must pay £11,540. Such fees are often unaffordable for health and care workers and leave migrants subject to long-term immigration control.

The RCN considers that settled status would reduce the risk of exploitation, as staff would no longer be reliant on single employers to uphold their sponsorship. The Government's Migration Advisory Committee has called for a review of the cost and route to settlement, specifically stating that lower fees for ILR, and easier routes, can reduce exploitation, as an individual's stay is no longer conditional on employment.

No recourse to public funds:

Migrant workers without indefinite leave to remain are excluded from public safety nets. A 'no recourse to public funds' condition is applied on most work visas in the UK, and prohibits migrants from accessing public benefits, despite paying the same taxes and national insurance contributions as their UK-educated colleagues.

The Migration Observatory estimates that at the end of 2022, as many as 2.6 million people in the UK held visas that typically have a 'no recourse to public funds' (NRPF) condition.

RCN (unpublished) research finds that internationally educated members face difficulties navigating their living costs without state funded support. RCN members who are internationally educated report struggling more with finding adequate housing, childcare costs, and general household expenditure, compared to their UK-educated counterparts.

Family visas:

Internationally educated nurses also face difficulties in bringing their family members to the UK due to the high burden of evidence that is required by the Home Office. Members often report difficulties in bringing their children to the UK particularly in cases where parents are separated with one parent outside of the UK with no plans to migrate. Legal custody arrangements, for example, are insufficient evidence to prove Sole Responsibility. Member cases also suggest that the Home Office makes false assumptions that children who are temporarily staying with extended family members can continue to do so, and these decisions leave staff separated from their children for extended periods.

RCN members also report challenges in bringing their adult dependents to the UK through the Adult Dependent Relative (ADR) route. Nurses and other healthcare workers can provide expert levels of care to their loved ones, and as such will often be the most suitable member of the family to look after an adult dependent relative in need of care. The RCN is aware of at least one case where a registered nurse was initially refused a visa through ADR on the basis that they could leave the UK to care for their parent in-country.

Source of information
- https://www.gov.uk/government/statistics/immigration-system-statistics-year-ending-march-2024/why-do-people-come-to-the-uk-to-work - https://www.gov.uk/government/news/biggest-visa-boost-for-social-care-as-health-and-care-visa-scheme-expanded#:~:text=Thousands%20of%20additional%20care%20workers,for%20a%2012%2Dmonth%20period. - https://www.gov.uk/government/news/over-50000-extra-nurses-in-nhs-hitting-government-target-early - https://www.gov.uk/government/publications/visa-regulations-revised-table/home-office-immigration-and-nationality-fees-4-october-2023 - https://commonslibrary.parliament.uk/research-briefings/cbp-9859/ - https://www.migrantvoice.org/img/upload/Visa_fees_report_-_digital_final_to_upload.pdf - https://migrationobservatory.ox.ac.uk/resources/briefings/deprivation-and-the-no-recourse-to-public-funds-nrpf-condition/#:~:text=The%20No%20Recourse%20to%20Public%20Funds%20(NRPF)%20condition%20is%20a,Immigration%20and%20Asylum%20Act%201999.

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
Exploitation in the care sector: The RCN has received increasing reports of unethical and exploitative employment practices faced by internationally recruited staff in the care sector. These include reports of repayment fees, which RCN members have reported to be as high as £16,000 charged to workers attempting to leave their employment before a specified time. The RCN is aware of cases where passports have been taken and wages withheld in order to enforce payment of these fees. Internationally educated members also report being offered fraudulent job offers. In some cases, nursing staff have been scammed into paying up to £20,000 in illegal work finding fees. Unseen UK, which runs a helpline for victims of modern slavery & exploitation, reported a sixfold increase in the number of modern slavery cases in the care sector between 2021 and 2022. The care sector accounted for 18% of all potential victims that called the helpline in 2022, over 700 individuals. The Gangmasters Labour Abuse Authority (GLAA) has also found evidence of labour abuse in the sector, including overcrowded accommodation, payment below minimum wage, and debt bondage. In 2023, the GLAA received 123 reports of modern slavery and human trafficking within the care sector, with the sector representing between 26% and 48% of all referrals made in each quarter. The Director for Labour Market Enforcement, which sits above the GLAA, assessed the care sector as high risk, given the prevalence of non-compliance with labour standards and cases of modern slavery. Most recently, in its 2024 report, it was found that non-compliance with the National Minimum Wage and non-payment was endemic in the care sector. Due to the widespread use of repayment clauses in the employment contracts of migrant health personnel, in conjunction with a visa system that requires migrants to be sponsored by an individual employer, the RCN also considers that there is a significant risk that internationally recruited nurses may feel that they have no choice but to stay in employment or domestic situations which might cause them physical or psychological harm. Education and career development for migrant health personnel: Internationally trained nurses bring a wealth of diverse experience and extensive knowledge that is often not recognised by UK employers or rewarded financially. Many internationally educated nursing staff may have been employed in senior roles in their home countries but their international experience is often unrecognised. Internationally recruited nurses have also reported feeling undervalued and experiencing fewer opportunities for career progression and promotion than UK educated colleagues, including a lack of support from their employers in accessing continuing professional development. There is also significant variation in onboarding. Inadequate inductions can contribute to a difficult experience of transitioning to life and work in the UK. Induction and pastoral support are crucial in making staff feel welcome in their new communities, highlighting career development pathways, and signposting to trade unions and other sources of external support. The UK as a 'staging post': The UK-based Health Foundation has recently published data that shows the UK is at risk of becoming a 'staging post' in the careers of internationally educated nurses. Whilst the UK remains a popular destination for nursing practice, it is also clear that a growing number of internationally educated nurses are considering leaving the UK. Nurses on the UK register for nursing and midwifery professionals can apply for a Certificate of Current Professional Status (CCPS) from the UK Nursing and Midwifery Council to prove their practising status when applying for roles in other countries. Data from the Nursing and Midwifery Council shows that applications for these certificates recently reached the highest on record, with 7 in 10 of these applications coming from internationally educated nurses. In 2022/23, 8,931 applications for CCPS were received from internationally educated nurses, more than 14 times higher than in 2018/2019. These findings demonstrate the extent to which internationally educated nurses have been undervalued by UK health and care systems and treated unfairly by punitive immigration policies.

Source of information
- https://www.unseenuk.org/reports/care-sector-report/ - https://www.gov.uk/government/publications/labour-market-enforcement-strategy-2021-to-2022 - https://www.gov.uk/government/publications/labour-market-enforcement-strategy-2022-to-2023#:~:text=Margaret%20Beels%20was%20appointed%20Director,to%202023%20in%20March%202022. - https://assets.publishing.service.gov.uk/media/65324dd526b9b1000daf1c7d/uk_labour_market_enforcement_strategy_2023_2024_annex_a_emerging_issues_around_compliance_and_enforcement_in_the_uk_labour_market.pdf - https://www.gla.gov.uk/our-impact/intelligence-picture/glaa-intelligence-picture-q1-january-march-2023/ - https://www.gla.gov.uk/our-impact/intelligence-picture/glaa-intelligence-picture-q2-april-june-2023 - https://www.gla.gov.uk/our-impact/intelligence-picture/glaa-intelligence-picture-q3-july-september-2023 - https://www.gla.gov.uk/our-impact/intelligence-picture/glaa-intelligence-picture-q4-october-december-2023 - https://www.rcn.org.uk/Professional-Development/publications/valuing-nursing-in-the-uk-uk-pub-010-695 - https://www.health.org.uk/publications/long-reads/nursing-locally-thinking-globally-uk-registered-nurses-and-their-intentions

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
Bilateral Labour Agreements: The UK has signed bilateral labour agreements on the migration of health and care workers with six different countries: Philippines, Malaysia, Kenya, Sri Lanka, India and Nepal. Of the six countries, only Nepal is listed on the WHO health workforce support and safeguards list. The UK-Nepal agreement was signed in August 2022. Between September 2022 - March 2024, NMC data shows that 820 nursing and midwifery staff joined the UK register from Nepal. Despite sustained high levels of recruitment from countries such as Nigeria and Ghana the UK does not have any bilateral labour agreements with either country. Existing bilateral labour agreements signed by the UK have not included UK trade unions or nursing associations in discussions, which limits our capacity to ensure that agreements are genuinely mutually beneficial. It's also imperative that the implementation of bilateral labour agreements is monitored by independent stakeholders to assure full compliance by all parties. The RCN is also concerned that the UK's existing bilateral agreements do not include necessary provisions included in the updated WHO (2024) guidance on bilateral agreements. Provisions on data collection and monitoring, specifically on implementation and evaluation of existing agreements, are not specified in the UK's bilateral agreements. Enhanced data collection, monitoring and information sharing between countries would allow for more accurate monitoring of how such agreements are being implemented, and the respective impact on health systems in destination and origin countries. Gender considerations are also absent from UK agreements, despite the global nursing workforce being an overwhelmingly female occupation. The WHO guidance makes clear that female migrants are also acutely vulnerable during the migration process and raises global concerns about the lack of a gendered lens in the creation of bilateral agreements. UK agreements must include gender-specific provisions, and make provisions for other protected characteristics. Official Development Assistance and Migrant Remittances: In 2020 the UK Government announced a temporary reduction in Official Development Assistance (ODA) spending from 0.7% to 0.5% of GNI, cutting aid at a time when investment in health systems was needed more than ever. It was announced that the UK would return to the 0.7% target when the fiscal situation allowed, with ODA spending standing at 0.58% for 2023. WHO data estimates that an additional 4.8 million nurses and midwives will be needed by 2030 to deliver Universal Health Coverage but in 2022 just 2% of the UK's health-related ODA spend was allocated to developing the global health workforce. Cuts to UK aid are happening when investment in the global nursing workforce is critical in post-pandemic recovery and to achieve global health goals. In May 2023, the UK Government announced the allocation of £15 million pounds to support the development of the global health workforce. £6 million pounds was promised to the WHO to work with governments to support workforce planning, management and policy. In September 2023, the remaining £9 million pounds was awarded to Tropical Health and Education Trust (THET) to coordinate the delivery of partnership work. The programme will target specific workforce needs in Ghana, Kenya and Nigeria identified through a scoping assessment in partnership with national governments and in liaison with WHO country offices. Data is not available for remittances sent to source countries by migrant health personnel working in the UK. However, despite the Sustainable Development Goals target to reduce the cost of remittance transactions to 3% by 2030, the cost of sending remittances from the UK stood at 7.12% in 2019.

Source of information
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6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
Benefits of migration of health personnel to the UK: UK health and care systems are highly reliant on international recruitment to meet workforce needs. In the 12 months to March 2024, almost half (49.4%) of all new registrants joining the NMC register for the first time (new joiners) were internationally educated. There is a significant economic benefit to the UK from recruiting internationally. In the 12 months to March 2024, the most common country of initial training for new joiners to the NMC register other than the UK was India (14,615 new joiners in this period received their initial training in India). Recent estimates of the cost of recruiting a nurse from India put the figure at between £10,000 and £12,000. By contrast, a study conducted by researchers at the University of Kent found that the typical cost of educating a nurse in the UK was £71,582. International recruitment also brings other benefits to the UK health and care systems, including the exchange of experience and expertise of nursing staff from around the world. As has already been mentioned, many internationally educated nurses joining the UK workforce have previously been employed in senior roles, bringing a wealth of experience in leadership and management to UK health systems. A diverse nursing workforce can also help to ensure the delivery of culturally competent care. The extent to which different national governments across the UK rely on the recruitment of international nurses differ due to workforce issues, vacancy rates, and policy decisions. International recruitment across the UK: England has the highest rates of international recruitment in the UK with 21.2% of NMC registrants having trained overseas in March 2024. In 2019 the Government committed to increasing the number of registered nurses working in NHS England by 50,000. This was achieved in 2024, with 42,000-61,000 additional FTE nurses in the NHS compared to March 2019. However, 92% of this target has been met through the recruitment of international nurses, reflecting the Government’s strategy of filling workforce gaps with increased international recruitment. In April 2022, the Scottish Government announced that it had recruited over 1,000 additional healthcare support staff and 191 registered nurses internationally. Following the announcement of an additional £8 million in recruitment funding from October 2022, in June 2023 the Scottish Government celebrated the recruitment of an additional 800 nurses, midwives and allied health professionals from overseas. Overall, international recruitment in Scotland is accelerating, with 5.3% of the NMC register in Scotland being educated internationally in March 2024. In Wales, recruitment of international health and care staff was traditionally conducted on a health board basis, with specific areas responding to workforce needs through international recruitment. However, in 2022, the Chief Nursing Officer for Wales outlined a ‘Once for Wales’ approach with backing from the Welsh Government, aiming to fill service needs by recruiting a further 400 nurses from overseas. In March 2024, 10.8% of NMC register in Wales had been educated overseas. In Northern Ireland, the Department of Health Nursing and Midwifery Task Group [NMTG], on which the RCN was represented, was established with the core aim of developing a roadmap to provide direction in achieving world class nursing and midwifery services in a reconfigured HSC system over the next 10-15 years. As of 31 July 2022, the project had recruited 1,209 nurses, of which 1,121 remained in post at that point. The following month, the Department of Health confirmed that funding had been secured for the remainder of 2022-2023. This equated to approximately 350 new recruits by the end of March 2023. In response to a question raised in the Northern Island Assembly in May 2024, the Minister of Health shared that 1,666 international nurses had been recruited through the International Nurse Recruitment project across Northern Ireland’s Health & Social Care Trusts. In March 2024, 15.0% of NMC registrants in Northern Ireland had been educated overseas.

Source of information

- https://gh.bmj.com/content/bmjgh/9/2/e014096.full.pdf - https://kar.kent.ac.uk/105685/1/The%20unit%20costs%20of%20health%20and%20social%20care_Final3.pdf - https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2022/03/national-workforce-strategy-health-social-care/documents/national-workforce-strategy-health-social-care-scotland/national-workforce-strategy-health-social-care-scotland/govscot%3Adocument/national-workforce-strategy-health-social-care-scotland.pdf - https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/sep-2023/0130d-mid-year-data-report-scotland-web.pdf - https://www.gov.wales/chief-nursing-officer-wales-priorities-2022-2024 - https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/sep-2023/0130e-mid-year-data-report-wales-web.pdf - https://www.health-ni.gov.uk/publications/nursing-and-midwifery-task-group-nmtg-report-and-recommendations - https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/sep-2023/0130c-mid-year-data-report-ni-web.pdf - https://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=401634

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable

In the UK, the Code of practice for the international recruitment of health and social care personnel sets out the policy for international recruitment in the UK. Devolved administrations adhere to the principles of The Code but hold their own Code to reflect the different organisational structures in each nation.

The UK's Code is closely aligned with the WHO's Global Code. It includes reference to a RAG rating system for international recruitment, with 'green list' countries approved for active recruitment, 'amber list' countries approved for active recruitment only where it take place under the terms of a bilateral labour agreement (as is the case for Kenya and Nepal) and the 'red list', a list of countries that should not be target for active recruitment. In February 2021, the UK aligned its 'red list' of countries that should not be targeted for active recruitment with the countries named on the WHO's health workforce support and safeguards list.

The RCN supports the principles set out in the Code, however we have concerns regarding compliance and implementation. Since the UK's alignment with the WHO health workforce support and safeguards list, the RCN has raised concerns that continuing high levels of recruitment from countries on the list indicate that active recruitment is still taking place, contravening the Code. The RCN would welcome increased transparency on how active recruitment from red list countries is monitored including the data sources used.

The Code requires compliance by all agencies and employers recruiting from overseas, however this requirement is not set out by legislation. It is evident that unscrupulous employers and agencies continue to operate against the principles of the Code. Enshrining principles of the Code through legislation would be a positive step to ensure compliance.

The RCN also has specific concerns around the levels of information that are being made available to internationally educated nurses as part of the recruitment process when considering coming to the UK. A number of RCN members have reported experiences where some recruitment agencies have allegedly underplayed the difficulty of bringing family and dependents to the UK, and not provided adequate information to applicants regarding the complexities of the UK's immigration system. Where this occurs, this increases the risk that any individual is able to make fully informed decisions on whether to migrate and can result in families being separated.

Under the previous UK Government, the RCN had the opportunity provide feedback on the Code. The UK's newly established Labour Government has indicated that they will be looking into exploitation of staff and labour rights more generally. They have also committed to reduce the UK's dependence on international recruitment to meet its health workforce needs. This could lead to a reduction in recruitment of health and care personnel from countries listed on the WHO health workforce support and safeguards list, with positive impacts for countries facing critical workforce shortages. We will look for opportunities to work with the Government and to raise our concerns regarding implementation of the UK's Code of Practice.

Source of information

- https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england
- https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/conr-0422

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).

Nursing and Midwifery Council Data:

The UK Nursing Midwifery Council publish data reports from the nursing and midwifery register every six months. This data shows the number of nurses and midwives that are currently able to practice, as well as other information including the country in which they received their initial training. The Nursing and Midwifery Council publishes registration data on its website going back to 2016. The publication of this data has improved the ability of stakeholders to monitor the UK's reliance on international recruitment and identify trends of unethical recruitment from countries on the WHO health workforce support and safeguards list.

Adoption of the WHO health workforce support and safeguards list:

In February 2021, the UK aligned its 'red list' of countries that should not be targeted for active recruitment with the countries named on the WHO's health workforce support and safeguards list. However, this move marked a downgraded commitment by the UK, which previously maintained their own more extensive list. The UK's previous list was compiled in partnership with the former Department for International Development and based on the Organisation for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC) list of countries eligible to receive official development assistance (ODA). This list included of 152 countries, including all 47 countries on the 2020 WHO health workforce support and safeguards list. In the UK context, alignment with the universal standard established by the health workforce support and safeguards list effectively allowed UK employers to recruit from an additional 86 countries.

To take one example, Zimbabwe had previously been identified by the UK's own list as a country that should not be targeted for international recruitment. In the 6 months to September 2020, just 51 nurses and midwives who had received their initial training in Zimbabwe joined the UK register. For the same period in 2021, following alignment with the WHO health workforce support and safeguards list and the removal of Zimbabwe from the UK 'red list', this figure was over 9 times higher, at 463. Despite the later addition of Zimbabwe to the updated WHO health workforce support and safeguards list in 2023, around 30,000 Health & Care Worker visas have been granted to Zimbabwean nationals since 2022.

WHO guidance stresses that it is good practice for high-income countries to extend the safeguarding approach to additional low- and middle-income countries beyond those specified by the list. As a high-income country with a relatively strong health system, the UK's full adherence to the spirit of the health workforce support and safeguards list should encompass setting a higher threshold for its own international recruitment and role modelling the standards appropriate to comparable countries. However, the example of the UK highlights the need for additional guidance from WHO for high-income countries that encourages them to exceed the universal minimum standard established by the health workforce support and safeguards list.

Trends in Unethical International Recruitment since 2016:

International recruitment, including from countries identified as facing pressing workforce shortages, has increased year on year despite the introduction of the WHO's health workforce support and safeguards list. Between September 2020 and September 2021, during which time the UK first aligned its Code of Practice with the health workforce support and safeguards list, 3431 nurses and midwives who received their initial training in one of these countries joined the UK register. In the 12 months to March 2024, the most recent period for which we have date, this figure rose to 6625. By comparison, in the 12 months to September 2016, just 68 nurses and midwives who received their initial training in a country on the current (2023) health workforce support and safeguards list joined the UK register for the first time.

The policy context for this dramatic increase in recruitment from countries designated as requiring support and safeguards include the UK's departure from the European Union and the subsequent introduction of the Health & Care Worker visa as a relatively low-cost visa route to ensure health and care workforce supply. However, it is evident that the UK Government's alignment with the WHO Global Code of Practice and the WHO health workforce support and safeguards list has not been effective in reducing the number of nurses and midwives from listed countries taking up employment in the UK.

Official Development Assistance:

Despite the UK's reliance on international recruitment to fill domestic workforce gaps, efforts to health workforce strengthening overseas have been hindered by the previous UK Government's decision to temporarily reduce Official Development Assistance (ODA) spending from the United Nations target of 0.7% of gross national income (GNI) to just 0.5% of GNI. The cut to ODA spending was announced at a time when investment in strengthening and building a resilient nursing workforce was needed more than ever. Had the target of 0.7% of GNI been maintained, an additional £9,188 million would have been available to fund vital development projects around the world between 2021 and 2022. This downgraded commitment to sustainable development has had stark consequences for spending on health-related initiatives. Between 2020 and 2022, the UK's ODA spending on health fell by 38.6% to just 7.6% of total spend in 2022.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
- https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england - https://www.gov.scot/publications/scottish-code-practice-international-recruitment-health-social-care-personnel-march-2023-revised/ - https://www.gov.wales/employing-international-workers-social-care-health-and-care-worker-visa-html

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Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking ‘Submit’.

Survey response 9

Response ID
252

Date submitted
2024-07-30 18:30:46

Last page
4

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en

Seed
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Date started
2024-07-30 18:15:40

Date last action
2024-07-30 18:30:46

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Nurses in Charge

First and Last Name of Contact Person:
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1-704-246-9582

Mailing address:
110 Spirit Lake Rd Suite 4 Winter Haven FL 33880

Website URL:
Nursesincharge.org

Description of the entity submitting the report:
US 501 C3 Non profit Organization Mission to Connect Celebrate and Empower Frontline Nurses and their pipeline internationally. Our Programs target the Sustainability of the Nursing WorkForce.

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
We are a community of Diverse Frontline Nurses around the globe to hold accountable the sustainable use of the Nursing Profession.

Please specify the country(ies) or region(s) where entity is involved:
North American Region, South American Region, Caribbean Region, African Region, Australia and Asian Regions and Middle Eastern Regions

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
AUSTRALIAN REGION 'Australia relies substantially on overseas trained health professionals to address the problems of health workforce shortages and distribution. In the last decade, Australia has remained in the top ten OECD countries with the highest shares of foreign-trained health professionals. According to the most recent OECD data, the share of foreign-trained nurses in Australia was 18%, tripling the United States' numbers.' (2) 1. Trend in International Migration and Mobility of Health Personnel in Australia (2020-2023) Trend: There has been an increasing trend in the migration of health personnel to Australia over the past three years. This trend has been marked by a growing reliance on international health personnel to address local workforce shortages. Quantitative Data: Australia relies heavily on foreign-trained workforces to address shortages, especially in rural areas. In 2021, 33,216 overseas doctors and 59,665 overseas nurses were practicing in Australia. Over 30% of Australian doctors were foreign trained, whereas 17% of nurses were foreign trained (2). Source and Destination Countries: The majority of international health personnel come from India, the Philippines, the United Kingdom, and South Africa. These professionals primarily migrate to major Australian cities such as Sydney, Melbourne, and Brisbane (3,4)

Source of information

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
AUSTRALIAN REGION Measures for Health and Care Workforce Sustainability in Australia Measures Taken: Aligning Workforce Education: Australian universities and TAFEs have been aligning their health workforce education programs with the needs of the healthcare system, ensuring that graduates are ready to meet current demands. Employment Opportunities: Efforts have been made to create sufficient employment opportunities, particularly in rural and remote areas, through incentives and support programs (2,4). Geographical Distribution and Retention: Programs like the Rural Health Multidisciplinary Training (RHMT) program and various scholarships and grants aim to address geographical maldistribution (4). Sustainable Financing: Increased government funding and private investments have been directed towards health workforce development. Emergency Recruitment: Special provisions during the COVID-19 pandemic facilitated rapid recruitment and deployment of health personnel. Data Collection: Systematic data collection on international health workers has been improved to inform workforce planning and policy decisions (4). Effectiveness: These measures have shown positive outcomes in terms of better distribution of health personnel and increased retention in underserved areas (3,4).

Source of information

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
AUSTRALIAN REGION Mobility/Migration Pathways for Health Personnel to Australia Common Pathways: Active and Targeted Recruitment: Employers and recruitment agencies actively recruit health personnel from countries like India and the Philippines. Direct Application: Health personnel often apply directly to Australian employers or educational institutions. Education Pathways: Many international students pursue health-related education in Australia and subsequently join the workforce. Immigration Programs: Programs like the Skilled Migration Program (1) provide a pathway for health professionals to migrate and work in Australia (5). Advantages and Disadvantages: Advantages: These pathways help address workforce shortages and bring in skilled professionals (2). Disadvantages: Challenges include the high cost of migration, complex regulatory requirements, and potential underutilisation of skills due to credential recognition issues (2,4).

Source of information

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
AUSTRALIAN REGION Arrangements for Migrant Health Personnel Recruitment and Integration: Recruitment Process: Recruitment processes are generally transparent, with support from recruitment agencies and employers. Safe Migration and Integration: Australia has policies in place to ensure safe migration and integration, including orientation programs and professional support networks. Remuneration and Working Conditions: Migrant health personnel typically receive competitive salaries and have access to similar working conditions and career development opportunities as their domestic counterparts. Labour Standards: Australia maintains high labour standards, ensuring the rights of health workers are protected. Return and Reintegration: Support for returning health personnel includes programs to facilitate re-entry into the source country's labour market. Gender Considerations: Special considerations are made for gender, ensuring equality and support for female health workers (2,3,4).
Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
AUSTRALIAN REGION Benefits to Source Countries Benefits: Diaspora Contributions: The diaspora significantly contributes to the source country's health systems through remittances and knowledge transfer. Investment in Education: Increased investments in health professional education, both domestic and foreign, have been observed. Health System Investments: Migration has led to greater investments in the health systems of source countries by international organizations and through circular migration. Circular Migration: Allows for the exchange of skills and knowledge, benefiting both the source and destination countries (3,4).
Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
AUSTRALIAN REGION Benefits to Destination Countries (Australia) Benefits: Health Services: Australia relies on international health personnel to meet healthcare demands, particularly in underserved areas such as rural and remote regions (3). Economic Contributions: Migrant health personnel contribute to the economy through taxes, regulatory fees, and local spending. Educational Savings: Australia benefits from the savings on the cost of educating health professionals who were trained abroad (2,3,4).
Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable

AUSTRALIAN REGION

Use of Data and Research for Policy
Australia uses comprehensive data collection and research on health personnel to inform workforce planning and policy development. This includes tracking migration trends, workforce distribution, and the impact of international health personnel on the healthcare system (3,4).

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable

AUSTRALIAN REGION

Use of WHO Health Workforce Support and Safeguards List
International organisations, donors, and stakeholders use the WHO health workforce support and safeguards list to guide policies and ensure ethical recruitment practices. This helps in maintaining a balanced and sustainable health workforce (3,4,5).

Source of information

AUSTRALIAN REGION

Reference List
Australian Government Department of Home Affairs. (2023). Skilled Migration Program, https://immi.homeaffairs.gov.au/what-we-do/skilled-migration-program
Australian National University. (2024, April), NCHWS Data Insight Series https://nceph.anu.edu.au/files/NCHWS%20Data%20Insight%20Serries%20-%20Apr2024.pdf#:~:text=Australia%20relies%20heavily%20on%20foreign-trained%20workforces%20to%20address,trained%2C%20whereas%2017%25%20of%20nurses%20were%20%28Figure%202%29
Cambridge University Press. (2023). Global Health Worker Migration https://www.cambridge.org/core/elements/abs/global-health-worker-migration/2FBA9946E676411D3B6FB1ED4F545105
OECD. (2019, July). Recent Trends in International Migration of Doctors, Nurses, and Medical Students, https://www.oecd.org/en/publications/2019/07/recent-trends-in-international-migration-of-doctors-nurses-and-medical-students_dbd9ed7f.html
World Health Organization. (2023). WHO Global Code of Practice on the International Recruitment of Health Personnel, https://www.who.int/publications/i/item/9789240069787
United Nations. (2023). Sustainable Development Goals, https://sdgs.un.org/goals

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).

AUSTRALIAN REGION

Reflection on the Code's Impact
Over the past 14 years, the WHO Global Code of Practice on the International Recruitment of Health Personnel (5) has been relevant in guiding ethical recruitment and migration of health personnel. It aligns well with other global instruments and has contributed to achieving the Sustainable Development Goals (5) by promoting fair practices and workforce sustainability (2,3).
For further detailed data and specific case studies, you may refer to the OECD and Australian government health reports available online as indicated by the references below:

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Upload document

[{ "title":"AUSTRALIAN REGION","comment":"Compiled by Nurses in Charge Australiasia Regions Adjunct Professor Sonia Martin","size":84.982421875,"name":"Australia%20relies%20heavily%20on%20foreign-trained%20workforces%20to%20ad.docx.pdf","filename":"fu_2dq7jq6tgbecpdq","ext":"pdf" }]

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking ‘Submit’.

Survey response 10

Response ID
253

Date submitted
2024-07-30 18:51:35

Last page
4

Start language
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Date started
2024-07-30 18:32:58

Date last action
2024-07-30 18:51:35

Background

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Nurses in Charge

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1-704-246-9582

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Website URL:
Nursesincharge.org

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We are a community of Diverse Frontline Nurses around the globe to hold accountable the sustainable use of the Nursing Profession.

Please specify the country(ies) or region(s) where entity is involved:
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Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code’s implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Trends in International Migration and Mobility of Health Personnel in Hispaniola Haiti Increasing Migration of Health Personnel: Haiti has experienced a significant increase in the migration of health personnel over the past three years. Several factors drive this trend, including economic instability, inadequate working conditions, and opportunities for better pay and career advancement abroad. Quantitative Data: According to the International Organization for Migration (IOM), Haiti has seen a notable rise in the emigration of healthcare workers, with a significant number moving to countries like the United States, Canada, and France. Effects on Healthcare System: Brain Drain: The emigration of skilled health workers has led to a critical shortage of healthcare professionals in Haiti, adversely impacting the healthcare system's ability to provide adequate services. Increased Reliance on International Aid: To mitigate the shortage, Haiti relies heavily on international aid and temporary foreign medical teams to fill gaps in healthcare provision. Dominican Republic Increased Inflow of Health Personnel: The Dominican Republic has seen an increased inflow of international health personnel, particularly from neighboring countries and regions facing economic or political challenges. Quantitative Data: The Dominican Republic has seen a steady influx of healthcare workers from countries such as Venezuela and Haiti, contributing to the diversity and expansion of its healthcare workforce. Effects on Healthcare System: Enhanced Healthcare Services: The inflow of international health workers has helped improve healthcare services, especially in underserved and rural areas. Economic Contributions: Migrant health workers contribute economically by paying taxes, investing in housing, and participating in the local economy. They also help reduce training costs and educate new health professionals domestically. Interpretation Haiti and the Dominican Republic have experienced significant trends in the international migration and mobility of health personnel, each with unique impacts on their healthcare systems. Haiti faces challenges related to brain drain and increased reliance on international aid, while the Dominican Republic benefits from the economic and service enhancements provided by incoming health workers. Sources: WHO OECD International Organization for Migration (IOM) Measures for Health and Care Workforce Sustainability in Hispaniola Haiti Aligning Domestic Health Workforce Education with Health System Needs: Medical Education Reform: Haiti has been working on reforming its medical education system to better align with the needs of its healthcare system. This includes updating curricula to focus on primary care and community health. Effectiveness: These reforms have shown some success in increasing the number of healthcare professionals with relevant skills for local needs, but the overall impact is limited by resource constraints and infrastructure challenges (World Health Organization (WHO)) (Site homepage). Creating Employment Opportunities: Government Initiatives: The Haitian government has implemented initiatives to create more employment opportunities for healthcare workers, particularly in rural and underserved areas. Effectiveness: While these efforts have increased employment, they are often hampered by economic instability and limited funding, leading to inconsistent results (International Organization for Migration). Addressing Geographical Mal-Distribution and Retention: Incentive Programs: Haiti has introduced incentive programs, including financial bonuses and housing assistance, to encourage healthcare workers to serve in rural and underserved areas. Effectiveness: These programs have had some success in improving the distribution of healthcare workers, but retention remains a significant challenge due to poor working conditions and low salaries (World Health Organization (WHO)) (Site homepage). Sustainable Financing for Essential Workforce: International Aid: Haiti relies heavily on international aid to fund its healthcare workforce. Programs supported by WHO, PAHO, and other international organizations provide crucial financial resources. Effectiveness: While international aid helps sustain the workforce, reliance on external funding is not sustainable in the long term. There is a need for more robust domestic financing mechanisms (World Health Organization (WHO)) (International Organization for Migration). Regulation and Recruitment During Emergencies: Emergency Response Plans: Haiti has developed emergency response plans that include provisions for rapidly recruiting and deploying health personnel during crises.

Effectiveness: These plans have effectively mobilized health workers during emergencies, such as the 2010 earthquake and the COVID-19 pandemic, but they are limited by the overall scarcity of health professionals (World Health Organization (WHO)).
Systematic Collection of Data on Health Workers:
Health Workforce Information Systems: Haiti is improving its health workforce information systems to track better and manage health personnel.
Effectiveness: Enhanced data collection has improved workforce planning and policy-making, but data accuracy and comprehensiveness remain areas for improvement (World Health Organization (WHO)).
Conducting Research to Inform Policies:
Collaborative Research: Collaborations with international organizations and universities have helped research health workforce issues, informing policies and strategic plans.
Effectiveness: Research has provided valuable insights, but resource and implementation challenges often hinder translating findings into actionable policies (International Organization for Migration).
Dominican Republic
Aligning Domestic Health Workforce Education with Health System Needs:
Medical Education Expansion: The Dominican Republic has expanded its medical education programs and updated curricula to meet the evolving needs of its healthcare system.
Effectiveness: These efforts have increased the number of trained healthcare professionals, though alignment with specific local needs can still be improved (Site homepage).
Creating Employment Opportunities:
Public and Private Sector Initiatives: Both public and private sector initiatives aim to create more job opportunities for healthcare workers, focusing on expanding healthcare services in underserved areas.
Effectiveness: These initiatives have moderately increased employment opportunities, though economic disparities still pose challenges (Site homepage).
Addressing Geographical Mal-Distribution and Retention:
Incentive Programs: Like Haiti, the Dominican Republic has implemented financial incentives and support programs to encourage health workers to work in rural areas.
Effectiveness: These programs have improved the distribution of healthcare workers, but retention remains a challenge due to better opportunities in urban areas and abroad (Site homepage).
Sustainable Financing for Essential Workforce:
Government Funding and International Aid: The Dominican Republic combines government funding with international aid to finance its healthcare workforce.
Effectiveness: While these measures help sustain the workforce, there is a need for more sustainable domestic funding solutions (World Health Organization (WHO)) (Site homepage).
Regulation and Recruitment During Emergencies:
Emergency Recruitment Plans: The Dominican Republic has established emergency recruitment plans to mobilize health personnel during crises quickly.
Effectiveness: These plans have effectively responded to emergencies, though the overall healthcare infrastructure can be strained during large-scale crises (World Health Organization (WHO)).
Systematic Collection of Data on Health Workers:
Health Workforce Databases: The Dominican Republic maintains comprehensive databases to track the distribution and status of health workers.
Effectiveness: This systematic data collection supports better workforce planning and policy development, leading to more informed decisions (Site homepage).
Conducting Research to Inform Policies:
National and International Research Projects: Research collaborations with international organizations and academic institutions help inform policies and strategies for health workforce development.
Effectiveness: Research has contributed to more effective policies, though there is always room for further integration of research findings into practical applications (World Health Organization (WHO)) (Site homepage).
Interpretation
Both Haiti and the Dominican Republic have implemented various measures to ensure the sustainability of their health and care workforce. These measures include aligning education with system needs, creating employment opportunities, addressing geographical mal-distribution, ensuring sustainable financing, and enhancing data collection and research. While there have been successes, both countries face challenges in fully realizing these goals due to economic constraints and systemic issues.

Source of information

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Mobility/Migration Pathways for Health Personnel from Hispaniola (Haiti and the Dominican Republic) Haiti Government-to-Government Agreements: Description: Haitian health personnel often participate in government-to-government agreements, where the Haitian government collaborates with foreign governments to send health workers abroad. This is common in countries like Cuba, which provides medical training and employment opportunities for Haitian doctors and nurses. Advantages: These agreements provide structured and secure opportunities for health workers, often including training, housing, and a guaranteed income. Disadvantages: The health workers' autonomy is limited, and they may face restrictions on movement and personal freedom abroad. Example: Haiti's collaboration with Cuba under medical diplomacy programs has sent numerous Haitian health professionals to work and train in Cuba. Direct Application: Description: Many Haitian health personnel apply directly to employers or educational institutions in destination countries, particularly the United States, Canada, and France. Advantages: This pathway allows for greater personal autonomy and the potential for better working conditions and higher salaries. Disadvantages: Navigating the application and immigration processes can be challenging and resource-intensive. Example: Many Haitian nurses and doctors have successfully moved to the US and Canada through direct applications to hospitals and healthcare institutions. Education Pathways: Description: Haitian students often move to destination countries to pursue medical and nursing education. Scholarships and educational exchange programs facilitate this mobility. Advantages: Provides high-quality education and the potential for residency and employment in the host country post-graduation. Disadvantages: High cost of education and potential difficulties in securing employment post-graduation due to visa restrictions. Example: Haitian students frequently pursue medical degrees in the United States and Canada, with some returning to Haiti while others remain abroad for better opportunities. Immigration Pathways: Description: Many Haitian health professionals migrate through general immigration programs like family reunification or skilled worker visas. Advantages: These pathways often lead to permanent residency and provide opportunities for family members to migrate together. Disadvantages: The process can be lengthy and complex, and integration into the new healthcare system can be challenging. Example: The US Diversity Visa Program and Canada's Express Entry system have been popular routes for Haitian healthcare workers seeking to immigrate. Dominican Republic Active and Targeted Recruitment: Description: Health personnel from the Dominican Republic are often recruited actively by employers in countries with healthcare shortages, such as the United States and Spain. Advantages: Recruitment agencies often assist with relocation and integration, making the transition smoother. Disadvantages: There can be issues with exploitation and poor working conditions if recruitment is not managed ethically. Example: US healthcare facilities frequently recruit Dominican nurses to address nursing shortages, offering incentives such as relocation packages and higher salaries. Education Pathways: Description: Dominican students pursue medical and nursing education abroad, particularly in the United States and Europe. Advantages: Access to high-quality education and the opportunity to remain in the host country for work. Disadvantages: The high cost of education and the competitive nature of obtaining residency positions post-graduation. Example: Dominican medical students often attend universities in the US and Spain, with many opting to stay and work in these countries after graduation. Government-to-Government Agreements: Description: Similar to Haiti, the Dominican Republic also engages in government-to-government agreements to train and employ health personnel. Advantages: Structured opportunities with guaranteed employment and benefits. Disadvantages: Limited autonomy and potential restrictions on personal freedom while on assignment.

Example: Agreements with countries like Cuba and Spain facilitate the exchange and employment of Dominican health professionals.
Quantitative Data and Sources
Haiti to Cuba Medical Diplomacy: Over the past decade, thousands of Haitian health professionals have trained and worked in Cuba under bilateral agreements (source: WHO, IOM).
US Visa Programs: The US Diversity Visa Program and family reunification visas have allowed significant numbers of Haitian and Dominican health professionals to migrate to the US (source: USCIS, Department of State).
Active Recruitment: Recruitment agencies in the US and Spain report hiring hundreds of Dominican nurses annually to meet local healthcare demands (source: OECD, PAHO).
Interpretation
Haiti and the Dominican Republic health personnel utilize various migration pathways, including government-to-government agreements, direct applications, education pathways, and immigration programs. Each pathway offers different advantages and disadvantages, balancing opportunities for professional growth with challenges in autonomy and integration. These pathways contribute significantly to the source and destination countries' healthcare systems, albeit with complex implications for sustainability and workforce distribution.

Source of information

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Mobility/Migration Pathways for Health Personnel from Hispaniola (Haiti and the Dominican Republic) Haiti Government-to-Government Agreements: Description: Haitian health personnel often participate in government-to-government agreements, where the Haitian government collaborates with foreign governments to send health workers abroad. This is common in countries like Cuba, which provides medical training and employment opportunities for Haitian doctors and nurses. Advantages: These agreements provide structured and secure opportunities for health workers, often including training, housing, and a guaranteed income. Disadvantages: The health workers' autonomy is limited, and they may face restrictions on movement and personal freedom abroad. Example: Haiti's collaboration with Cuba under medical diplomacy programs has sent numerous Haitian health professionals to work and train in Cuba. Direct Application: Description: Many Haitian health personnel apply directly to employers or educational institutions in destination countries, particularly the United States, Canada, and France. Advantages: This pathway allows for greater personal autonomy and the potential for better working conditions and higher salaries. Disadvantages: Navigating the application and immigration processes can be challenging and resource-intensive. Example: Many Haitian nurses and doctors have successfully moved to the US and Canada through direct applications to hospitals and healthcare institutions. Education Pathways: Description: Haitian students often move to destination countries to pursue medical and nursing education. Scholarships and educational exchange programs facilitate this mobility. Advantages: Provides high-quality education and the potential for residency and employment in the host country post-graduation. Disadvantages: High cost of education and potential difficulties in securing employment post-graduation due to visa restrictions. Example: Haitian students frequently pursue medical degrees in the United States and Canada, with some returning to Haiti while others remain abroad for better opportunities. Immigration Pathways: Description: Many Haitian health professionals migrate through general immigration programs like family reunification or skilled worker visas. Advantages: These pathways often lead to permanent residency and provide opportunities for family members to migrate together. Disadvantages: The process can be lengthy and complex, and integration into the new healthcare system can be challenging. Example: The US Diversity Visa Program and Canada's Express Entry system have been popular routes for Haitian healthcare workers seeking to immigrate. Dominican Republic Active and Targeted Recruitment: Description: Health personnel from the Dominican Republic are often recruited actively by employers in countries with healthcare shortages, such as the United States and Spain. Advantages: Recruitment agencies often assist with relocation and integration, making the transition smoother. Disadvantages: There can be issues with exploitation and poor working conditions if recruitment is not managed ethically. Example: US healthcare facilities frequently recruit Dominican nurses to address nursing shortages, offering incentives such as relocation packages and higher salaries. Education Pathways: Description: Dominican students pursue medical and nursing education abroad, particularly in the United States and Europe. Advantages: Access to high-quality education and the opportunity to remain in the host country for work. Disadvantages: The high cost of education and the competitive nature of obtaining residency positions post-graduation. Example: Dominican medical students often attend universities in the US and Spain, with many opting to stay and work in these countries after graduation. Government-to-Government Agreements: Description: Similar to Haiti, the Dominican Republic also engages in government-to-government agreements to train and employ health personnel. Advantages: Structured opportunities with guaranteed employment and benefits.

Disadvantages: Limited autonomy and potential restrictions on personal freedom while on assignment.
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Active Recruitment: Recruitment agencies in the US and Spain report hiring hundreds of Dominican nurses annually to meet local healthcare demands (source: OECD, PAHO).
Interpretation
Haiti and the Dominican Republic health personnel utilize various migration pathways, including government-to-government agreements, direct applications, education pathways, and immigration programs. Each pathway offers different advantages and disadvantages, balancing opportunities for professional growth with challenges in autonomy and integration. These pathways contribute significantly to the source and destination countries' healthcare systems, albeit with complex implications for sustainability and workforce distribution.

Source of information

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Health Workers' Perspective on Migration Arrangements and Implementation Haiti and the Dominican Republic Recruitment Process in Source Countries Haiti: Government-Managed Recruitment: The recruitment process for Haitian health professionals often involves government-to-government agreements, with the Haitian Ministry of Health overseeing the selection and deployment of personnel. Private Recruitment: Direct applications and active recruitment by foreign employers also play a role. Private recruitment agencies facilitate the process, but there can be risks of exploitation and insufficient support. Effectiveness: Government-managed recruitment ensures structured opportunities but may limit personal freedom and choice. Private recruitment can offer more autonomy but carries risks of inadequate support and exploitation (World Health Organization (WHO)) (International Organization for Migration). Dominican Republic: Active Recruitment: Dominican health workers are frequently recruited by foreign employers, especially in the United States and Spain. Recruitment agencies often manage these processes. Direct Applications: Many health professionals apply directly to hospitals and educational institutions abroad. Effectiveness: Active recruitment provides structured opportunities supporting relocation and integration. However, workers may face challenges related to differing labor standards and working conditions (Site homepage). Safe Migration and Integration in Destination Countries Safety and Support: Support Systems: Both Haitian and Dominican health professionals often receive support from recruitment agencies and international organizations, which can include assistance with visas, housing, and cultural integration. Challenges: Despite support systems, challenges include language barriers, cultural adjustments, and navigating different healthcare systems. Effectiveness: While support systems are generally effective, the level of support varies by destination country and specific circumstances of the migrants (World Health Organization (WHO)) (International Organization for Migration). Remuneration, Working Conditions, and Opportunities for Education and Career Development Haiti: Remuneration: Haitian health professionals earn significantly more abroad than domestically, providing a strong financial incentive to migrate. Working Conditions: Working conditions abroad can be better but vary widely. Some face exploitation and poor working conditions, especially in private-sector jobs without strong labor protections. Career Development: Opportunities for further education and career advancement are generally better abroad, but integration into local professional networks can be challenging (World Health Organization (WHO)) (International Organization for Migration). Dominican Republic: Remuneration: Dominican professionals, like Haitian health workers, often earn higher salaries abroad. Working Conditions: Generally, working conditions are better in destination countries, but disparities exist, particularly in countries with less rigorous labor standards. Career Development: Improved education and career advancement opportunities, especially in the US and Europe, where health systems invest in continuous professional development (Site homepage). Labour Standards and Health Worker Rights in the Destination Country United States and Europe: Labor Standards: Health workers generally benefit from strong labor standards and protections, including fair wages, reasonable working hours, and safe working conditions. Rights and Protections: Migrant health workers are entitled to the same protections as domestic workers, though enforcement can vary. Effectiveness: High effectiveness in countries with strong labor laws, but variability in enforcement and protection remains challenging (International Organization for Migration). Return to Source Country and Reintegration to Source Country Labour Market Haiti: Facilitators: Programs supported by international organizations aim to facilitate reintegration through skills transfer and employment support. Barriers include limited job opportunities, lower salaries, and inadequate infrastructure. Effectiveness: Mixed; while some returnees successfully reintegrate, many face significant barriers (World Health Organization (WHO)). Dominican Republic: Facilitators: Government programs and international partnerships support reintegration, focusing on utilizing returned

professionals' skills.
Barriers: Economic conditions and professional opportunities can be limiting factors.
Effectiveness: Generally positive, with challenges related to matching skills with available job opportunities (Site homepage).
Other Arrangements (Special Considerations for Gender Aspects)
Gender Considerations:
Support for Female Health Workers: Programs often include specific support for female health workers, addressing issues such as gender-based discrimination, family support, and work-life balance.
Challenges: Female health workers may face additional challenges abroad, including gender discrimination and balancing family responsibilities.
Effectiveness: Programs addressing gender-specific needs can significantly improve female health workers' migration experience and outcomes, though implementation varies (International Organization for Migration).
Interpretation
From the perspective of health workers from Haiti and the Dominican Republic, the arrangements and implementation of migration pathways have benefits and challenges. Structured recruitment processes and strong support systems are crucial for safe migration and integration. However, disparities in labor standards, working conditions, and reintegration support remain significant issues that need ongoing attention and improvement.

Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Benefits to Source Countries from the International Migration of Health Personnel Haiti and the Dominican Republic Contribution of the Diaspora to Source Country Health Systems Remittances: Haiti: Remittances from the Haitian diaspora, including health professionals, significantly contribute to the national economy. In 2021, remittances to Haiti were estimated at around $3.8 billion, accounting for approximately 23% of the country's GDP (World Health Organization (WHO)). These funds support families and contribute indirectly to the healthcare system by enabling the purchase of medical supplies and services. Dominican Republic: Remittances also play a crucial role, with the Dominican diaspora sending home over $8 billion in 2021 (Site homepage). These funds often support healthcare expenses and local health initiatives. Knowledge Transfer: Haiti: Haitian health professionals abroad often engage in knowledge transfer through telemedicine, training sessions, and temporary missions back to Haiti, improving local healthcare practices. Dominican Republic: Similar contributions occur with Dominican health professionals, who participate in medical missions and provide training and expertise to local healthcare providers. Increase in Investments in Health Professional Education International Scholarships and Partnerships: Haiti: Scholarships and educational partnerships with institutions in countries like the United States, Canada, and Cuba have increased investment in health professional education. Programs such as the Cuban medical scholarships have trained thousands of Haitian doctors (World Health Organization (WHO)) (Site homepage). Dominican Republic: Partnerships with international universities and medical institutions provide advanced training opportunities for Dominican health professionals, enhancing the overall quality of medical education. Domestic Educational Investments: Haiti: Increased awareness of the need for qualified health professionals has led to more investments in domestic medical schools and training programs supported by both public and private sectors. Dominican Republic: Similar trends are seen with investments in medical schools and training programs to improve the quality and quantity of healthcare professionals. Increase in Domestic Investment in Health Systems Infrastructure Development: Haiti: Remittances and international aid contribute to developing healthcare infrastructure, including constructing clinics and hospitals and providing medical equipment. Dominican Republic: Increased investments in healthcare infrastructure, partly driven by remittances and diaspora contributions, enhance the capacity and quality of healthcare services. Increase in International Investment in Health System Strengthening or Health Workforce Development International Aid and Programs: Haiti: International organizations like WHO, PAHO, and NGOs provide substantial aid aimed at health system strengthening. These investments focus on training, infrastructure, and healthcare delivery improvements (World Health Organization (WHO)) (International Organization for Migration). Dominican Republic: Similar international support bolsters the Dominican health system with investments in workforce development and system improvements. Circular Migration Temporary Returns: Haiti: Health professionals often return temporarily to Haiti for medical missions, contributing to local healthcare and sharing new knowledge and practices. Dominican Republic: Dominican health professionals also engage in circular migration, participating in short-term missions that benefit the local health system. Other Benefits Policy Advocacy and Development: Haiti: The diaspora actively advocates for improved health policies and supports initiatives that benefit the healthcare system in Haiti. Dominican Republic: Similar advocacy efforts by the Dominican diaspora lead to policy changes and improvements in the health sector. Cultural and Professional Networks: Haiti and the Dominican Republic: Both countries benefit from their diasporas' cultural and professional networks, facilitating international collaborations and support. Quantitative Data Haiti:

Remittances: $3.8 billion in 2021.
Cuban medical scholarships: Thousands of Haitian doctors trained (World Health Organization (WHO)) (Site homepage).
Dominican Republic:
Remittances: Over $8 billion in 2021.
International partnerships and investments in health education and infrastructure.
Interpretation
The international migration of health personnel from Haiti and the Dominican Republic provides numerous benefits to the source countries, including financial remittances, knowledge transfer, increased investments in health professional education, and strengthened health systems. While there are challenges associated with brain drain, the diaspora's contributions and international partnerships significantly support the healthcare systems in both countries.

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Benefits to Destination Countries from the Migration of Nursing Personnel United States and Canada Reliance on International Nursing Personnel for Health and Care Services Filling Critical Gaps: United States: The U.S. healthcare system relies heavily on internationally educated nurses to address nursing shortages. The Migration Policy Institute states foreign-born nurses constitute about 15% of the U.S. nursing workforce (International Organization for Migration). Canada: Similarly, Canada depends on internationally trained nurses to meet healthcare demands. According to recent data, approximately 21% of registered nurses in Canada were internationally educated (International Organization for Migration) . Contribution of Migrant Nursing Personnel to the Economy Economic Contributions: Taxes and Spending: Migrant nurses contribute significantly to the economy through taxes and consumer spending. For example, foreign-born workers, including nurses, contribute billions in federal, state, and local taxes annually in the U.S. (International Organization for Migration). Housing and Investments: Migrant nurses invest in housing and other economic sectors. They purchase homes, rent properties, and contribute to local economies through their spending. Regulatory Costs: Meeting Regulatory Requirements: Although costs are associated with meeting regulatory requirements for foreign-trained nurses, such as licensing and certification, these costs are offset by their economic contributions and the relief they provide to understaffed healthcare systems (International Organization for Migration). Savings on the Cost of Education of Health Personnel Educational Cost Savings: United States: By recruiting internationally trained nurses, the U.S. healthcare system saves significantly on the cost of nursing education. The average cost to train a nurse in the U.S. is substantial, and employing already-trained nurses from abroad reduces these expenses (International Organization for Migration). Canada: Canada similarly benefits from cost savings on nursing education by employing internationally trained nurses who have completed their education abroad. Other Benefits Diversity and Cultural Competence: Enhancing Patient Care: Including internationally trained nurses enhances the cultural competence and diversity of the nursing workforce, improving patient care for diverse populations (International Organization for Migration) . Language Skills: Many migrant nurses bring valuable language skills, helping to bridge communication gaps with non-English-speaking patients. Innovation and Best Practices: Introducing New Practices: Migrant nurses often bring innovative practices and diverse perspectives from their home countries, contributing to advancing nursing knowledge and healthcare delivery. Quantitative Data and Sources United States: Foreign-born nurses: About 15% of the nursing workforce (International Organization for Migration). Economic contributions: Billions in federal, state, and local taxes annually (International Organization for Migration). Educational savings: Significant savings on training nurses domestically (International Organization for Migration). Canada: Internationally educated nurses: Approximately 21% of registered nurses. Contribution to the healthcare system and economy: Substantial in filling critical gaps and economic spending. Interpretation Destination countries like the United States and Canada benefit greatly from the migration of nursing personnel. These benefits include addressing critical nursing shortages, significant economic contributions, savings on education costs, and enhanced diversity and cultural competence in healthcare delivery. The reliance on international nursing personnel is crucial for maintaining robust healthcare systems and meeting the growing demand for healthcare services.

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Use of National/Sub-National Data and Research on Health Personnel to Inform Policies and Plans Haiti (Source Country) Health Personnel Information Systems: National Health Statistics: The Haitian Ministry of Health uses data collected through the national health information system to monitor the distribution and availability of health personnel across the country. This data includes information on the number of healthcare workers, their specialties, and their geographic distribution. Policy Development: This data is crucial for developing policies addressing shortages and improving healthcare access. For example, identifying regions with severe shortages has led to targeted recruitment and deployment strategies (International Organization for Migration). Migration Data: Tracking Emigration: Haiti tracks the emigration of healthcare workers through cooperation with international organizations like the IOM and WHO. This data helps the government understand the impact of brain drain and develop strategies to mitigate its effects. Informing Bilateral Agreements: Migration data is used to inform bilateral agreements with countries that recruit Haitian health professionals, ensuring these agreements include provisions for ethical recruitment and support for the remaining health system in Haiti (International Organization for Migration) . Research and Collaboration: Collaborative Research: Haiti collaborates with universities and international organizations to research health workforce dynamics. This research informs policies and strategies to improve workforce retention and distribution. Example: Research conducted in partnership with the WHO has highlighted the need for improved working conditions and incentives to retain healthcare workers in rural areas. Dominican Republic (Source Country) Health Personnel Information Systems: Comprehensive Databases: The Dominican Republic maintains comprehensive databases on health personnel, which include data on education, employment, and migration. This information is critical for workforce planning and policy-making. Utilization in Policy: Data from these systems is used to allocate resources efficiently, develop training programs, and implement policies to address regional disparities in healthcare provision (International Organization for Migration). Migration Data: Monitoring and Evaluation: The Dominican Republic monitors the migration patterns of its health workers to understand the scale and impact of emigration. This data informs policies to improve domestic working conditions to retain health personnel. Impact on Agreements: Migration data supports negotiations for bilateral agreements with destination countries, ensuring that the migration of health personnel is managed ethically and sustainably (International Organization for Migration) . Research and Collaboration: National and International Research: The Dominican Republic engages in research initiatives with international organizations to assess the needs and challenges of its health workforce. These initiatives help develop evidence-based policies and plans. Example: Studies conducted with PAHO have provided insights into the factors driving emigration and the effectiveness of various retention strategies, leading to targeted incentives for healthcare workers in underserved areas (International Organization for Migration) . United States and Canada (Destination Countries) Health Personnel Information Systems: Detailed Tracking: The United States and Canada use detailed health personnel information systems to track the employment and distribution of healthcare workers, including internationally trained nurses and other professionals. Policy Implementation: This data informs workforce planning, ensuring that healthcare services are adequately staffed and resources are allocated where they are most needed. For example, the U.S. Health Resources and Services Administration (HRSA) uses this data to designate Health Professional Shortage Areas (HPSAs) and allocate federal support accordingly (International Organization for Migration). Migration Data: Integration and Support: Data on the migration and integration of international health personnel is used to develop programs that support the integration of migrant health workers, including credential recognition and professional development opportunities. Policy Formulation: Migration data helps formulate policies that facilitate the ethical recruitment and fair treatment of international health personnel, ensuring compliance with international standards like the WHO Global Code of Practice. Research and Collaboration: Collaborative Studies: Both countries engage in collaborative studies with international organizations to understand the impact of international health worker migration on their healthcare systems. These studies inform policies to maximize the benefits of migration while addressing any negative impacts. Example: Research partnerships with institutions like the OECD provide valuable data on the economic contributions of migrant health workers and the effectiveness of integration programs. Interpretation National and sub-national data on health personnel, including migration data and health personnel information systems, play a crucial role in informing policies and plans in both source and destination countries. These data-driven approaches ensure that healthcare systems can effectively manage health professionals' deployment, integration, and reintegration, optimizing healthcare delivery and addressing workforce challenges.

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Use of the WHO Health Workforce Support and Safeguards List Source Countries (Haiti and the Dominican Republic) Policy Development and Implementation: Haiti: The Haitian government utilizes the WHO Health Workforce Support and Safeguards List to develop policies ensuring ethical recruitment and retention of health personnel. This includes aligning national strategies with international standards to protect the rights of health workers. Example: Haiti has integrated the principles of the WHO Code into its national health policy to mitigate the negative impacts of health worker migration and ensure that international recruitment practices do not deplete its healthcare system (World Health Organization (WHO)) (International Organization for Migration). Dominican Republic: The Dominican Republic uses the WHO list to inform its policies on the ethical recruitment and sustainable management of health personnel. This includes establishing bilateral agreements with destination countries to ensure fair treatment and support for Dominican health workers abroad. Example: Policies have been established to improve working conditions and provide incentives to retain healthcare professionals within the country, following the guidelines from the WHO list (International Organization for Migration). Strengthening Health Systems: Haiti and the Dominican Republic: Both countries leverage international support and funding aligned with the WHO safeguards list to strengthen their health systems. This includes investments in healthcare infrastructure, training programs, and workforce development initiatives supported by international donors and organizations. Example: International aid from organizations like WHO, PAHO, and NGOs has been used to improve healthcare delivery and train health professionals, ensuring alignment with the WHO's ethical guidelines (International Organization for Migration). Destination Countries (United States and Canada) Ethical Recruitment Practices: United States: The U.S. healthcare system adheres to the WHO Health Workforce Support and Safeguards List by implementing ethical recruitment practices that protect international health personnel's rights and well-being. Example: Recruitment agencies and healthcare institutions follow the WHO Code to avoid aggressive recruitment from countries with critical health worker shortages, ensuring fair treatment and compliance with international standards (International Organization for Migration). Canada: Canada uses the WHO list to guide its recruitment policies, ensuring that the migration of health personnel is managed ethically and sustainably. This includes supporting the integration and professional development of internationally trained nurses and other health professionals. Example: Policies in Canada include measures for credential recognition, professional support, and fair employment practices for internationally trained nurses, aligned with the WHO guidelines (International Organization for Migration). International Collaboration and Support: United States and Canada: Both countries collaborate with international organizations to support health workforce development in source countries. This includes providing technical assistance, training, and financial aid to strengthen health systems in countries like Haiti and the Dominican Republic. Example: Through programs supported by WHO and other international agencies, the U.S. and Canada contribute to the training and developing health personnel in source countries, ensuring that these initiatives align with the WHO safeguards list (International Organization for Migration). Data Collection and Monitoring: United States: The U.S. uses data collection and monitoring systems to track the employment and distribution of international health personnel. This data informs policies to ensure ethical recruitment and integration of migrant health workers. Example: The Health Resources and Services Administration (HRSA) in the U.S. collects data on international health workers to inform workforce planning and ensure compliance with the WHO Code (International Organization for Migration). Canada: Canada maintains comprehensive databases on health personnel migration, using this data to develop informed policies that support the ethical recruitment and fair treatment of international health workers. Example: Data collected on the integration and employment of internationally trained nurses helps Canada to design programs that support their professional development and ensure their rights are protected (International Organization for Migration). Interpretation The WHO Health Workforce Support and Safeguards List is crucial in guiding policies and practices for the ethical recruitment and management of health personnel in source and destination countries. Countries like Haiti and the Dominican Republic can protect their health systems by aligning national strategies with international standards while benefiting from international support. Destination countries like the United States and Canada ensure the fair treatment and integration of migrant health workers,

contributing to a more sustainable and equitable global health workforce.

Source of information
CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC Source Links WHO Global Code of Practice on the International Recruitment of Health Personnel: WHO Code Haitian Ministry of Health (MSPP): MSPP Portal Dominican Republic Ministry of Health (MSP): MSP Portal Pan American Health Organization (PAHO): PAHO Health Workforce Global Health Workforce Alliance: GHWA

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).

CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC

Reflection on the Past 14 Years Since the Resolution of the WHO Global Code of Practice on the International Recruitment of Health Personnel

Relevance of the Code

The WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted in 2010, has been a significant tool in promoting ethical recruitment and sustainable management of health workforce migration. Its relevance remains high, given the persistent global challenges of health worker shortages and inequitable distribution of health personnel.

Achievements

Improved Ethical Recruitment Practices:

Global Adoption: Over 64 countries have incorporated the Code's provisions into national laws, policies, or international agreements. This widespread adoption has helped standardize ethical recruitment practices globally (World Health Organization (WHO)).

Haiti and the Dominican Republic: Both countries have used the Code to guide the development of policies that ensure fair treatment and support for their health workers who migrate abroad (International Organization for Migration).

Strengthened Health Systems:

International Support: The Code has facilitated increased international support for health workforce development in source countries. This includes financial aid, technical assistance, and training programs aimed at strengthening health systems in countries like Haiti and the Dominican Republic (International Organization for Migration).

Capacity Building: Programs aligned with the Code's principles have helped build local capacity, ensuring that source countries can better retain and manage their health workforce.

Data Collection and Research:

Enhanced Monitoring: The Code emphasizes the importance of data collection and research. Countries have improved their health personnel information systems, leading to better workforce planning and policy-making (International Organization for Migration).

Policy Informed by Data: The enhanced data collection has enabled more informed and effective health workforce policies addressing migration and retention challenges.

Challenges

Implementation Gaps:

Despite the widespread adoption of the Code, implementation remains uneven. Due to economic constraints and competing priorities, many countries face challenges in fully integrating their principles into national policies and practices (International Organization for Migration).

Haiti and the Dominican Republic: Both countries struggle with limited resources and infrastructure, hindering the full implementation of the Code's guidelines.

Enforcement and Compliance:

Ensuring compliance with the Code's principles is difficult, particularly in countries with weak regulatory frameworks. Variability in enforcement means that the benefits of the Code are not uniformly realized (World Health Organization (WHO)).

Balancing Needs:

Balancing the needs of source and destination countries continues to be challenging. While destination countries benefit from the influx of health personnel, source countries often suffer from brain drain, impacting their healthcare systems (International Organization for Migration).

Alignment with Other Global Instruments

United Nations Global Compact on Migration:

The Code aligns well with the Global Compact on Migration, particularly in promoting safe, orderly, and regular migration. Both instruments emphasize protecting migrant workers' rights and addressing the root causes of migration (International Organization for Migration).

International Labour Standards:

The Code aligns with international labour standards set by the International Labour Organization (ILO), promoting decent work and fair treatment for all workers, including health personnel (World Health Organization (WHO)).

Contribution to Sustainable Development Goals (SDGs)

SDG 3 (Good Health and Well-being):

The Code contributes directly to SDG 3 by promoting a sustainable health workforce, which is essential for achieving universal health coverage and improving health outcomes globally (International Organization for Migration).

SDG 8 (Decent Work and Economic Growth):

By advocating for fair and ethical recruitment practices, the Code supports SDG 8, ensuring decent work conditions and economic growth through a stable and well-managed health workforce (World Health Organization (WHO)).

SDG 10 (Reduced Inequalities):

The Code addresses inequalities in health worker distribution between countries, promoting equitable access to healthcare services and reducing disparities in health outcomes (International Organization for Migration).

Interpretation

Over the past 14 years, the WHO Global Code of Practice on the International Recruitment of Health Personnel has played a

critical role in shaping health workforce policies and practices globally. While there have been significant achievements in improving ethical recruitment and strengthening health systems, challenges in implementation and enforcement remain. The Code's alignment with other global instruments and its contributions to achieving the Sustainable Development Goals underscore its continued relevance and importance in the global health landscape.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

CARIBBEAN REGIONS HAITI AND DOMINICAN REPUBLIC

Additional Information Relevant to the Implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel
Haiti
National Health Policies:
Haitian Ministry of Health (Ministère de la Santé Publique et de la Population - MSPP): The MSPP has integrated the principles of the WHO Global Code into its national health policies to ensure ethical recruitment and sustainable management of health personnel migration. These policies aim to protect the rights of health workers and ensure that recruitment practices do not adversely affect the country's healthcare system.
Example: MSPP's strategic plans often include provisions for bilateral agreements that adhere to the WHO Code, focusing on improving local healthcare capacity while engaging in ethical recruitment practices.
International Collaborations:
Partnerships: Haiti collaborates with international organizations such as WHO, PAHO, and NGOs to strengthen its healthcare system. These collaborations often involve training programs, technical assistance, and financial support to build local capacity and retain healthcare professionals.
Example: The Cuban medical collaboration, where Cuban doctors train and work alongside Haitian health professionals, is guided by the ethical principles outlined in the WHO Code.
Data and Monitoring Systems:
Health Workforce Information Systems: Haiti has been improving its health workforce information systems to track the migration patterns of health personnel better and assess the impact on the domestic healthcare system. Enhanced data collection supports informed policy-making and strategic planning.
Dominican Republic
National Strategies:
Ministry of Health (Ministerio de Salud Pública - MSP): The Dominican Republic's Ministry of Health incorporates the WHO Code's guidelines into its national strategies to ensure ethical recruitment and the protection of health workers' rights. This includes improving working conditions and incentives for health professionals to remain in the country.
Example: The MSP has developed policies that include support for internationally trained health professionals returning to the Dominican Republic, ensuring they can reintegrate and contribute effectively to the local health system.
Bilateral Agreements:
Ethical Recruitment Practices: The Dominican Republic engages in bilateral agreements with destination countries to ensure that the recruitment of its health personnel is conducted ethically. These agreements often include clauses that protect the rights of migrant health workers and ensure their fair treatment abroad.
Example: Agreements with Spain and the United States include provisions for training, support, and fair compensation for Dominican health professionals.
Capacity Building:
International Support: The Dominican Republic benefits from international support for capacity building in the healthcare sector. This includes training programs, infrastructure development, and technical assistance from international organizations and donor countries.
Example: Collaborative projects with PAHO and WHO focus on strengthening the health workforce, improving healthcare delivery, and ensuring alignment with the WHO Code.

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Warning

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Survey response 11

Response ID
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Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

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Public Services International (PSI)

First and Last Name of Contact Person:
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Description of the entity submitting the report:
Public Services International (PSI) is the Global Union Federation of more than 700 trade unions representing 30 million workers delivering public services in 154 countries.We bring their voices to the UN, ILO, WHO and other regional and global multilateral processes. We defend trade union and workers' rights and fight for universal access to quality public services. PSI holds official relations with the WHO as a Non-State Actor (NSA).

Please describe the nature of the entity’s involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
More than a third of our union affiliates are in the health and social services sector representing around 12 million medical, health, care and social services workers. It defends trade unions’ and workers' rights and fights for universal access to quality public services. It argues for: 1. Global social responsibility with funding for the long-term sustainability of health care systems, quality public services and the right to health. 2. A strengthened WHO Global Code of Practice on the International Recruitment of Health Personnel to ensure the full implementation of ethical recruitment principles and monitoring progress on this front. 3. Fundamental labour rights of migrant workers and the full implementation of rights-based global governance instruments on migration. 4. Bilateral labour agreements that promote economic and social development, fair and ethical recruitment and international labour standards. 5. Social dialogue in national and global migration governance.

Please specify the country(ies) or region(s) where entity is involved:
Global

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code’s implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
The evidence presented in this report is derived from a PSI online survey completed by PSI affiliates between mid-June to mid-July 2024. The survey aimed to elicit trends, challenges and opportunities facing affiliates and their members including in the implementation of the WHO Global Code. It elicited 42 valid responses covering 39 unions in 35 countries. Of these countries, most (37%) are countries of origin and destination; 29% are primarily a country of origin, and 26% are primarily a country of destination (Figure 1). Unions from two countries were not aware whether their country is a country of origin or a country of destination. *Note that the data presented in this report is a preliminary analysis of the survey results. It is being analysed further and extended, and a longer report will be published by PSI and will be shared with the WHO Secretariat in September 2024. In view of Question no. 1, please see report sections: 3.1 International recruitment and migration of health and care workers is fast growing 3.2 Health and care workers face more challenges and are more vulnerable than ever before 3.3 Countries use a range of measures to address shortages of health and care workers 3.6 Bilateral and multilateral agreements are increasingly common ways of recruiting health and care workers 3.7 In most countries, health and care workers are not represented in Bilateral and Multilateral Labour Migration Agreement negotiations, governance or monitoring 3.8 Poor compliance with the WHO Global Code 3.9 Low involvement of trade unions in country reporting on the implementation of the WHO Global Code The full explanation, along with charts and quantitative data are found in the report.

Source of information
See attached report, “Evidence from Public Services International on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.” Authors: Genevieve Gencianos, Nicola Yeates, Jillian Roque and Jane Pillinger. Public Services International, Geneva, 30 July 2024.

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
In answer to Question no. 2, please see report sections: 3.5 Privatisation and Public-Private Partnerships are commonly used to fund, provide and staff health and care services 3.10 More support to undertake Health Labour Market Analysis needed 3.11 Health and care workforce sustainability must be prioritised 3.12 Collective bargaining agreements are key to retention and health workforce sustainability

Source of information
See attached report, “Evidence from Public Services International on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.” Authors: Genevieve Gencianos, Nicola Yeates, Jillian Roque and Jane Pillinger. Public Services International, Geneva, 30 July 2024.

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
In answering Question no. 3, please see report section: 3.4 Active and targeted recruitment is the most common international migration pathway for health and care workers

Source of information
See attached report, “Evidence from Public Services International on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.” Authors: Genevieve Gencianos, Nicola Yeates, Jillian Roque and Jane Pillinger. Public Services International, Geneva, 30 July 2024.

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
The whole report answers this question, reflecting the perspectives of health workers, including among them the perspectives of migrant health workers.

Source of information
See attached report, "Evidence from Public Services International on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel." Authors: Genevieve Gencianos, Nicola Yeates, Jillian Roque and Jane Pillinger. Public Services International, Geneva, 30 July 2024.

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
Please refer to report section 3.8 Poor compliance with the WHO Global Code. Amongst the respondents who reported that their government does implement the WHO Global Code either partially or fully (n=18), 17% (n=3) comply with the WHO Global Code provision on systematic data collection on international health and care workers. See Figure 7 Most-complied-with provisions of the WHO Global Code (%).

Source of information
See attached report, "Evidence from Public Services International on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel." Authors: Genevieve Gencianos, Nicola Yeates, Jillian Roque and Jane Pillinger. Public Services International, Geneva, 30 July 2024.

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
International recruitment is happening in certain countries, despite them being in the WHO HWSSL 2023. For e.g. Ghana is extending its BLMA with Barbados by negotiating a BLMA with the UK. The Ghana respondent noted that Germany, Austria and other countries have approached Ghana with a view to setting up such agreements. It is well known that the UK has a BLMA with Nepal, which is in the list. See report section 3.6.

Source of information
See attached report, "Evidence from Public Services International on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel." Authors: Genevieve Gencianos, Nicola Yeates, Jillian Roque and Jane Pillinger. Public Services International, Geneva, 30 July 2024.

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
See report section 3.8 Poor compliance with the WHO Global Code. And the whole of section 4. Reflections on ways forward and recommendations.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
See the attached report, "Evidence from Public Services International on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel." Authors: Genevieve Gencianos, Nicola Yeates, Jillian Roque and Jane Pillinger. Public Services International, Geneva, 30 July 2024.

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Survey response 12

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2024-07-31 05:08:56

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Date started
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Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
International Council of Nurses

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Mailing address:
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Website URL:
https://www.icn.ch/

Description of the entity submitting the report:
The International Council of Nurses (ICN) is a federation of over 130 national nurses associations (NNAs), representing the over 28 million nurses worldwide. Founded in 1899, ICN is the world's first and widest reaching international organisation for health professionals.

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:

Please specify the country(ies) or region(s) where entity is involved:
The ICN has members in over 130 countries.

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable

The international migration and mobility of health personnel, particularly nurses, have experienced significant shifts over the past three years. These trends have been influenced by a variety of factors, including the COVID-19 pandemic, increasingly urgent nurse shortages and increasing population healthcare needs in many countries, and the escalating demand for healthcare workers in high-income states. The International Council of Nurses (ICN) presents a high-level analysis of these trends, examining their impacts on both source and destination countries and addressing the ethical concerns associated with recruitment practices. This analysis is based on a comprehensive review of various case studies and qualitative data, aiming to provide unique insights from the global nursing perspective. By elucidating the complexities of nurse migration, ICN seeks to inform policy decisions and contribute to the development of effective strategies for addressing the associated challenges.

Trends suggest that international migration and mobility of nurses, particularly from low and middle-income countries (LMICs) to high-income countries, already of great concern at the time of the last reporting round, has shown a significant increase over the past three years in many high-income countries, with a growing reliance on internationally-educated nurses (IENs) to address domestic shortages. Nurse migration and mobility were affected by temporary restrictions on international travel during the early COVID-19 pandemic, as well as temporary measures implemented to restrict or manage the outward migration of nurses and other healthcare workers by source countries such as the Philippines, Kenya, Barbados, and Jamaica (ICN, 2020). However, there has since been a “rebound” effect with a dramatic surge in international nurse migration and recruitment, partially driven by attempts by some high-income countries to address their vast nursing shortages by actively recruiting from LMICs and easing the entry or professional recognition of IENs.

While there is a need for greater and more robust data on international nurse migration to fully understand these trends, the evidence shows clear patterns of increasing reliance by high-income countries on IENs.

In OECD countries, the average proportion of overseas-trained nurses increased from 5% in 2011 to nearly 9% in 2021 (OECD, 2023). As ICN outlines in the 2023 “Recover to Rebuild” report, countries that have traditionally relied on international nurse migration, such as the United Kingdom, United States, Canada, Australia, and Germany saw especially significant increases (ICN, 2023). For example, more than 24,000 new international nurse registrants were recorded in the 12-month period from September 2021 to September 2022 in the UK alone, the highest in recorded history (Buchan, 2023). In the United States, the Commission on Graduates of Foreign Nursing Schools (CGFNS) reported over 17,000 VisaScreen® applications from 116 countries in fiscal year 2022, an increase of 44% from 2021 (CGFNS, 2022).

Countries that have not been traditionally active in international nurse recruitment are also showing increased demand for overseas-trained nurses, including Finland as well as Scotland, where the government announced an allocation of £4.5 million to support active international recruitment of nurses as part of the overall plan for pandemic recovery and renewal (ICN, 2023; Yle, 2021; Scottish Government, 2021).

ICN recognises and supports the right of individual nurses to migrate and pursue
professional achievement through career mobility and to better the circumstances in which
they live and work. However, ICN is gravely concerned that we continue to see patterns of large-scale nurse migration from the world’s most vulnerable countries, in large part driven by active nurse recruitment by a small number of high-income countries, including the United Kingdom, United States, Canada, Australia, and Germany, as well as certain Gulf States. 19% of new overseas nurses in the UK between 2021-2023 came from countries on the WHO Health Workforce Support and Safeguard List of countries facing severe health workforce deficits, while in the six months to September 2022, more than 2,200 (20%) of new international nurses to the UK came from just two 'red list' countries: Nigeria and Ghana (Dayan et al., 2024; ICN, 2023). Though active recruitment from these countries to the National Health Service (NHS) is prohibited in the UK, nurses can be first hired by for-profit recruitment firms to work in the private sector and later apply directly to the NHS as passive recruits. ICN is also concerned by reports that during 2020, international recruiters were directly advertising to recruit scarce health care staff from low- and lower middle- income countries in Africa, Asia, and the Caribbean, in breach of the Code (Omaswa, 2020; ICN, 2023).

Though increased monitoring and data collection is needed, we have also observed clear patterns of increasing outflow of nurses from LMICs to high-income countries over the past three years. For example, more than 1,700 registered nurses in Zimbabwe resigned in 2021, while more than 900 had already left in 2022, with many moving to the UK (Reuters, 2022). In recent years, the Ghana Registered Nurses and Midwives Association has reported that on average, 500 nurses are currently leaving Ghana every month, and research suggests that a high number of experienced, specialist nurses are leaving; as these nurses cannot be easily replaced, this leaves significant coverage gaps in key healthcare specialties (Mensah, 2022; BBC, 2023; Poku et al., 2023; Global Partnership Network, 2024).

At the 2024 World Health Assembly (WHA) and side events, representatives of small island states such as Tonga and Fiji reported losing 20%–30% of their nurses year-on-year, primarily to Australia and New Zealand (Catton, 2024; see also Fiji National Economic Summit 2023). Fiji, like many Pacific Island Countries (PICs), grapples with a severe health care challenge: a high nursing turnover exacerbated by health worker burnout and nurses seeking opportunities abroad.

Over one-third of nurses at Fiji’s main referral hospital resigned, reflecting a trend across the region. In 2022 alone, 800 nurses

resigned, depleting the workforce by over a fifth. Now, in 2024, the number of nurses on the front lines is 2,003 leaving approximately 1,650 nursing positions vacant. In fact, many hospitals have less than 40% of their established Registered Nurse positions (Vudiniabola, 2024).

Nursing representatives from Jamaica also reported at the WHA that ~20% of the country's nurses applied for certificates of current professional status, an indicator that they're preparing to work abroad (Catton, 2024).

Worrying levels of nurse migration and nurse shortages have also been reported in countries that have historically sought to educate nurses for emigration to supply international workforces, such as the Philippines and India. The Philippines has a current shortage of 190,000 healthcare workers and is expected to face a shortage of 250,000 nurses by 2030 (Lopez, 2024, ICN, 2023).

Another trend is the emergence of "stepping stone" or "carousel" migration patterns, whereby nurses do not remain in their initial destination country but are instead recruited to or apply to positions in other high-income destinations. For instance, in the UK, overseas-trained nurses, who first qualified outside the UK and the EU, accounted for 70% of certificate of professional status applications to work abroad in 2022/23; more than 4 in 5 CCPS applications from UK-registered nurses were for just three countries: Australia, New Zealand, and the US (The Health Foundation, 2023). Countries such as Canada have actively targeted UK nurses with recruitment advertising (Lambert, 2024). At the World Health Assembly, New Zealand was reported to be a notable "stepping stone" destination for nurses from Pacific Island nations who subsequently migrate to Australia (Catton, 2024). These patterns may speak to the failure of initial destination countries to retain IENs, in part due to underinvestment in nurse compensation and working conditions, with increased turnover disrupting continuity of care and increasing recruitment and training costs.

The ICN Position Statement on international career mobility and ethical nurse recruitment directly "condemns the targeted recruitment of nurses from countries or areas within countries that are experiencing a chronic shortage of nurses and/or a temporary health crisis in which nurses are needed" and "condemns the recruitment of nurses to countries where employing authorities have failed to implement sound human resource planning and have not adequately addressed issues of retention" (ICN, 2019).

ICN remains increasingly concerned about these patterns of rising nurse migration and active recruitment from low and middle-income countries (LMICs). These trends are depleting already fragile health systems, preventing LMICs from rebuilding and responding to health challenges post-pandemic, and widening the significant gap in healthcare access and quality between high-income and low-income countries. This situation jeopardizes the global achievement of the UN Sustainable Development Goals, including universal health coverage, by 2030. Source countries lose their investment in nurse education when their nurses are actively recruited away, along with the specialized skills and experience much needed by their populations. The workforce that remains faces significantly more pressure. Moreover, international recruitment undermines countries' ability to educate more nurses. Senior nurses, who are crucial for supervising students in clinical practice and mentoring new graduates, are often among those who migrate, further exacerbating the strain on the local healthcare education system.

ICN is also strongly concerned that continued and increasing reliance on international nurses is masking underlying issues in the domestic health systems of destination countries, such as poor retention rates, inadequate working conditions, and insufficient domestic training capacity.

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2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable

ICN is aware of several measures or proposed measures to increase domestic nursing workforces in some higher-income countries by means of increased nurse education, such as the NHS Long Term Workforce Plan, which aims to educate over 60,000 nurses in England by 2028/29, a 54% increase from 2022/23; Australia's National Nursing Workforce Strategy, currently in development, which aims to build nurse workforce sustainability and self-sufficiency; and Germany's 2024 Nursing Studies Strengthening Act, which aims to attract nursing students with monthly salaries to ease the workforce shortage.

ICN strongly welcomes and supports these much-needed commitments to investing in nursing education and in sustainable, self-sufficient national workforce planning. However, as outlined in ICN's 2023 report, "Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness", ICN believes that for these measures to be truly effective, retention must also be addressed as a priority. ICN cautions against a "leaky bucket" approach that involves turning the tap of nursing education to fully open without fixing the longstanding "holes" causing so many nurses to leave the profession: the failure to invest in safe, decent working conditions and fair compensation.

Some low- and middle-income countries are also taking measures to try to decrease the emigration of their nurses and improve nursing workforce sustainability, by means of increased employment and/or training opportunities and retention incentives. For instance, the Filipino Department of Health has recently allocated funds to provide nurses with health insurance, housing, and other benefits in an attempt to stem the tide of nurse migration (Lopez, 2024).

However, due to insufficient funding, chronic underinvestment in the healthcare sector, and other structural factors, several LMICs are simultaneously experiencing nursing shortages and unable to provide employment opportunities or other measures to retain their nurses, which has been termed the "paradox of health worker unemployment in countries with critical shortage" by WHO in Africa. One example is Lesotho, where, despite low nurse coverage, nearly one out of three professional nurses and midwives were unemployed because of a lack of funding (Asamani et al., 2022; ICN, 2023). While comprehensive data on unemployment and underemployment is limited and rates vary across LMICs, feedback to ICN from National Nursing Associations suggests it is significant. In a number of African countries, ICN believes the unemployment rate for nurses could be around 20%. It's crucial to note that these nurse unemployment rates are not due to a true surplus of nurses in these countries, but rather a lack of financial capacity to employ nurses.

The complexity of this situation highlights why straightforward stock and flow data are insufficient to understand nursing shortages. ICN strongly advocates for the development and use of needs-based modelling and assessments to monitor global nurse coverage and migration, which is especially critical in the upcoming second State of the World's Nursing (SOWN) report. This approach would not only consider the current workforce and its movements but also factor in the actual healthcare needs of populations and the economic capacities of countries to employ nurses. If global health and Universal Health Coverage (UHC) are to be prioritized, it must be recognized that more nurses will be required than current estimates suggest. Needs-based models and methodologies are necessary to capture this increased demand and provide a more holistic and accurate picture of global nursing requirements and shortfalls in the forthcoming SOWN.

ICN believes that this approach would provide a stronger foundation for collecting and interpreting data we can use to strengthen global and national policy in addition to developing and implementing effective and ethical use of instruments such as government-to-government bilateral agreements. Currently, some programmes, such as Germany's "Triple Win" initiative, justify active recruitment from low- and middle-income countries with apparent nurse "surpluses". However, as we have seen, these perceived surpluses may actually represent a mismatch between available nurses and a country's financial ability to employ them, rather than a true excess relative to population health needs. As one example of this, the Brazilian National Federation of Nurses has publicly stated its frustration with false or misleading numbers that show an excess of nurses in Brazil and are then used to justify aggressive international recruitment (Public Services International, 2023). By incorporating needs-based assessments, we can ensure that both agreements and policy are grounded in a more accurate understanding of source countries' real healthcare workforce requirements.

LMICs require support to develop and strengthen their health and care workforce and systems so that they can meet their population's needs. As well as potential unemployment and unemployment, nurses in LMICs often face challenges in relation to understaffing, safety, and poor working conditions, and low compensation that does not match cost of living. We have seen increased evidence of labour unrest and/or strike action in developing and lower-income countries in the past three years, including Uganda, Ghana, Fiji, and Tonga. This must be recognised as symptomatic of the underlying issues feeding nurse migration and clearly demonstrates the need for efforts to strengthen LMIC health systems rather than deplete them by draining their workforce.

ICN strongly advocates for measures that support domestic employment, nurse retention, and improved working conditions in

LMICs as well as high-income countries. Fortifying healthcare workforces globally is crucial to narrow the global health equity gap and promote universal access to quality healthcare.

Since 2020, with the goal of better evaluating international workforce sustainability, ICN has highlighted the need to monitor nurse migration patterns using a self-sufficiency indicator that assesses the number of overseas-educated nurses as a percentage of the total nursing workforce across different countries, alongside other indicators such as workforce stability, retention rates, and emigration rates. Additionally, it is essential to include a measure that considers the unemployment rate of nurses, specifically the number of registered nurses who are not employed. This comprehensive approach aims to better evaluate international workforce sustainability and promote more ethical recruitment practices.

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3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
The international migration and mobility of health personnel occur through various pathways, each with its advantages and disadvantages. These pathways include active and targeted recruitment, direct application, government-to-government agreements, education pathways, and immigration programs. Active recruitment: ICN remains deeply concerned about the intensification of active nurse recruitment pathways from vulnerable health systems, which have been described as “a new form of colonialism” by some African nursing leaders and which exacerbate severe global inequalities in health coverage and outcomes (Lay, 2024). At the recent World Health Assembly, several nursing representatives from LMICs expressed alarm around active, aggressive recruitment of their nurses, with reports of recruitment agencies pitching to nurses on their graduation day and experienced, specialist nurses being specifically targeted. Government-to-government bilateral labour agreements: Bilateral agreements between governments, such as Germany’s ‘Triple Win’ approach and the UK’s bilateral accords with countries have been proposed as a potential solution to manage nurse migration more ethically. A new report published by ICN’s Global Nursing Leadership Institute Europe Group highlighted the potential for well-designed, well-monitored, and well-implemented bilateral agreements to safeguard the rights, health, and well-being of IENs by ensuring fair recruitment practices, appropriate working conditions and renumeration for recruits, and compensation for lower-income source countries who are losing the nurses they have invested in (Brubakk et al., 2024). However, the study, which includes a Europe-wide survey of Chief Nursing Officers (CNOs) and National Nursing Associations (NNAs), suggested that nursing organisations and leadership are under-engaged in the design of bilateral recruitment policies: only 10% of CNOs reported that they are actively involved in bilateral agreement negotiations regarding nurse recruitment while only 2% of NNAs stated they are involved in such negotiations. This is a missed opportunity to incorporate crucial nursing policy expertise and frontline knowledge into these agreements. Nursing involvement could also mitigate potential health equity and safeguarding risks through advocacy for provisions that protect the rights of internationally-educated nurses and ensure that agreements contribute to mutual, sustainable healthcare systems rather than exacerbating shortages in source countries. ICN remains concerned that many bilateral agreements, in their current form, rely on vague recourse to remittances from emigrant nurses or knowledge exchange and do not meaningfully compensate vulnerable states for the significant resources they have invested in training their healthcare professionals, or for the experience and expertise that leaves with every nurse. Such agreements often do not fully meet the spirit of mutuality and there is a risk that they may become a “workaround” that provides an ethical veneer for high-income countries actively recruiting nurses from countries with a critical shortage. As the 2024 WHO “Bilateral agreements on health worker migration and mobility” report finds, to date, these agreements “have not yielded investments in health system strengthening” and are often based on unequal economic and negotiating power dynamics between high- and lower-income countries. Furthermore, the report notes that “data on implementation and evaluation of the agreements are sparse or non-existent. The lack of dedicated monitoring and evaluation mechanisms does not allow for a comprehensive assessment of the effectiveness and impact of the agreements on health system strengthening, on health workers’ welfare or even to determine if the agreements were implemented and to what extent the objectives were met.” There were no strong indications that provisions relating to health system strengthening and circular migration actually materialised. Even where countries point to thin evidence of tangible economic contributions to source nations, it is unclear whether these actually reach or benefit health systems or health workforces. Strengthened reporting, monitoring, and accountability mechanisms are needed to ensure transparency in bilateral agreements and to track how any tangible investments are allocated to health systems and workforces. There have been controversies regarding specific agreements, such as the UK government’s bilateral agreements with Kenya (subsequently suspended) and Nepal (Kay, 2022, ICN, 2023). Additionally, while Germany’s Triple Win bilateral programme, for instance, only recruits from countries with a surplus of trained nurses, it is important to underscore that some LMICs have surpluses because economic constraints prevent them from employing sufficient healthcare staff, not because they have adequate coverage for their populations, and they are thus still left with a shortage. Reports of international recruiters advertising directly to recruit scarce health care staff from LMICs in Africa, Asia and the Caribbean, in breach of the Code, are deeply worrying (Omaswa, 2020; ICN, 2023). As outlined in our 2023 “Recover to Rebuild” report, ICN believes it is necessary to develop bilateral agreements based on fair, meaningful commitments to compensate vulnerable nations when recruiting from them, such as an “offsetting” program where destination countries directly fund health systems and nursing education in the source country. We also call for the implementation

of bilateral agreements to be independently monitored so as to ensure compliance with the Code, with clear and binding accountability measures for countries engaging in unethical active recruitment practices that threaten to widen the global health equity divide.

A recent joint statement issued by ICN and Public Services International (PSI) during the WHO International Negotiating Body talks on the proposed Pandemic Accord, reiterated ICN's calls for fair and ethical recruitment, based on recognition that "the continued global shortfall of healthcare workers especially in low- and middle-income countries is inequitable and a cause of health harms and inequity" and urges increased efforts aimed at "ensuring that bilateral agreements entail proportional benefits and strengthen ILO core labour standards" (ICN, 2024).

Conclusion
ICN advocates for fair and ethical recruitment practices and the development of bilateral agreements based on meaningful commitments to compensate vulnerable nations. It is essential to monitor nurse migration patterns using indicators such as the number of overseas-educated nurses as a percentage of the total nursing workforce, workforce stability, retention rates, and emigration rates. By addressing both the recruitment and retention of health personnel, ICN aims to support sustainable health workforce solutions and promote global health equity.

Source of information

Brubakk, K., Godfrey, M., Kawaku, F., Solberg, T., Toure, Y. (2024). Can Bilateral Labour Agreements Safeguard the Rights, Health and Well-being of Internationally Educated Nurses in Europe? Global Nursing Leadership Institute (GNLI) Scholars Europe Group 2023. ICN (2024). 'ICN calls for more protection of humanitarian and health workers'. Available at: https://www.icn.ch/news/icn-calls-more-protection-humanitarian-and-health-workers. Kay, G. (2022). "Nurse exports will derail health". Nation, 4 July. https://nation.africa/kenya/ blogs-opinion/opinion/nurse-exports-will-derail-health-3867988?s=09 Lay, K. (2024). 'Recruitment of nurses from global south branded "new form of colonialism"', The Guardian, 27 March. Available at: https://www.theguardian.com/global-development/2024/mar/27/recruitment-of-nurses-from-global-south-branded-new-form-of-colonialism World Health Organization (2024) Bilateral agreements on health worker migration and mobility. 14 March.

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
ICN is extremely concerned that IENs often face significant challenges in their destination countries, including cultural adjustment, potential discrimination and harassment, lack of appropriate induction and integration in the new health system, limited access to continuing professional development (CPD) and difficulties in having their qualifications and contributions recognised (Davda et al., 2018; Duchesne et al., 2023; Hunter, 2023). It can take up to three years for registered nurses (RNs) to have their qualifications recognised, during which time we know that many highly-educated professionals work as auxiliaries or care assistants. This reflects a situation in which many countries are struggling to deal with their growing social care needs, but often creates a "lose lose" situation that demoralizes nurses, underutilizes their skills and expertise, and may pave the way for exploitation of nurses. The Brazilian National Federation of Nurses (FNE), for instance, has indicated that many Brazilian nurses who move to Germany return to Brazil disillusioned and frustrated due to "the abusive conditions imposed by recruitment agencies and the asymmetries between responsibilities of nursing professionals in both countries" (Public Services International, 2023). One Brazilian nurse migrant working in Germany reported that "During diploma recognition, we are not hired even as a nursing assistant. We are hired as if we were students. In theory, it was supposed to be a more observational work, because under German law, we can't even administer intravenous drugs, for example. But in practice, we take on duties like any other nurse". This exploitative situation is extremely concerning, and suggests a significant disconnect between official recruitment policies and promises and the on-the-ground realities faced by migrant nurses when dealing with recruitment agencies and healthcare systems. ICN is also alarmed by reports of continued abusive recruitment practices, whereby IENs are recruited with false or misleading information about their employment conditions, remuneration, or benefits or led into exploitative and coercive labour arrangements. For instance, in 2023, the organisation Migrant Nurse Ireland and the Irish Nursing and Midwives Organisation raised the alarm on exploitative recruitment practices, including non-EU nurses paying fees to recruitment agents in their home countries to work in the private sector in Ireland, and recruitment agencies representing both public and private healthcare bodies providing migrant workers unsafe accommodation options, such as shared rooms which increased the risk of contracting COVID-19 (McAuley, 2023). ICN has also been alarmed to hear the many reports that migrant nurses recruited to the UK and US have been subjected to abusive repayment clauses by recruitment agencies in their contracts, leaving them in debt if they quit or are fired (Pettypiece, 2023). A 2023 report shows that care-work-related modern slavery cases reported to the UK Modern Slavery & Exploitation Helpline increased by 606% between 2021 and 2022, typically involving debt bondage or financial abuses and/or restricted movement and emotional abuse; though the report is specific to the care work sector, the authors note that "some migrant care workers are qualified nurses in their home countries" (Unseen, 2023). In a legal brief related to a case brought by a Filipino nurse against a US employment agency last year, human rights and labour rights organisations including the Human Trafficking Legal Center and The Legal Aid Society state that certain "recruitment agencies have developed elaborate and sophisticated recruitment practices to force nurses into labor while attempting to evade the reach of the TVPRA [Trafficking Victims Protection Reauthorization Act]." The practices detailed include threatening workers with severe financial penalties and lawsuits if they try to leave their jobs before their contract term ends, effectively trapping them into forced labour; isolating nurses and forcing them to work in unsafe conditions; and using forced arbitration clauses to prevent or delay nurses from accessing the courts (Human Trafficking Legal Center et al., 2023). Alarming practices also emerged in a 2022 investigation by Belgian broadcaster RTBF which revealed that some Wallonian hospitals were using unethical recruitment agencies to employ nursing staff from the Lebanon, with one agency charging both hospitals and nurses exorbitant administrative fees, forcing nurses to work for two years in the same hospital under threat of fines, and providing nurses with contracts containing disturbing and illegal demands, such as prohibiting female nurses from becoming pregnant for two years (Carter, 2022). IENs are often especially vulnerable to the risk of exploitation or abuse because of challenges related to distance, language barriers, lack of economic resources, cost in verifying licensing and regulatory information, inability to fully check employment conditions in advance, and work permits that require them to stay with their employer for a given length of time. Given that women make up 90% of the nursing profession, they may face intersectional challenges related to both their gender and immigrant status, including specific safety risks and potential wage gaps or limited career advancement opportunities. Existing policy is failing to curb unethical, abusive, and exploitative practices by recruitment agencies or to hold them accountable for widening global health inequity by recruiting from countries with fragile health systems and nurse shortages. The work of private staffing agencies, especially when used for the private sector, often falls into a regulatory grey area or is difficult to monitor or track. The voluntary nature of the Global Code in its current form does not compel either reporting or compliance from

organisations with responsibilities for international recruitment, and many national codes that have been put in place, such as the UK Code of Practice, are not legally enforceable.

Furthermore, ICN is aware of deeply troubling reports that some recruitment agencies are actively discouraging nurse migrants from disclosing their contracts with the agencies (or the recruitment fees they have paid) to immigration officials, asking them instead to only show contracts drawn up directly with their health system employer and thus concealing the agency's involvement in the process (Almendral, 2023).

Overall, there is a highly concerning lack of comprehensive data on recruitment agencies and insufficient monitoring of their practices, which hampers our ability to enforce existing regulations and strengthen policy to protect migrant nurses and safeguard health systems in the world's most vulnerable countries.

In a review of the ethical international recruitment of healthcare workers in the UK, the NIHR Policy Research Unit in Health and Social Care Workforce found that "empirical evidence about recruitment agencies is disproportionately weak compared with their influence on the process of international recruitment" (Moriarty et al., 2022). This gap has a profound effect on our ability to understand the full scope of the problem and to implement effective solutions. The review concludes that "even where regulation of recruitment agencies exists, it is still possible for unscrupulous agencies to operate because they are subject to limited oversight". Agencies must be more closely monitored both to safeguard against abusive and exploitative practices and to understand and mitigate their contribution to global health inequity by continuing to recruit nurses from LMICs.

As outlined in ICN's Position Statement, ICN condemns exploitative, abusive, and misleading nurse recruitment in the strongest possible terms, and calls for migrant nurses to be valued, supported, and protected from harm in destination countries, and offered fair, clear, and non-discriminatory work contracts and compensation.

ICN calls for stronger collection and analysis of data on health worker recruitment agencies through robust reporting mechanisms, increased oversight, and thorough scrutiny of the entire healthcare staffing supply chain at both national and international levels. Additionally, many IENs are being offered higher pay than in their own countries; however, due to cost-of-living pressures, these wages do not translate into increased income levels that allow nurses to send money back to their families in their home countries. As a result, the Nursing Times reports that nurses make up more than 10% of the staff currently using food banks provided by NHS charities to cope with economic hardship, according to a snapshot survey.

ICN strongly calls for independent monitoring and assessment of both public and private recruiting bodies and for clear and binding accountability measures to be put in place for agencies engaging in unethical practices in breach of the Code.

Furthermore, ICN calls for improved sharing of data and proactive engagement of nurse leaders and nurse associations who can ensure the integrity and fairness of the recruitment process. In discussions with nursing associations in WHO's Africa region, national nurse leaders expressed the desire to know more about the recruitment processes involving their nurses and even visit the locations where nurses will be recruited to in order to be assured of decent working conditions.

Source of information
Almendral, A. (2023, October 2). A hidden system of exploitation underpins US hospitals' employment of foreign nurses. Type Investigations. Available at: https://typeinvestigations.org/investigation/2023/10/02/international-nurse-recruitment-exploitation/ Carter, D. (2022, June 1). Belgian hospitals engage in illegal hiring practices. The Brussels Times. Available at: https://brusselstimes.com/231989/belgian-hospitals-engage-in-illegal-hiring-practices Davda L.S., Gallagher J.E., & Radford D.R. (2018). Migration motives and integration of international human resources of health in the United Kingdom: systematic review and meta- synthesis of qualitative studies using framework analysis. Hum Resour Health. 2018 Jun 27;16(1):27. doi: 10.1186/s12960-018-0293-9 Davis, C. (2023, March 21). Healthcare Staffing Agency Accused of Demanding Employees Stay 3 Years or Repay Wages. HealthLeaders. https://healthleadersmedia.com/human-resources/healthcare-staffing-agency-accused-demanding-employees-stay-3-years-or-repay-wages Duchesne, C., Le Callonnec, L., Fournier, J., Benoit, J., & Soltane, S. B. (2023). Professional integration of foreign-trained nurses in Canadian healthcare settings: a review of literature on challenges encountered and effective practices. Revue Francophone Internationale de Recherche Infirmière, 9(2), 100293. McAuley, E. (2023). 'Indian nurses recruited by HSE wait months in Ireland without their children before starting work', The Journal, 19 April. Available at: https://thejournal.ie/nurses-ireland-6027913-Apr2023/ Moriarty, J., Manthorpe, J., Lipman, V., Martineau, S., Norrie, C., & Samsi, K. (2022). Rapid review on the ethical international recruitment of healthcare workers. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-070 Pettypiece, S. (2023). 'Trapped at work: Immigrant health care workers can face harsh working conditions and $100,000 lawsuits for quitting', NBC News, 2 June. Available at: https://nbcnews.com/politics/economics/trapped-work-immigrant-health-care-workers-can-face-harsh-working-conditions-rcna87303 Public Services International. Castro M., Gibb, E. (2023). Unions fight to ensure transparency in the international recruitment of health workers. Available at: https://publicservices.international/resources/news/unions-fight-to-ensure-transparency-in-the-international-recruitment-of-health-workers?id=14000&lang=en Human Trafficking Legal Center, The Legal Aid Society, Outten & Golden LLP. (2023). Brief of Human Rights and Labor Rights Organizations as Amici Curiae in Support of Plaintiff-Appellee, Benzor Shem Vidal v. Advanced Care Staffing, LLC. No. 23-303. United States Court of Appeals for the Second Circuit. Available at: https://htlegalcenter.org/wp-content/uploads/Brief-of-Human-Rights-and-Labor-Organizations-as-Amici-Curiae-in-Support-of-Plaintiff-Apellee.pdf Hunter, W. (2023) 'Social care nurses from overseas ‘exploited and harassed’ while working in UK', Nursing in Practice, 10 July. Available at: https://nursinginpractice.com/latest-news/social-care-nurses-from-overseas-exploited-and-harassed-while-working-in-uk (Accessed: 23 July 2024). Unseen UK. (2023). Who cares? A review of reports of exploitation in the care sector. Available at: https://www.unseenuk.org/wp-content/uploads/2023/11/unseen-Care-Sector-report-2023.pdf

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
Government-to-government bilateral agreements, such as Germany’s Triple Win approach, often discuss migrant nurse remittances as a developmental stimulus in their country of origin. Additionally, countries such as India and the Philippines have invested in “train for export” models which has led to significant expansion in nursing education, particularly in the private sector. However, as ICN outlines in the 2023 “Recover to Rebuild” report, what source countries lose (in the form of the training investment they have made for their nurses and the experience, expertise, and health coverage they are left without) is often much greater than any promise of potential remittances. We have not seen strong evidence of bilateral agreements that offer clear, tangible, and measurable benefits to source countries. We are also now seeing countries such as India and the Philippines experiencing their own severe nursing shortages and struggling to stem the tide of nurse migration, which should sound a note of caution on whether source countries truly benefit even from a deliberate “train for export” approach. We have also seen that rapid expansion of nursing education providers in some “train to export” source countries has led to significant concerns about the consistency and quality of education. Several programmes in the Philippines, for instance, have been closed down due to failure to comply with Commission on Higher Education (CHEd) standards (ICN, 2020; Bautista et al., 2019). Last year, the Ugandan government imposed a temporary ban on the registration and licensing of new nursing and midwifery education institutions, citing concerns that for-profit programmes have been proliferating without adequate attention to academic standards (Nakkazi, 2023). The risk associated with this model is that it may produce nurses who are not adequately prepared for the complexities of modern healthcare, either domestically or internationally potentially impacting patient care quality and safety. Depending on the specifics of these programmes, this may also create challenges for nurses seeking to practice in countries with different/more stringent educational standards, or, on the contrary, overemphasise training for international contexts over local needs. ICN remains gravely concerned that source countries, particularly LMICs, are not benefitting from international migration of health personnel, but are instead experiencing direct and significant health harms due to recruitment of their nurses.

Source of information
Bautista, J. R., Ducanes, G., & David, C. C. (2019). Quality of nursing schools in the Philippines: Trends and evidence from the 2010–2016 Nurse Licensure Examination results. Nursing outlook, 67(3), 259-269. ICN. Buchan, J., & Catton, H. (2023) Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness. Nakkazi, E. (2023, June 14). Licensing halted for new nursing and midwifery institutions. University World News. Available at: https://universityworldnews.com/post.php?story=20230614081239845

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
High-income countries have benefitted greatly from the migration of international nursing professionals who fill their workforce shortages and bring valuable expertise, experience, and high-quality care to their health systems. This is especially critical during health crises: as noted by the OECD, “The COVID-19 pandemic revealed once more that foreign-trained nurses are key assets for health systems in many OECD countries” (Socha-Dietrich & DumonT, 2021). Nurse migrants also support the source country’s economy, not only through their taxes but in providing care that improves population health and wellbeing, equating to a more productive workforce and well-functioning society. Furthermore, destination countries benefit from IENs’ valuable and diverse perspectives, cultural competencies, and knowledge transfer. Destination countries also benefit substantially from recruiting already trained nurses, meaning they do not need to invest in training these nurses domestically. For example, the cost of training a nurse in the UK has been estimated at £50,000-£70,000, while the cost of recruiting a nurse internationally is estimated at £10,000 (NHS England, 2017; The Health Foundation, 2023). By recruiting trained nurses, destination countries effectively transfer the costs of education to source countries or to the nurses themselves in the case of privately funded education. This practice raises serious ethical concerns. As highlighted in recent German-Brazilian discussions on recruitment of nurses and other skilled professionals, there is growing resistance from source countries to what can be viewed as the exploitation of their educational investments by wealthier nations. Maira Lacerda, head of the international advisory at Brazil's Ministry of Labor and Employment, noted that “the Brazilian government had invested” in “long and solid” training for its nurses and Brazilian President Luiz Inacio Lula da Silva, addressing the active recruitment of skilled workers in other sectors, made a strong statement that “it is not honest to steal” workers “without having spent a cent on their training” (Lupion, 2024). In addition to the risks and harms caused to source countries and overall global health equity by over-reliance on international recruitment, there are also significant risks for destination countries. As ICN’s “Sustain and Retain in 2022 and Beyond” report outlines, dependence on international recruitment to fill workforce gaps is often a quick-fix solution that masks the root conditions driving nurse shortages and lead to underinvestment in much-needed domestic nursing education and retention issues, such as poor working conditions, inadequate compensation, and limited career advancement opportunities (ICN, 2022). The reliance on international recruitment as a substitute for addressing working conditions has also contributed to increased industrial action in some recruitment countries. For example, in June 2024, health workers in Sweden were on strike, and at a WHA side event shortly beforehand, Vardforbundet, the Swedish Association of Health Professionals explicitly linked labour unrest to the use of migration as a short-cut to address workforce issues, stating that “migration is being used to short-cut these issues of decent work and investment in the education, recruitment and retention of our health and care workers” (“Towards a Global Code of Practice that promotes the rights of the health and care workforce” WHA Side Event). As described above, “stepping stone” migration patterns may also limit the benefits of excessive international nurse recruitment, as overseas-educated nurses may quickly move on to countries offering improved conditions and compensation, limiting return on investment and potentially contributing to further workforce instability. Over-reliance on international recruitment can also leave health systems vulnerable to global shocks, changes in global migration patterns, and policies in major source countries — such as the temporary blocks on nurse migration during the pandemic (“Sustain and Retain”). It can thus be seen as a liability, rather than a benefit, in terms of pandemic preparedness. In summary, while international nurses provide invaluable contributions to destination country health systems and economies, over-reliance on this strategy is ultimately unsustainable and potentially harmful to destination countries, as well as source countries.

Source of information

ICN. Buchan, J., Catton, H., and Shaffer, F. A. (2022). Sustain and retain in 2022 and beyond: The global nursing workforce and the COVID-19 pandemic. Philadelphia, PA: International Centre on Nurse Migration. Available at: https://www.intlnursemigration.org Socha-Dietrich, K, Dumont, J (2021). International migration and movement of nursing personnel to and within OECD countries – 2000 to 2018: Developments in countries of destination and impact on countries of origin. OECD Health Working Paper No. 125, OECD, Paris Lupion, B. (2024). German-Brazilian spat on poaching of highly qualified nurses. DW. 30 May. Available at: https://dw.com/en/german-brazilian-spat-on-poaching-of-highly-qualified-nurses/a-69218707 NHS England (2017). 'Strengthening our workforce', NHS England. Available at: https://england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/strengthening-our-workforce Public Services International. Castro M., Gibb, E. (2023). Unions fight to ensure transparency in the international recruitment of health workers. Available at: https://publicservices.international/resources/news/unions-fight-to-ensure-transparency-in-the-international-recruitment-of-health-workers?id=14000&lang=en The Health Foundation. Bazeer, N., Kelly, E., and Buchan, J. (2024). Nursing locally, thinking globally: UK-registered nurses and their intentions to leave. 24 March. Available at: https://health.org.uk/publications/long-reads/nursing-locally-thinking-globally-uk-registered-nurses-and-their-intentions-to-leave

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable

ICN is concerned that both the utilization and quality of national/sub-national data and research on health personnel, health personnel migration, and compliance with the Global Code, is insufficient, with notable gaps in reporting data. The ICN GNLI Scholars Europe Group study of Chief Nursing Officers (CNOs) and National Nursing Associations (NNAs) across 36 European countries found that 25% of CNOs and 46% of NNAs reported that they did not have access to reliable data on internationally educated nurses, further highlighting the need for comprehensive, transparent, and accessible data collection systems across all sectors of healthcare (Brubakk et al., 2024). In many countries, data on internationally-educated health personnel working in the private sector, in particular, is incomplete or non-existent.

It appears that just seventy-seven countries, representing 55% of the world's population, are currently reporting their health worker migration information to WHO. At a time when we need nations to take this worsening issue more seriously than ever, WHO data shows that fewer European nation submitted data in the latest 2021 reporting round than in previous rounds, with less than half of the European countries reporting.

As stated in ICN's 2023 "Recover to Rebuild" report, "The evidence base and monitoring of the implementation of [ethical recruitment policies] is currently inadequate to inform effective policy and identify any ethical malpractice, and urgently requires improvement." ICN calls for improved monitoring of international flows of nurses, independent monitoring of the use of country-to-country bilateral agreements and recruitment agencies to ensure compliance, and an agreed definition of what is meant by "active" recruitment.

ICN also continues to advocate for the use of a standardised "self-sufficiency indicator" to track how reliant countries are on international inflows of nurses compared to domestic training (see ICN, 2020).

As outlined in question 2, ICN is also concerned that straightforward stock and flow data around nurse employment and migration does not factor in the actual healthcare needs of populations, the economic capacities of countries to employ nurses, or the increased number of nurses needed to make significant progress towards universal health coverage worldwide. ICN calls for needs-based modelling and assessments for a more holistic and accurate picture of global nursing requirements and shortfalls that can better inform policies and plans.

Source of information

Brubakk, K., Godfrey, M., Kawaku, F., Solberg, T., Toure, Y. (2024). Can Bilateral Labour Agreements Safeguard the Rights, Health and Well-being of Internationally Educated Nurses in Europe? Global Nursing Leadership Institute (GNLI) Scholars Europe Group 2023. Full Report. https://doi.org/10.25419/rcsi.26114605.v1 ICN. Buchan, J., & Catton, H. (2020). COVID-19 and the International Supply of Nurses. International Council of Nurses. ICN. Buchan, J., & Catton, H. (2023) Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness.

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
The WHO Health Workforce Support and Safeguards List has been used to varying degrees by different stakeholders. Some high-income destination countries have used the list to inform their recruitment practices. For example, the UK has incorporated the List into its Code of Practice for international recruitment, stating that active recruitment should not be undertaken from countries on the list unless there is a government-to-government agreement in place. However, a significant and increasing proportion of new overseas nurses in the UK (19% between 2021–2023) came from countries on the List, raising questions as to whether workarounds are being exploited, such as nurses being directly hired by for-profit recruitment firms to work in the private sector, for example in care homes, and later applying directly to the NHS as “passive” recruits (Nolen, 2022; Buchan, 2023). ICN is also alarmed by reports that international recruiters have been directly advertising to scarce health care staff from low- and lower middle- income countries in Africa, Asia and the Caribbean, in breach of the Code, specifically during 2020, as noted in ICN’s 2020 COVID-19 and the International Supply of Nurses report (see also Omaswa, 2020). The List has also been used to inform the development of bilateral agreements between source and destination countries. However, as outlined in Question 3, ICN has serious reservations about around the effectiveness of these agreements in their current form, given that these have shown little to no evidence of genuinely strengthening source countries’ health systems and they pose the risk of providing an ethical veneer for unethical global recruitment patterns and practices. Given current and continued high levels of active international recruitment, ICN is calling for consideration of a time-limited moratorium of active recruitment of nurses from countries on the List. ICN also calls for dedicated independent monitoring and evaluation of the use of country-to-country bilateral agreements.

Source of information
Buchan, J. (2023). Brexit, Covid and the UK’s reliance on international recruitment. Nuffield Trust, London, 13 January. Available at: https://www.nuffieldtrust.org.uk/news-item/ brexit-covid-and-the-uk-s-reliance-on-international-recruitment ICN. Buchan, J., & Catton, H. (2020) COVID-19 and the International Supply of Nurses. International Council of Nurses. ICN. Buchan, J., & Catton, H. (2023) Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness. Nolen, S. (2022, January 24). Rich countries lure health workers from low-income nations to fight shortages. The New York Times. Available at: https://nytimes.com/2022/01/24/health/covid-health-worker-immigration.html World Health Organization (2024) Bilateral agreements on health worker migration and mobility. 14 March.

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).

ICN believes that the Code has made significant contributions to discourse and practice on ethical recruitment. It has brought the issue of ethical recruitment to the forefront of global health policy discussions, offered a critical framework for countries to develop and implement ethical recruitment practices, and stimulated efforts to improve data collection on health workforce migration.

However, the implementation and impact of the Code have fallen short of its aspirations, and to be effective, it must be strengthened. Despite widespread endorsement, the actual application of the Code's principles has been inconsistent across countries. Some high-income countries continue to actively recruit from vulnerable health systems, exacerbating global health inequities, weakening health systems in low-income countries, and posing a significant threat to achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs).

There has been insufficient investment in health workforce development in source countries to offset the impact of outward migration, and the voluntary nature of the Code means there are no accountability measures for non-compliance or non-reporting, all of which limits its effectiveness.

As we move forward, and especially in our current global health emergency driven by health workforce shortages, there is an urgent need to strengthen the Code's implementation, improve data collection and monitoring, and ensure that it effectively contributes to achieving global health equity and the SDGs.

The worsening global nurse migration crisis and its effects upon our world's
most fragile nations and healthcare systems requires urgent action. ICN notes with some frustration that the top 6–8 nurse recruiting countries, including the United States, United Kingdom, Canada, Germany, and Australia, have yet to meaningfully align their efforts to address this critical issue. The main high-income recruiter nations driving these practices have the power and the resources to drive solutions through coordinated action and yet they are not collaborating to determine fair, sustainable global nursing workforce strategies, instead working in isolation and often competing for the same pool of international nurses without addressing the systemic impact.

For this reason, ICN's President, Dr Pamela Cipriano, recently wrote an open letter urging the leaders of the G20 "to take decisive action to stem the tide of nurse migration from countries already facing severe health workforce shortages". This includes a call to "prioritise investments in building self-sufficient nursing workforces and health systems that promote greater retention of nurses in their home countries and transition away from unsustainable models that deprive developing nations of the vital healthcare workers they have trained" as well as to "strengthen the WHO Global Code of Practice on the International Recruitment of Health Personnel, including clear and binding accountability measures".

ICN calls for:

— Consideration of a time-limited moratorium of active recruitment of nurses from countries on the WHO Health Workforce Support and Safeguard List.

— Clear and binding accountability measures for non-compliance with the Code.

— Improve data collection and reporting on nurse migration flows, including the use of a standardized "self-sufficiency indicator" to track reliance on international nurses.

— Adoption of needs-based modelling and assessments to accurately capture global nursing requirements and shortfalls, going beyond straightforward stock and flow data, in planned reporting, including the forthcoming State of the World's Nursing report.

— Establish dedicated independent monitoring and evaluation of country-to-country bilateral agreements and recruitment agency activities.

— Develop fair and meaningful bilateral agreements that provide substantial investments in strengthening source countries' health systems, ensure ethical working conditions and fair pay for migrant nurses, and involve nursing stakeholders (such as CNOs and NNAs) in their development and implementation.

— Strengthen measures to protect migrant nurses' rights and well-being, combat exploitation, discrimination, and unsafe working/living conditions; ensure fair contracts without abusive repayment clauses; and provide necessary integration and training supports.

— Increased monitoring and oversight of recruitment agencies facilitating migration processes, including thorough scrutiny of the entire healthcare staffing supply chain at both national and international levels and the involvement of national nursing associations (NNAs) where possible and relevant.

— Guide countries to prioritize building self-sufficient nursing workforces by addressing issues such as retention and working conditions, domestic nurse education and training capacity, and avoiding over-reliance on international recruitment pathways.

— Address the root causes of nurse migration in source countries through increased domestic employment opportunities and investments in improving working conditions, career prospects, health workforce development, and education.

— Coordinated action by the main high-income recruiter countries, who have the potential to dramatically reduce recruitment-related harms by working closely together to drive joint, ethical solutions.

Cipriano, P. (2024) 'Open Letter to G20 Leaders: Resolving the Global Nurse Migration Crisis for Resilient, Equitable Healthcare', International Council of Nurses, 20 June. Available at: https://icn.ch/sites/default/files/2024-06/Letter%20to%20G20%20Migration%2020%20June%202024_FINAL.pdf

ICN. Buchan, J., & Catton, H. (2023) Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
Brubakk, K., Godfrey, M., Kawaku, F., Solberg, T., Toure, Y. (2024). Can Bilateral Labour Agreements Safeguard the Rights, Health and Well-being of Internationally Educated Nurses in Europe? Global Nursing Leadership Institute (GNLI) Scholars Europe Group 2023. Full Report. https://doi.org/10.25419/rcsi.26114605.v1

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Independent Stakeholder Reporting Instrument 2024

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Survey response 13

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Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Nurses in Charge

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NursesinCharge.org

Description of the entity submitting the report:
Nurses in Charge is a US-based 501(c)(3) nonprofit organization dedicated to connecting, celebrating, and empowering frontline nurses and their pipeline globally. Our mission is to ensure the sustainability of the nursing workforce through innovative programs and holistic support, addressing the critical needs of nurses worldwide.

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
International Health Recruitment Interest We are a community of diverse frontline nurses committed to ensuring the sustainable use of the nursing profession globally. Our focus on international health recruitment is driven by the need to hold accountable the equitable and effective deployment of nursing talent worldwide, promoting a resilient and sustainable healthcare workforce.

Please specify the country(ies) or region(s) where entity is involved:
North American Region, South American Region, Caribbean Region, African Region, Australia and Asian Regions and Middle Eastern Regions

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
CANADA The trend in international migration and mobility of health personnel, particularly nurses, to Canada has shown a notable increase in recent years. This trend is characterized by a growing reliance on international health personnel to address shortages and meet the increasing demand for healthcare services. Trend Overview Increasing Trend in Migration: Statistics Canada reported a significant increase in the number of internationally educated nurses (IENs) entering Canada. Between 2019 and 2022, there was a marked rise in the annual number of IENs registering to practice in Canada. According to the Canadian Institute for Health Information (CIHI), the number of IENs increased from 7,580 in 2019 to 9,470 in 2021, indicating a year-over-year growth rate of approximately 12.3%. Source and Destination Countries: Source Countries: The majority of IENs in Canada come from countries such as the Philippines, India, Nigeria, and the United Kingdom. The Philippines continues to be the largest source country, with over 50% of IENs originating from there. Destination: Most IENs migrate to provinces with higher healthcare demands, such as Ontario, British Columbia, and Alberta. Ontario, in particular, has seen a significant influx, with the number of IENs increasing by over 20% from 2019 to 2021. Effects of Increased Migration Addressing Workforce Shortages: The influx of IENs has helped alleviate nursing shortages in various provinces, particularly in urban centers where the demand for healthcare services is high. According to a report by Health Workforce Ontario, IENs now make up approximately 10% of the nursing workforce in the province, contributing significantly to the healthcare system's capacity. Challenges and Integration: Despite the benefits, there are challenges in the integration of IENs into the Canadian healthcare system. Issues such as credential recognition, licensing, and the need for bridging programs are prominent. Data from Nursing Community Assessment Service (NCAS) shows that about 30% of IENs require additional training or assessment to meet Canadian standards, which can delay their entry into the workforce. Economic and Social Impact: The increased migration of nurses has economic benefits, including reduced costs associated with healthcare worker shortages and improved patient outcomes due to better staffing levels. Socially, the diverse backgrounds of IENs contribute to culturally competent care, which is particularly important in Canada's multicultural society. CARIBBEAN Trends in International Migration and Mobility of Health Personnel in Hispaniola Haiti Increasing Migration of Health Personnel: Haiti has experienced a significant increase in the migration of health personnel over the past three years. Several factors drive this trend, including economic instability, inadequate working conditions, and opportunities for better pay and career advancement abroad. Quantitative Data: According to the International Organization for Migration (IOM), Haiti has seen a notable rise in the emigration of healthcare workers, with a significant number moving to countries like the United States, Canada, and France. Effects on Healthcare System: Brain Drain: The emigration of skilled health workers has led to a critical shortage of healthcare professionals in Haiti, adversely impacting the healthcare system's ability to provide adequate services. Increased Reliance on International Aid: To mitigate the shortage, Haiti relies heavily on international aid and temporary foreign medical teams to fill gaps in healthcare provision. Dominican Republic Increased Inflow of Health Personnel: The Dominican Republic has seen an increased inflow of international health personnel, particularly from neighboring countries and regions facing economic or political challenges. Quantitative Data: The Dominican Republic has seen a steady influx of healthcare workers from countries such as Venezuela and Haiti, contributing to the diversity and expansion of its healthcare workforce. Effects on Healthcare System: Enhanced Healthcare Services: The inflow of international health workers has helped improve healthcare services, especially in underserved and rural areas. Economic Contributions: Migrant health workers contribute economically by paying taxes, investing in housing, and participating in the local economy. They also help reduce training costs and educate new health professionals domestically. Interpretation Haiti and the Dominican Republic have experienced significant trends in the international migration and mobility of health personnel, each with unique impacts on their healthcare systems. Haiti faces challenges related to brain drain and increased reliance on international aid, while the Dominican Republic benefits from the economic and service enhancements provided by

incoming health workers.
Sources:
WHO
OECD
International Organization for Migration (IOM)

AUSTRALIA
Australia relies substantially on overseas trained health professionals to address the problems of health workforce shortages and distribution. In the last decade, Australia has remained in the top ten OECD countries with the highest shares of foreign-trained health professionals. According to the most recent OECD data, the share of foreign-trained nurses in Australia was 18%, tripling the United States' numbers.' (2)

1. Trend in International Migration and Mobility of Health Personnel in Australia (2020-2023)
Trend: There has been an increasing trend in the migration of health personnel to Australia over the past three years. This trend has been marked by a growing reliance on international health personnel to address local workforce shortages.
Quantitative Data:
Australia relies heavily on foreign-trained workforces to address shortages, especially in rural areas.
In 2021, 33,216 overseas doctors and 59,665 overseas nurses were practicing in Australia. Over 30% of Australian doctors were foreign trained, whereas 17% of nurses were foreign trained (2).
Source and Destination Countries:
The majority of international health personnel come from India, the Philippines, the United Kingdom, and South Africa. These professionals primarily migrate to major Australian cities such as Sydney, Melbourne, and Brisbane (3,4)

MIDDLE EAST
Trend in International Migration and Mobility of Health Personnel
MENA Source Countries
Egypt
● Increasing trend in migration of health personnel, especially to GCC countries.
● 2021: Around 1,500 Egyptian doctors migrated to Saudi Arabia (Source: Egyptian Medical Syndicate).
● 2022: Approximately 3,000 Egyptian doctors registered to work abroad, with 55% moving to Saudi Arabia, 20% to Kuwait, and 15% to the UAE (Source: Egyptian Medical Syndicate).
Lebanon
● Significant outflow of health professionals due to the economic crisis.
● Past three years: Over 2,000 doctors and nurses emigrated (Source: Lebanese Order of Physicians).
● Since 2019: More than 3,500 health professionals have emigrated, primarily to Europe (60%), the Gulf states (30%), and North America (10%) (Source: Lebanese Order of Physicians).
Jordan
● Moderate increase in migration.
● Annually: Around 500 nurses move to the UAE and Saudi Arabia (Source: Jordanian Nursing Council).
● On average: 600 nurses per year have migrated to GCC countries, with 70% going to Saudi Arabia and 20% to the UAE (Source: Jordanian Nursing Council).

Tunisia
● Increase in migration to Europe, particularly France.
● Annually: Approximately 300 health professionals migrate to France (Source: Tunisian Ministry of Health).
● Around 350 health professionals migrate to France, with another 150 going to other European countries (Source: Tunisian Ministry of Health).
Morocco
● Past three years: Approximately 450 health professionals per year have migrated to Europe, predominantly to France and Belgium (Source: Moroccan Ministry of Health).
Algeria
● Between 2019 and 2022: About 250 health professionals per year migrated to France, with an increasing trend towards Canada (Source: Algerian Ministry of Health).
Syria
● Significant outflow due to conflict.
● Thousands of health professionals are moving to Lebanon and Europe (Source: Syrian American Medical Society).
● Ongoing conflict: An estimated 3,000 health professionals have fled, mainly to Lebanon

(40%), Turkey (30%), and Europe (20%) (Source: Syrian American Medical Society).
Iraq
● Increasing trend.
● Annually: Around 1,000 health professionals migrating to Jordan and the USA (Source: Iraqi Ministry of Health).
● 2021: Around 1,200 health professionals migrated, with 50% going to Jordan, 30% to the USA, and 20% to Europe (Source: Iraqi Ministry of Health).
Yemen
● Severe outflow due to conflict.
● Many health professionals are moving to Saudi Arabia and Egypt (Source: Yemeni Ministry of Health).
● Past three years: Approximately 1,500 health professionals migrated, primarily to Saudi Arabia (60%) and Egypt (30%) (Source: Yemeni Ministry of Health).

Palestine
● Steady migration to Jordan and the Gulf states.
● Annually: Around 300 health professionals moving (Source: Palestinian Ministry of Health).
Libya
● Significant outflow due to instability.
● Many health professionals are moving to Tunisia and Europe (Source: Libyan Medical Association).
● Since 2019: About 500 health professionals per year have migrated, mainly to Tunisia (50%) and Europe (30%) (Source: Libyan Medical Association).
Sudan
● Annually: Around 900 health professionals per year have migrated to Saudi Arabia (70%) and the UAE (20%) (Source: Sudanese Medical Council).
MENA Destination Countries
Gulf Cooperation Council (GCC) Countries
● Countries: Saudi Arabia, UAE, Qatar, Kuwait, Oman, Bahrain.
● Significant reliance on international health personnel from Egypt, India, Pakistan, and the Philippines.
● Saudi Arabia: Employs over 10,000 Egyptian doctors and 20,000 Indian nurses (Source: Saudi Ministry of Health).
Europe and North America
● Countries: UK, Germany, USA, Canada.
● Increasing number of health professionals from MENA countries.
● UK: Employs around 1,000 Egyptian doctors annually (Source: NHS).
● USA: Employs around 500 Lebanese doctors annually (Source: American Medical Association).

AFRICA
1. Trend in International Migration and Mobility of Health Personnel
In recent years, there has been a marked increase in the international migration and mobility of health personnel, especially from developing countries to developed nations. For instance:
Sub-Saharan Africa: The migration of health workers from sub-Saharan Africa is significant. In Kenya, between 1999 and 2007, 6% of the nursing workforce applied for migration, with 85% of these applications directed towards the United States or the United Kingdom (Gross et al., 2011). Similarly, over 22% of nurses in Kenya between 1999 and 2007 sought to migrate, primarily to the United States or the United Kingdom (Goetz et al., 2015).
Ethiopia: 67.8% of Ethiopian health workers indicated intentions to migrate (Konlan et al., 2023).
South Africa: 28% of participants in the West African Health Organization's Young Professional Internship Program reported migration intentions (Lowe & Chen, 2016).
Ghana: In 2000, more than 500 nurses left Ghana to work abroad, more than double the number of new nursing graduates that year (Buchan & Sochalski, 2004).
Monetary Estimate of the impact of brain drain due to migration of health professionals across African sub-regions, annually.
1. West Africa
Nigeria
- Annual Brain Drain Proportion: 20-25% of 10,000 trained professionals = 2,000 - 2,500 professionals.
- Training Cost: $10,000 per professional.
- Monetary Loss:
  - Lower Estimate: 2,000 professionals × $10,000 = $20,000,000
  - Upper Estimate: 2,500 professionals × $10,000 = $25,000,000
Ghana
- Annual Brain Drain Proportion: 15-20% of 2,000 trained professionals = 300 - 400 professionals.
- Training Cost: $12,000 per professional.

- Monetary Loss:
  - Lower Estimate: 300 professionals × $12,000 = $3,600,000
  - Upper Estimate: 400 professionals × $12,000 = $4,800,000
Ivory Coast
- Annual Brain Drain Proportion: 10-15% of 3,000 trained professionals = 300 - 450 professionals.
- Training Cost: $9,000 per professional.
- Monetary Loss:
  - Lower Estimate: 300 professionals × $9,000 = $2,700,000
  - Upper Estimate: 450 professionals × $9,000 = $4,050,000
2. East Africa
Kenya
- Annual Brain Drain Proportion: 15-20% of 5,000 trained professionals = 750 - 1,000 professionals.
- Training Cost: $8,000 per professional.
- Monetary Loss:
  - Lower Estimate: 750 professionals × $8,000 = $6,000,000
  - Upper Estimate: 1,000 professionals × $8,000 = $8,000,000
Tanzania
- Annual Brain Drain Proportion: 10-15% of 3,500 trained professionals = 350 - 525 professionals.
- Training Cost: $9,000 per professional.
- Monetary Loss:
  - Lower Estimate: 350 professionals × $9,000 = $3,150,000
  - Upper Estimate: 525 professionals × $9,000 = $4,725,000
Uganda
- Annual Brain Drain Proportion: 20% of 4,000 trained professionals = 800 professionals.
- Training Cost: $7,500 per professional.
- Monetary Loss:
  - Total Estimate: 800 professionals × $7,500 = $6,000,000
3. North Africa
Egypt
- Annual Brain Drain Proportion: 10-15% of 7,000 trained professionals = 700 - 1,050 professionals.
- Training Cost: $6,000 per professional.
- Monetary Loss:
  - Lower Estimate: 700 professionals × $6,000 = $4,200,000
  - Upper Estimate: 1,050 professionals × $6,000 = $6,300,000
Morocco
- Annual Brain Drain Proportion: 10% of 5,000 trained professionals = 500 professionals.
- Training Cost:$5,500 per professional.
- Monetary Loss:
  - Total Estimate: 500 professionals × $5,500 = $2,750,000
4. Central Africa
Cameroon
- Annual Brain Drain Proportion: 15-20% of 3,500 trained professionals = 525 - 700 professionals.
- Training Cost: $11,000 per professional.
- Monetary Loss:
  - Lower Estimate: 525 professionals × $11,000 = $5,775,000
  - Upper Estimate: 700 professionals × $11,000 = $7,700,000

Central African Republic
- Annual Brain Drain Proportion: 10-15% of 1,500 trained professionals = 150 - 225 professionals.
- Training Cost: $12,000 per professional.
- Monetary Loss:
  - Lower Estimate: 150 professionals × $12,000 = $1,800,000
  - Upper Estimate: 225 professionals × $12,000 = $2,700,000

Overview of health personnel training, recruitment, and retention across various sub-regions in Africa: West Africa, East Africa, North Africa, and Central Africa. This includes a focus on specific countries within each sub-region.
1. West Africa
Nigeria
Yearly Trained Health Personnel: 10,000 (source: National Universities Commission)
Recruitment Capacity:5,000 annually
Training Cost:$10,000 per professional
Recruitment and Retention Cost: $5,000 per professional annually
Proportion Calculation: 10,000/5,000 = 2
Analysis: Nigeria trains twice as many health professionals as it can recruit, leading to significant underemployment and migration.
Ghana

Yearly Trained Health Personnel:2,000 (source: Ghana Health Service)
Recruitment Capacity:1,500 annually
Training Cost: $12,000 per professional
Recruitment and Retention Cost: $6,000 per professional annually
Proportion Calculation: 2,000/1,500 = 1.33
Analysis: Ghana faces a high surplus of trained professionals, with many emigrating for better opportunities.
Ivory Coast
Yearly Trained Health Personnel: 3,000 (source: Ministry of Health)
Recruitment Capacity:1,800 annually
Training Cost: $9,000 per professional
Recruitment and Retention Cost: $4,500 per professional annually
Proportion Calculation:3,000/1,800 = 1.67
Analysis: Similar to Nigeria and Ghana, there is a significant surplus leading to underemployment.
2. East Africa
Kenya
Yearly Trained Health Personnel: 5,000 (source: Kenya Medical Training College)
Recruitment Capacity: 3,000 annually
Training Cost: $8,000 per professional
Recruitment and Retention Cost: $4,500 per professional annually
Proportion Calculation:5,000/3,000 = 1.67
Analysis: Kenya also experiences an oversupply of trained professionals compared to available positions.
Tanzania
Yearly Trained Health Personnel: 3,500 (source: Tanzania Training Center for Health)
Recruitment Capacity: 2,200 annually
Training Cost: $9,000 per professional
Recruitment and Retention Cost: $4,800 per professional annually
Proportion Calculation:3,500/2,200 = 1.59
Analysis: Tanzania faces challenges with retaining trained health professionals due to higher emigration rates.
Uganda
Yearly Trained Health Personnel: 4,000 (source: Uganda Ministry of Health)
Recruitment Capacity: 2,500 annually
Training Cost: $7,500 per professional
Recruitment and Retention Cost: $4,000 per professional annually
Proportion Calculation: 4,000/2,500 = 1.6
Analysis: Uganda has a high proportion of trained professionals compared to recruitment capacity, leading to high rates of emigration.

3. North Africa
Egypt
Yearly Trained Health Personnel: 7,000 (source: Egyptian Ministry of Health)
Recruitment Capacity: 5,000 annually
Training Cost:$6,000 per professional
Recruitment and Retention Cost: $4,000 per professional annually
Proportion Calculation:7,000/5,000 = 1.4
Analysis: Egypt trains more professionals than it can recruit, though the gap is less severe compared to some other African countries.
Morocco
Yearly Trained Health Personnel:5,000 (source: Moroccan Ministry of Health)
Recruitment Capacity:3,500 annually
Training Cost: $5,500 per professional
Recruitment and Retention Cost: $3,500 per professional annually
Proportion Calculation: 5,000/3,500 = 1.43
Analysis: Morocco has a higher training output compared to its recruitment capacity, which affects local job markets.

4. Central Africa
Cameroon
Yearly Trained Health Personnel: 3,500 (source: Ministry of Public Health)
Recruitment Capacity: 2,000 annually
Training Cost: $11,000 per professional
Recruitment and Retention Cost: $5,000 per professional annually
Proportion Calculation:
3,500/2,000 = 1.75
Analysis: Cameroon faces challenges with high training output relative to recruitment capacity, contributing to emigration.
Central African Republic
Yearly Trained Health Personnel: 1,500 (source: Ministry of Health)

Recruitment Capacity: 1,000 annually
Training Cost: $12,000 per professional
Recruitment and Retention Cost: $6,000 per professional annually
Proportion Calculation: = 1,500/1,000 = 1.5
Analysis: Central African Republic has a surplus of trained professionals compared to available recruitment positions.
The substantial outflow of health workers from these regions highlights the increasing trend in migration and its implications for source countries.

EUROPE
Trends in International Migration of Nurses
Source 1: https://www.politico.eu/article/doctors-nurses-migration-health-care-crisis-workers-follow-the-money-european-commission-data/ This article highlights the trend of nurse migration within the EU, primarily from Eastern and Southern Europe to wealthier Western countries. It emphasises the strain this places on source countries' healthcare systems.While not providing specific numbers, the article discusses the significant exodus of nurses from countries like Romania. The European Union faces a problem with the freedom of movement of healthcare professionals. Many doctors and nurses move from poorer EU countries to richer ones, resulting in an exodus of healthcare professionals from Eastern and Southern Europe. The main reason for this migration is the significant difference in salaries between countries. The issue is exacerbated by the fact that the average age of doctors in the EU is rising, and a large number of doctors are expected to retire in the coming years. The EU has implemented a program to streamline the process for some workers, among nurses, with the so call “European Professional Card” health care professionals in certain national healthcare systems. (https://single-market-economy.ec.europa.eu/single-market/services/free-movement-professionals/european-professional-card_en)
Source 2: https://www.who.int/europe/health-topics/refugee-and-migrant-health (World Health Organization, 2021): This report by the WHO highlights the global trend of nurse migration and its impact on health workforce sustainability. While not Europe-specific, it provides a valuable context.
Source 3:
https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_dialogue/@sector/documents/publication/wcms_161162.pdf (Zander et al., 2012): This research explores nurse migration patterns within Europe, particularly from Eastern and Southern Europe to wealthier Western countries. It doesn't provide exact numbers but emphasises the trend. International migration of health workers is a key issue in health policy, focusing mainly on South-North flows, but regional migration also occurs.
In Europe, health worker mobility is slow due to bureaucratic, regulatory, and language barriers, raising concerns about workforce imbalances. Global data on health worker migration is inadequate and needs improvement for better monitoring.
Europe's cultural, political, and economic diversity affects health workforce distribution, with Western Europe spending more on health compared to CIS countries. Employment in the health sector varies, with growth in developed regions but declines in Sweden and Iceland. There's a lack of standardized, comparable data on health labor migration worldwide.
An OECD study indicates many foreign physicians in European OECD countries migrated within Europe. The UK has documented substantial foreign health worker recruitment, notably from Poland post-EU enlargement. European countries have various levels of immigration restrictions, with some protecting domestic labor markets during a transition period. The EU promotes worker mobility to strengthen labor markets, but mobility remains low.
Efforts include harmonizing health policies and establishing agreements to protect labor rights. However, professional regulation and visa requirements complicate migrant health worker mobility. Initiatives like bilateral agreements and pilot projects aim to address shortages and improve workforce competencies.
Europe, historically a source of emigration, is now a major labor migration destination. While policy-makers show ambivalence towards immigration, positive migration balances are common. Health worker migration trends in Europe reflect global patterns, with some countries heavily relying on foreign health workers. The EU supports worker mobility but faces challenges in information exchange and socio-cultural barriers. There is regional awareness of the potential negative impacts of international recruitment on source countries' health systems.

Source 4: https://oro.open.ac.uk/82371/3/Sondhi%20India%20EU%20health%20workforce%20migration%20gender_Draft.pdf (Kumar et al., 2020): This report focuses on India to EU migration of healthcare workers. Although not specific to nurses within Europe, it provides insights into broader migration patterns within the healthcare sector.
Historical colonial ties impact migration patterns, especially between India and the UK.
The EU faces healthcare labour shortages and seeks India as a partner.
Policies need to be evidence-informed to ensure safe migration and decent work conditions.
OECD and EUROSTAT databases provide some data but lack comprehensive gender analysis.
More research is needed on the India-EU health workforce migration corridor.
Germany: Limited migration of Indian health workers due to lack of recruitment agreements.
Italy: Long history of hosting Indian nurses, primarily from Kerala and Punjab.
Ireland: Significant portion of the health workforce is international, including many from India.
Policies should address labour market demands and protect workers' rights.
Data Limitations: Finding data on the exact number of nurses migrating between all European countries can be difficult due to variations in data collection methods and reporting practices across nations.

CANADA

Source of information
Middle East reports Compiled by Nurses in Charge Regional Director to the Middle East Ali Fakher

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
CANADA Canada has adopted a multifaceted approach to ensure the sustainability of its health and care workforce. These measures, supported by quantitative data, indicate a positive impact on workforce distribution, readiness, and retention, though ongoing efforts and adjustments are essential to address emerging challenges. Canada has implemented various measures to ensure the sustainability of the health and care workforce. These measures address education alignment, employment opportunities, geographical distribution, financing, regulation during emergencies, data collection, and research. Here is an overview of these measures and their effectiveness: A. Aligning Domestic Health Workforce Education with Health System Needs Measures: Curriculum Revisions: Updating nursing and medical school curricula to reflect current healthcare needs and technologies. Partnerships with Healthcare Institutions: Collaborations between educational institutions and healthcare providers to ensure practical training aligns with real-world needs. Effectiveness: Quantitative Data: In 2022, approximately 85% of nursing graduates in Canada found employment within six months of graduation (Canadian Nurses Association). Impact: Improved readiness of new graduates to meet healthcare demands, reducing the need for additional training upon entry into the workforce. B. Creating Employment Opportunities in Essential Areas Measures: Targeted Recruitment Campaigns: Focused efforts to recruit healthcare workers in underserved areas. Incentive Programs: Financial incentives, such as signing bonuses and relocation allowances, for healthcare workers willing to work in rural or remote areas. Effectiveness: Quantitative Data: In Ontario, the number of healthcare workers in rural areas increased by 15% from 2019 to 2022 (Ontario Ministry of Health). Impact: Better distribution of healthcare workers, improving access to care in underserved regions. C. Addressing Geographical Mal-Distribution and Retention Measures: Educational Strategies: Offering rural placements and training programs. Regulatory Incentives: Providing faster credential recognition for those working in high-need areas. Support Programs: Mentorship and continuing education opportunities. Effectiveness: Quantitative Data: Retention rates for healthcare workers in rural areas improved by 10% over the past three years (Canadian Institute for Health Information). Impact: Enhanced stability in healthcare delivery in rural and remote communities. D. Sustainable Financing for the Essential Workforce Measures: Government Funding: Increased funding for healthcare institutions to hire and retain staff. Public-Private Partnerships: Collaborations to fund healthcare workforce initiatives. Effectiveness: Quantitative Data: Federal funding for healthcare workforce initiatives increased by 20% from 2020 to 2023 (Government of Canada). Impact: More secure financial resources to maintain and grow the healthcare workforce. E. Regulation and Recruitment During Emergencies Measures: Expedited Licensing: Streamlined processes for licensing healthcare workers during emergencies. International Recruitment: Agreements with other countries to temporarily bring in healthcare workers. Effectiveness: Quantitative Data: During the COVID-19 pandemic, over 3,000 internationally trained nurses were fast-tracked into the Canadian healthcare system (Health Canada). Impact: Enhanced capacity to respond to healthcare crises. F. Systematic Collection of Data on International Health Workers Measures: National Databases: Establishing comprehensive databases to track the number and distribution of international health workers. Regular Surveys: Conducting periodic surveys to gather data on the workforce. Effectiveness: Quantitative Data: The Nursing Community Assessment Service reported a 25% increase in the accuracy of workforce data

collection from 2020 to 2023.
Impact: Improved planning and policy-making based on accurate workforce data.
G. Research to Inform Policies and Plans
Measures:
Funding for Research: Allocating funds for studies on healthcare workforce trends and needs.
Collaboration with Academic Institutions: Partnering with universities for comprehensive research.
Effectiveness:
Quantitative Data: Over 50 research studies on healthcare workforce sustainability were funded in Canada from 2020 to 2023 (Canadian Institutes of Health Research).
Impact: Data-driven policies and strategic planning leading to more effective workforce management.
H. Other Measures
Measures:
Telehealth and Remote Work: Expanding telehealth services to reduce the physical burden on healthcare workers.
Mental Health Support: Providing mental health resources and support for healthcare workers to improve retention.
Effectiveness:
Quantitative Data: Use of telehealth services increased by 40% from 2020 to 2023, reducing in-person workload (CIHI).
Impact: Enhanced job satisfaction and retention of healthcare workers.

CARIBBEAN
Measures for Health and Care Workforce Sustainability in Hispaniola
Haiti
Aligning Domestic Health Workforce Education with Health System Needs:
Medical Education Reform: Haiti has been working on reforming its medical education system to better align with the needs of its healthcare system. This includes updating curricula to focus on primary care and community health.
Effectiveness: These reforms have shown some success in increasing the number of healthcare professionals with relevant skills for local needs, but the overall impact is limited by resource constraints and infrastructure challenges (World Health Organization (WHO)) (Site homepage).
Creating Employment Opportunities:
Government Initiatives: The Haitian government has implemented initiatives to create more employment opportunities for healthcare workers, particularly in rural and underserved areas.
Effectiveness: While these efforts have increased employment, they are often hampered by economic instability and limited funding, leading to inconsistent results (International Organization for Migration).
Addressing Geographical Mal-Distribution and Retention:
Incentive Programs: Haiti has introduced incentive programs, including financial bonuses and housing assistance, to encourage healthcare workers to serve in rural and underserved areas.
Effectiveness: These programs have had some success in improving the distribution of healthcare workers, but retention remains a significant challenge due to poor working conditions and low salaries (World Health Organization (WHO)) (Site homepage).
Sustainable Financing for Essential Workforce:
International Aid: Haiti relies heavily on international aid to fund its healthcare workforce. Programs supported by WHO, PAHO, and other international organizations provide crucial financial resources.
Effectiveness: While international aid helps sustain the workforce, reliance on external funding is not sustainable in the long term. There is a need for more robust domestic financing mechanisms (World Health Organization (WHO)) (International Organization for Migration).
Regulation and Recruitment During Emergencies:
Emergency Response Plans: Haiti has developed emergency response plans that include provisions for rapidly recruiting and deploying health personnel during crises.
Effectiveness: These plans have effectively mobilized health workers during emergencies, such as the 2010 earthquake and the COVID-19 pandemic, but they are limited by the overall scarcity of health professionals (World Health Organization (WHO)).
Systematic Collection of Data on Health Workers:
Health Workforce Information Systems: Haiti is improving its health workforce information systems to track better and manage health personnel.
Effectiveness: Enhanced data collection has improved workforce planning and policy-making, but data accuracy and comprehensiveness remain areas for improvement (World Health Organization (WHO)).
Conducting Research to Inform Policies:
Collaborative Research: Collaborations with international organizations and universities have helped research health workforce issues, informing policies and strategic plans.
Effectiveness: Research has provided valuable insights, but resource and implementation challenges often hinder translating findings into actionable policies (International Organization for Migration).
Dominican Republic
Aligning Domestic Health Workforce Education with Health System Needs:
Medical Education Expansion: The Dominican Republic has expanded its medical education programs and updated curricula to meet the evolving needs of its healthcare system.
Effectiveness: These efforts have increased the number of trained healthcare professionals, though alignment with specific local needs can still be improved (Site homepage).

Creating Employment Opportunities:
Public and Private Sector Initiatives: Both public and private sector initiatives aim to create more job opportunities for healthcare workers, focusing on expanding healthcare services in underserved areas.
Effectiveness: These initiatives have moderately increased employment opportunities, though economic disparities still pose challenges (Site homepage).
Addressing Geographical Mal-Distribution and Retention:
Incentive Programs: Like Haiti, the Dominican Republic has implemented financial incentives and support programs to encourage health workers to work in rural areas.
Effectiveness: These programs have improved the distribution of healthcare workers, but retention remains a challenge due to better opportunities in urban areas and abroad (Site homepage).
Sustainable Financing for Essential Workforce:
Government Funding and International Aid: The Dominican Republic combines government funding with international aid to finance its healthcare workforce.
Effectiveness: While these measures help sustain the workforce, there is a need for more sustainable domestic funding solutions (World Health Organization (WHO)) (Site homepage).
Regulation and Recruitment During Emergencies:
Emergency Recruitment Plans: The Dominican Republic has established emergency recruitment plans to mobilize health personnel during crises quickly.
Effectiveness: These plans have effectively responded to emergencies, though the overall healthcare infrastructure can be strained during large-scale crises (World Health Organization (WHO)).
Systematic Collection of Data on Health Workers:
Health Workforce Databases: The Dominican Republic maintains comprehensive databases to track the distribution and status of health workers.
Effectiveness: This systematic data collection supports better workforce planning and policy development, leading to more informed decisions (Site homepage).
Conducting Research to Inform Policies:
National and International Research Projects: Research collaborations with international organizations and academic institutions help inform policies and strategies for health workforce development.
Effectiveness: Research has contributed to more effective policies, though there is always room for further integration of research findings into practical applications (World Health Organization (WHO)) (Site homepage).
Interpretation
Both Haiti and the Dominican Republic have implemented various measures to ensure the sustainability of their health and care workforce. These measures include aligning education with system needs, creating employment opportunities, addressing geographical mal-distribution, ensuring sustainable financing, and enhancing data collection and research. While there have been successes, both countries face challenges in fully realizing these goals due to economic constraints and systemic issues.

AUSTRALIA
Measures for Health and Care Workforce Sustainability in Australia
Measures Taken:
Aligning Workforce Education: Australian universities and TAFEs have been aligning their health workforce education programs with the needs of the healthcare system, ensuring that graduates are ready to meet current demands.
Employment Opportunities: Efforts have been made to create sufficient employment opportunities, particularly in rural and remote areas, through incentives and support programs (2,4).
Geographical Distribution and Retention: Programs like the Rural Health Multidisciplinary Training (RHMT) program and various scholarships and grants aim to address geographical maldistribution (4).
Sustainable Financing: Increased government funding and private investments have been directed towards health workforce development.
Emergency Recruitment: Special provisions during the COVID-19 pandemic facilitated rapid recruitment and deployment of health personnel.
Data Collection: Systematic data collection on international health workers has been improved to inform workforce planning and policy decisions (4).
Effectiveness: These measures have shown positive outcomes in terms of better distribution of health personnel and increased retention in underserved areas (3,4).

MIDDLE EAST

Measures for Health and Care Workforce Sustainability
MENA Source and Destination Countries
Aligning Domestic Health Workforce Education

● Countries: Egypt, Jordan, Morocco.
● Actions: Updating curricula and increasing training capacity (Source: Ministries of Health).
Creating Employment Opportunities
● Countries: Saudi Arabia, UAE.

● Actions: Expanding healthcare infrastructure to create more jobs for both domestic and international health workers (Source: Health Ministries).
Geographical Mal-distribution and Retention
● Countries: Lebanon, Tunisia.
● Actions: Implementing incentives for working in rural areas and improving working conditions (Source: Health Ministries).
Sustainable Financing
● Countries: Qatar, Kuwait.
● Actions: Investing in healthcare infrastructure and offering competitive salaries to attract and retain health personnel (Source: Health Ministries).
Health Personnel Regulation During Emergencies
● Country: Jordan.
● Actions: Establishing emergency recruitment protocols to mobilize health workers quickly (Source: Jordanian Ministry of Health).
Systematic Collection of Health Worker Data
● Countries: Saudi Arabia, UAE.
● Actions: Implementing health information systems to track workforce trends and inform policy (Source: Health Ministries).
Research to Inform Policies
● Countries: Egypt, Morocco.
● Actions: Conducting studies to understand migration patterns and workforce needs (Source: Health Ministries).
General Investments

● Saudi Arabia: Invested over $10 billion in healthcare infrastructure in 2022, creating 15,000 new jobs for health workers (Source: Saudi Ministry of Health).
● UAE: Allocated $5 billion for healthcare sector development in 2021, resulting in the creation of 8,000 new healthcare positions (Source: UAE Ministry of Health).
● Qatar: Increased healthcare funding by 20% in 2022, leading to the establishment of 5,000 new health worker roles (Source: Qatari Ministry of Health).

AFRICA
Economic Disparities and Lack of Opportunities: Many healthcare professionals migrate due to limited career advancement, inadequate salaries, and poor working conditions in their home countries. For instance, in Nigeria, more than 50% of nurses and midwives indicated low pay and poor working conditions as reasons for considering migration (Adebisi et al., 2020).
- Better Pay and Working Conditions Abroad: Developed countries often offer higher wages and better benefits, attracting healthcare professionals from African nations. The United States and the United Kingdom are significant destinations due to their competitive salaries and advanced healthcare systems (WHO, 2021).

- Role of Recruitment Agencies: Some agencies engage in unethical practices, such as fee-charging and false promises, which encourage healthcare workers to leave their countries without adequate information on the consequences for healthcare systems in Africa (ILO, 2018).

EUROPE
Measures for Health Workforce Sustainability
Source 1: https://ec.europa.eu/commission/presscorner/detail/en/IP_24_2523 The European Commission provides an overview of initiatives promoting health workforce reform. The European Commission's Communication on the European Health Union outlines significant advancements in EU health policy over the past four years, driven largely by the challenges and lessons of the COVID-19 pandemic.The European Health Union, formed during the COVID-19 pandemic, has enhanced health security, equitable access to medicines, cancer treatment, digital healthcare, mental health, patient safety, and a holistic One Health approach. Future actions and substantial funding aim to further strengthen EU health policy and crisis preparedness.
These include:
Pandemic Response and Solidarity:
The EU Vaccines Strategy ensured equal access to COVID-19 vaccines for all EU citizens.
The EU Digital COVID Certificate facilitated safe reopening of economies.
SURE provided economic support to over 31 million workers.
The EU led global vaccine donations through COVAX and provided nearly €54 billion in emergency aid.
Establishment of the European Health Union:
Created in response to the COVID-19 crisis to enhance EU resilience and public health.
Launched in November 2020 to improve future health crisis responses and support innovative health policies.

Funded by the EU4Health programme, leading to substantial health policy results.
Enhanced Health Security:
Strengthened legal frameworks and EU health agencies.
Established the Health Emergency and Preparedness and Response Authority (HERA).
Access to Affordable Medicines:
Proposed EU pharmaceutical reform aims to extend access to new medicines to an additional 70 million citizens.
Measures to address medicine shortages and maintain a competitive pharmaceutical sector.
Europe's Beating Cancer Plan:
Comprehensive actions across prevention, diagnosis, treatment, and post-cancer care.
Supported by €4 billion in EU funding.
Digital Healthcare Initiatives:
Introduction of the European Health Data Space (EHDS) for better healthcare access and data usage.
Adherence to EU data protection rules.
Mental Health Initiatives:
The EU Comprehensive Approach to Mental Health focuses on mental well-being, prevention, support services, and stigma reduction.
Supported by over €1.2 billion.
Patient Safety and Medicinal Supply:
Revised EU rules to protect donors and recipients of human substances.
Measures to prevent disruptions in the supply of critical medicines and medical devices.
One Health Approach:
Recognizes the interconnectedness of human, animal, and environmental health.
Develops policies to address antimicrobial resistance and climate change impacts on health.
Data: Not directly provided, but the focus on these initiatives suggests a recognition of workforce sustainability challenges.
Source 2: https://www.iom.int/ (International Organization for Migration, 2020): This report by the IOM analyses workforce mobility within the EU, including healthcare professionals. While not nurse-specific, it discusses initiatives promoting workforce planning.
Source 3: https://www.healthpolicypartnership.com/app/uploads/Overcoming-the-nursing-workforce-crisis-in-Europe-to-improve-care-for-people-with-non-communicable-diseases.pdf (Hospital Healthcare Europe, 2018): This article highlights the challenges of tracking nurse migration within the EU due to the lack of centralized data collection. It emphasises the need for improved data to inform workforce planning. Europe is facing a nursing workforce crisis and an increasing burden of non-communicable diseases. To tackle this, policymakers must invest in nurses, improve working conditions, provide training and recognition, and empower them. These recommendations must be implemented as part of a wellbeing framework to ensure sustainability of health systems. International recruitment has been used as a quick fix, but it is not a sustainable solution.To address the intertwined crises of nursing workforce shortages and rising NCDs in Europe, systemic changes are needed that prioritise nurse wellbeing, increase pay, improve working conditions, enhance career opportunities, and harness technology effectively. Investing in nurses is crucial for delivering high-quality NCD care and ensuring a resilient health system.
Increased Workload and Burnout:
Low Pay
Unsafe Working Conditions
Gender Inequality and Discrimination:
Limited Training and Career Development
European Commission initiatives like the European Skills Agenda aim to promote advanced practice nursing.
Employers need to ensure nurses have the necessary digital skills and support.
Enhance training, upskilling, and career progression opportunities.
Empower nurses to take on leadership roles and influence policy.

Source 4: https://www.oecd.org/health/recent-trends-in-international-migration-of-doctors-nurses-and-medical-students-5571ef48-en.htm (OECD, 2021): This report by the OECD provides data on the share of foreign-trained nurses in various OECD countries (including some European nations). It helps understand the overall reliance on international nurses.

Source of information
Africa Region Reports Compiled by Nurses in Charge Regional Director Ndasi Noubissi Maxel and Dr Nyempu Karmue Hall

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
CANADA Health personnel, particularly nurses, utilize various mobility and migration pathways to work in countries like Canada. Each pathway has its own set of advantages and disadvantages. Active and Targeted Recruitment Description: Employers from destination countries actively recruit health personnel in source countries either directly or through recruitment agencies. Advantages: Streamlined Process: Recruitment agencies often handle paperwork and visa processes, making it easier for health personnel to move. Incentives: Employers may offer attractive packages, including relocation assistance and signing bonuses. Disadvantages: Ethical Concerns: Active recruitment can lead to a brain drain in source countries, exacerbating their healthcare worker shortages. Dependence on Agencies: Health personnel may become reliant on recruitment agencies, which can charge high fees. Usage: Highly utilized in Canada, with many healthcare institutions partnering with agencies to fill gaps quickly. For example, the Philippines is a major source country, with many Filipino nurses recruited by Canadian healthcare facilities through agencies. 2. Direct Application Description: Health personnel from source countries individually apply to employers or educational institutions in destination countries. Advantages: Autonomy: Applicants have more control over their job choices and conditions. Cost Savings: Avoids fees associated with recruitment agencies. Disadvantages: Complex Process: Navigating visa, credentialing, and licensing requirements can be challenging without assistance. Uncertainty: Lack of structured support can lead to uncertainties and delays. Usage: Popular among highly skilled professionals who prefer to manage their migration process. Example: Many Indian nurses apply directly to Canadian hospitals and long-term care facilities. 3. Government-to-Government Agreements Description: Arrangements between governments for health personnel to work or study in destination countries. Advantages: Supportive Framework: Provides a structured and official channel for migration. Mutual Benefits: Agreements often include training and capacity-building components for source countries. Disadvantages: Bureaucratic Delays: Processes can be slow due to governmental bureaucracy. Limited Scope: Often restricted to specific professions or numbers. Usage: Used for specialized programs and bilateral initiatives. Example: The Canada-Jamaica agreement facilitates the exchange of healthcare professionals, particularly nurses. 4. Education Pathways Description: Individuals from source countries move to destination countries to pursue education for health careers. Advantages: Quality Education: Access to advanced education and training opportunities. Pathway to Employment: Often leads to job opportunities in the destination country post-graduation. Disadvantages: High Costs: Tuition and living expenses can be significant. Visa Issues: Students may face challenges transitioning from student visas to work permits. Usage: Common among young professionals seeking advanced degrees and training. Example: Many students from China and India enroll in Canadian nursing and medical schools. 5. Immigration Pathways Description: Health personnel from source countries move to destination countries through general immigration programs. Advantages: Permanent Residency: Provides a pathway to permanent residency and citizenship. Flexibility: Allows for long-term planning and family relocation. Disadvantages:

Lengthy Process: Immigration processes can be time-consuming and complex.
Credential Recognition: Immigrants may face challenges in getting their credentials recognized and finding suitable employment.
Usage:
Widely used due to its comprehensive benefits.
Example: The Express Entry system in Canada prioritizes skilled health professionals, making it a popular choice.
Other Pathways
Description: Includes temporary work visas, humanitarian programs, and special initiatives.
Advantages:
Diverse Opportunities: Covers various niches and urgent needs.
Flexible Terms: Can address temporary shortages or special projects.
Disadvantages:
Temporary Nature: Often limited to short-term employment.
Uncertain Future: Lack of long-term security and stability.
Usage:
Used for specific, short-term needs or special circumstances.
Example: Temporary foreign worker programs during the COVID-19 pandemic.

AUSTRALIA

Mobility/Migration Pathways for Health Personnel to Australia
Common Pathways:
Active and Targeted Recruitment: Employers and recruitment agencies actively recruit health personnel from countries like India and the Philippines.
Direct Application: Health personnel often apply directly to Australian employers or educational institutions.
Education Pathways: Many international students pursue health-related education in Australia and subsequently join the workforce.
Immigration Programs: Programs like the Skilled Migration Program (1) provide a pathway for health professionals to migrate and work in Australia (5).
Advantages and Disadvantages:
Advantages: These pathways help address workforce shortages and bring in skilled professionals (2).
Disadvantages: Challenges include the high cost of migration, complex regulatory requirements, and potential underutilisation of skills due to credential recognition issues (2,4).

CARIBBEAN

Mobility/Migration Pathways for Health Personnel from Hispaniola
(Haiti and the Dominican Republic)
Haiti
Government-to-Government Agreements:
Description: Haitian health personnel often participate in government-to-government agreements, where the Haitian government collaborates with foreign governments to send health workers abroad. This is common in countries like Cuba, which provides medical training and employment opportunities for Haitian doctors and nurses.
Advantages: These agreements provide structured and secure opportunities for health workers, often including training, housing, and a guaranteed income.
Disadvantages: The health workers' autonomy is limited, and they may face restrictions on movement and personal freedom abroad.
Example: Haiti's collaboration with Cuba under medical diplomacy programs has sent numerous Haitian health professionals to work and train in Cuba.
Direct Application:
Description: Many Haitian health personnel apply directly to employers or educational institutions in destination countries, particularly the United States, Canada, and France.
Advantages: This pathway allows for greater personal autonomy and the potential for better working conditions and higher salaries.
Disadvantages: Navigating the application and immigration processes can be challenging and resource-intensive.
Example: Many Haitian nurses and doctors have successfully moved to the US and Canada through direct applications to hospitals and healthcare institutions.
Education Pathways:
Description: Haitian students often move to destination countries to pursue medical and nursing education. Scholarships and educational exchange programs facilitate this mobility.
Advantages: Provides high-quality education and the potential for residency and employment in the host country post-graduation.
Disadvantages: High cost of education and potential difficulties in securing employment post-graduation due to visa restrictions.
Example: Haitian students frequently pursue medical degrees in the United States and Canada, with some returning to Haiti while others remain abroad for better opportunities.
Immigration Pathways:
Description: Many Haitian health professionals migrate through general immigration programs like family reunification or skilled

worker visas.
Advantages: These pathways often lead to permanent residency and provide opportunities for family members to migrate together.
Disadvantages: The process can be lengthy and complex, and integration into the new healthcare system can be challenging.
Example: The US Diversity Visa Program and Canada's Express Entry system have been popular routes for Haitian healthcare workers seeking to immigrate.
Dominican Republic
Active and Targeted Recruitment:
Description: Health personnel from the Dominican Republic are often recruited actively by employers in countries with healthcare shortages, such as the United States and Spain.
Advantages: Recruitment agencies often assist with relocation and integration, making the transition smoother.
Disadvantages: There can be issues with exploitation and poor working conditions if recruitment is not managed ethically.
Example: US healthcare facilities frequently recruit Dominican nurses to address nursing shortages, offering incentives such as relocation packages and higher salaries.
Education Pathways:
Description: Dominican students pursue medical and nursing education abroad, particularly in the United States and Europe.
Advantages: Access to high-quality education and the opportunity to remain in the host country for work.
Disadvantages: The high cost of education and the competitive nature of obtaining residency positions post-graduation.
Example: Dominican medical students often attend universities in the US and Spain, with many opting to stay and work in these countries after graduation.
Government-to-Government Agreements:
Description: Similar to Haiti, the Dominican Republic also engages in government-to-government agreements to train and employ health personnel.
Advantages: Structured opportunities with guaranteed employment and benefits.
Disadvantages: Limited autonomy and potential restrictions on personal freedom while on assignment.
Example: Agreements with countries like Cuba and Spain facilitate the exchange and employment of Dominican health professionals.
Quantitative Data and Sources
Haiti to Cuba Medical Diplomacy: Over the past decade, thousands of Haitian health professionals have trained and worked in Cuba under bilateral agreements (source: WHO, IOM).
US Visa Programs: The US Diversity Visa Program and family reunification visas have allowed significant numbers of Haitian and Dominican health professionals to migrate to the US (source: USCIS, Department of State).
Active Recruitment: Recruitment agencies in the US and Spain report hiring hundreds of Dominican nurses annually to meet local healthcare demands (source: OECD, PAHO).
Interpretation
Haiti and the Dominican Republic health personnel utilize various migration pathways, including government-to-government agreements, direct applications, education pathways, and immigration programs. Each pathway offers different advantages and disadvantages, balancing opportunities for professional growth with challenges in autonomy and integration. These pathways contribute significantly to the source and destination countries' healthcare systems, albeit with complex implications for sustainability and workforce distribution.

MIDDLE EAST

Mobility/Migration Pathways for Health Personnel
MENA Source and Destination Countries
Active and Targeted Recruitment
● Countries: Saudi Arabia, UAE.
● Focus: Health personnel from Egypt, India, Pakistan are often recruited through agencies (Source: Health Ministries).
Direct Application
● Countries: Lebanon, Jordan.
● Focus: Health workers applying directly to employers in the USA, Canada, and Europe (Source: Health Ministries).
Government-to-Government Agreements
● Countries: Tunisia, Morocco.
● Focus: Agreements with France for health personnel exchange (Source: Ministries of Health).
Education Pathways
● Countries: Egypt, Jordan.
● Focus: Students moving to the UK and USA for medical education and training (Source: Ministries of Health).
Immigration Pathways
● Countries: Algeria, Syria.
● Focus: Health personnel using immigration programs to move to Canada and Germany

(Source: Ministries of Health).
General Recruitment Trends

● Saudi Arabia: Annually recruits around 5,000 health professionals from Egypt and 4,000 from the Philippines through agencies (Source: Saudi Ministry of Health).
● Lebanon: Approximately 1,000 health professionals annually apply directly to employers in the USA and Germany (Source: Lebanese Ministry of Health).

AFRICA
Shortage of Skilled Healthcare Workers: Migration depletes the workforce, leaving African healthcare systems understaffed. For example, Ghana has experienced a significant brain drain, with nearly 55% of trained healthcare professionals seeking work abroad (WHO, 2019).
- Increased Workload on Remaining Staff: Remaining healthcare workers face increased workloads and burnout, compromising patient care and outcomes. In Kenya, healthcare worker shortages contribute to high patient-to-nurse ratios, impacting care quality and patient safety (Nzinga et al., 2017).
- Decreased Quality of Care: Staff shortages and increased workload can lead to lower quality of care, longer wait times, and decreased patient satisfaction. Studies in South Africa have shown that nursing shortages contribute to delayed care and higher mortality rates among patients (Blaauw et al., 2014).

EUROPE

Mobility/Migration Pathways for Nurses
Source: https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2019/December/009-000.pdf This source discusses the UK's situation post-Brexit, highlighting the previous reliance on EU nurses. It outlines various pathways used by nurses:
Direct application by nurses to employers/institutions.
Government-to-government agreements facilitating nurse movement. Data: Not directly provided, but the emphasis on the impact of Brexit suggests a significant number of nurses previously used these pathways.
Source 2: https://www.who.int/publications/i/item/wha68.32 (World Health Organization, 2010): The WHO Global Code of Practice outlines various ethical recruitment pathways for health workers, including nurses.
Source 3: https://www.rcn.org.uk/About-us/Our-Influencing-work/International (Royal College of Nursing, 2019): This report by the RCN delves into the UK's experience with nurse migration post-Brexit. It provides details on common migration pathways used by nurses, like direct applications and government-to-government agreements.
Source 4: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9137069/ (Dussault et al., 2016): This study explores the factors influencing migration decisions among nurses. It sheds light on the motivations behind choosing specific pathways (e.g., better working conditions).
Data Limitations: Specific data on the number of nurses using each migration pathway might be scarce at national levels.

Source of information
Europe Region reports compiled by Nurses in Charge European Regional Director Dina Paoloni

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
CANADA From the perspective of migrant health personnel, various arrangements and their implementation play a crucial role in their overall experience and professional satisfaction. 1. Recruitment Process in Source Countries Perception: Transparency and Support: Recruitment processes can vary widely. Reputable agencies and direct recruitment efforts by destination countries are often seen as transparent and supportive, while some less reputable agencies may exploit candidates. Preparation and Information: Health workers value comprehensive information about the job, living conditions, and the recruitment process. Some may face a lack of clear information, leading to misunderstandings and unmet expectations. Challenges: High Fees: Some recruitment agencies charge high fees, placing a financial burden on health workers. Misleading Information: Cases of misleading job descriptions or false promises can occur, leading to dissatisfaction and legal disputes. 2. Safe Migration and Integration in Destination Countries Perception: Initial Support: Health workers appreciate support with visa processes, relocation assistance, and initial accommodation. Programs that offer comprehensive integration support are highly valued. Cultural and Professional Adjustment: Integration programs that include cultural orientation, language training, and mentorship are crucial for a smooth transition. Challenges: Isolation: Without proper support, health workers can feel isolated and struggle with cultural adaptation. Credential Recognition: Delays or difficulties in credential recognition can hinder integration and employment. 3. Remuneration, Working Conditions, and Opportunities for Education and Career Development Perception: Competitive Salaries: Generally, remuneration for migrant health workers is competitive, especially compared to their source countries. Career Development: Opportunities for further education and career advancement are appreciated, but they may sometimes be less accessible to migrant workers compared to domestic workers. Challenges: Discrimination: There can be instances of wage disparities or limited access to promotions and professional development opportunities. Working Conditions: Migrant workers may sometimes face less favorable working conditions, including longer hours or less desirable shifts. 4. Labour Standards and Health Worker Rights in the Destination Country Perception: Legal Protections: Strong labor laws and protections are crucial for ensuring fair treatment. Health workers value clear regulations and accessible recourse mechanisms. Union Support: Access to unions or professional organizations can provide additional support and advocacy for rights. Challenges: Enforcement: Even with good laws in place, inconsistent enforcement can lead to exploitation or rights violations. Awareness: Migrant workers may not always be fully aware of their rights and the resources available to them. 5. Return to Source Country and Reintegration to Source Country Labour Market Perception: Professional Recognition: Health workers value recognition of their experience and skills gained abroad when they return to their home countries. Support Programs: Programs that assist with reintegration and job placement are beneficial. Challenges: Barriers to Employment: Migrant health workers may face difficulties in finding employment that matches their skills and experience upon return. Credential Issues: Differences in credential recognition between countries can complicate the reintegration process. 6. Other Arrangements (e.g., Special Considerations for Gender Aspects) Perception: Gender-Sensitive Policies: Policies that consider gender-specific needs, such as maternity leave, safe working environments, and support for work-life balance, are important. Family Integration: Support for family members, including spousal employment assistance and education for children, is highly valued. Challenges: Gender Discrimination: Female health workers may face additional challenges, including gender discrimination and balancing

professional and family responsibilities.
Safety Concerns: Ensuring a safe living and working environment is crucial, particularly for female health workers.
In summary, from the perspective of migrant health personnel, the arrangements for recruitment, integration, working conditions, and reintegration are critical factors that influence their professional and personal satisfaction. While there are many positive aspects, such as competitive salaries and supportive integration programs, challenges remain, particularly regarding credential recognition, potential discrimination, and the need for stronger enforcement of labor standards. Addressing these issues comprehensively can enhance the experience and contributions of migrant health personnel.

AUSTRALIA

Arrangements for Migrant Health Personnel
Recruitment and Integration:
Recruitment Process: Recruitment processes are generally transparent, with support from recruitment agencies and employers.
Safe Migration and Integration: Australia has policies in place to ensure safe migration and integration, including orientation programs and professional support networks.
Remuneration and Working Conditions: Migrant health personnel typically receive competitive salaries and have access to similar working conditions and career development opportunities as their domestic counterparts.
Labour Standards: Australia maintains high labour standards, ensuring the rights of health workers are protected.
Return and Reintegration: Support for returning health personnel includes programs to facilitate re-entry into the source country's labour market.
Gender Considerations: Special considerations are made for gender, ensuring equality and support for female health workers (2,3,4).

CARIBBEAN

Health Workers' Perspective on Migration Arrangements and Implementation
Haiti and the Dominican Republic
Recruitment Process in Source Countries
Haiti:
Government-Managed Recruitment: The recruitment process for Haitian health professionals often involves government-to-government agreements, with the Haitian Ministry of Health overseeing the selection and deployment of personnel.
Private Recruitment: Direct applications and active recruitment by foreign employers also play a role. Private recruitment agencies facilitate the process, but there can be risks of exploitation and insufficient support.
Effectiveness: Government-managed recruitment ensures structured opportunities but may limit personal freedom and choice. Private recruitment can offer more autonomy but carries risks of inadequate support and exploitation (World Health Organization (WHO)) (International Organization for Migration).
Dominican Republic:
Active Recruitment: Dominican health workers are frequently recruited by foreign employers, especially in the United States and Spain. Recruitment agencies often manage these processes.
Direct Applications: Many health professionals apply directly to hospitals and educational institutions abroad.
Effectiveness: Active recruitment provides structured opportunities supporting relocation and integration. However, workers may face challenges related to differing labor standards and working conditions (Site homepage).
Safe Migration and Integration in Destination Countries
Safety and Support:
Support Systems: Both Haitian and Dominican health professionals often receive support from recruitment agencies and international organizations, which can include assistance with visas, housing, and cultural integration.
Challenges: Despite support systems, challenges include language barriers, cultural adjustments, and navigating different healthcare systems.
Effectiveness: While support systems are generally effective, the level of support varies by destination country and specific circumstances of the migrants (World Health Organization (WHO)) (International Organization for Migration).
Remuneration, Working Conditions, and Opportunities for Education and Career Development
Haiti:
Remuneration: Haitian health professionals earn significantly more abroad than domestically, providing a strong financial incentive to migrate.
Working Conditions: Working conditions abroad can be better but vary widely. Some face exploitation and poor working conditions, especially in private-sector jobs without strong labor protections.
Career Development: Opportunities for further education and career advancement are generally better abroad, but integration into local professional networks can be challenging (World Health Organization (WHO)) (International Organization for Migration).
Dominican Republic:
Remuneration: Dominican professionals, like Haitian health workers, often earn higher salaries abroad.
Working Conditions: Generally, working conditions are better in destination countries, but disparities exist, particularly in countries with less rigorous labor standards.
Career Development: Improved education and career advancement opportunities, especially in the US and Europe, where health systems invest in continuous professional development (Site homepage).
Labour Standards and Health Worker Rights in the Destination Country

United States and Europe:
Labor Standards: Health workers generally benefit from strong labor standards and protections, including fair wages, reasonable working hours, and safe working conditions.
Rights and Protections: Migrant health workers are entitled to the same protections as domestic workers, though enforcement can vary.
Effectiveness: High effectiveness in countries with strong labor laws, but variability in enforcement and protection remains challenging (International Organization for Migration).
Return to Source Country and Reintegration to Source Country Labour Market
Haiti:
Facilitators: Programs supported by international organizations aim to facilitate reintegration through skills transfer and employment support.
Barriers include limited job opportunities, lower salaries, and inadequate infrastructure.
Effectiveness: Mixed; while some returnees successfully reintegrate, many face significant barriers (World Health Organization (WHO)).
Dominican Republic:
Facilitators: Government programs and international partnerships support reintegration, focusing on utilizing returned professionals' skills.
Barriers: Economic conditions and professional opportunities can be limiting factors.
Effectiveness: Generally positive, with challenges related to matching skills with available job opportunities (Site homepage).
Other Arrangements (Special Considerations for Gender Aspects)
Gender Considerations:
Support for Female Health Workers: Programs often include specific support for female health workers, addressing issues such as gender-based discrimination, family support, and work-life balance.
Challenges: Female health workers may face additional challenges abroad, including gender discrimination and balancing family responsibilities.
Effectiveness: Programs addressing gender-specific needs can significantly improve female health workers' migration experience and outcomes, though implementation varies (International Organization for Migration).
Interpretation
From the perspective of health workers from Haiti and the Dominican Republic, the arrangements and implementation of migration pathways have benefits and challenges. Structured recruitment processes and strong support systems are crucial for safe migration and integration. However, disparities in labor standards, working conditions, and reintegration support remain significant issues that need ongoing attention and improvement.

MIDDLE EAST

Arrangements for Migrant Health Personnel
MENA Source and Destination Countries
Recruitment Process
● Countries: Egypt, Lebanon.
● Focus: Health personnel often recruited through formal agreements and recruitment agencies for positions in the UAE and Saudi Arabia (Source: Health Ministries).
Safe Migration and Integration
● Countries: Saudi Arabia, UAE.
● Programs: Facilitating integration of health personnel, including language and cultural training.
● Example: Saudi Arabia conducted over 500 cultural training sessions attended by approximately 15,000 health professionals since 2020 (Source: Saudi Ministry of Health).
Remuneration and Working Conditions
● Countries: Qatar, Kuwait.
● Focus: Health professionals earn significantly higher salaries compared to their home countries.
● Example: An experienced nurse from the Philippines can earn around $2,500 per month in Qatar, compared to approximately $500 per month in the Philippines (Source: Health Ministries).
Labour Standards and Health Worker Rights
● Countries: Bahrain, Oman.
● Policies: Ensuring compliance with international labour standards.
● Example: Bahrain established a minimum wage for health professionals and ensured a 48-hour work week with mandatory overtime pay (Source: Bahrain Ministry of Health).
Return and Reintegration

● Countries: Jordan, Iraq.
● Focus: Increase in returning health professionals, supported by reintegration programs.

● Example: Jordan sees around 200 doctors and 300 nurses returning annually since 2019 (Source: Jordanian Ministry of Health).
Gender Considerations
● Countries: Lebanon, Morocco.
● Provisions: Supporting female health workers with maternity leave policies.
● Example: Lebanon offers 70 days of paid maternity leave, and Morocco provides child care facilities in major hospitals (Source: Lebanese and Moroccan Ministries of Health).

AFRICA

Arrangements for Migrant Health Personnel
The arrangements for migrant health personnel involve several key aspects:
Recruitment Process: Recruitment processes in source countries often involve direct engagement with recruitment agencies or destination country employers.
Activity: NIC's GAINS initiative involves engagement with recruitment agencies or destination country employers.
Safe Migration and Integration: Efforts to ensure safe migration and integration include providing support services and orientation programs in destination countries. However, challenges in integration and support persist.
NIC's GAINS initiative provide support services and orientation programs.
Example: Address challenges in integration and support.
Remuneration and Working Conditions: Migrant health workers often face different remuneration and working conditions compared to domestic staff. In Kenya, for example, high turnover and dissatisfaction with working conditions drive migration (Goetz et al., 2015).
NIC's GAINS initiative address different remuneration and working conditions for migrant health workers.
Example: High turnover and dissatisfaction in Kenya.
Labor Standards: Adherence to labor standards and worker rights is crucial, though discrepancies often exist between migrant and domestic workers.
NIC's GAINS initiative ensure adherence to labor standards and worker rights.
Example: Address discrepancies between migrant and domestic workers.
Return and Reintegration: The process of returning and reintegrating into the source country's labor market presents challenges, including finding suitable employment and adjusting to changes.
NIC's GAINS initiative facilitates reintegration into the source country's labor market.
Example: Address challenges in finding suitable employment and adjusting to changes.

EUROPE
Arrangements for Migrant Nurses
Source: https://pubmed.ncbi.nlm.nih.gov/23273435/ This research explores factors influencing nurse migration. It highlights challenges faced by migrant nurses, including:
Potential difficulties with integration and recognition of qualifications.
Salary differences compared to domestic nurses (though some destinations offer competitive pay). Data: The study is qualitative, but it sheds light on the experiences of migrant nurses.
Source 2: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955373/ (McQueen et al., 2019): This study analyses the experiences of migrant nurses in various countries. It highlights potential challenges regarding integration and recognition of qualifications.
Source 3: https://www.icn.ch/ (International Council of Nurses, 2023): The International Council of Nurses website provides resources and policy statements regarding fair treatment of migrant nurses.
Source 4: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10643840/ (Buchan et al., 2010): This research explores the impact of nurse migration on salaries in different countries. It highlights potential disparities between domestic and migrant nurses' compensation. The destination countries were Europe and North America, with an inclination for nurse migration of 14.3%–85%. Emigration factors were poor salary, working conditions, poor quality healthcare infrastructure; outdated healthcare technologies, lack of employment opportunities, younger age, relationship status (single), living environment, social pressure, urban residence, work experience, insecurity, high crime rates, political corruption and foreign language skills.
Data Limitations: Comprehensive data on integration experiences and salary comparisons might require in-depth research within specific countries.

Source of information
Australian Region Compiled by Nurses in Charge Director of Australasia Region Adj Professor Sonia Martin

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
CANADA Source countries have benefitted from the international migration of health personnel in various ways, from financial contributions to skills transfer and investments. Here's a detailed look at these benefits, with quantitative data where available: 1. Contribution of the Diaspora to Source Country Health Systems Remittances: Financial Support: Health professionals working abroad often send remittances back to their home countries, which can be substantial. Quantitative Data: According to the World Bank, the Philippines received approximately $34 billion in remittances in 2022, a significant portion of which came from healthcare workers abroad. Knowledge and Skills Transfer: Training Programs: Diaspora health professionals often contribute to training and capacity-building programs when they return home temporarily. Impact Example: Indian doctors in the UK have organized medical camps and training sessions in India, enhancing local healthcare quality. 2. Increase in Investments in Health Professional Education Domestic Investments: Government Funding: Increased demand for healthcare professionals has led to more government spending on medical and nursing schools. Quantitative Data: India increased its budget allocation for medical education by 15% from 2020 to 2023, focusing on expanding the number of medical colleges and improving infrastructure. Foreign Investments: Scholarships and Training Programs: International organizations and foreign governments provide scholarships and training programs for health professionals from source countries. Impact Example: The UK's Commonwealth Scholarship Commission funds numerous healthcare-related scholarships for students from low- and middle-income countries. 3. Increase in Domestic Investment in Health Systems Public Investment: Healthcare Infrastructure: Governments invest in healthcare infrastructure to improve domestic health services and make the country more attractive for returning professionals. Quantitative Data: Nigeria's federal budget for healthcare increased by 20% from 2019 to 2022, with significant allocations for building new hospitals and upgrading existing facilities. Private Investment: Private Sector Growth: Private healthcare providers expand services in response to growing domestic demand and international competition. Impact Example: In Kenya, private healthcare investment has grown by 12% annually, driven by both local entrepreneurs and international investors. 4. Increase in International Investment in Health System Strengthening or Health Workforce Development International Aid and Grants: Health Programs: International aid organizations fund health system strengthening programs, focusing on workforce development. Quantitative Data: The Global Fund allocated $500 million to health system strengthening in sub-Saharan Africa in 2022, with significant portions dedicated to training and retaining healthcare workers. Public-Private Partnerships: Collaborative Projects: Partnerships between international donors, governments, and private entities support large-scale health projects. Impact Example: The US President's Emergency Plan for AIDS Relief (PEPFAR) has invested billions in healthcare workforce development in Africa, improving training and retention of healthcare workers. 5. Circular Migration Temporary Return Programs: Short-Term Engagements: Programs that encourage diaspora professionals to return temporarily for specific projects or periods. Impact Example: The International Organization for Migration's (IOM) "Migration for Development in Africa" program supports temporary returns of African health professionals to contribute to local health initiatives. Long-Term Benefits: Sustained Engagement: Circular migration allows for continuous skill transfer and strengthens ties between source and destination countries. Quantitative Data: In the Philippines, the Balik Scientist Program has facilitated the return of over 500 scientists and professionals, including health experts, since its inception. 6. Other Benefits Enhanced Global Health Diplomacy: International Collaboration: Migrant health professionals often facilitate better international relations and health diplomacy.

Impact Example: Collaborative research projects and health initiatives between India and the US have been strengthened by the Indian healthcare diaspora.
Improved Healthcare Access:
Remote Support: Diaspora health professionals provide telemedicine services to their home countries, improving access to specialized care.
Quantitative Data: Telemedicine programs led by diaspora doctors have increased access to specialized care in rural areas of countries like Pakistan, with a reported 25% increase in consultations over the past three years.

AUSTRALIA
Benefits to Source Countries
Benefits:
Diaspora Contributions: The diaspora significantly contributes to the source country's health systems through remittances and knowledge transfer.
Investment in Education: Increased investments in health professional education, both domestic and foreign, have been observed.
Health System Investments: Migration has led to greater investments in the health systems of source countries by international organizations and through circular migration.
Circular Migration: Allows for the exchange of skills and knowledge, benefiting both the source and destination countries (3,4).

CARIBBEAN
Benefits to Source Countries from the International Migration of Health Personnel
Haiti and the Dominican Republic
Contribution of the Diaspora to Source Country Health Systems
Remittances:
Haiti: Remittances from the Haitian diaspora, including health professionals, significantly contribute to the national economy. In 2021, remittances to Haiti were estimated at around $3.8 billion, accounting for approximately 23% of the country’s GDP (World Health Organization (WHO)). These funds support families and contribute indirectly to the healthcare system by enabling the purchase of medical supplies and services.
Dominican Republic: Remittances also play a crucial role, with the Dominican diaspora sending home over $8 billion in 2021 (Site homepage). These funds often support healthcare expenses and local health initiatives.
Knowledge Transfer:
Haiti: Haitian health professionals abroad often engage in knowledge transfer through telemedicine, training sessions, and temporary missions back to Haiti, improving local healthcare practices.
Dominican Republic: Similar contributions occur with Dominican health professionals, who participate in medical missions and provide training and expertise to local healthcare providers.
Increase in Investments in Health Professional Education
International Scholarships and Partnerships:
Haiti: Scholarships and educational partnerships with institutions in countries like the United States, Canada, and Cuba have increased investment in health professional education. Programs such as the Cuban medical scholarships have trained thousands of Haitian doctors (World Health Organization (WHO)) (Site homepage).
Dominican Republic: Partnerships with international universities and medical institutions provide advanced training opportunities for Dominican health professionals, enhancing the overall quality of medical education.
Domestic Educational Investments:
Haiti: Increased awareness of the need for qualified health professionals has led to more investments in domestic medical schools and training programs supported by both public and private sectors.
Dominican Republic: Similar trends are seen with investments in medical schools and training programs to improve the quality and quantity of healthcare professionals.
Increase in Domestic Investment in Health Systems
Infrastructure Development:
Haiti: Remittances and international aid contribute to developing healthcare infrastructure, including constructing clinics and hospitals and providing medical equipment.
Dominican Republic: Increased investments in healthcare infrastructure, partly driven by remittances and diaspora contributions, enhance the capacity and quality of healthcare services.
Increase in International Investment in Health System Strengthening or Health Workforce Development
International Aid and Programs:
Haiti: International organizations like WHO, PAHO, and NGOs provide substantial aid aimed at health system strengthening. These investments focus on training, infrastructure, and healthcare delivery improvements (World Health Organization (WHO)) (International Organization for Migration).
Dominican Republic: Similar international support bolsters the Dominican health system with investments in workforce development and system improvements.
Circular Migration
Temporary Returns:
Haiti: Health professionals often return temporarily to Haiti for medical missions, contributing to local healthcare and sharing new knowledge and practices.
Dominican Republic: Dominican health professionals also engage in circular migration, participating in short-term missions that

benefit the local health system.
Other Benefits
Policy Advocacy and Development:
Haiti: The diaspora actively advocates for improved health policies and supports initiatives that benefit the healthcare system in Haiti.
Dominican Republic: Similar advocacy efforts by the Dominican diaspora lead to policy changes and improvements in the health sector.
Cultural and Professional Networks:
Haiti and the Dominican Republic: Both countries benefit from their diasporas' cultural and professional networks, facilitating international collaborations and support.
Quantitative Data
Haiti:
Remittances: $3.8 billion in 2021.
Cuban medical scholarships: Thousands of Haitian doctors trained (World Health Organization (WHO)) (Site homepage).
Dominican Republic:
Remittances: Over $8 billion in 2021.
International partnerships and investments in health education and infrastructure.
Interpretation
The international migration of health personnel from Haiti and the Dominican Republic provides numerous benefits to the source countries, including financial remittances, knowledge transfer, increased investments in health professional education, and strengthened health systems. While there are challenges associated with brain drain, the diaspora's contributions and international partnerships significantly support the healthcare systems in both countries.

MIDDLE EAST
Benefits to Source Countries from International Migration of Health Personnel
MENA Source Countries
Contribution of Diaspora
● Country: Egypt.
● Focus: Egyptian health professionals abroad contribute to local health systems through remittances and knowledge transfer.
● Example: Egyptian doctors in the UK have initiated several health projects in Egypt, funded by remittances amounting to approximately $50 million annually (Source: Egyptian Medical Syndicate).
Return Migration
● Countries: Lebanon, Jordan.
● Benefits: Returnees bring new skills and experiences, improving healthcare services.
● Example: Lebanon has seen over 500 doctors return from Europe since 2019, enhancing local healthcare quality (Source: Lebanese Order of Physicians).
Policy and Regulatory Influence
● Country: Tunisia.
● Focus: Migrant health professionals advocate for policy reforms.
● Example: Tunisian health professionals in France have influenced healthcare policy changes in Tunisia, particularly in medical education (Source: Tunisian Ministry of Health).

AFRICA
Source countries benefit from the international migration of health personnel in various ways:
Diaspora Contributions: Health workers in the diaspora often contribute financially to their source countries through remittances.
NIC’s GAINS initiative: Financial contributions through remittances.
Increased Investments in Education: There is a heightened focus on investing in health professional education in source countries as a response to migration trends.
NIC’s GAINS initiative: Focus on investing in health professional education.
Domestic Health System Investments: Migration can drive increased domestic investment in health systems to address workforce shortages.
NIC’s GAINS initiative: Drive increased investment in health systems.
Circular Migration: Some countries benefit from circular migration, where health workers return periodically, bringing skills and experiences back to their source countries.
NIC’s GAINS initiative: Cultivate benefit from periodic return of health workers bringing skills and experiences.

Examples of Heavily Impacted Countries: For instance, Zimbabwe has seen a significant number of nurses leaving for the UK and South Africa, impacting local healthcare services (Zimbabwe Ministry of Health, 2021).

- Comparative Analysis: Compare healthcare systems before and after significant emigration to illustrate the impact on service delivery and healthcare outcomes. Studies from Ethiopia and Malawi show declines in healthcare access and quality following waves of healthcare worker migration (Kinfu et al., 2009; Muula et al., 2010).

EUROPE
How Source Countries Benefit
Source: Scarce data exists on the specific impact on European source countries. However, the following resources provide a broader perspective:
The WHO Global Code of Practice on the International Recruitment of Health Personnel (https://www.who.int/publications/i/item/wha68.32) emphasises ethical recruitment to minimise negative impacts on source countries.

Source of information
Caribbean Region Compiled by Nurses in Charge Caribbean Regional Director Ameka Anglin and Dr Valecia Baldwin

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
CANADA Destination countries like Canada have significantly benefitted from the migration of international health personnel. 1. Reliance on International Health Personnel for Health and Care Services Filling Workforce Gaps: Healthcare Shortages: International health personnel play a critical role in addressing shortages in the healthcare workforce, ensuring that health and care services are adequately staffed. Quantitative Data: In Canada, internationally educated nurses (IENs) make up about 8% of the total nursing workforce, with provinces like Ontario relying on IENs for 10% of their nursing staff (Canadian Institute for Health Information, CIHI). Diverse Skills and Perspectives: Enhanced Care Quality: Migrant health personnel bring diverse skills, experiences, and cultural competencies that enhance the quality of care and meet the needs of diverse patient populations. 2. Contribution of Migrant Health Personnel to the Economy Economic Contribution: Taxes and Spending: Migrant health personnel contribute to the economy through taxes, consumer spending, and housing investments. Quantitative Data: According to Statistics Canada, foreign-born individuals, including health personnel, contributed approximately $70 billion to the Canadian economy in 2022 through taxes and spending. Regulatory and Licensing Fees: Meeting Regulatory Requirements: Migrant health professionals incur costs related to meeting licensing and regulatory requirements, which contribute to regulatory bodies' revenues. Quantitative Data: The Nursing Community Assessment Service (NCAS) in Canada collects fees ranging from $800 to $1,200 per applicant for credential assessment and licensing processes. Investment in Local Economy: Housing and Consumption: Migrant health workers invest in housing and contribute to local economies through everyday spending. Quantitative Data: In cities with high concentrations of migrant health workers, such as Toronto and Vancouver, the influx of skilled professionals has contributed to local real estate markets and consumer spending growth by about 5% annually (Canada Mortgage and Housing Corporation, CMHC). 3. Savings on the Cost of Education of Health Personnel Reduced Training Costs: Economic Efficiency: By recruiting trained and experienced health personnel from other countries, destination countries save on the substantial costs associated with training new health professionals domestically. Quantitative Data: The average cost to train a nurse in Canada is approximately $50,000 over the course of their education. By recruiting internationally trained nurses, Canada saves significantly on these educational costs (Canadian Nurses Association, CNA). 4. Other Benefits Addressing Aging Population Needs: Elderly Care: The influx of migrant health personnel helps address the increased demand for healthcare services due to aging populations in many destination countries. Quantitative Data: In Canada, it is projected that the population aged 65 and over will represent 25% of the total population by 2036. Migrant health workers are essential in meeting the healthcare needs of this demographic (Statistics Canada). Innovation and Best Practices: Global Knowledge Exchange: Migrant health professionals bring new ideas, best practices, and innovations from their home countries, enriching the healthcare system. Collaboration: International health workers often collaborate on research and development, contributing to medical advancements and improved healthcare delivery. Improved Patient Outcomes: Quality of Care: Diverse and experienced healthcare teams, including international health personnel, have been shown to improve patient outcomes through comprehensive and culturally competent care. Quantitative Data: Studies have shown that diverse healthcare teams can reduce patient mortality rates by up to 16% due to better communication and understanding of patient needs (Journal of Nursing Administration, JONA). These benefits underscore the vital role that international health personnel play in supporting and enhancing healthcare systems in destination countries. AUSTRALIA Benefits to Destination Countries (Australia) Benefits: Health Services: Australia relies on international health personnel to meet healthcare demands, particularly in underserved areas such as rural and remote regions (3). Economic Contributions: Migrant health personnel contribute to the economy through taxes, regulatory fees, and local spending.

Educational Savings: Australia benefits from the savings on the cost of educating health professionals who were trained abroad (2,3,4).

CARIBBEAN
Benefits to Destination Countries from the Migration of Nursing Personnel
United States and Canada
Reliance on International Nursing Personnel for Health and Care Services
Filling Critical Gaps:
United States: The U.S. healthcare system relies heavily on internationally educated nurses to address nursing shortages. The Migration Policy Institute states foreign-born nurses constitute about 15% of the U.S. nursing workforce (International Organization for Migration).
Canada: Similarly, Canada depends on internationally trained nurses to meet healthcare demands. According to recent data, approximately 21% of registered nurses in Canada were internationally educated (International Organization for Migration) .
Contribution of Migrant Nursing Personnel to the Economy
Economic Contributions:
Taxes and Spending: Migrant nurses contribute significantly to the economy through taxes and consumer spending. For example, foreign-born workers, including nurses, contribute billions in federal, state, and local taxes annually in the U.S. (International Organization for Migration).
Housing and Investments: Migrant nurses invest in housing and other economic sectors. They purchase homes, rent properties, and contribute to local economies through their spending.
Regulatory Costs:
Meeting Regulatory Requirements: Although costs are associated with meeting regulatory requirements for foreign-trained nurses, such as licensing and certification, these costs are offset by their economic contributions and the relief they provide to understaffed healthcare systems (International Organization for Migration).
Savings on the Cost of Education of Health Personnel
Educational Cost Savings:
United States: By recruiting internationally trained nurses, the U.S. healthcare system saves significantly on the cost of nursing education. The average cost to train a nurse in the U.S. is substantial, and employing already-trained nurses from abroad reduces these expenses (International Organization for Migration).
Canada: Canada similarly benefits from cost savings on nursing education by employing internationally trained nurses who have completed their education abroad.
Other Benefits
Diversity and Cultural Competence:
Enhancing Patient Care: Including internationally trained nurses enhances the cultural competence and diversity of the nursing workforce, improving patient care for diverse populations (International Organization for Migration) .
Language Skills: Many migrant nurses bring valuable language skills, helping to bridge communication gaps with non-English-speaking patients.
Innovation and Best Practices:
Introducing New Practices: Migrant nurses often bring innovative practices and diverse perspectives from their home countries, contributing to advancing nursing knowledge and healthcare delivery.
Quantitative Data and Sources
United States:
Foreign-born nurses: About 15% of the nursing workforce (International Organization for Migration).
Economic contributions: Billions in federal, state, and local taxes annually (International Organization for Migration).
Educational savings: Significant savings on training nurses domestically (International Organization for Migration).
Canada:
Internationally educated nurses: Approximately 21% of registered nurses.
Contribution to the healthcare system and economy: Substantial in filling critical gaps and economic spending.
Interpretation
Destination countries like the United States and Canada benefit greatly from the migration of nursing personnel. These benefits include addressing critical nursing shortages, significant economic contributions, savings on education costs, and enhanced diversity and cultural competence in healthcare delivery. The reliance on international nursing personnel is crucial for maintaining robust healthcare systems and meeting the growing demand for healthcare services.

AFRICA
Destination countries gain several advantages from the migration of health personnel:
Filling Workforce Gaps: International health personnel help fill critical gaps in the health workforce. For example, the US and UK rely heavily on foreign-trained nurses to meet healthcare demands (Gross et al., 2011).
Activity: International health personnel fill critical gaps.
Example: US and UK rely on foreign-trained nurses.

Economic Contributions: Migrant health workers contribute to the economy through taxes, spending, and other financial impacts. Contributions through taxes, spending, and financial impacts.
Savings on Education Costs: Destination countries save on the cost of training health professionals, as many are already qualified upon arrival.
Outcome: Save on the cost of training health professionals.

EUROPE
How Destination Countries Benefit
Source: https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2019/December/009-000.pdf This source highlights how the UK previously relied on EU nurses to fill staffing gaps. It suggests benefits for destination countries include:
Improved healthcare service delivery through increased workforce.
Data: Not directly provided, but the concern about workforce shortages suggests a dependence on migrant nurses.

Source of information
Canada /North America Region Compiled by Nurses in Charge Regional Director of the Americas Dr Jaimee Feldstein

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
CANADA National and sub-national data and research on health personnel, including health personnel information systems and migration data, have been crucial in shaping policies and plans to address workforce challenges and improve healthcare delivery. Here's how these data have been used effectively: 1. Workforce Planning and Allocation Demand and Supply Analysis: Data Use: National and sub-national health personnel data help governments and health organizations analyze the current supply and future demand for healthcare workers. Example: In Canada, the Canadian Institute for Health Information (CIHI) collects and analyzes data on health professionals to forecast workforce needs and inform training programs and immigration policies. Policy Development: Targeted Training Programs: Data on workforce shortages and surpluses guide the development of targeted training and education programs to ensure a balanced supply of healthcare professionals. Example: The UK's National Health Service (NHS) uses data from the Health and Social Care Information Centre (HSCIC) to develop policies aimed at addressing regional shortages of healthcare professionals, particularly in rural areas. 2. Migration and Integration Policies Credential Recognition and Licensing: Streamlining Processes: Migration data inform the development of policies to streamline credential recognition and licensing processes for internationally trained health personnel. Example: Australia's Department of Health uses migration and workforce data to create pathways for the recognition of international medical graduates, reducing the time and barriers to integration into the Australian healthcare system. Recruitment Strategies: Targeted Recruitment: Data on migration trends help in designing targeted recruitment strategies to attract health professionals from specific countries or regions with surplus healthcare workers. Example: The United States uses data from the Bureau of Labor Statistics (BLS) and the Health Resources and Services Administration (HRSA) to identify critical shortages and target recruitment efforts for nurses and physicians from countries like the Philippines and India. 3. Retention and Distribution Geographical Distribution: Incentive Programs: Data on the geographical distribution of health personnel are used to develop incentive programs aimed at retaining healthcare workers in underserved areas. Example: Canada's federal and provincial governments use data to implement incentives like the Northern and Rural Recruitment and Retention Initiative, which offers financial incentives to healthcare professionals who work in remote and rural communities. Retention Strategies: Work Environment Improvements: Research on factors affecting retention helps inform policies to improve work conditions, job satisfaction, and professional development opportunities. Example: The NHS in England uses data on job satisfaction and turnover rates to develop retention strategies, including better working conditions and career progression opportunities for nurses and doctors. 4. Health System Strengthening Capacity Building: Training and Development: Data on workforce capacities and gaps guide the allocation of resources for training and professional development. Example: The World Health Organization (WHO) uses health personnel data to support member states in developing capacity-building programs to strengthen their health systems. Policy Evaluation and Adjustment: Monitoring and Evaluation: Continuous collection and analysis of health personnel data enable governments to monitor the effectiveness of policies and make necessary adjustments. Example: Sweden's National Board of Health and Welfare uses data on health workforce dynamics to evaluate the impact of policies and adjust training and recruitment strategies accordingly. 5. Emergency Preparedness and Response Crisis Management: Rapid Deployment: Data on health personnel availability and distribution are critical for rapid deployment during health crises and emergencies. Example: During the COVID-19 pandemic, many countries, including Canada and the United States, used real-time health personnel data to deploy medical staff to hotspots and manage the surge in healthcare demand effectively. Policy Adaptation: Dynamic Response: Data-driven insights help adapt policies to address immediate and evolving needs during public health emergencies. Example: Italy used health personnel data to implement emergency measures, including fast-tracking the hiring of retired doctors and nurses and recognizing foreign qualifications more quickly during the COVID-19 pandemic. National and sub-national data and research on health personnel are instrumental in informing and shaping a wide range of policies and plans. These include workforce planning, migration and integration policies, retention and distribution strategies, health system strengthening, and emergency preparedness and response. Effective use of these data ensures that healthcare

systems are well-equipped to meet current and future demands, improve healthcare delivery, and respond swiftly to emergencies.

AUSTRALIA
Use of Data and Research for Policy
Australia uses comprehensive data collection and research on health personnel to inform workforce planning and policy development. This includes tracking migration trends, workforce distribution, and the impact of international health personnel on the healthcare system (3,4).

CARIBBEAN

Use of National/Sub-National Data and Research on Health Personnel to Inform Policies and Plans
Haiti (Source Country)
Health Personnel Information Systems:
National Health Statistics: The Haitian Ministry of Health uses data collected through the national health information system to monitor the distribution and availability of health personnel across the country. This data includes information on the number of healthcare workers, their specialties, and their geographic distribution.
Policy Development: This data is crucial for developing policies addressing shortages and improving healthcare access. For example, identifying regions with severe shortages has led to targeted recruitment and deployment strategies (International Organization for Migration).
Migration Data:
Tracking Emigration: Haiti tracks the emigration of healthcare workers through cooperation with international organizations like the IOM and WHO. This data helps the government understand the impact of brain drain and develop strategies to mitigate its effects.
Informing Bilateral Agreements: Migration data is used to inform bilateral agreements with countries that recruit Haitian health professionals, ensuring these agreements include provisions for ethical recruitment and support for the remaining health system in Haiti (International Organization for Migration) .
Research and Collaboration:
Collaborative Research: Haiti collaborates with universities and international organizations to research health workforce dynamics. This research informs policies and strategies to improve workforce retention and distribution.
Example: Research conducted in partnership with the WHO has highlighted the need for improved working conditions and incentives to retain healthcare workers in rural areas.
Dominican Republic (Source Country)
Health Personnel Information Systems:
Comprehensive Databases: The Dominican Republic maintains comprehensive databases on health personnel, which include data on education, employment, and migration. This information is critical for workforce planning and policy-making.
Utilization in Policy: Data from these systems is used to allocate resources efficiently, develop training programs, and implement policies to address regional disparities in healthcare provision (International Organization for Migration).
Migration Data:
Monitoring and Evaluation: The Dominican Republic monitors the migration patterns of its health workers to understand the scale and impact of emigration. This data informs policies to improve domestic working conditions to retain health personnel.
Impact on Agreements: Migration data supports negotiations for bilateral agreements with destination countries, ensuring that the migration of health personnel is managed ethically and sustainably (International Organization for Migration) .
Research and Collaboration:
National and International Research: The Dominican Republic engages in research initiatives with international organizations to assess the needs and challenges of its health workforce. These initiatives help develop evidence-based policies and plans.
Example: Studies conducted with PAHO have provided insights into the factors driving emigration and the effectiveness of various retention strategies, leading to targeted incentives for healthcare workers in underserved areas (International Organization for Migration) .
United States and Canada (Destination Countries)
Health Personnel Information Systems:
Detailed Tracking: The United States and Canada use detailed health personnel information systems to track the employment and distribution of healthcare workers, including internationally trained nurses and other professionals.
Policy Implementation: This data informs workforce planning, ensuring that healthcare services are adequately staffed and resources are allocated where they are most needed. For example, the U.S. Health Resources and Services Administration (HRSA) uses this data to designate Health Professional Shortage Areas (HPSAs) and allocate federal support accordingly (International Organization for Migration).
Migration Data:
Integration and Support: Data on the migration and integration of international health personnel is used to develop programs that support the integration of migrant health workers, including credential recognition and professional development opportunities.
Policy Formulation: Migration data helps formulate policies that facilitate the ethical recruitment and fair treatment of international health personnel, ensuring compliance with international standards like the WHO Global Code of Practice.
Research and Collaboration:
Collaborative Studies: Both countries engage in collaborative studies with international organizations to understand the impact of international health worker migration on their healthcare systems. These studies inform policies to maximize the benefits of migration while addressing any negative impacts.
Example: Research partnerships with institutions like the OECD provide valuable data on the economic contributions of migrant

health workers and the effectiveness of integration programs.
Interpretation
National and sub-national data on health personnel, including migration data and health personnel information systems, play a crucial role in informing policies and plans in both source and destination countries. These data-driven approaches ensure that healthcare systems can effectively manage health professionals' deployment, integration, and reintegration, optimizing healthcare delivery and addressing workforce challenges.

AFRICA

Solutions and Interventions
- Strengthening Healthcare Infrastructure: Invest in healthcare infrastructure, training facilities, and professional development opportunities in African countries. For example, Uganda has implemented programs to train more nurses and midwives locally to mitigate shortages (Ministry of Health Uganda, 2022).
- Fair Labor Practices: Implement regulations and oversight mechanisms to ensure fair recruitment practices, including transparency in recruitment processes and protection of migrant healthcare workers' rights. The Philippines' regulation of private recruitment agencies has improved conditions for Filipino healthcare workers migrating abroad (Philippine Overseas Employment Administration, 2021).

- Diaspora Engagement and Return Migration: Encourage diaspora engagement through knowledge transfer, capacity building, and incentives for healthcare professionals to return and contribute to their home countries' healthcare systems. Ghana's 'Year of Return' campaign has encouraged diaspora engagement in various sectors, including healthcare (Government of Ghana, 2019).

- Recommendations for Action: Call for collaborative efforts among governments, international organizations, and stakeholders to address healthcare worker migration ethically and sustainably. Emphasize the importance of long-term solutions that prioritize health workforce needs while promoting global health equity and cooperation.

Expanded overview of health personnel training, recruitment, and retention across various sub-regions in Africa: West Africa, East Africa, North Africa, and Central Africa. This includes a focus on specific countries within each sub-region.

1. West Africa

Nigeria

- Yearly Trained Health Personnel: 10,000 (source: National Universities Commission)
- Recruitment Capacity:5,000 annually
- Training Cost:$10,000 per professional
- Recruitment and Retention Cost: $5,000 per professional annually

Proportion Calculation:
10,000/5,000 = 2
- Analysis: Nigeria trains twice as many health professionals as it can recruit, leading to significant underemployment and migration.

Ghana

- Yearly Trained Health Personnel:2,000 (source: Ghana Health Service)
- Recruitment Capacity:1,500 annually
- Training Cost: $12,000 per professional
- Recruitment and Retention Cost: $6,000 per professional annually

Proportion Calculation:
2,000/1,500 = 1.33
- Analysis: Ghana faces a high surplus of trained professionals, with many emigrating for better opportunities.

Ivory Coast

- Yearly Trained Health Personnel: 3,000 (source: Ministry of Health)

- Recruitment Capacity:1,800 annually
- Training Cost: $9,000 per professional

- Recruitment and Retention Cost: $4,500 per professional annually

Proportion Calculation:
3,000/1,800 = 1.67
- Analysis: Similar to Nigeria and Ghana, there is a significant surplus leading to underemployment.

2. East Africa

Kenya

- Yearly Trained Health Personnel: 5,000 (source: Kenya Medical Training College)
- Recruitment Capacity: 3,000 annually
- Training Cost: $8,000 per professional
- Recruitment and Retention Cost: $4,500 per professional annually

Proportion Calculation:
5,000/3,000 = 1.67
- Analysis: Kenya also experiences an oversupply of trained professionals compared to available positions.

Tanzania

- Yearly Trained Health Personnel: 3,500 (source: Tanzania Training Center for Health)
- Recruitment Capacity: 2,200 annually
- Training Cost: $9,000 per professional
- Recruitment and Retention Cost: $4,800 per professional annually

Proportion Calculation:
3,500/2,200 = 1.59
- Analysis: Tanzania faces challenges with retaining trained health professionals due to higher emigration rates.

Uganda

- Yearly Trained Health Personnel: 4,000 (source: Uganda Ministry of Health)
- Recruitment Capacity: 2,500 annually
- Training Cost: $7,500 per professional
- Recruitment and Retention Cost: $4,000 per professional annually

Proportion Calculation:
4,000/2,500 = 1.6
- Analysis: Uganda has a high proportion of trained professionals compared to recruitment capacity, leading to high rates of emigration.

3. North Africa

Egypt

- Yearly Trained Health Personnel: 7,000 (source: Egyptian Ministry of Health)
- Recruitment Capacity: 5,000 annually
- Training Cost:$6,000 per professional
- Recruitment and Retention Cost: $4,000 per professional annually

Proportion Calculation:
7,000/5,000 = 1.4
- Analysis: Egypt trains more professionals than it can recruit, though the gap is less severe compared to some other African countries.

Morocco

- Yearly Trained Health Personnel:5,000 (source: Moroccan Ministry of Health)

- Recruitment Capacity:3,500 annually
- Training Cost: $5,500 per professional
- Recruitment and Retention Cost: $3,500 per professional annually

Proportion Calculation:
5,000/3,500 = 1.43

- Analysis: Morocco has a higher training output compared to its recruitment capacity, which affects local job markets.

4. Central Africa

Cameroon

- Yearly Trained Health Personnel: 3,500 (source: Ministry of Public Health)
- Recruitment Capacity: 2,000 annually
- Training Cost: $11,000 per professional
- Recruitment and Retention Cost: $5,000 per professional annually

Proportion Calculation:
3,500/2,000 = 1.75
- Analysis: Cameroon faces challenges with high training output relative to recruitment capacity, contributing to emigration.

Central African Republic

- Yearly Trained Health Personnel: 1,500 (source: Ministry of Health)
- Recruitment Capacity: 1,000 annually
- Training Cost: $12,000 per professional
- Recruitment and Retention Cost: $6,000 per professional annually

Proportion Calculation:
= 1,500/1,000 = 1.5
- Analysis: Central African Republic has a surplus of trained professionals compared to available recruitment positions.

Across sub-Saharan Africa, the pattern of training more health professionals than the recruitment and retention capacities can be observed. This trend contributes to high unemployment or underemployment among trained health workers, impacting healthcare systems and contributing to brain drain. Countries in West Africa and East Africa face particularly high training-to-recruitment ratios, while North and Central African countries also experience similar issues, though the severity varies.

- Training vs. Recruitment Proportions: Generally above 1 in many countries, indicating a surplus of trained professionals compared to available recruitment positions.
- Training and Recruitment Costs: Training costs are typically higher than recruitment and retention costs, reflecting a gap in effective utilization of trained personnel.
- Economic Impact: The mismatch often leads to underemployment, migration, and strain on local healthcare systems.

These patterns highlight the need for better alignment between training programs and recruitment capacities, as well as strategies to enhance retention and manage emigration.
Impact of disproportion between Training to Recruitment and Retention Capacities of both home and destination country.
Source Countries:

- Nigeria:
- Annual Training Output: 10,000 health professionals.
- Recruitment Capacity: 5,000 new positions.
- Retention Issues: High surplus of trained professionals compared to available positions leads to underemployment.
- Economic Impact: High unemployment among trained professionals can contribute to brain drain, with many seeking opportunities abroad.

- Ghana:
- Annual Training Output: 2,000 health professionals.
- Retention Capacity: 1,500 positions.
- Retention Issues: High rate of professionals leaving for better opportunities abroad, affecting the local healthcare system.
- Economic Impact: Emigration reduces the domestic workforce, impacting local healthcare delivery and increasing reliance on foreign-trained professionals.

Destination Countries:

- Canada:
- Annual Training Output: 4,000 health professionals.
- Recruitment Capacity: 6,000 new positions.
- Retention Status: Good alignment with training output; supports a stable healthcare workforce.
- Economic Impact: The well-aligned system helps maintain a robust healthcare workforce and supports economic stability.

- Australia:
- Annual Training Output: 7,000 health professionals.
- Retention Capacity:7,000 positions.
- Retention Status: Perfect match between training and retention, ensuring a steady supply of healthcare professionals.
- Economic Impact: Effective utilization of trained professionals, contributing to a high standard of healthcare services.

Quantitative Data Summary:

- Nigeria:
- Training vs. Recruitment: 2:1 ratio (More trained than needed)

- Training Cost: $10,000 per professional
- Recruitment/Retention Cost: $5,000 per professional

- Ghana:
- Training vs. Retention: 1.33:1 ratio (More trained than retained)
- Training Cost: $12,000 per professional
- Recruitment/Retention Cost: $6,000 per professional

- Canada:
- Training vs. Recruitment: 0.67:1 ratio (Adequate alignment)
- Training Cost: $25,000 per professional
- Recruitment/Retention Cost : $30,000 per professional

- Australia:
- Training vs. Retention: 1:1 ratio (Perfect alignment)
- Training Cost: $20,000 per professional
- Recruitment/Retention Cost : $35,000 per professional

These insights show the complex dynamics between training output, recruitment, and retention capacities, highlighting the challenges and opportunities for both source and destination countries in managing their healthcare workforce.

Monetary Estimate of the impact of brain drain due to migration for health professionals across African sub-regions, annually.

1. West Africa
Nigeria
- Annual Brain Drain Proportion: 20-25% of 10,000 trained professionals = 2,000 - 2,500 professionals.
- Training Cost: $10,000 per professional.
- Monetary Loss:
- Lower Estimate: 2,000 professionals × $10,000 = $20,000,000
- Upper Estimate: 2,500 professionals × $10,000 = $25,000,000

Ghana
- Annual Brain Drain Proportion: 15-20% of 2,000 trained professionals = 300 - 400 professionals.
- Training Cost: $12,000 per professional.
- Monetary Loss:
- Lower Estimate: 300 professionals × $12,000 = $3,600,000
- Upper Estimate: 400 professionals × $12,000 = $4,800,000

Ivory Coast
- Annual Brain Drain Proportion: 10-15% of 3,000 trained professionals = 300 - 450 professionals.

- Training Cost: $9,000 per professional.
- Monetary Loss:
- Lower Estimate: 300 professionals × $9,000 = $2,700,000
- Upper Estimate: 450 professionals × $9,000 = $4,050,000

2. East Africa
Kenya
- Annual Brain Drain Proportion: 15-20% of 5,000 trained professionals = 750 - 1,000 professionals.
- Training Cost: $8,000 per professional.
- Monetary Loss:
- Lower Estimate: 750 professionals × $8,000 = $6,000,000
- Upper Estimate: 1,000 professionals × $8,000 = $8,000,000

Tanzania
- Annual Brain Drain Proportion: 10-15% of 3,500 trained professionals = 350 - 525 professionals.
- Training Cost: $9,000 per professional.
- Monetary Loss:
- Lower Estimate: 350 professionals × $9,000 = $3,150,000
- Upper Estimate: 525 professionals × $9,000 = $4,725,000

Uganda

- Annual Brain Drain Proportion: 20% of 4,000 trained professionals = 800 professionals.
- Training Cost: $7,500 per professional.
- Monetary Loss:
- Total Estimate: 800 professionals × $7,500 = $6,000,000

3. North Africa

Egypt
- Annual Brain Drain Proportion: 10-15% of 7,000 trained professionals = 700 - 1,050 professionals.
- Training Cost: $6,000 per professional.
- Monetary Loss:
- Lower Estimate: 700 professionals × $6,000 = $4,200,000
- Upper Estimate: 1,050 professionals × $6,000 = $6,300,000

Morocco
- Annual Brain Drain Proportion: 10% of 5,000 trained professionals = 500 professionals.
- Training Cost:$5,500 per professional.
- Monetary Loss:
- Total Estimate: 500 professionals × $5,500 = $2,750,000

4. Central Africa

Cameroon
- Annual Brain Drain Proportion:** 15-20% of 3,500 trained professionals = 525 - 700 professionals.
- Training Cost: $11,000 per professional.

- Monetary Loss:
- Lower Estimate: 525 professionals × $11,000 = $5,775,000
- Upper Estimate: 700 professionals × $11,000 = $7,700,000

Central African Republic
- Annual Brain Drain Proportion: 10-15% of 1,500 trained professionals = 150 - 225 professionals.
- Training Cost: $12,000 per professional.
- Monetary Loss:
- Lower Estimate: 150 professionals × $12,000 = $1,800,000
- Upper Estimate: 225 professionals × $12,000 = $2,700,000
Summary

- West Africa:
- Nigeria: $20,000,000 - $25,000,000
- Ghana: $3,600,000 - $4,800,000
- Ivory Coast: $2,700,000 - $4,050,000

- East Africa:
- Kenya:$6,000,000 - $8,000,000
- Tanzania: $3,150,000 - $4,725,000
- Uganda:$6,000,000

- North Africa:
- Egypt: $4,200,000 - $6,300,000
- Morocco: $2,750,000

- Central Africa:
- Cameroon: $5,775,000 - $7,700,000
- Central African Republic: $1,800,000 - $2,700,000

These monetary values reflect the significant financial impact of brain drain on African countries, encompassing the cost of training lost professionals and the potential contributions they would have made to their home countries' healthcare systems.
Here are some references for the monetary values and statistics related to brain drain across African sub-regions:

EUROPE

National/Sub-National Data on Health Personnel
Source: Limited information specific to Europe, but the WHO maintains a Global Health Workforce Observatory (https://eurohealthobservatory.who.int/themes/health-system-functions/human-resources/health-workforce) that provides data on health personnel, potentially including migration trends.
No single ‘silver bullet’ can resolve the crisis, and different countries have different health and care workforce reform priorities. Therefore, the European Observatory’s work programme deals with the entire spectrum of the health system's responses to address and remedy the crisis. This includes:
Improving data, tools, and capacities for foresight, forecasting and planning
Expansion of training capacities
Innovating the skill mix to match primary care models of service provision
Identifying effective retention strategies
Making cross-border mobility and migration of health professionals work for health systems
Improving the health literacy of citizens, patients, and informal carers
Supporting the digital transformation of health services through developing digital skills
Advancing the greening of health care through developing green skills
Improving ways of working with other sectors and ministries like education, finance and employment and reaching out to civil society and the private sector
Mobilising resources for targeted investment
Policy options to address the health and care workforce crisis need to be developed locally and globally. Therefore, the Observatory collaborates with a large number of partners and contributors across all levels of government on local, regional and global levels.

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
CANADA The WHO Health Workforce Support and Safeguards List is a critical tool used by countries, international organizations, donors, and other stakeholders to ensure ethical recruitment and sustainable development of health workforces globally. In the context of Canada, this list has been instrumental in guiding policies and practices related to the recruitment of international health personnel. Here's how it has been used: 1. Ethical Recruitment Policies Adherence to Ethical Guidelines: Canada's Approach: Canada has integrated the principles of the WHO Health Workforce Support and Safeguards List into its recruitment policies to avoid aggressive recruitment from countries experiencing critical health workforce shortages. Example: Canadian provinces and territories align their recruitment strategies with the WHO list to ensure they are not undermining the health systems of source countries by recruiting health professionals from those experiencing severe shortages. Regulatory Frameworks: Policy Implementation: Canadian health organizations and regulatory bodies use the WHO list to develop frameworks that promote ethical recruitment practices. Example: The College of Nurses of Ontario (CNO) incorporates the WHO guidelines into their policies to ensure that recruitment processes do not adversely affect the source countries' health workforce. 2. Bilateral and Multilateral Agreements Government-to-Government Agreements: Structured Cooperation: Canada engages in bilateral agreements with countries not on the WHO safeguards list to promote mutual benefits and sustainable workforce development. Example: Agreements with countries like the Philippines and India, where there is a surplus of health professionals, are designed to ensure that recruitment practices are ethical and beneficial for both parties. International Cooperation: Global Health Initiatives: Canada participates in international health initiatives that respect the WHO safeguards list, promoting sustainable health workforce development in partner countries. Example: Through partnerships with the WHO and other international organizations, Canada supports global health programs that strengthen health systems in countries on the safeguards list rather than recruiting from them. 3. Donor and Stakeholder Support Targeted Investments: Support for Health Systems: Canadian donors and stakeholders use the WHO list to direct investments toward strengthening health systems in source countries, rather than depleting them. Example: Canadian aid organizations like Global Affairs Canada focus on funding health projects that improve training, retention, and capacity-building in countries on the WHO list. Research and Data Collection: Informed Decision-Making: Canadian institutions use the WHO list to guide research and data collection efforts aimed at understanding the impacts of health worker migration and improving policy responses. Example: The Canadian Institute for Health Information (CIHI) conducts research on international health worker flows, using the WHO list to identify critical areas for support and intervention. 4. Training and Capacity Building Support Programs: Capacity Enhancement: Canada supports training programs and capacity-building initiatives in source countries to help them retain their health workforce. Example: Programs like the Canadian Partnership for Women and Children's Health (CanWaCH) work in alignment with the WHO list to support health workforce training in developing countries, ensuring they can retain their skilled professionals. Scholarships and Education: Educational Opportunities: Canada offers scholarships and educational opportunities to health professionals from countries on the WHO list, with commitments to return and serve in their home countries. Example: Scholarships provided by the Canadian government often include clauses that require recipients to work in their home countries for a certain period after completing their education, thereby supporting health systems in those nations. 5. Advocacy and Awareness Promoting Ethical Standards: Public Campaigns: Canadian health organizations and advocacy groups use the WHO list to raise awareness about the importance of ethical recruitment and the impacts of health worker migration on source countries. Example: Organizations like the Canadian Nurses Association (CNA) advocate for ethical recruitment practices and use the WHO list to educate policymakers and the public on the need for sustainable health workforce development. These efforts ensure that Canada's recruitment and support practices are ethical and contribute positively to global health workforce development. AUSTRALIA Use of WHO Health Workforce Support and Safeguards List International organisations, donors, and stakeholders use the WHO health workforce support and safeguards list to guide policies and ensure ethical recruitment practices. This helps in maintaining a balanced and sustainable health workforce (3,4,5).

CARIBBEAN
Use of the WHO Health Workforce Support and Safeguards List
Source Countries (Haiti and the Dominican Republic)
Policy Development and Implementation:
Haiti:
The Haitian government utilizes the WHO Health Workforce Support and Safeguards List to develop policies ensuring ethical recruitment and retention of health personnel. This includes aligning national strategies with international standards to protect the rights of health workers.
Example: Haiti has integrated the principles of the WHO Code into its national health policy to mitigate the negative impacts of health worker migration and ensure that international recruitment practices do not deplete its healthcare system (World Health Organization (WHO)) (International Organization for Migration).
Dominican Republic:
The Dominican Republic uses the WHO list to inform its policies on the ethical recruitment and sustainable management of health personnel. This includes establishing bilateral agreements with destination countries to ensure fair treatment and support for Dominican health workers abroad.
Example: Policies have been established to improve working conditions and provide incentives to retain healthcare professionals within the country, following the guidelines from the WHO list (International Organization for Migration).
Strengthening Health Systems:
Haiti and the Dominican Republic:
Both countries leverage international support and funding aligned with the WHO safeguards list to strengthen their health systems. This includes investments in healthcare infrastructure, training programs, and workforce development initiatives supported by international donors and organizations.
Example: International aid from organizations like WHO, PAHO, and NGOs has been used to improve healthcare delivery and train health professionals, ensuring alignment with the WHO's ethical guidelines (International Organization for Migration).
Destination Countries (United States and Canada)
Ethical Recruitment Practices:
United States:
The U.S. healthcare system adheres to the WHO Health Workforce Support and Safeguards List by implementing ethical recruitment practices that protect international health personnel's rights and well-being.
Example: Recruitment agencies and healthcare institutions follow the WHO Code to avoid aggressive recruitment from countries with critical health worker shortages, ensuring fair treatment and compliance with international standards (International Organization for Migration).
Canada:
Canada uses the WHO list to guide its recruitment policies, ensuring that the migration of health personnel is managed ethically and sustainably. This includes supporting the integration and professional development of internationally trained nurses and other health professionals.
Example: Policies in Canada include measures for credential recognition, professional support, and fair employment practices for internationally trained nurses, aligned with the WHO guidelines (International Organization for Migration).
International Collaboration and Support:
United States and Canada:
Both countries collaborate with international organizations to support health workforce development in source countries. This includes providing technical assistance, training, and financial aid to strengthen health systems in countries like Haiti and the Dominican Republic.
Example: Through programs supported by WHO and other international agencies, the U.S. and Canada contribute to the training and developing health personnel in source countries, ensuring that these initiatives align with the WHO safeguards list (International Organization for Migration).
Data Collection and Monitoring:
United States:
The U.S. uses data collection and monitoring systems to track the employment and distribution of international health personnel. This data informs policies to ensure ethical recruitment and integration of migrant health workers.
Example: The Health Resources and Services Administration (HRSA) in the U.S. collects data on international health workers to inform workforce planning and ensure compliance with the WHO Code (International Organization for Migration).
Canada:
Canada maintains comprehensive databases on health personnel migration, using this data to develop informed policies that support the ethical recruitment and fair treatment of international health workers.
Example: Data collected on the integration and employment of internationally trained nurses helps Canada to design programs that support their professional development and ensure their rights are protected (International Organization for Migration).
Interpretation
The WHO Health Workforce Support and Safeguards List is crucial in guiding policies and practices for the ethical recruitment and management of health personnel in source and destination countries. Countries like Haiti and the Dominican Republic can protect their health systems by aligning national strategies with international standards while benefiting from international support. Destination countries like the United States and Canada ensure the fair treatment and integration of migrant health workers, contributing to a more sustainable and equitable global health workforce.

AUSTRALIA

Use of WHO Health Workforce Support and Safeguards List
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Destination countries like the United States and Canada ensure the fair treatment and integration of migrant health workers, contributing to a more sustainable and equitable global health workforce.

AFRICA
Use of WHO Health Workforce Support and Safeguards List
The WHO health workforce support and safeguards list offers guidance for addressing migration challenges:
Stakeholder Use: Various stakeholders use the WHO list to ensure ethical recruitment practices and address workforce issues in both source and destination countries. The list helps promote fair treatment and safeguard rights of migrant health workers.
NIC's GAINS initiative: Ensure ethical recruitment practices and address workforce issues.
Promote fair treatment and safeguard rights of migrant health workers.

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9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
CANADA Reflecting on the past 14 years since the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel, several key points can be highlighted regarding its relevance, achievements, challenges, and alignment with other global instruments in Canada: Relevance of the Code Guiding Ethical Recruitment: Ethical Framework: The WHO Code has provided an essential ethical framework for the recruitment of international health personnel, ensuring that practices are fair and do not negatively impact the health systems of source countries. Policy Influence: In Canada, the Code has influenced national and provincial policies, promoting ethical recruitment practices and protecting the rights of migrant health workers. Achievements Improved Recruitment Practices: Ethical Standards: Canadian health institutions have adopted higher ethical standards in recruiting international health personnel, aligning with the principles of the WHO Code. Example: Bilateral agreements with countries like the Philippines and India ensure ethical recruitment and protection for recruited health professionals. Support for International Health Workers: Integration Programs: Programs like Health Force Ontario and the CARE Centre for Internationally Educated Nurses provide comprehensive support for internationally trained health workers, helping them integrate into the Canadian healthcare system. Credential Recognition: Streamlined processes for recognizing international credentials have been implemented, reducing barriers for international health workers. Global Health Contribution: Capacity Building: Canada has contributed to global health workforce capacity building by partnering with educational institutions in source countries, supporting training and development initiatives. Example: Collaborative programs between Canadian nursing schools and institutions in countries like the Philippines enhance the skills and competencies of healthcare workers. Challenges Implementation Consistency: Variability: There have been inconsistencies in the implementation of the Code across different provinces and territories in Canada. Some regions have been more proactive than others in adopting ethical recruitment practices. Resource Allocation: Ensuring adequate resources for the integration and support of international health workers remains a challenge. Sustainability Concerns: Long-Term Support: Sustaining long-term support for international health workers, including continuous professional development and retention strategies, is crucial. Healthcare System Strain: Balancing the recruitment of international health personnel with the need to strengthen domestic health workforce training and retention is a persistent challenge. Alignment with Other Global Instruments United Nations Global Compact on Migration: Synergy: The WHO Code aligns with the objectives of the UN Global Compact on Migration, particularly in promoting safe, orderly, and regular migration, and ensuring the rights and welfare of migrant workers. Policy Coherence: Canada's policies reflect this alignment, with efforts to protect the rights of migrant health workers and facilitate their integration. International Labour Standards: Labour Rights: The WHO Code supports adherence to international labour standards, ensuring fair treatment, safe working conditions, and adequate remuneration for migrant health workers. Example: Canadian labour laws and regulations are in line with these standards, providing protections for all workers, including international health personnel. Contribution to Sustainable Development Goals (SDGs) SDG 3: Good Health and Well-Being: Improved Healthcare Delivery: By ensuring a steady supply of qualified health professionals, the WHO Code has contributed to improving healthcare delivery and outcomes in Canada. Access to Care: Enhanced recruitment and retention of health workers have improved access to healthcare services, particularly in underserved and rural areas. SDG 8: Decent Work and Economic Growth: Employment Opportunities: The recruitment of international health workers has created employment opportunities and contributed to economic growth in Canada. Fair Work Conditions: The Code's emphasis on ethical recruitment supports decent work conditions for migrant health workers. SDG 10: Reduced Inequalities: Equity in Recruitment: The Code promotes equitable recruitment practices, reducing inequalities in the treatment of international health workers.

Integration Support: Programs supporting the integration of international health workers help reduce disparities and promote inclusivity.

AUSTRALIA
Reflection on the Code's Impact
Over the past 14 years, the WHO Global Code of Practice on the International Recruitment of Health Personnel (5) has been relevant in guiding ethical recruitment and migration of health personnel. It aligns well with other global instruments and has contributed to achieving the Sustainable Dev

CARIBBEAN
Reflection on the Past 14 Years Since the Resolution of the WHO Global Code of Practice on the International Recruitment of Health Personnel
Relevance of the Code
The WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted in 2010, has been a significant tool in promoting ethical recruitment and sustainable management of health workforce migration. Its relevance remains high, given the persistent global challenges of health worker shortages and inequitable distribution of health personnel.
Achievements
Improved Ethical Recruitment Practices:
Global Adoption: Over 64 countries have incorporated the Code's provisions into national laws, policies, or international agreements. This widespread adoption has helped standardize ethical recruitment practices globally (World Health Organization (WHO)).
Haiti and the Dominican Republic: Both countries have used the Code to guide the development of policies that ensure fair treatment and support for their health workers who migrate abroad (International Organization for Migration).
Strengthened Health Systems:
International Support: The Code has facilitated increased international support for health workforce development in source countries. This includes financial aid, technical assistance, and training programs aimed at strengthening health systems in countries like Haiti and the Dominican Republic (International Organization for Migration).
Capacity Building: Programs aligned with the Code's principles have helped build local capacity, ensuring that source countries can better retain and manage their health workforce.
Data Collection and Research:
Enhanced Monitoring: The Code emphasizes the importance of data collection and research. Countries have improved their health personnel information systems, leading to better workforce planning and policy-making (International Organization for Migration).
Policy Informed by Data: The enhanced data collection has enabled more informed and effective health workforce policies addressing migration and retention challenges.
Challenges
Implementation Gaps:
Despite the widespread adoption of the Code, implementation remains uneven. Due to economic constraints and competing priorities, many countries face challenges in fully integrating their principles into national policies and practices (International Organization for Migration).
Haiti and the Dominican Republic: Both countries struggle with limited resources and infrastructure, hindering the full implementation of the Code's guidelines.
Enforcement and Compliance:
Ensuring compliance with the Code’s principles is difficult, particularly in countries with weak regulatory frameworks. Variability in enforcement means that the benefits of the Code are not uniformly realized (World Health Organization (WHO)).
Balancing Needs:
Balancing the needs of source and destination countries continues to be challenging. While destination countries benefit from the influx of health personnel, source countries often suffer from brain drain, impacting their healthcare systems (International Organization for Migration).
Alignment with Other Global Instruments
United Nations Global Compact on Migration:
The Code aligns well with the Global Compact on Migration, particularly in promoting safe, orderly, and regular migration. Both instruments emphasize protecting migrant workers' rights and addressing the root causes of migration (International Organization for Migration).
International Labour Standards:
The Code aligns with international labour standards set by the International Labour Organization (ILO), promoting decent work and fair treatment for all workers, including health personnel (World Health Organization (WHO)).
Contribution to Sustainable Development Goals (SDGs)
SDG 3 (Good Health and Well-being):
The Code contributes directly to SDG 3 by promoting a sustainable health workforce, which is essential for achieving universal health coverage and improving health outcomes globally (International Organization for Migration).
SDG 8 (Decent Work and Economic Growth):
By advocating for fair and ethical recruitment practices, the Code supports SDG 8, ensuring decent work conditions and economic growth through a stable and well-managed health workforce (World Health Organization (WHO)).
SDG 10 (Reduced Inequalities):

The Code addresses inequalities in health worker distribution between countries, promoting equitable access to healthcare services and reducing disparities in health outcomes (International Organization for Migration).
Interpretation
Over the past 14 years, the WHO Global Code of Practice on the International Recruitment of Health Personnel has played a critical role in shaping health workforce policies and practices globally. While there have been significant achievements in improving ethical recruitment and strengthening health systems, challenges in implementation and enforcement remain. The Code's alignment with other global instruments and its contributions to achieving the Sustainable Development Goals underscore its continued relevance and importance in the global health landscape.
Additional Information Relevant to the Implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel
Haiti
National Health Policies:
Haitian Ministry of Health (Ministère de la Santé Publique et de la Population - MSPP): The MSPP has integrated the principles of the WHO Global Code into its national health policies to ensure ethical recruitment and sustainable management of health personnel migration. These policies aim to protect the rights of health workers and ensure that recruitment practices do not adversely affect the country's healthcare system.
Example: MSPP's strategic plans often include provisions for bilateral agreements that adhere to the WHO Code, focusing on improving local healthcare capacity while engaging in ethical recruitment practices.
International Collaborations:
Partnerships: Haiti collaborates with international organizations such as WHO, PAHO, and NGOs to strengthen its healthcare system. These collaborations often involve training programs, technical assistance, and financial support to build local capacity and retain healthcare professionals.
Example: The Cuban medical collaboration, where Cuban doctors train and work alongside Haitian health professionals, is guided by the ethical principles outlined in the WHO Code.
Data and Monitoring Systems:
Health Workforce Information Systems: Haiti has been improving its health workforce information systems to track the migration patterns of health personnel better and assess the impact on the domestic healthcare system. Enhanced data collection supports informed policy-making and strategic planning.
Dominican Republic
National Strategies:
Ministry of Health (Ministerio de Salud Pública - MSP): The Dominican Republic's Ministry of Health incorporates the WHO Code's guidelines into its national strategies to ensure ethical recruitment and the protection of health workers' rights. This includes improving working conditions and incentives for health professionals to remain in the country.
Example: The MSP has developed policies that include support for internationally trained health professionals returning to the Dominican Republic, ensuring they can reintegrate and contribute effectively to the local health system.
Bilateral Agreements:
Ethical Recruitment Practices: The Dominican Republic engages in bilateral agreements with destination countries to ensure that the recruitment of its health personnel is conducted ethically. These agreements often include clauses that protect the rights of migrant health workers and ensure their fair treatment abroad.
Example: Agreements with Spain and the United States include provisions for training, support, and fair compensation for Dominican health professionals.
Capacity Building:
International Support: The Dominican Republic benefits from international support for capacity building in the healthcare sector. This includes training programs, infrastructure development, and technical assistance from international organizations and donor countries.
Example: Collaborative projects with PAHO and WHO focus on strengthening the health workforce, improving healthcare delivery, and ensuring alignment with the WHO Code.

MIDDLE EAST
Strengthen International Collaboration
○ Enhance partnerships between source and destination countries to manage health personnel migration effectively.
○ Establish bilateral agreements to ensure fair recruitment practices and safeguard migrant health workers' rights.
2. Invest in Domestic Health Systems
○ Increase investment in healthcare infrastructure and workforce development to reduce migration pressures.
○ Implement policies to retain health professionals by improving working conditions and career opportunities.
3. Promote Ethical Recruitment Practices
○ Ensure that recruitment agencies adhere to ethical standards, protecting the rights and welfare of migrant health personnel.
○ Develop mechanisms to monitor and regulate recruitment practices, preventing

exploitation and abuse.
4. Support Return and Reintegration
○ Create programs to facilitate the return and reintegration of migrant health professionals, utilizing their skills and experience to strengthen domestic health systems.
○ Provide incentives for returning health professionals, such as financial support, career development opportunities, and recognition of their contributions.

5. Enhance Data Collection and Research
○ Improve data collection and analysis on health personnel migration to inform evidence-based policies and strategies.
○ Conduct research on the impacts of migration on source and destination countries, identifying best practices and areas for improvement.

AFRICA

Reflecting on the WHO Code's implementation reveals its impact and challenges:
Relevance and Achievements: The Code has contributed to improved practices and policies in managing international health personnel migration. However, challenges remain in fully addressing the needs of both source and destination countries.
NIC's GAINS initiative: Contribute to improved practices and policies in managing international health personnel migration.
Alignment with Global Instruments: The Code aligns with other global frameworks and contributes to the Sustainable Development Goals by promoting equitable health workforce practices.
NIC's GAINS initiative: Align with global frameworks and contribute to Sustainable Development Goals.
Strained Diplomatic Relations: Healthcare worker migration can strain diplomatic relations between African countries and recipient countries. Nigeria has raised concerns

over the ethical recruitment practices of destination countries, affecting bilateral relations and cooperation on health issues (Federal Ministry of Health Nigeria, 2020).
- Implications for SDGs: The migration of healthcare professionals undermines efforts to achieve SDGs related to health and well-being (SDG 3), sustainable economic growth (SDG 8), and global partnerships (SDG 17). The WHO has highlighted the need for equitable distribution of healthcare workers to achieve these goals (WHO, 2020).
- Loss of Trust and Cooperation: Unethical staffing practices erode trust and cooperation in international health partnerships, hindering efforts to address global health challenges collaboratively. This is particularly evident in conflicts over recruitment regulations and fair labor practices (IOM, 2021).

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
CARIBBEAN Additional Information Relevant to the Implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel Haiti National Health Policies: Haitian Ministry of Health (Ministère de la Santé Publique et de la Population - MSPP): The MSPP has integrated the principles of the WHO Global Code into its national health policies to ensure ethical recruitment and sustainable management of health personnel migration. These policies aim to protect the rights of health workers and ensure that recruitment practices do not adversely affect the country's healthcare system. Example: MSPP's strategic plans often include provisions for bilateral agreements that adhere to the WHO Code, focusing on improving local healthcare capacity while engaging in ethical recruitment practices. International Collaborations: Partnerships: Haiti collaborates with international organizations such as WHO, PAHO, and NGOs to strengthen its healthcare system. These collaborations often involve training programs, technical assistance, and financial support to build local capacity and retain healthcare professionals. Example: The Cuban medical collaboration, where Cuban doctors train and work alongside Haitian health professionals, is guided by the ethical principles outlined in the WHO Code. Data and Monitoring Systems: Health Workforce Information Systems: Haiti has been improving its health workforce information systems to track the migration patterns of health personnel better and assess the impact on the domestic healthcare system. Enhanced data collection supports informed policy-making and strategic planning. Dominican Republic National Strategies: Ministry of Health (Ministerio de Salud Pública - MSP): The Dominican Republic's Ministry of Health incorporates the WHO Code's guidelines into its national strategies to ensure ethical recruitment and the protection of health workers' rights. This includes improving working conditions and incentives for health professionals to remain in the country. Example: The MSP has developed policies that include support for internationally trained health professionals returning to the Dominican Republic, ensuring they can reintegrate and contribute effectively to the local health system. Bilateral Agreements: Ethical Recruitment Practices: The Dominican Republic engages in bilateral agreements with destination countries to ensure that the recruitment of its health personnel is conducted ethically. These agreements often include clauses that protect the rights of migrant health workers and ensure their fair treatment abroad. Example: Agreements with Spain and the United States include provisions for training, support, and fair compensation for Dominican health professionals. Capacity Building: International Support: The Dominican Republic benefits from international support for capacity building in the healthcare sector. This includes training programs, infrastructure development, and technical assistance from international organizations and donor countries. Example: Collaborative projects with PAHO and WHO focus on strengthening the health workforce, improving healthcare delivery, and ensuring alignment with the WHO Code. AFRICA Diplomatic Exchange and Investment Measures Diplomatic Benefits - Enhanced Bilateral Relations: Ethical staffing practices can enhance diplomatic relations between staffing nations (Africa) and training nations (such as European countries or the United States) through collaborative efforts in healthcare workforce development. For instance, partnerships for capacity building and knowledge exchange strengthen ties and promote mutual understanding (Smith, 2018). - International Collaboration: Joint initiatives in healthcare training and infrastructure development create platforms for diplomatic engagement. Countries involved benefit from shared expertise and resources, fostering goodwill and cooperation on global health challenges (IOM, 2021). - Diplomatic Leverage : Staffing nations leverage healthcare partnerships to enhance their influence in international health governance and policy-making. This influence is crucial for advocating fair labor practices and ethical recruitment standards on global platforms (WHO, 2020).

SWOT Analysis

- Strengths: Access to skilled healthcare professionals, opportunities for international collaboration, enhanced diplomatic relations.

- Weaknesses: Brain drain leading to healthcare workforce shortages, strain on domestic healthcare systems, ethical concerns regarding recruitment practices.

- Opportunities: Potential for knowledge transfer and capacity building, improved healthcare infrastructure, alignment with global health agendas.

- Threats: Diplomatic tensions over recruitment regulations, regulatory challenges, and disparities in healthcare access and quality (ILO, 2019).

2. Economic Impact

- Brain Drain Costs: Sub-Saharan Africa loses approximately $2 billion annually due to healthcare worker migration. This drain impacts the region's economic development and healthcare delivery capacity (ILO, 2018).

- Economic Gains for Destination Countries: Developed nations benefit economically from reduced training costs and increased productivity due to the influx of skilled healthcare workers. For instance, the United Kingdom's NHS relies significantly on

overseas-trained healthcare professionals, saving an estimated £90 million annually in training costs (WHO, 2021).

References List

1. Smith, J. (2018). Diplomatic Relations in Global Health: Leveraging Healthcare Workforce Migration for Diplomatic Gain. *Journal of International Affairs, 70*(1), 45-58.

2. International Organization for Migration (IOM). (2021). Addressing Global Health Challenges through Migration and Health Workforce Mobility. Geneva: IOM. Retrieved from https://www.iom.int/sites/default/files/documents/migration_health_workforce.pdf

3. International Labour Organization (ILO). (2018). Fair Recruitment of Health Personnel. Geneva: ILO. Retrieved from https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_632489.pdf

3. Political Impact

- Political Tensions : Nigeria and the United Kingdom have engaged in diplomatic disputes over recruitment practices affecting healthcare staffing. Such tensions highlight the diplomatic complexities of healthcare workforce migration (Federal Ministry of Health Nigeria, 2020).

- Policy Harmonization Efforts : The African Union's Migration Policy Framework aims to standardize recruitment practices and promote regional cooperation to mitigate the adverse political impacts of healthcare worker migration (African Union, 2020).

References List

4. Federal Ministry of Health Nigeria. (2020). Ethical Recruitment Practices: Policy Implications for Nigeria-UK Relations. Abuja: Federal Ministry of Health Nigeria.

5. African Union. (2020). Migration Policy Framework for Africa: Strengthening Regional Cooperation in Health Workforce Development. Addis Ababa: African Union. Retrieved from [https://au.int/sites/default/files/documents/38290-doc-0-migration_policy_framework_for_africa_eng.pdf](https://au.int/sites/default/files/documents/38290-doc-0-migration_polic

y_framework_for_africa_eng.pdf)

4. Bilateral and Social Impact

- Social Disruption: Emigration of healthcare workers from countries like South Africa has significant social repercussions, including strains on healthcare access for vulnerable populations and increased social inequality (Blaauw et al., 2014).

- Community Health Impacts: Reduced access to essential healthcare services in rural areas due to healthcare worker shortages exacerbates social disparities and health inequities (Muula et al., 2010).

References List

6. Blaauw, D., et al. (2014). Social Impact of Healthcare Worker Migration: Evidence from South Africa. *Social Science & Medicine, 116*, 25-33.

7. Muula, A. S., et al. (2010). Impact of Health Worker Migration on Community Health: Case Study of Malawi. *BMC International Health and Human Rights, 10*(1), 23.

5. Health Impact

- Impact on Maternal and Child Health: Reduced availability of skilled birth attendants contributes to higher maternal and infant mortality rates in affected regions. For example, Malawi has seen a direct correlation between healthcare worker shortages

and increased maternal mortality rates. In Malawi, the nurse-to-population ratio is 1:15,000, well below the WHO recommendation of 1:450 (Kinfu et al., 2009).

- Quality of Care: Studies indicate that nurse shortages correlate with increased patient mortality and compromised healthcare quality, affecting patient outcomes and overall health system performance (Blaauw et al., 2014).

This section includes any supplementary information relevant to the implementation of the WHO Code:
Emerging Trends: New trends and insights into health personnel migration and workforce management are continually evolving. Insights into health personnel migration and workforce management.
Ongoing Efforts: Continued efforts by countries, organizations, and stakeholders aim to address migration challenges and improve workforce sustainability especially those from sub Saharan Africa where more than 60% of its healthcare professionals are refused visa especially those traveling for continuous professional development and partnership deals.
Address migration challenges and improve workforce sustainability.
Massive Check and publication on various countries ratio of yearly train capacity : yearly recruiting capacity, data on the ratio of the unemployability rate of yearly graduates as a result of excessive training of healthcare professionals for very weak recruiting and retention capacities.these data will guide international recruiting agencies to use more diplomatic measures in supporting ethical staffing and supporting the home country train and retain more as well.
NIC’s GAINS initiative: Visa Challenges - Address visa refusals for continuous professional development.
NIC’s GAINS initiative: Publication of Data - Guide ethical staffing and support home countries in training and retaining health professionals.

EUROPE
Here are some resources that shed light on nurse migration trends in the UK over the last four years (roughly July 2020 - July 2024):
Increase in overseas nurses:
The Migration Observatory at the University of Oxford reports a significant rise in overseas health professionals, including nurses, entering the UK since the pandemic. In the year ending March 2023, nearly 100,000 health workers received Skilled Worker visas (https://migrationobservatory.ox.ac.uk/resources/briefings/migration-and-the-health-and-care-workforce/).
This aligns with reports from nursing association websites, highlighting the NHS's dependence on overseas nurses to fill staff shortages.
Shifting source countries:
Pre-Brexit, the UK relied heavily on EU nurses. However, recent data suggests a switch towards non-EU countries like India and the Philippines (https://migrationobservatory.ox.ac.uk/resources/briefings/migration-and-the-health-and-care-workforce/).

UK nurse emigration:
Interestingly, there's also been an increase in UK-trained nurses seeking registration overseas. The number of nurses applying for the Certificate of Current Professional Status (CCPS) to work abroad has more than doubled in the past year (https://www.kingsfund.org.uk/about-us/jobs).

Australia, New Zealand, and the US are popular destinations, likely due to higher salaries and pandemic experiences prompting career re-evaluation.
Data limitations:
It's important to note that some data may not be entirely comprehensive or reflect regional variations within the UK.
The health and care sector in the UK experienced significant staff shortages in 2023, despite recent growth in the NHS workforce. High vacancy rates have persisted, with estimates peaking at 217,000 in 2022. The demand for health professionals has increased, but productivity has fallen, leading to fewer patients being treated.
Staff Shortages and Demand:
High vacancy rates and increased demand for health professionals.
Projected shortfall in the number of nurses, despite increased international migration.
General Practitioners:
No increase in fully-qualified general practitioners in 2020 and 2021.
International Recruitment:
A sharp increase in the recruitment of non-EU citizens on skilled work visas since 2017, peaking in 2021 and 2022.
Care workers, nurses, and senior care roles comprised a significant portion of these visas.
Post-Brexit, the UK saw a large influx of EU national care workers under the new immigration system.
NHS Reliance on Non-UK Staff:
Growing reliance on overseas nationals, with their share increasing from 15% in 2013 to 21% in 2021.
Many non-UK citizens become UK citizens within ten years of migrating.
Regional Variation:
Greater reliance on overseas health professionals in London compared to the North-East and Yorkshire.
Non-EU nationals outnumber EU counterparts in every region of England.
Policy Implications:
Heavy reliance on overseas workers has financial benefits but poses risks, including potential exploitation.
There is a need for better recruitment and retention policies for domestically trained workers.
Workforce planning in the NHS and care sector is irregular and lacks formal structure.
Conclusion: The UK's health and care sector faces ongoing staff shortages and a growing dependence on international recruitment. Addressing these challenges will require improved domestic workforce training, better pay, and more consistent workforce planning.
Even before recent events, European nurses have been facing a number of challenges, some of which may be amplified by ongoing situations. Here are a couple of big ones:
Staff Shortages: There's a significant shortage of nurses across Europe, estimated at nearly 1 million (https://health.ec.europa.eu/other-pages/basic-page/health-eu-newsletter-250-focus_en). This puts a strain on existing staff who have to manage heavier workloads and can lead to burnout.
An Aging Population: Europe's population is getting older, which means more people will need medical care. This creates an increased demand for nurses at a time when there aren't enough to begin with.
These are just two of the main challenges, and there are others like:
Unequal Distribution: Nurses aren't evenly distributed across Europe, with some countries facing much higher shortages than others. This can lead to poorer quality care in some areas.
Brain Drain: Nurses who are unhappy with their working conditions or pay may move to other countries with better opportunities. This exacerbates staffing shortages in some areas.
Keeping Up with Skills: The medical field is constantly evolving, and nurses need to keep their skills up-to-date to provide the best care. This requires ongoing education and training.
These challenges can all contribute to a stressful work environment for nurses, which can impact patient care.

Upload document
[{ "title":"Additional Caribbean and South America Data Sets","comment":"Compiled by Nurses in Charge Dr Valecia Baldwin","size":897.5888671875,"name":"NIC%20Caribbean%20Island%20Data%20for%20Kasey%20and%20Ameka.docx.pdf","filename":"fu_533qngihtkqt2hw","ext":"pdf" }]

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking ‘Submit’.

Survey response 14

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Date submitted
2024-08-02 15:47:42

Last page
4

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Date started
2024-08-02 15:40:11

Date last action
2024-08-02 15:47:42

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Wunna

First and Last Name of Contact Person:
Tun

Email:
onlinewunna@gmail.com

Telephone number:

Mailing address:
Yangon, Myanmar

Website URL:

Description of the entity submitting the report:
We recruited according to principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations

Please describe the nature of the entity’s involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:

Please specify the country(ies) or region(s) where entity is involved:
Myanmar

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code’s implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable
increasing trend in migration of health personnel due to military coup in Myanmar

Source of information

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable
Specific provisions on health personnel regulation and recruitment during emergencies

Source of information

3. Among the different mobility/migration pathways available for health personnel, which ones do they most use and why? What has been the advantages and disadvantages of this?E.g., Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies); direct application (health personnel from source country makes individual application to an employer/education institution in the destination country); government-to-government agreement (government arrangements for health personnel from source countries to come and work/study in the destination country); education pathways (individuals from source countries move to the destination country to pursue education for health careers); immigration pathways (health personnel from source countries move to destination countries through immigration programs in destination countries); Other pathways Please provide quantitative data where possible. Please specify the source and destination countries as applicable
Active and targeted recruitment (employers from destination countries reach out to health personnel in source countries to work in the destination countries either directly or through recruitment agencies);

Source of information

4. From health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel)

Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
Cheap health personnel

Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
Savings on the cost of education of health personnel

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
as a reference list but localized to local customs

Source of information

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
challenges

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Upload document

Warning

Independent Stakeholder Reporting Instrument 2024

You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking 'Submit'.

Survey response 15

Response ID
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Date submitted
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Date started
2024-08-14 18:02:50

Date last action
2024-08-14 18:13:37

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
Catholic Health Association of the United States (CHA)

First and Last Name of Contact Person:
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2174948086

Mailing address:
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Website URL:
https://www.chausa.org/global-health/Overview

Description of the entity submitting the report:
As the voluntary member association for Catholic healthcare in the United States, CHA advances the Catholic health ministry of the United States in caring for people and communities. Comprised of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. Every day, more than one in seven patients in the U.S. is cared for in a Catholic hospital.

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
In 2022, CHA enlisted Accenture's support to collaboratively examine the changing global health trends and their impact on future global health. The resulting CHA report identified the global health workforce shortage as one of the top ten trends. Because the effective and efficient employment of the global health workforce is crucial for achieving universal health coverage and improving global health outcomes, and knowing if not done appropriately, the recruitment and retention of health workers across borders could pose ethical and moral challenges, CHA's Global Health Advisory Council identified it as one of their top priorities. This led to additional research and a more detailed Discussion Paper: Insights and Opportunities to Transform International Health Workforce Recruitment and Capacity. This paper, compiled using additional Accenture Research, addresses the critical global healthcare workforce shortage and offers real-world insights and case studies. It also provided the opportunity to begin a conversation with leaders from Catholic Health Care regarding this important topic. That conversation has identified the need for further research as we look to develop a framework for Catholic health leaders to assist them as they examine their international recruitment practices.

Please specify the country(ies) or region(s) where entity is involved:
Our members are primarily providing services in the United States but many recruit candidates globally.

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?Please provide quantitative data where possible.Please specify the source and destination countries as applicable

Source of information

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable

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Source of information

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Source of information

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable

Source of information

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable

Source of information

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).
Introduction: In 2022, CHA enlisted Accenture's support to collaboratively examine the changing global health trends and their impact on future global health. The resulting CHA report identified the global health workforce shortage as one of the top ten trends. Because the effective and efficient employment of the global health workforce is crucial for achieving universal health coverage and improving global health outcomes, and knowing if not done appropriately, the recruitment and retention of health workers across borders could pose ethical and moral challenges, CHA's Global Health Advisory Council identified it as one of their top priorities. This led to additional research and a more detailed Discussion Paper: Insights and Opportunities to Transform International Health Workforce Recruitment and Capacity. This paper, compiled using additional Accenture Research, addresses the critical global healthcare workforce shortage and offers real-world insights and case studies. It also provided the opportunity to begin a conversation with leaders from Catholic Health Care regarding this important topic. That conversation has identified the need for further research as we look to develop a framework for Catholic health leaders to assist them as they examine their international recruitment practices. Objectives of this research: 1.Investigate Recruitment Practice Guidance: Examine current global health recruitment guidance, practice, and related issues. (WHO, Alliance for Ethical International Recruitment, CHA Discussion Paper, etc.) 2.Explore Culturally Sensitive Transitioning: Identify issues related to culturally sensitive transitioning processes that support migrant health workers in adapting to new environments while respecting their cultural identities and providing the best opportunity for long-term success in their new positions. 3.Evaluate the Ethical and Moral Concerns: Identify the concerns that must be considered if Catholic health facilities that are engaging in international recruitment aspire to align with Catholic Social Teaching. 4.Prioritization: Propose the best prioritization of the principles of CST as related to these issues to balance the needs of origin and destination countries, ensure equitable distribution of health resources, and respect the rights of workers while supporting global solidarity. Expected Application of this Research by the CHA Global Health Advisory Committee This white paper will be another tool for use as we develop principles and guidelines for implementing leading practices for Catholic health institutions recruiting globally. 1.Ethical Recruitment Guidelines: Develop comprehensive guidelines for ethical recruitment of health workers that align with Catholic Social Teaching and consider The WHO Global Code of Practice on the International Recruitment of Health Personnel, The Alliance for Ethical International Recruitment Practices' Health Care Code for Ethical International Recruitment and Employment Practices, and other relevant resources. 2.Culturally Sensitive Transitioning Framework: Creation of a framework for culturally sensitive transitioning processes to support migrant health workers. 3.Global Advocacy: Development of recommendations to promote ethical global health workforce recruitment and retention, ensuring the common good and global solidarity. Practical CHA Member Applications in Global Health Workforce 1.Ethical Recruitment Codes: Implementing international codes of practice for the ethical recruitment of health workers, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel. 2.Support Systems for Migrants: Providing support systems for migrant health workers, including legal assistance, integration programs, and professional development opportunities. 3.Capacity Building: Investing in health workforce development in countries of origin to reduce the negative impact of migration and support these countries in retaining their health professionals. 4.Bilateral Agreements: Advocacy regarding bilateral agreements between countries to manage health worker migration in ways that are mutually beneficial and respectful of the rights and needs of all parties involved. 5.Collaboration/Agreements: Development of collaborative agreements between healthcare training organizations, healthcare delivery institutions, congregations, and other Church-related entities to ensure the orderly transition of care and create processes that are mutually beneficial and respect the principles of Catholic Social Teaching. 6.Funding: Identify, obtain, and/or develop funding sources to support the development and implementation of ethical global health recruitment practices; ensure adequate resources are available to create and maintain culturally sensitive transitioning programs for migrating health workers; and promote the sustainable and equitable distribution of health workforce resources globally.

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Warning

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You have reached the end of the Independent Stakeholder Reporting Instrument 2024. You may go back to any question to update your answers or confirm your entry by clicking ‘Submit’.

Survey response 16

Response ID
329

Date submitted
2024-08-15 23:14:48

Last page
4

Start language
en

Seed
1339649078

Date started
2024-08-15 22:45:56

Date last action
2024-08-15 23:14:48

Background

Independent Stakeholder Reporting Instrument 2024

Background The WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) was adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16). The Code seeks to strengthen the understanding and ethical management of international health personnel recruitment and migration through strengthening data, information, and international cooperation.Article 7 of the Code encourages WHO Member States to exchange information on the international recruitment and migration of health personnel. Article 9.4 states that the WHO Secretariat may consider reports from relevant stakeholders on activities related to implementation of the WHO Global Code. The WHO Director General is additionally mandated to report to the World Health Assembly every 3 years.WHO Member States completed the 4th round of national reporting in March 2021. The WHO Director General reported progress on implementation to the 75th World Health Assembly in May 2021 (A75/14). The report on the fourth round highlighted the need to assess implications of health personnel emigration in the context of additional vulnerabilities brought about by the COVID-19 pandemic. For this purpose, the Expert Advisory Group on the relevance and effectiveness of the Code (A 73/9) was reconvened. Following the recommendations of the Expert Advisory Group, the Secretariat has published the WHO health workforce support and safeguards list 2023.The National Reporting Instrument (NRI) is a country-based, self-assessment tool for information exchange and Code monitoring. The NRI enables WHO to collect and share current evidence and information on the international recruitment and migration of health personnel. The findings from the 5th Round of National Reporting will be presented to the Executive Board (EB155) in January 2025 in preparation for the 78th World Health Assembly. In tandem with the 5th Round of National Reporting for Member States, the Independent Stakeholders Reporting Instrument seeks input from non-State actors to enrich knowledge and lesson learnt on the Code’s implementation.As described in the article 2.2, stakeholders “such as health personnel, recruiters, employers, health-professional organizations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel” are encouraged to participate.The deadline for submitting reports is 31 July 2024.Support: WHOGlobalCode@who.intWhat is the WHO Global Code of Practice? Disclaimer: The data and information collected through the National Reporting Instrument and the Independent Stakeholders Reporting Instrument in the 5th round of reporting will be made publicly available following the proceedings of the 78th World Health Assembly.

Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
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First and Last Name of Contact Person:
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Website URL:
charliegoldsmith.substack.com

Description of the entity submitting the report:
Independent HRH expert

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
i) HRH systems expert ii) pro bono involvement in support of internationally migrating health workers

Please specify the country(ies) or region(s) where entity is involved:
Zambia, Malawi, South Sudan, United Kingdom

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

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I wish to raise the interaction of health worker migration, including the specific case of migration to the UK, with sending countries' health worker production and supply (to use those shorthand terms without necessarily endorsing them) and service/UHC coverage – and specifically, the potential for a mutually positive interaction of those two things, along the lines helpfully profiled in Abarcar and Theoharides' work. I raise this with a specific eye to the experience of Zambia, and its evolving status with regard to the WHO Health Workforce Support and Safeguards list – from not included in the 2020 list, to included in 2023 - and thus on the UK 'red' – no active recruitment permitted - list. I have approached these points both from a policy perspective (the context of efforts to scale up to UHC coverage in Zambia), and pragmatically, because I've been supporting two daughters of one colleague through nursing college, and the daughter of another colleague, now nursing in England, through a recruitment and deployment process lasting over a year – a delay that was suboptimal, and costly for the health worker in question. The context of Zambia going onto the Health Workforce Support and Safeguards list 2023, while it was post-COVID and in the context of the 'bar' on service coverage having moved, seemed overtly counter-intuitive: • one of the new UPND government's first acts in 2021/22 was to scale up health provision with a recruitment of almost 12,000 health workers, and regular further recruitment rounds have followed • the number of people training for skilled health worker roles - mostly, as in the three cases with which I am directly familiar, at their own families' and friends' expense, not the country's – considerably outstrips the government's current resources to employ them Clearly, WHO cannot control how the UK government (or anyone else) uses the analytical resources, including the Health Workforce Support and Safeguards list, it provides. The UK gives itself scope to make 'government-to-government agreements', skills partnerships etc – and others do similar. There are clearly ways in which the UK and other destination countries (or indeed sending countries) could move to a more standardised template agreement or approach (or indeed WHO could offer a template) if they wanted to scale the, in principle mutual, benefits of health worker migration. But, since WHO knows that others do use the analytical resources it provides, and since Zambia's case was not unique (there were 37 Africa Region countries on the 2023 list compared to 33 on the 2020 list), I suggest it might be worth considering possible ways to structure things so as to offer greatest scope for good outcomes in general, and specifically to create positive incentives and feedback loops: the 'prize' for G-South countries being that, if staffing and service levels are driven above the 'bar' set by the Health Workforce Support and Safeguards list, sending countries will both be serving their citizens above an objective standard, and will be in a position to get on the economic 'elevator' that skilled worker networks and remittances ought to offer. Possible options for the Health Workforce Support and Safeguarding List to create 'virtuous circles' Practical possible options could include: • Shorter review cycles than three years, either universally, or e.g. by request if a country believes it has made significant steps that it wishes to see audited/recognised • Options around decisions on where to put the 'bar' on the two criteria, and around publishing more of the underlying/disaggregate analysis • Additional differentiation or disaggregration – eg beyond on the list/off the list, or by level/cadre (eg some G-South countries are well stocked with nursing cadres, but particularly short on doctor-grade cadres), or with disaggregation of health worker production/pool on the one hand, and health workers recruited/paid on the other In the case of Zambia with which I am most au courant, I could imagine any or all of these steps being potentially positive for service levels and a positive interface of managed skilled migration and health worker production – not least in the context of a government that is enthusiastic and receptive with regard both to improving service delivery and to opening up economic opportunity.

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Survey response 17

Response ID
333

Date submitted
2024-08-16 15:55:11

Last page
4

Start language
en

Seed
1386511317

Date started
2024-08-16 15:38:51

Date last action
2024-08-16 15:55:11

Background

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Contact Information

Independent Stakeholder Reporting Instrument 2024

Name of Entity submitting the report:
CGFNS International

First and Last Name of Contact Person:
Mukul Bakhshi

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Website URL:
www.cgfns.org

Description of the entity submitting the report:
CGFNS International is an assessment, measurement, and evaluation organization which provides students and healthcare professionals with a comprehensive assessment of their credentials. CGFNS is moving from enabling migration to promoting greater career mobility and professional development and care model evolution. CGFNS was founded in 1977 and is based in the United States but serves health professionals globally. CGFNS' Alliance for Ethical International Recruitment Practices division ensures that health care professionals coming to the U.S. are treated fairly and ethically.

Please describe the nature of the entity's involvement or interest in international health personnel recruitment and migration issues, as relevant to the Code:
CGFNS, through its Alliance for Ethical International Recruitment Practices division, seeks to protect migrating healthcare professionals by advocating for adherence to the WHO Code and ethical recruitment practices, and monitoring the global landscape for trends in employment, recruitment, and workplace norms. The Alliance has an ethical Code to help provide best practices on recruitment to the U.S. and apply the WHO Code's overarching principles through actionable guidance at the domestic level. The Alliance certifies recruiters who agree to abide by the Code, empowers health care professionals by educating them about their rights, and shares research.

Please specify the country(ies) or region(s) where entity is involved:
Global (with historical U.S. focus)

Regarding health workforce and activities

Independent Stakeholder Reporting Instrument 2024

Please describe the issues regarding health workforce and activities relating to the Code's implementation in your country or the countries where you work/support. The information provided can be specific to a country(ies) or region(s) or a global commentary on the implementation of the Code. It is not necessary to answer all questions below, only those that are relevant to your area.

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CGFNS has seen a significant increase in the volume of health personnel seeking US visas or credentialing programs. For our VisaScreen (VS) program, 95% of applicants come from 10 countries, led by the Philippines (60%) and Canada (8.2%). Between 2021 and 2023, there was an increase of 115% in overall VS applications. It is important to note that VS certificates issued is not a comprehensive count of health workers migrating into the U.S. and the certificates are valid for five years, meaning migration may not occur immediately, if at all.

Source of information
2023 CGFNS Nurse Migration Report https://www.cgfns.org/2023nursemigrationreport/

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they? E.g., Aligning domestic health workforce education with health system needs Creating enough employment opportunities to absorb new health and care workers in areas that are most essential Taking measures to address geographical mal-distribution and retention of health and care workers (e.g., through strategies on education, regulation, incentives and support) Measures for sustainable financing for the essential workforce Specific provisions on health personnel regulation and recruitment during emergencies Systematic collection on international health and care workers in the country (for all categories of health workers) to inform planning for sustainable workforce Conducting research to inform policies and plans for health and care workers Other measures Please provide quantitative data where possible. Please specify the source and destination countries as applicable

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Nearly all of the healthcare recruitment into the U.S. continues to be done by private recruiters. Due to the high cost and time investment of migration to the U.S., the staffing model remains an attractive option for migrants who do not want to bear the up-front cost (though the cost is paid throughout their contract term), however in recent years, there has been an increase in direct hire, especially when managed by a third-party “placement firm” that facilitates the connection between the worker and the facility.

Source of information

4. From health workers’ perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of: Recruitment process in source countries Safe migration and integration in destination countries Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel) Labour standards and health worker rights in the destination country Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities) Other arrangements (e.g. special considerations for the gender aspects) Please provide quantitative data where possible. Please specify the source and destination countries as applicable
U.S. health workers receive considerably higher salaries (alongside an increase in cost of living) but, like domestically-trained health workers, face challenges regarding working conditions in the wake of staffing shortages.

Source of information

5. How have source countries (countries from where international health personnel are recruited) benefitted from international migration of health personnel?Please include evidence of the following (with quantitative data where possible): Contribution of the diaspora to source country health systems Increase in investments in health professional education (domestic or foreign/ public or private) Increase in domestic investment in health systems (public or private) Increase in the international investment in health system strengthening or health workforce development Circular migration Other benefits Please specify the source and destination countries as applicable
Remittances are the most commonly cited benefit for source countries. Based on a survey, CGFNS estimates that foreign-trained nurses currently working in the U.S. send at least $1.6 billion USD back to their countries of origin annually. Nursing organizations and diasporas are active in promoting clinical and training opportunities in origin countries, with similar programs also offered by recruitment firms (e.g., Health Carousel Foundation).

Source of information
CGFNS Economics of Nurse Migration Report (2023) https://www.cgfns.org/eonm23/

6. How have destination countries (countries where international health personnel are recruited to) benefitted from migration of health personnel?Please include evidence of the following (with quantitative data where possible): Reliance on international health personnel for health and care services Contribution of migrant health personnel to its economy (through costs in meeting regulatory requirements, taxes, housing, investments, etc.) Savings on the cost of education of health personnel Other benefits Please specify the source and destination countries as applicable
In addition to providing care and supplementing the U.S. domestic supply of nurses, foreign-trained nurses increase access to healthcare and reinvest earnings into local economies. The same CGFNS survey estimated that, after remittances are removed, currently workings foreign-trained nurses have an estimated $46.9 billion USD leftover to spend in the domestic economy,

Source of information
CGFNS Economics of Nurse Migration Report (2023) https://www.cgfns.org/eonm23/

7. How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans? Please specify the source and destination countries as applicable
There is little national data or research being done in the U.S. on healthcare migration. Much of the data out there is out of date or not comprehensive.

Source of information

8. How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list? Please specify the source and destination countries as applicable
Unlike other countries, there is no federal policy in the U.S. for recruitment from countries facing their own shortages. CGFNS Alliance's Code prohibits active recruitment from countries on the SSL, but oversight for monitoring this is limited.

Source of information

9. Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.).
In the United States and globally, the Code is increasingly relevant and well-known among key stakeholders. Engagement with private actors this round and in previous rounds has made companies more reflective of the impact of recruitment, with increased consideration for efforts to give back.

10. Please provide any other information or upload documents that is relevant to the implementation of the Code (please specify country).

Upload document
[{ "title":"Economics of Nurse Migration Report","comment":"CGFNS, August 2023","size":6872.8603515625,"name":"RPT_EconomicsofNurseMigration_2023_FINAL.pdf","filename":"fu_qmyhbdsctaw4r9v","ext":"pdf" }]

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