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Human Resources for Health Migration:

global policy responses, initiatives, and emerging issues

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Abbreviations

EU	European Union
GATS	General Agreement on Trade in Services
GFMD	Global Forum on Migration and Development
GHWA	Global Health Workforce Alliance
HRH	Human Resources for Health
ILO	International Labour Organization
IOM	International Organization for Migration
ITUC	International Trade Union Confederation
INGOs	International Non-Governmental Organisations
OECD	Organisation for Economic Cooperation and Development
OSCE	Organization for Security and Cooperation in Europe
PAHO	Pan-American Health Organization
PSI	Public Services International
TISA	Trade in Services Agreement
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UN-GMG	United Nations Global Migration Group
UNHCR	United Nations High Commissioner for Refugees
UNHLD-MD	United Nations High-Level Dialogue on Migration and Development
UNICEF	United Nations Children's Fund
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

Overall messages

- Skilled health worker migration has emerged as a major issue in global policy making over the last decade. Global dialogue on skilled health worker migration takes place through a range of multilateral organisations, with different missions and remits, inside and outside the UN system.

- Evolving global policy on migration for development, universal health coverage and HRH in the post-2015 development agenda are shaping global dialogue on HRH migration in tangible ways.

- Global governance on HRH migration has led to a range of global, regional and bilateral mechanisms resulting in varying levels of cooperation and policy development. They include normative frameworks for rights-based approaches to migration, voluntary codes on ethical recruitment with a specific focus on HRH in source countries, diasporic initiatives aimed at 'brain gain' and development for source countries, data and forecasting on future HRH requirements, measures to 'scale up' HRH in source countries, and regional and bilateral agreements and partnerships on HRH migration, amongst others.

- This report argues that integrated and coordinated global responses are needed to address a range of policy issues concerning workforce planning, retention of health workers and mechanisms to ensure that source countries benefit from migration in ways that are proportionate to the benefits gained by destination countries. These are complex, multifaceted issues to address, not least because of the different policy domains under which global health and global migration have evolved, differences in health policy and financing in high-, medium- and low income countries, and unequal economic and social development. Articulating what the 'right to health' and the 'right to migrate' mean in this context is equally complex.

- An overriding message from this report is that better are needed systems for: monitoring and capturing HRH requirements and HRH migration flows in source and destination countries; enforcing and monitoring ethical recruitment practices; ensuring that source countries benefit from global financial and technical assistance on HRH across a health system; facilitating reciprocal HRH arrangements and partnerships between source and destination countries; and promoting multistakeholder alliances and partnerships. It raises key questions about how to progress HRH migration policy in the context of global health, shared/global social responsibility, ethical recruitment and rights-based approaches to migration.

Executive Summary

- The *Global Health Report* (WHO 2006) marked a call to action in the international community to address the estimated global shortage of more than 4.3 million health personnel. It reflected growing international concern about the Human Resources for Health (HRH) 'crisis' during the 2000s, which engendered increased activity by multilateral organisations as well as global mobilization for the creation of alliances on HRH migration. At the same time it defined the HRH shortages as a *global issue*, and marked a turning point in awareness of the need for improved coherence of *global* action, cooperation and coordination on this issue.

- Apart from the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO 2010a) knowledge about the nature and range of global policy actors, policy responses and initiatives in HRH migration is very limited. This report constitutes the first attempt to comprehensively map how issues of health worker migration are framed and taken up by different global actors, and how these in turn are being addressed through their policy responses and advocacy initiatives.

- This report identifies and maps contemporary global policy responses to, and initiatives on, international HRH migration, with particular reference to low-income source countries. It reports on a systematic review and analysis of the responses and initiatives of twelve multilateral organisations and global fora: European Union; Global Forum on Migration and Development; Global Health Workforce Alliance; International Labour Organization; International Organization for Migration; Organisation for Economic Cooperation and Development; Pan-American Health Organization; UN Global Migration Group; UN High-Level Dialogue on Migration and Development; World Bank; World Health Organization; and the World Trade Organization.

- The report documents how these global policy actors are presently engaging with the HRH migration field through their activities, initiatives and policy responses. It situates this engagement within global policy initiatives spanning health, migration and development. In addition to reviewing and mapping current initiatives and policy responses and their outcomes, the report identifies emerging issues, upcoming promising initiatives and global policy scenarios.

- The research on which this report is based involved primary and secondary research data collection and analysis. Key informant interviews with senior officials working in operational, research and policy divisions in twelve multilateral organisations and global policy fora were carried out between April-July 2013. In addition, we undertook a comprehensive review and

analysis of key policy documents of the organisations examined, along with academic policy-oriented research and 'grey' literature on global governance and policy on HRH migration.

- Over the last decade there have been specific and notable developments in the global HRH migration governance and policy. HRH migration issues have been taken up as matters of on-going concern in multiple global policy fora focused on issues of migration, health and development. All of the organisations examined in this study discuss HRH migration as part of their broader dialogue, but the only fora dedicated to a global dialogue on HRH migration are the Health Worker Migration Initiative (HWMI) and Global Health Workforce Alliance (GHWA), allied to the World Health Organization. The institutional actors involved are multiform in terms of their mandates, resources, perspectives, and engagement with the issue field.

- Global responses operate on many scales and take many different forms. Across activities spanning policy development, normative standard-setting, technical assistance, data gathering and research, distinctive global, regional and cross-national responses can be identified. *Global*-level responses on HRH migration are developing in the context of ethical recruitment, and wider policy initiatives to strengthen health systems with a focus on scaling up HRH and retaining health workers in countries facing critical health workforce shortages. *Regional* approaches to HRH migration take the form of regional guidelines, regulatory frameworks and action plans, 'mobility partnerships' (between non-EU countries and the EU), and observatory systems. *Inter-state* partnerships and agreements include diasporic initiatives, financial and technical cooperation agreements, and bilateral initiatives, some of which aim at embedding principles of decent work, ethical recruitment and mutual exchange, while others are signed on the basis of economic partnerships. *Sector-wide* approaches develop and disseminate good practice between countries on the governance of HRH migration. *Ethical recruitment* initiatives include voluntary codes of practice, globally, regionally, inter-state and nationally.

- This global policy field is characterised by: an emphasis on cross-border (inter-state, regional, bilateral) initiatives; growing levels of collaboration *between* multilateral agencies around issues of HRH migration; greater emphasis on multi-stakeholder initiatives and participation in policymaking involving multilateral organisations, governments, civil society organisations, trades unions, and employers; and an emphasis on non-binding initiatives and consultative forums.

- Rather than simply framed as a problem of 'brain drain', there is increasing emphasis on the responsibilities of destination countries in global HRH migration management as well as on

the scaling-up and retention strategies of source countries. There is also an increased emphasis on ensuring that HRH migration is better harnessed in the interests of source countries' development through, for example, diaspora initiatives and circular migration approaches, although examples of reciprocal arrangements to support HRH development and capacity in source countries remain the exception rather than the rule.

- The commitment to universal health coverage (UHC) as a major development objective will have significant implications for HRH in the future. The additional two million health workers that are estimated as being needed to meet the population health needs associated with UHC underscore the need for continued progress in workforce planning and HRH strategies. At the same time, the 'mainstreaming' of migration into development policy raises issues for international development aid and donor programmes amidst calls for these programmes to be better focused on HRH issues and the goals of development, training, management, forecasting, recruitment and retention of health workers.

- Perspectives that seek to harness the potential of international trade agreements as a means of managing migration, including in HRH migration, and scaling up health systems and workforces occupy a key role in present development policy debates. These may accelerate an emphasis on temporary forms of HRH migration. The absence of in-built mechanisms in services trade agreements to build the capacity of health workers and the health sector and to support ethical recruitment and rights-based approaches to HRH migration remains a concern.

- There is an urgent need to build momentum in monitoring and implementing the WHO Code. Compliance remains a concern. Better collaboration and shared responsibility for implementing and monitoring the Code among all stakeholders and between different Ministries (health, justice, finance, employment) in source and destination countries are needed. The lack of comparable global data remains a fundamental obstacle to monitoring the WHO Code, improving workforce planning and mapping trends in international health work migration.

- A major challenge for the future is how to institute coordinated and robust responses to the complex and multifaceted nature of HRH migration. Four overarching challenges stand out in discussion on the global governance of HRH migration; the need to: coordinate diverse public policies affecting HRH migration; situate HRH issues in the context of unequal development and distribution of resources; visibilise HRH migration in evolving global policy agendas spanning health, migration, trade and development policy; and strengthen and resource global alliances and networks around HRH migration issues.

Section 1. Introduction and Context

1.1 Scope of this Report

This report documents research into the policy responses of multilateral actors on the international migration of skilled health professionals. This research project was led by Professor Nicola Yeates (The Open University, UK) and carried out jointly by Professor Nicola Yeates and Dr. Jane Pillinger (Independent Researcher and Social Policy Analyst, Ireland) over the period from 2nd January to 30th September 2013.

This research report:

- presents 'state of the art' policy perspectives and initiatives of key international organisations and global fora having a direct bearing on issues of the migration of highly skilled health personnel; and

- situates the findings and recommendations from this research project in the broader context of current global issues, debates, initiatives and policy development processes at the intersection of two substantive areas: human resources for health and international migration.

- is based on an analysis of comprehensive research data on the policy responses and initiatives of twelve international organisations and policy fora with regard to highly skilled health worker migration. These are listed below, in alphabetical order:
  - European Union
  - Global Forum on Migration and Development
  - Global Health Workforce Alliance
  - International Labour Organization
  - International Organization for Migration
  - Organisation for Economic Cooperation and Development
  - Pan-American Health Organization
  - UN Global Migration Group
  - UN High-Level Dialogue on Migration and Development
  - World Bank
  - World Health Organization
  - World Trade Organization

See Annex 1 for further information on research data and methods.

1.2 Research context

The publication of the *Global Health Report* (WHO 2006) marked a call to action in the international community to address the estimated a global shortage of more than 4.3 million health personnel, and particularly in the 57 low income countries facing critical shortages, 36 of which were in sub-Saharan African. It marked the growing international concern about the HRH 'crisis' and urged member states to prioritise HRH in policy initiatives and to address the moral and ethical implications of health worker recruitment from 'developing' countries. It also marked a turning point in awareness of the need for *global* cooperation and coordination in this field. Such responses were at the time already seen from increasing levels of collaboration between multilateral organisations and global mobilization for the creation of alliances on HRH migration, as seen in the establishment of the Health Worker Migration Initiative (HWMI) and Global Health Workforce Alliance (GHWA), allied to the WHO. These forms of collaboration and alliances culminated in global action for a multilateral level instrument to promote dialogue and good practices in connecting source and destination countries on ethical recruitment - the 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO 2010a). Joint OECD/WHO work in building data and indicators of HRH migration in source and destination countries helped to shift thinking about the need for multilateral responses in this area and for countries of destination to engage more systematically in health planning and forecasting of future training and staffing needs.

Whereas the impacts of out-migration of health workers on health care systems and access to health care in source countries and policy responses instituted by source countries have been the focus of considerable attention, there has been little research into policy responses and initiatives of international organisations. Beyond the WHO Code, knowledge about the range of global policy actors, policy responses and initiatives in HRH migration is very limited. Our report thus constitutes the first attempt to comprehensively map how issues of health worker migration are framed and taken up by different global actors, and how these in turn are being addressed through policy responses and advocacy initiatives. Resource constraints mean that it has not been possible to undertake anything more than a preliminary overview of this area.

As this report details, over the last decade specific and notable developments in the global governance of HRH migration have taken place. HRH migration issues have risen up the policy agendas of a range of international and non-governmental organisations and have been taken up as matters of global concern in the multiple global policy fora focused on issues of migration, health and development. At the same time, there has been growing levels of collaboration *between* multilateral agencies around issues of HRH migration. During the 2000s

onwards, a range of international agreements and initiatives have emerged that seek to address HRH migration issues in various ways. These in turn reflect a now-established international consensus on the need for collective action. At the same time, HRH migration issues continue to be addressed in very different ways through international collective action and cooperation. The range and nature of action taken in pursuit of HRH migration in relation to source countries show that global responses to HRH migration are nuanced and multifaceted, rather than simply framed as a problem of the 'brain drain', and that they take many different forms and operate on many scales.

1.3 Structure of the Report

The remainder of this report is organised around three principal sections. Section 2 outlines the organisations' current responses to and initiatives on HRH migration. Distinguishing between country-based and cross-border approaches, the emphasis lies with initiatives addressed to HRH migration in source countries, and with inter-state, bilateral, regional and global initiatives and responses. Section 3 provides an overview of emerging issues and upcoming initiatives in relation to highly skilled HRH migration. This part of the report is drawn together from our analysis of the findings from the research, based on key informant interviews, a review of policy positions in multilateral organisations and a review of the literature. Section 4 concludes the report, setting out four overarching challenges in the global governance of HRH migration. Annex 1 details the data sources and methods. A References List is provided at the end.

Section 2. Multilateral organisations' initiatives on HRH migration

2.1 Institutional governance and policy framework of HRH migration

The global institutional governance framework of HRH migration shares many of the characteristics of migration more generally. While the World Trade Organization oversees trade negotiations, and the International Monetary Fund, along with the Global Financial Board, manages capital mobility, there is no international organisation regulating migration. The WHO approaches issues of migration from a health perspective, while the ILO focuses on labour and social protection issues affecting all categories of labour. The WB has an interest in migration as one factor in wider development. Only the IOM has a sole focus on migration issues, but it has no regulatory or standard setting role. The UN's sponsored Global Commission on International Migration (GCIM 2005), the UN High Level Dialogue on Migration and Development UNHLD-MD), the UN Global Migration Group (UN-GMG), the Global Forum

on Migration and Development (GFMD) are examples of global fora established to promote multilateral dialogue through consultative forums on migration, rather than through the development of multilateral migration policies or standards. However, there is limited evidence these forums have resulted in better coordination and policy coherence, either within or between institutions.

Although these organisations discuss HRH migration as part of their broader dialogue, the only specific fora that a global migration dialogue takes place on HRH migration is through the GMHI and GHWA. There is no overarching global migration governance framework on HRH migration, although a wide range of multilateral organisations participate in HRH migration-specific policy and programmes, and recent years have seen these organisations giving more attention to strategies to address the HRH 'crisis' and have put in place various measures and initiatives to build capacity to do so; resulting in varying forms of inter-state cooperation (bilateral, plurilateral, regional) that have had a lens on HRH migration. Nevertheless, it is evident that there has been a lack of progress in strengthening the global institutional framework. This is seen as a reflection of the unwillingness of destination country governments to engage in binding measures, for example, as seen in the growth of multilateral non-binding initiatives and consultative forums, and in the increasing liberalization of global labour markets (Wickramasekara 2008).

2.2 Overview of multilateral organisations' initiatives on HRH migration

Table 1 sets out the broad types of activities in which multilateral organisations are engaged, showing the divergent and sometimes complementary roles that exist. ILO, for example, is responsible for the protection of migrant workers' rights and normative standards on labour migration; IOM has played a specific role in promoting diaspora exchanges and knowledge transfer; WHO/PAHO has had a role in data collection, research and providing technical assistance on HRH and health systems. The OECD's role, in partnership with WHO and the WB, has been focussed on data collection and in forecasting HRH staffing needs in a range of countries. Although all have an understanding of HRH migration as a global issue, technical assistance, project assistance or consultative fora at sub-global (regional, inter-state, national levels) are more common; in most cases, however, they have collaborated through multilateral partnerships on specific programmes of HRH migration, the most important of which to date is the 2010 WHO Code.

Table 1: Multilateral organisations: type of activity on HRH migration

	Policy	Normative standard setting	Technical assistance	Data	Research
European Union	X	X	X	X	X
Global Forum on Migration and Development	X				
Global Health Workforce Alliance	X				X
International Labour Organization	X	X	X	X	X
International Organization for Migration	X		X	X	X
OECD	X			X	X
PAHO	X	X	X	X	X
UN High Level Dialogue on Migration and Development	X				
World Bank	X		X	X	X
World Health Organization	X	X	X	X	X
World Trade Organization	X			X	

The specificities of the summary information presented in Table 1 are incorporated into the remainder of this report.

2.3 Global-level initiatives

Aside from the WHO Code (discussed later in this report), recent multilateral HRH migration-relevant policy initiatives addressing the sphere of global policy making have focused on the role of HRH in building health systems in achieving the development goals set out in the United Nations Millennium Declaration.

Scaling up the health workforce and workforce retention in countries facing critical health workforce shortages:

- ***World Health Assembly resolutions:*** Resolution of the 59th World Health Assembly (2006) called for "human resources for health development as a top-priority programme area in WHO's General Programme of Work 2006–2015"; specific attention was given to building multisectoral workforce planning capacity and the development of innovative approaches to health workforce teaching, through training partnerships between source and destination countries and with support from global health partners in strengthening health-teaching institutions. Resolution 64.6 passed at the 64th WHA (2011) on strengthening the health workforce stated that there was an urgent and strategic importance for low-income countries to address workforce shortages as a contribution to population health and socioeconomic development,

and urged member governments to educate, retain and sustain a health workforce with skills that are commensurate to population needs. Resolution WHA 64.7 focused on strengthening nursing and midwifery through action plans for nursing and midwifery as integral elements of national, regional or local health planning, as well as on collaborating in the strengthening of the relevant legislation and regulatory processes, and scaling up education and training in nursing and midwifery.

- ***Kampala Declaration and Agenda for Action*** under the banner of 'Health workers for all and all for health workers' (WHO/GWHA 2008) is an example of multistakeholder collaboration inspired by the First Global Human Resources for Health Forum. It called for national and global leadership for health workforce solutions with specific recommendations for "Leaders of bilateral and multilateral development partners to provide coordinated and coherent support to formulate and implement comprehensive country health workforce strategies and plans" and for "Multilateral and bilateral development partners to provide dependable, sustained and adequate financial support and immediately to fulfill existing pledges concerning health and development". It called on governments to provide incentives to provide a working environment to promote retention and equitable distribution of the workforce, and work in the WHO HRH team on retention of workers in underserved, rural and remote areas (WHO 2010b).

Strengthening health systems: the growing evidence of the need for 'horizontal support' for the health workforce as part of the health system has led to a call for development partners to develop new strategies to ensure that HRH become integral to development policies. Examples include the WHO's Maternal Newborn Child Health (MNCH) programme (Muskoka Initiative), agreed at the G8 Summit in June 2010, and the Global Strategy for Women's and Children's Health, launched by the UN Secretary-General at the 2010 MDG Summit. The latter involved a multilateral consultation sponsored by WHO and USAID in 2005, leading to the development of a global technical framework to address the global HRH crisis (Poz et al. 2006). The WB and WHO have initiated joint work on a monitoring framework for UHC, for countries to adapt to their national needs as well as for international monitoring, particularly in the context of the process for the establishment of the post-2015 international sustainable development goals (WHO/WB 2013). This is expected to be completed by the end of 2013; it remains unclear as to whether HRH (migration) will be included in the future development framework.

2.4 Regional initiatives

East African Community (EAC) Multi-sectoral Technical Committee of Experts on Migration of Human Resources for Health. This forms part of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) programme of work on health worker migration and retention in co-operation with the Secretariat of the East, Central and Southern Africa Health Community (ECSA- HC). It has examined a number of issues on migration and displacement in East Africa including a report on *Regional Guidelines for Harmonization of Migration/Displacement Health Policies and Programmes in East Africa* (EAC 2005) which included recommendations for EAC partner states to review existing migration and displacement health policies and programmes with a view progressing a common approach across the EAC, taking into account the EAC Common Markets Protocol.

Regional Managed Migration Programme in the context of the Caribbean Community (CARICOM) includes measures on: temporary nurse migration between the Caribbean and destination countries; intra-regional sharing of nurse-training resources; and emigrant Caribbean nurses returning to share their nursing expertise. The programme has thirteen national, regional, bilateral and international public and private partners in addition to Caribbean governments (Yeates 2010). Evaluations of the measures and their outcomes are unavailable. However, the WB continues to be active in advocating a regional trade-based approach to HRH migration management in this region (WB 2009, 2012), most recently proposing a new policy instrument (a multi-lateral Memorandum of Understanding) outside the framework of the UN to "to translate high levels of political commitment into an actionable regional strategy" (WB 2012: 7).

Mobility Partnerships are non-legally binding migration frameworks between the European Union and other countries. Funded by the EC and bilateral assistance, five EU mobility partnerships have to date been concluded between the EU and Morocco (2013), Armenia (2011), Georgia (2009), Moldova and Cape Verde (2008). Some of these are delivered in partnership with other multilateral organisations. Under the EU-Moldova partnership, for example, the WHO has a role in implementing a project on the "Efficient management of the mobility of the healthcare staff of the Republic of Moldova", with a particular focus on minimizing the negative impact of the migration of healthcare staff through the promotion of circular migration schemes.

Regional action plans for the health workforce aim to build cooperation between member states to respond to some of the challenges facing the health workforce in the medium- to longer-term. Initiatives include:

- The *EU Joint Action with Member States on Health Workforce*, launched in April 2013, focuses on forecasting workforce needs and improving workforce planning methodologies; anticipating future skills needs in the health professions; and sharing good practice on recruitment within Europe (EC 2012; WHO-Europe 2012). It includes all EU countries and certain non-EU countries such Serbia and Moldova.

- The EU is also leading a project (with PAHO) to improve the management of migration flows of doctors and nurses between the Ibero-American Region and the European Union. Phase I (2009-2011) included research and training activities to build capacity in the region for human resource planning and engagement to improve cooperation with development agencies. Phase II (2013-2015) includes specific activities with WHO on human resource planning and impacts of migration on health systems and bilateral agreements.

- *PAHO Regional Plan for Action for Human Resources for Health* (2007–15): an intergovernmental, non-binding resolution, under the strategic objective to 'Promote national and international initiatives for developing countries to retain their health workers and avoid personnel deficits'. Three specific goals are set out regarding the adoption of a code of practice/ethical norms on the international recruitment of health care workers, a policy regarding self-sufficiency, and mechanisms for the recognition of foreign-trained professionals (PAHO/WHO 2007a). PAHO is currently finalising a report on the implementation of the Plan.

Observatories on Human Resources for Health (OHRH) (http://observatoriorh.org): were established in Latin America in the late 1990s. The purpose of the OHRH was to "to raise the awareness of the importance of integrating human resources in the health policy agenda, and to support the participatory development of appropriate human resources policies" (PAHO/WHO 2004: 1). OHRH is a regional initiative, operating through national observatory groups involving relevant institutional stakeholders (ministries of health, social security institutes, universities, professional associations, amongst others) to discuss and analyze data, monitor trends, prioritize issues and build consensus for policy interventions. Outside Latin America, six such observatories are in place, three of which have a regional focus (Eastern Mediterranean Region Observatory on Human Resources for Health; Africa Health Workforce

Observatory; European Observatory on Health Systems and Policies). HRH Observatories are primarily a WHO initiative, and are attracting support by USAID, the EU and the WB.

2.5 Inter-state partnerships and bilateral agreements

Diaspora engagement forms a key plinth of IOM approaches to HRH migration, underpinned by an approach that seeks to harness 'social remittances' for 'development' by supporting the transfer of knowledge, skills and technology and diaspora capacity building to benefit source countries. Enabling and empowering the diaspora are other key aspects of the IOM approach (IOM n.d.).

- *Mobility of Health Professionals Project (MoHPROF)*: IOM-managed research on the mobility of health professionals in twenty-five countries within and from the EU in relation to diaspora engagement and mapping of diaspora skills in countries of destination and diaspora database of health workers (see country profiles on www.mohprof.eu) (IOM 2012b). MoHPROF was funded by EC/DG Research in order to develop EC policy on HRH migration.

- *Migration for Development in Africa (MIDA) strategy* (2006-2010): links African states and their diasporas to build institutional capacity to support economic and social development and migration management. The MIDA Ghana Health Project (2008-2012) (IOM 2012a), the longest running health project under the MIDA programme, links migration more concretely to development and specifically "to the development of human resources in the health sector in Ghana" (IOM 2012a: 4). It aims to do so through the transfer of knowledge, skills and experience in Ghana and enables health professionals working in Ghana to participate in specialist training and internships in health care institutions in the Netherlands, Germany and the UK. The programme has been linked to Ghana's five-year Human Resources Policies and Strategies for the Health Sector (2007-2011). Over 30,000 health workers and students are estimated to have benefited from the programme.

Inter-state cooperation. Following the 13th Organisation for Security and Cooperation in Europe's Economic Forum, held in Prague in May 2005, guidelines were drawn up jointly between the OSCE, IOM and ILO on *Establishing Effective Labour Migration Policies in Countries of Origin and Destination* (OSCE/IOM/ILO 2006). The guidelines refer to the specific issues facing source and destination countries and specifically the shortage of skilled workers in the public, health and education sectors and in the context of labour market needs and demographic trends. The guidelines refer specifically to the importance of inter-state cooperation for the management of labour migration. Over 2009-10, further guides and

training manuals on labour migration management and gender-sensitive labour migration policies were produced in collaboration between OSCE, IOM, ILO, Council of Europe, and many other international and non-governmental organisations (see http://www.osce.org).

Other types of cooperation include financial and technical cooperation agreements, examples of which are the agreements within the Ibero-American Network on Migration of Health Professionals; the agreement between the Governments of Cuba, Egypt, Nigeria, Rwanda; the Indonesia-Japan collaboration on the enhancement of nursing competency through in-service training; and the 'Triple Win' pilot project involving Albania, Bosnia and Herzegovina, Germany and Viet Nam.

Bilateral agreements can be an important mechanism to protect the rights of migrant workers and mitigate the negative impacts of outward migration. The ILO and IOM provide technical assistance to governments about standard agreements and bilateral agreements between countries on circular migration. The IOM's role has been largely confined to lower-skilled workers, though it is increasingly looking at higher-skilled workers in the context of brain circulation and economic growth; the ILO has covered all workers, including skilled health workers. Good practice in using ILO decent work standards and ethical recruitment principles can be seen in a Memorandum of Agreement (MOA) between the Philippines and Bahrain on Health Services Cooperation (Republic of the Philippines and Kingdom of Bahrain 2007) which is embedded in a framework of equal treatment on the basis that "Human resources for health recruited from the Philippines shall enjoy the same rights and responsibilities as provided for by relevant ILO conventions". An ethical framework for the recruitment of health workers was established through a partnership between Philippine and Bahraini healthcare and educational institutions, designed to enhance international education and professional development. The agreement covers exchange of HRH in recruitment, rights of workers, capacity building, sustainability of the development of HRH and mutual recognition agreements on qualifications. The agreement also covers scholarships, academic cooperation on HRH and technology cooperation. There are currently 1,500-2,000 Filipino health professionals in Bahrain (Pillinger 2013). The MOA is also a reflection that the Philippines had ratified ILO C97 and C143 and other core conventions, which was not the case with Bahrain. The agreement also specifies the reintegration of HRH who return to their home country.

Equality of treatment has been embedded in some agreements. For example, an agreement between Spain and the Philippines provides for nurses and other highly skilled Filipino workers to work in Spain with the same protection and rights as Spanish workers. In some cases bilateral agreements are used as a basis for the recognition of qualifications; for example, a

UK-Spain agreement gives recognition to Spanish nurses' skills in the UK. Cooperation agreements for training, research and development include the provision of training for South African doctors in Cuba, Iran and Tunisia; the agreement covers the temporary recruitment of doctors and qualified health personnel from Cuba, Iran and Tunisia to fill labour shortages in the health sector in South Africa (GFMD 2008).

Some bilateral labour agreements have been signed on the basis of economic partnerships. Examples include bilateral agreements between the Economic Partnership Agreement signed between Japan and Indonesia, for a quota of nurses and nurse specialists from Indonesia to work in Japan. Requirements were put in place for Indonesian nurses to take Japanese language lessons and work as caregivers or assistant nurses at hospitals or nursing homes for the elderly. A similar agreement, the Japan-Philippines Economic Partnership Agreement (JPEPA) led to nurses returning to the Philippines amidst complaints from nurses about exploitative employment practices and poor support and integration (Pillinger 2013; Yagi et al. 2013).

2.6 Sector-wide approaches

Sector-wide approaches are common in several multilateral organisations and are often supported through technical assistance to individual countries or groups of countries.

ILO Action Programme on The International Migration of Health Service Workers: The Supply Side. Launched in 2006, IOM, ILO and WHO have cooperated in the project, which aimed to develop and disseminate good practices in source countries (Costa Rica, Kenya, Romania, Senegal, Sri Lanka, and Trinidad and Tobago). The project continues to be implemented in an ongoing basis only in Kenya where a range of policy initiatives have been developed to address HRH migration. The ILO has a mandate to promote the social dialogue in health sector development and migration of HRH through the Action Programme. Although this is a priority area the last sectoral meeting to promote health sector reforms and health sector plans was held ten years ago.

EU/ILO Decent Work Across Borders: A Pilot Project for Migrant Health Professionals and Skilled Workers (2011-2014) addresses skilled health worker migration from a source country perspective (partners in Philippines, India, and Viet Nam) with the aim of improving the governance of circular migration of professionals and highly skilled personnel in the health care sector. An objective of the project has been to improve the evidence based on health professional migration to Europe as a basis for informing European policy makers on how ethical standards can underpin migration policy. Various research studies were launched in

2011-2012 on working conditions of migrant workers, including an assessment of bilateral agreements and a comparative analysis of different Codes of Practice of relevance to professional health worker migration. Planned activities include the development of a pilot scheme of specialized employment services, a system for skills testing and certification for main destination countries in Europe, and the creation of a migrant assessment website, to enable migrant workers to anonymously report on recruitment processes and violations, which it is hoped could be managed and facilitated by the global trade unions.

2.7 Ethical recruitment initiatives

The WHO Global Code of Practice on the International Recruitment of Health Personnel is key amongst the range of policy measures, protocols and codes introduced on ethical recruitment to address HRH shortages and reciprocal arrangements between source and destination countries to mitigate the impact of migration on source countries with severe HRH shortages. However, ethical recruitment principles are also embedded in the EU Blue Card Directive (Council of the European Union 2009); the UK Department of Health's Code of Practice for NHS Employers (2001 and 2004); the Commonwealth Code of Practice for the International Recruitment of Health Workers (Commonwealth 2003a, 2003b); the Melbourne Manifesto (WONCA 2002) adopted by the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WMA 2003); the European Hospital and Healthcare Employers' Association (HOSPEEM) and the European Federation of Public Service Unions (EPSU) Code of Conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector) (EPSU-HOSPEEM 2008). The IOM also has its own initiative on ethical recruitment – the International Recruitment Integrity System (IRIS); this focuses on all labour recruitment, not just that of health professionals.

2.8 Conclusion

Multilateral organisations are increasingly of the view that HRH migration is a global issue. Low-, medium- and high-income countries all face challenges in workforce supply and demand, and the problems facing source countries need to be addressed at many levels and by all countries. This understanding has generated a diverse range of initiatives to improve the planning, management and monitoring of the health workforce, forecast future health worker requirements, and develop strategic approaches to providing a trained workforce that can meet population health needs and provide quality health services.

Voluntary approaches, sector-wide approaches, and cross-border (inter-state, regional, bilateral) and multistakeholder cooperation of the kind described in this section prevail. This

review also illustrates the nuanced debate about HRH shortages and the effects of migration on source countries' health systems. Disrupting the traditional 'brain drain' discourse, there is recognition that there are potential benefits to source countries' health care systems and labour forces from HRH migration, which nevertheless remain to be fully realised. In addition, attention has shifted from a focus on source countries to also focusing on the responsibilities of destination countries. This has led to an emphasis on addressing the twin concerns of managing and forecasting HRH in source and destination countries, and on promoting sustainability in health systems and social equity in access to health care.

Section 3. Emerging issues, upcoming initiatives and global policy agendas

3.1 The post-2015 development agenda

Universal Health Coverage (UHC) has emerged as a shared development objective among many of the multilateral organisations we reviewed (EC 2010; WHO 2010c; WHO/WB 2013; Giedion et al. 2013; ILO 2008, 2012; IOM 2012c; GWHA 2012). The global commitment to UHC will likely have significant implications for HRH. It is estimated that globally an additional two million health workers will be needed to meet the population health needs associated with UHC (GHWA 2012). The WHO Secretariat's report to the World Health Assembly highlights the challenges to HRH policy approaches from the commitment to realising UHC:

> The health workforce crisis is a global, multidimensional challenge. It requires a comprehensive global strategy to transform the production of health workers, encompassing labour market analysis as well as the transformation of education and training of the health workforce, at national and transnational levels. It is essential that countries wanting to improve access to health care meet the challenge posed by shortages in the health workforce. *Renewed approaches to the health workforce crisis will therefore be critical for moving towards universal health coverage*. (WHO 2013:6, emphasis added)

A key priority for GHWA is to enhance the profile of HRH issues in relation to the policy goal of UHC (GHWA 2013b). Its submission paper to the UN High Level Dialogue on Migration and Development (UNHLD-MD) makes a strong case for a goal on improving the health workforce globally:

> We believe human resources for health represent the critical pathway towards the attainment of UHC, and that they should be at the core a future health development agenda. Evidence has shown time and again that improving service coverage and health outcomes, across different disease-specific priorities and throughout health systems in the world, is conditional on an adequate, equitably distributed, competent and well-supported health workforce. (GHWA 2013c: 1)

As one respondent put it:

> ... something which was overlooked during the MDGs was this whole health systems approach but within that, the availability of health workers. And we strongly believe and our mission clearly states, without the availability of right, well-trained and well supported health workers, the MDGs simply cannot be met in most of the countries.

Similarly, the ILO is promoting universal access to healthcare as a priority goal. It anticipates that universal access to healthcare will increase the demand for health services, and has concerns about the impact on countries that have workforces depleted by out-migration. Its approach builds on ILO policy on equality of treatment in social protection, whose Conventions (19, 118, 157 and 167) cover all workers including skilled migrant workers unless specified otherwise. In the ILO this is one element of the new priority to establish a social protection floor, on the basis that: "The ILO's ultimate objective in the field of social health protection is to achieve universal access to affordable health care of adequate quality and financial protection in case of sickness" (ILO 2012). One priority for the ILO in 2014 will be to examine the effects of expanding social protection coverage on the health workforce.

The World Bank is also prioritizing an integrated approach to UHC, and HRH within that, through a lifecycle approach, as one respondent noted:

> I think part of the MDG problem is that we sort of silo them into different sectors, but that we want to integrate it much more into the broader economic as well as social development…And for the health sector we're using universal health coverage as sort of a broad theme on, we're still on health system strength, but it's maybe perhaps a little bit more inspiring to talk labour universal health coverage as a goal.

GHWA, along with other multilateral organisations, see HRH development as a global issue that requires multiple and complex responses from developed and developing countries alike. GHWA also argues that individual countries need to be supported in their work on HRH planning and although leadership is given by the WHO, member states, donor organisations and multilateral organisations also need to be mobilised to advocate for a global health policy.

It is apparent to many of the officials we interviewed that WHO leadership on this issue is changing and there is uncertainty about how this will be progressed in the future. As one policy actor stated:

> There needs to be willingness, resources to help individual countries to really come up with the plans and implement those plans at the country level… there is a lot of support already going but I think this needs a little more effort in that field…given that there's been almost a decade of action on HRH…we find ourselves in a situation where there is not much improvement. So, definitely something else, something new needs to be done…

The need for continued and concerted progress on ensuring comprehensive labour planning was highlighted by an official who commented in relation to the Caribbean region that:

> If we are not ensuring that our policies in human resource management is geared toward ensuring that we are training the type of individual we need, we are going to be in dire need in the Post 2015 period. …we seriously need to work with the tertiary institutions and with our government to see how we can get a clearer understanding of doing that sort of needs-based type planning if we are going to drive up the quality, improve the quality of health services. That for us is going to be crucial because we are training people and then they cannot get a job so they go seek a job outside and we are putting a lot of our resources in areas that don't meet the needs.

Although source countries have not been the subject of recent OECD studies, the OECD does acknowledge that better international cooperation and monitoring of health workforce policies and migration patterns are needed to address "imbalances in supply and demand in the global market for health workers" (OECD 2008: 11). Like the WHO, it argues that there is an urgent need for international policy responses to address the significant global movement of health workers. Rather than migration being used to fill gaps in the health workforce, better systems for training and retaining workers, management, use of skill-mix, productivity and data on health personnel are needed in countries of destination (OECD 2010:1). As one policy actor stated:

> It's not about becoming self-sufficient in the sense of zero migration, it's not about closing the door, but it's about avoiding to become dependent on migration to address issues which should be addressed by domestic policies.

Such policies include human resource policies in destination countries that can also contribute to meeting the increasing demand for health workers by improving retention, adapting skill mix or making better use of people with foreign qualifications, could also help to match the supply to the demand for health workers.

GHWA identifies the need for workforce planning and HRH strategies as being of fundamental importance:

> The HRH landscape remains fundamentally lacking in sufficient numbers of, training for, and support to health workers. Many countries have failed to develop, fully implement or integrate health workforce strategies and quality HRH plans within national health services, while political attention has not always led to revised policies and adequate resources for HRH, and private sector potential has not been fully exploited. (GWHA 2012: 46)

Debates about HRH migration are taking place in the context of a global dialogue about the need for better *international cooperation on migration policy and development* more generally. Several multilateral organisations have actively pushed for a new global governance of migration, including rights-based migration, to be included as a new development goal, with an emphasis on addressing the impact of outward migration on HRH

in source countries and the capacity of health systems to meet population health needs. In particular, IOM's (2013) policy paper on migration for development post-2015 argues that migration needs to be factored into development planning and for migration and development to be based on a broad dialogue and participation, through the GFMD, the UNHLD-MD and the GMG, and across national and global institutions, which will shape new global policies post-2015. This paper builds on previous policymaker- and practitioner-focused work on mainstreaming migration into development planning (IOM 2010).

Many of these issues are to be deliberated at the UNHLD-MD in October 2013, while the Swedish chair of the 2014 GFMD has set as a priority to operationalise and mainstream migration in development policy and integrating migration in the Post-2015 UN Development Agenda. A significant part of this is to generate "a format for partnerships and a list of targets and indicators to assess how migration contributes as an enabler to development" (GFMD 2013). It is in this context that the Swedish chair is seeking the locate debates on the relationship between migration and health.

This poses an important question about the intersection of policy on the global management of migration with HRH/labour market governance policies with development goals. The need for a better integration of migration policy and policy on health reform/HRH planning is relevant to the issue of how partnerships and multilateral collaboration can be mobilized in the interests of development. Several respondents spoke of the contradictions that exist in the active promotion of HRH migration for development in countries in the South, though this is an issue for all countries as a growing number of countries now simultaneously receive and place workers overseas. Here, policy debates about the potential of diasporic and circular migration approaches assume key importance.

Multilateral organisations increasingly recognize the importance of reducing the 'brain drain' and 'brain waste' from developing countries by supporting the transfer of knowledge, skills and technology and diaspora capacity building for source countries. The World Bank estimates that the contribution of diaspora to developing countries amounts to approximately US\$ 400 billion (Ratha and Mohapatra 2011). The IOM is the leading proponent of the view that diasporic initiatives can be a tool for harnessing the benefits of HRH migration for development and health capacity building in source countries (Section 2), but the role of diaspora communities is also included in the ILO Multilateral Framework on Labour Migration in facilitating the transfer of capital, skills and technology and promoting linkages with transnational communities. IOM has promoted circular migration as a concept relevant to the 'diaspora approach', where ex-pats are encouraged to help developing countries with

expertise and the opportunity to return to their source countries, with the objective of assisting the healthcare systems in source countries (Section 2; Tjadens, Weilandt and Eckert 2012).

Circular migration is "a generic term which can apply to migratory movements between any groups of countries" (Wickramasekara 2011: 13-14). Circular migration is actively promoted by the European Commission (EC 2007) and it has regularly surfaced in GFMD discussions. Thus, the GFMD recently argued that "bilateral or circular labour agreements; including MRAs, in specific sectors…are expedient, more targeted, mutually agreeable, and cost effective" (GFMD 2012). The IOM's MoHProf research project concluded that, "[g]enerally, circular and return migration should be encouraged instead of permanent migration" (Tjadens, Weilandt and Eckert 2012: 170).

However, these approaches may nonetheless be short-term solutions to more serious problems. As one respondent stated:

> Diaspora engagement projects are certainly no panacea for the global shortfall and misdistribution of health professionals. They can, however, offer short-term interim solutions to dealing with health worker shortages and lack of specific skills in countries of origin and by offering training to local staff support in their health systems development. More importantly perhaps, these programmes can raise political visibility of the issues at stake, and highlight especially low- and middle-income countries' struggles to provide sustainable health systems.

Another respondent stated the importance of framing circular-temporary migration as one strategy to avoid long-term out migration by skilled professionals, such as in health, and of clearly differentiating between circular migration for lower-skilled migrants and higher-skilled migrants:

> In today's highly mobile world and still restrictive permanent migration channels, temporary migration is a reality in many contexts and the only option for some migrant workers. Furthermore, different policy responses are needed to address different labour market needs and shortages. In the context of high skilled workers and health professionals, temporary migration can result in brain circulation which, together with other policy responses may alleviate brain-drain.

Of note is that the Swedish Chair of GFMD is seeking to pursue the circular migration-development nexus in 2014, by exploring the models that can be developed for managing HRH in low-income countries to "help retain or attract back skilled professionals" and the extent to which patterns of circular migration can facilitate 'brain gain' and 'brain circulation', so that specialist knowledge and experience gained from working overseas can be used as a tool for development and contribute to quality health services (GFMD 2013). It remains to be seen

how far the crucial distinctions and nuances highlighted by respondents (above) will be reflected in these discussions.

Although temporary migration can indeed generate remittances and benefits of 'brain gain', there is little evidence to suggest that it is preferred by skilled health workers; while as Wickramasekara (2011) notes, these forms of migration may restrict migration choices and the right to enjoy permanent patterns of migration. Global trade unions (ITUC 2011; PSI 2010) have been particularly critical of temporary and circular migration programmes as they can lead to precarious and exploitative work, diminish workers' rights to training, career development, decent work and family reunification. The PSI (2010) has argued that such programmes in relation to skilled health workers are only sustainable if they promote the development of skills and human resources necessary to strengthen public service delivery in both source and destination countries and facilitate knowledge transfer and 'brain gain' in low income countries. The absence of in-built mechanisms to build the capacity of the health workers and the health sector by, for example, reducing outflows of health workers from rural areas, reducing attrition and introducing incentives and policies to retain highly skilled workers, and putting in place policies for 'brain gain' and knowledge transfer, research and training between source and destination countries, means the potential for bilateral labour or trade agreements to contribute to a country's economic and social development is unrealised. The concern is that, in practice, there is limited evidence to suggest that circular migration is either preferred for skilled health workers, or employers, or that it results in a pattern of migration where there is continued connection with, an integration in, source and destination countries (Newland 2009), and that the boundaries between circular migration programmes and temporary migration programmes are hard to distinguish.

World Bank data highlights that a 5% of GDP increase in health expenditure would be insufficient to respond to the health financing needs of many developing countries, pointing to the need for a new policy framework for migration and development to be rooted in ***shared global responsibility***. Solutions based on shared global responsibility stem from the definition of the HRH 'crisis' as a global issue. Solutions based on shared global responsibility are cited as being necessary to tackle global inequalities in the distribution of HRH and in the management of migration in order for HRH migration to be mutually beneficial for both source and destination countries. Notably, this is not within the scope of the WHO Code or the WHO's remit alone, nor that of any one multilateral organisation. Moreover, it has wider implications for the post-2015 agenda in the sense that it gives rise to calls for the refocusing of international development aid and donor programmes.

A key aspect of this is how international development assistance can be mobilized to support HRH goals of development, training, management, forecasting and recruitment of health workers. There is limited research on the role of international development assistance in HRH, although it does appear that there is a low level of engagement and effectiveness at a sector level, and particularly in relation to human resources for health (Gómez and Atun 2013; Dodd et al. 2009; Campbell et al. 2011). There is also evidence that international aid agencies and the donor communities and HRH policy communities are increasingly engaging with one another. EU initiatives in Latin America (with PAHO) are promoting this, while the EU is currently working towards a better coherence within in its Global Health Policy. One issue to track is how the EU implements its commitments to ethical recruitment, developing HRH workforces and strengthening health systems through its Global Health Policy and its international aid programmes.

The international community and donor support is vital to the future implementation and monitoring of the WHO Code. The WHO, for example, will need donors behind it if it is to enhance coordinated global action on HRH issues and the implementation of the Code (see also Section 3.4). Accordingly, the WHO needs to show leadership on the issue and strengthen support for the implementation of the Code. This raises a question about how multilateral organisations can stimulate a more engaged debate about the global responsibility for health and the possibilities for 'shared health governance' between governments and global stakeholders (Ruger 2009, 2011; O'Brien and Gostin 2011; Youde 2012; Zacher and Keefe 2008; Davies 2010; McInnes and Lee 2012; Lee 2009).

Commentators have argued for a renewed emphasis on ***equity, social justice and the right to health*** alongside a better understanding of global care relationships, so that governments in high-income countries promote the right to health and global social justice (Shah 2010; Eckenwiler et al. 2009). Aside from the ILO and GWHA, these issues of social justice, social equity, the right to health and normative human rights frameworks as key determinants in mitigating the impact of migration in source countries rarely came up in interviews with respondents. This does suggest that much greater attention needs to be given to global social justice and the right to health in multilateral initiatives and in fully implementing the normative framework contained in ILO Conventions 97 and 143 on migration, the ILO Multilateral Framework on Labour Migration and the UN Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

3.2 The international services trade agenda

Despite the stalling of multilateral trade negotiations in the mid 2000s, the international services trade agenda remains a significant HRH migration policy perspective. HRH migration has been included in or affected by a range of inter-state economic partnerships and trade agreements (see Section 2). Of the range of international instruments linking migration and trade, the single most important multilateral initiative is the WTO's General Agreement on Trade in Services. The WTO does not participate in multilateral fora such as the UN HLD-MD, the GFMD and GHWA. The GATS is primarily a trade agreement, not a migration agreement. Nevertheless, HRH migration issues have featured in the context of a WTO review of Mode 4 (WTO 2009), and more recently in an assessment of how public health policies, intellectual property and trade can play in ensuring medical technology is available equitably to all who need it (WTO-WHO-WIPO 2012). The report considered GATS to be of little relevance to HRH migration, concluding that:

> Governments wishing to contain brain drain remain free to do so, as such measures are not subject to GATS disciplines which relate – particularly for Mode 4 – only to the temporary inward migration of foreign health workers. *The limited scope of Mode 4, both its definition and specific commitments, means that GATS probably plays an insignificant role in the international migration of health personnel*. (p. 80, emphasis added)

This was reiterated in interview by one of the respondents:

> Commitments on Mode 4 (presence of natural persons) have remained particularly poor in substance, lagging far behind the actual access conditions applied by many Members. Thus, the current impact of the GATS on health professional movements to provide services abroad is all but significant. And the strides made in the many preferential services agreements that have been concluded in recent years have generally remained modest as well. Political economy arguments contribute to explaining why governments' interests in advancing the liberalization of health services in general and Mode 4 in particular under international trade agreements are in practice very limited.

Despite the seeming irrelevance of the GATS, the use of the term 'probably' indicates a degree of uncertainty about what effects it may already have had (given the notable absence of research in this area) and its potential future significance. It is worth noting that the World Bank has invoked the potential value of international services trade agreements, both the GATS and at regional level, in managing HRH migration in the Caribbean context:

> A regional legal agreement could therefore shape policies and rulings on health personnel in the context of the GATS and CSME and provide granularity to the broad principles laid out in the Code of Practices and the PAHO Regional Plan for Action. (WB 2009: 6)

Echoing arguments set out in WTO (2009), Francois and Hoekman (2010) highlight the potential gains from Mode 4 as a means of managing temporary migration and the potential role of GATS in mitigating the effects of 'brain drain' on developing/low income source countries:

> Temporary movement of service suppliers through [GATS] mode 4 offers arguably a partial solution to the dilemma of how international migration is best managed given the substantial political resistance that exists against it in many high-income countries. It could allow the realization of gains from trade while addressing some of the concerns of opponents to migration in host countries, while also attenuating the brain drain costs for poor source countries that can be associated with permanent migration. (p. 671)

GATS continues to be invoked as a model multilateral agreement in discussions about the value of promoting temporary and circular migration and of strengthening the links between trade and (HRH) migration. In part this is because of the perceived value of multilateral over bilateral agreements. The potential of the GATS arose in the 2007 GFMD forum:

> Many smaller developing countries do not have the kinds of capacities or negotiating powers that the Philippines or Mexico or Morocco have to strike such complex agreements. A number of participants pointed to the importance of multilateral frameworks here, such as WTO GATS Mode 4, available on a non-discriminatory basis to all WTO Member States. While limited in application, Mode 4 has the comparative advantage of eliminating the need for countries to negotiate a myriad of separate bilateral agreements. Efforts should continue to expand the application of Mode 4 to achieve the developmental impacts aimed for through bilateral channels. (GFMD 2008: 62)

More generally, there is an appetite for harnessing the potential of international trade agreements as a means of managing migration in general, including in the context of HRH, and as part of efforts to promote trade-based development. This agenda is being advanced in negotiations over a new Trade in Services Agreement (TISA). TISA is a tangible manifestation of the 'built-in' trade liberalization agenda enshrined in GATS, and although it is presently unclear how encompassing TISA will be there are concerns that, like GATS, it will be restricted to temporary migration linked to the provision of commercial services and will not include guaranteed legal protections for migrant workers' human and labour rights. At the same time, there is a concern that the scope of its coverage may be broader than was able to be negotiated under the GATS; notably, that it will encompass public health services (PSI Briefing on TISA, at www.world-psi.org). That the reinvigoration of international trade agreement negotiations linking temporary migration and economic 'development' fails to address wider social objectives were raised as concerns during the interviews. One respondent articulated the problems in linking HRH migration with trade:

> If you don't look at health as a human right, then you just make health something else that you can sell, that you can buy and this is where it goes wrong...I can buy education therefore, I can sell my services as a nurse later on, and it just becomes this...it's when you don't look at health as a human right first and foremost.

More generally, there are concerns that the consolidation of multilateral trade instruments will potentially promote greater reliance on trade-based temporary (and circular) forms of migration in the HRH sector. Without the principles of ethical recruitment and reciprocal arrangements to compensate source countries for loss of HRH, trade agreements and economic partnerships – whether negotiated on a multilateral or bilateral basis - become little more than agreements to provide quotas of temporary health workers without corresponding development gains.

3.3 The Labour and Migrant Rights agendas

Our research suggests that the role of international agreements in promoting rights-based approaches to HRH migration is a key issue of concern to some organisations in our study. Bilateral agreements and circular migration agendas emerged as particular matters of concern.

Consistent with the ILO's rights-based approach to migration (ILO 2010), the importance of ***bilateral agreements*** (BLAs) being robust in guaranteeing rights to decent work and to reintegration when a health worker returns to his/her home country needs to be highlighted. In this, ensuring that BLAs make reference to the normative framework on equal treatment provisions in ILO migrant worker Conventions (97 and 143), the UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families and the ILO Multilateral Framework on Labour Migration was emphasised. The ILO is of the view that the participation of trade unions and employers in the public and private health sectors is essential to concluding effective BLAs. Practice shows that if all relevant stakeholders are involved it will be easier for BLAs to be implemented within a framework of equality of treatment. According to one respondent:

> Bilateral agreements work in some countries well, in others less well and it's all an issue of how you set them up and what the purpose is and if the main stakeholders have been involved in developing them.

Another respondent suggested that "One way to do that is to ensure that civil society plays a role in holding governments to their agreements".

However, there are many instances where bilateral agreements do not address decent work or labour market issues. Often these are negotiated and signed by the Ministry by Foreign

Affairs, with no links to the Ministry of Labour and representatives of employers' and workers' organisations who, according to one respondent:

> should be contributing with more richer information because they are the ones who are closer to the world of work that can provide direct data on labour market, demand and supply in that country, the real niche of the labour market.

Another respondent similarly commented that coordination between Ministries is essential:

> With bilateral agreements, ministers of health are not working with bilateral agreements, in some countries it is ministers of foreign affairs, in some countries ministers of labour and economics. So as a way ahead is better synergies and better collaboration and raising awareness because still there is a huge gap within the country, but bringing evidence and other country experiences is very, first of all useful, but at the same time is also encouraging and this is what we try to promote.

As policy instruments to manage migration flows, bilateral agreements do not in themselves address the causes of outward migration such as low salaries, inadequate staffing levels to meet population needs, poor and stressful working conditions, limited opportunities for career development and poor access to technology. An analysis of BLAs in the Philippines commissioned by the ILO/EU Decent Work Across Borders (Makulec 2013) project found numerous challenges need to be overcome if BLAs that take into account the role of health professional migration are to achieve their objectives. It made recommendations to enhance the role BLAs play in addressing the challenges faced by source countries, including depleted HRH. Foremost amongst these are the inclusion of normative standards on decent work and guidelines on ethical recruitment; portability of social protection; support with integration in destination countries; access to career and skills development, and support with return and reintegration (Makulec 2013).

BLAs open up possibilities not just for standards of decent work and social protection to be better embedded in international agreements, but for compensation mechanisms to be pursued. The WHO Code states that BLAs "should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate [compensation] measures" (WHO 2010a). Compensation mechanisms can take various forms, ranging from financial recompense to scholarships to exchanges of experts, alongside joint ventures and investments in healthcare facilities. One respondent highlighted that BLAs can provide source countries a means of recouping the cost of education on the basis that "training one nurse costs $15000…to put this money back into the health education…for training health professionals". A bilateral agreement between Germany and the Philippines is currently being negotiated with this objective. However, findings from research carried

out by the ILO/EU Decent Work Across Borders project on skilled health worker migration suggests that there needs to be a system for monitoring these provisions as there are examples of bilateral agreements that have contained clauses for destination countries to contribute back to the health education budget that have never been implemented. For example, some commitments to support HRH development in the Philippines with Canada have not been implemented in practice. Proper monitoring of implementation with the engagement of non-governmental actors is necessary.

Managed circular migration has been promoted for skilled health workers to ensure that the right skills are in the right place at the right time. According to one respondent, "this is a general development in labour markets - that workers are required to be more flexible". However, if the potential development benefits of circular migration are not without doubt (Section 3.3), the emphasis on circular migration is not without its problems from a labour and migrant rights perspective. In particular, countries of destination may tend to see migration as the solution to labour market shortages (Ruhs 2013). A key issue is the need to address working conditions in source and destination countries and particularly how working conditions in source countries can be improved. There are some doubts about circular migration as a policy goal, particularly if circular migration results in lesser rights to social protection or undermines the principle of equality of treatment enshrined in ILO standards. As one respondent highlighted:

> ..it's just a modern way of causing temporary migrant workers…In the context of the policy discourse on circular migration, particularly in a EU context, there is a danger that the trend toward more temporary migration could undermine workers rights' and decent work. It has the potential to undermine peoples' human rights to have the opportunity to stay or to stay in the country as a permanent migrant. There is a corresponding danger that the trend to temporary and circular migration could undermine principles of equality of treatment if temporary migrant workers receive lesser benefits or rights.

Central to this is recognition of migrant workers' skills, portability of social security benefits, access to social protection, protection against exploitation and improved work conditions, so that migration can take place in 'conditions of freedom, dignity, equity and security' and decent work. In the age of temporary and circular migration temporary visa holders should have access to social protection, including public healthcare, childcare, education/schooling for children and other public services.

A further problem identified for a multilateral organisation like the ILO, whose mandate is specifically on labour law, is how labour and immigration law interact. As one respondent stated:

> The question remains how are rights to migrate on a permanent basis developed by multilateral bodies and how are they formulated so that they effectively coordinate with labour laws. ILO advice to countries signing circular migration agreements or programmes is to ensure that there is equality of treatment as part of bilateral agreements.

One of the findings from the experience of skilled health workers, under the ILO/EU Decent Work Across Borders project, is that there is a different perspective from a source country like the Philippines, where migrant health professionals only return when a contract has ended and in order to find another overseas placement. In this sense one respondent commented:

> I think circular migration is something that has been promoted by receiving country more than anything. Here, at the country level, when I talk to the workers, when I talk to the recruitment agencies, they just tell me that it doesn't exist. People will return to the Philippines for their annual holidays or for their retirement. But they wouldn't come back as a worker and reintegrate a few months or a few years later, it does not take place…Circular migration does take place for the Gulf countries, for example. Nurses have a two-year contract in, or any other health professional, they have like, let's say a two-year contract, they come back here for the time of processing another contract and they leave again.

A further difficulty is that health employers in destination countries are unlikely to favour circular migration as many want to retain skilled staff with experience and who have been trained. As one respondent stated:

> Short-term placements are not necessarily of benefit to employers who will need to reorientate and train health workers, including ensuring that they are language proficient and familiar with a country's culture and mores in a health care setting. This picture is very different for unskilled workers who engage in seasonal agricultural work, for which training is not required.

One of the challenges of circular migration is how reintegration programmes for returning health professionals can be put in place. The GFMD argued that "Bilateral circular labour agreements should include a country of origin responsibility for skills recognition of workers when they return" (GFMD 2012: Annex E). This raises a question about the role of international actors in providing support, leadership and assistance in order for comprehensive and effective reintegration programmes to be instituted.

3.4 Implementing and monitoring the WHO Global Code of Practice on the International Recruitment of Health Personnel

Respondents spoke about the importance of the distinct new global focus given to HRH migration in the WHO Code, which is seen as an example of the positive role played by a global alliance between WHO/HRH, GHWA and Realizing Rights. Multilateral organisations are of the shared view that the Code is unlikely to become a binding tool in the future; the voluntary nature of the Code is seen as a "call for action" for governments, other national stakeholders and multilateral organisations to collaborate around good practice approaches to HRH migration. For one respondent, the Code has helped to raise awareness, but this needs to be set into a wider context on the basis that "…you cannot discuss migration without discussing health system issues". Similarly, another respondent remarked that the Code provided an opportunity to initiate a programme of research on regional health labour flows and "to engage a broader range of member states and discuss human resources for health migration".

Amongst the *challenges and opportunities in implementing the WHO Code*, several respondents highlighted the problems associated with the voluntary nature of the Code. The absence of a system for enforcement in the form of a binding global health instrument means that the effectiveness of the WHO Code in addressing the problems of building sustainable health care systems in low-income countries remains a significant challenge.

The monitoring of the implementation of the Code (World Health Assembly Resolution WHA63.16) is carried out through a national self-assessment tool – the National Reporting Instrument. As of July 2013, 84 countries have established Designated National Authorities for reporting on the Code, three-quarters of which are held by Ministries of Health; 54 countries have to date reported on the implementation of the Code, the majority of which are from within the Europe region and cover 80% of countries in the Europe region (WHO 2013, and interview with WHO). Compliance remains relatively limited, with only 10 countries maintaining records of recruiters authorised to operate (WHO 2013).

Multistakeholder participation in the implementation and monitoring of the Code has largely predominated in the WHO-Europe region, where a roadmap for implementing the Code in the European Region has been drawn up. A meeting organised by the WHO-Europe in Amsterdam in May 2013 with Asian countries led to a renewed focus on HRH migration, suggesting a shift of emphasis away from WHO head office monitoring to a regional focus. In Asia, multistakeholder engagement has taken place through the Asia-Pacific Action Alliance for Human Resources, and through multistakeholder workshops under the ILO Decent Work

Across Borders project in 2012. A key message from stakeholders at the workshops held in the Philippines was the need for the WHO to develop an instrument to capture the perspectives of source countries.

One issue is a lack of clarity about which organisation or government department has the responsibility for implementing and monitoring the Code at the national level, reflecting a general concern that WHO needs to promote better collaboration and shared responsibility for the implementation and monitoring of the WHO Code between different Ministries (health, justice, finance, employment) in source and destination countries.

A further issue is the lack of comparable data on the HRH workforce in source and destination countries and at a global level. In response to these challenges the WHO has emphasised the need to mobilise the engagement of all stakeholders on health worker migration and international recruitment; that coordinated, comparable and comprehensive data through technical cooperation is needed in building health information systems and in provision of information about regulations on health personnel recruitment; and problems associated with weak national capacity to address health workforce issues need to be rectified through technical cooperation and assistance (WHO 2013). In the WHO-Europe (WHO 2012) region, specific efforts have been made to address the challenges through improved stakeholder engagement in the health sector and beyond (education, finance, labour, and foreign affairs); building national capacity to produce, analyze and disseminate information; forecasting of future health worker needs and competencies; inter-country cooperation on data sharing; and exchanging good practices to enhance the management of the health workforce.

A future challenge is how the principles and norms set out in the WHO Code can be codified into international policies and programmes, including international aid programmes and the global development framework post-2015. One way in which the Code could become more effective is through "an enabling governance structure supported by sustainable financing mechanisms to operationalize the Code" (Mackey and Liang 2013: 20). In the EU context where there is an emphasis on efforts to institute greater coherence within and between policy areas, in line with principles of aid effectiveness, this may prove an opportune juncture at which to press for the Code to be integrated into EU development aid financing mechanisms. There may be similar opportunities in other development aid regimes, such as those operated by the WB and regional development banks.

Keeping the momentum going and having systems at the country level to push for the implementation of the Code is seen as being vitally important in the future. According to one

respondent: "…a lot of the action needs to happen at the country level. People just don't, it's not a priority", while another respondent raised the point that the adoption of the WHO Code led to a lot of initial activity but that much of the momentum has been lost:

> …the adoption of the Code at the World Health Assembly was a combination of events and after that not much is happening…one would have expected that there'd be a little more excitement about actually developing policies and putting actions in place that would change things.

The ILO has some additional concerns that the Code's provisions on the protection of workers (under Article 4.5) give insufficient attention to equality of treatment (this requires that member states ensure that under applicable laws migrant health personnel enjoy the same legal rights, and responsibilities as domestically trained health workforce in terms and conditions of employment). However, rights to equality of treatment are the responsibility of Justice Ministries, whereas the Code has its principal focus on labour legislation.

A further challenge is the absence of a precise operational definition to ethical recruitment. One respondent recommended that there needs to be a UN level meeting that could "advance our work on the definition of an operational definition of ethical recruitment; it could then be turned into a recognizable standard" in order that recruitment agencies and organizations involved in recruitment comply with the WHO Code. Having a high-level forum to discuss this issue in a systematic way was considered as crucial to ensuring that multilateral organisations continue to focus on the problems faced by source countries from the perspective of the 'right to health'.

Several policy actors stated that an immediate problem is the apparent lack of ***leadership and policy direction to implement the WHO Code*** from WHO head office, arising from restructuring within the WHO and a reduced level of resources to monitor the Code. The 35-person HRH team at the WHO has been disbanded, leaving one policy officer with responsibility for monitoring the Code. Some member governments have expressed their concerns about this at the WHO Executive Board, while GHWA, the IOM and the ILO, for example, see the 'downsizing' of the WHO as potentially impeding the implementation and longer term monitoring of the Code. According to one respondent:

> The team backing up the implementation of the Code and the other work that was done with other projects at the field level disappeared…but we need to have our WHO colleagues promoting it and advancing it.

Another respondent suggested that although there is a need to address leadership and resources to implement the WHO Code, it represents just one instrument that is not in itself a

sufficient policy response to the complexities of HRH migration. In this sense the post-2015 discussions are vital to opening up political space for discussions about HRH financing.

Several policy actors believe that GHWA should play a key role in the future in promoting the Code and its long-term implementation. However, there is a perceived lack of clarity of GHWA's role and effectiveness; several respondents suggested that there is an opportunity for GHWA to have a strategic role in monitoring the WHO Code the future, in the light of the anticipated changed role for GHWA as part of the WHO.

The *2013 Global Forum on Human Resources for Health* is seen as one vehicle for renewing efforts to implement the WHO Code around key determinants of access to healthcare, strategic workforce planning and HRH as priorities in development cooperation between high and low income countries. In preparation for the third Global Forum, the Norwegian government, WHO and GHWA hosted a meeting with high-income countries as a consultation exercise in advance of the November meeting, reflecting the shift in thinking from HRH in relation to developing countries to HRH as a global issue. An increasing number of high- and middle- income countries face challenges from demographic trends and are projecting HRH shortages in the next decade, adding extra urgency to the need to situate HRH challenges in a global context and in implementing the WHO Code within South-North, South-South and intra-regional contexts. By bringing together national stakeholders and multilateral organisation such as the WHO, ILO, WB, the Africa Development Bank and INGOs such as Save the Children and Intra-Health, it is anticipated that at the Forum new commitments will be made to addressing the complex and multi-faceted challenges at national, regional and global levels.

3.5 Data and monitoring of global HRH migration and its impacts

Our research has identified some significant concerns by multilateral organisations about the absence of comparable data on HRH migration at national, regional and global levels. Challenges for HRH data were raised in a WHO public hearing held in 2011 (WHO 2011). These concern the scarcity of country level data and the absence of a global HRH information system, including HRH information systems covering both public and private sectors in source and destination countries. Challenges in the reporting process on the WHO Code surround the comparability of data and the need for greater clarity on using migration data and recruitment data. In interviews for this project, the OECD, WHO, ILO and the World Bank all argued that comparable global data remains a fundamental obstacle to improved workforce planning and mapping international migration for health workers. In particular, the need for a global

professional skills classification was reiterated as being of importance to creating a common classification of health professionals titles, roles and scope of practice, as well as different career pathways, and levels of task shifting and skill-mix. Reliance on professional registration systems is generally regarded to be insufficient, as registers do not show if a person is actually working or if they have returned home. One official commented particularly on the poor quality of HRH data and the lack of comparability of data on pay levels and bonuses and the difficulties this poses in understanding health labour markets:

> So basically, when we do a labour market analysis, it's based on, there's no data, I mean if you don't know how much they're, what they're earning, we have no basis on which to model anything… So basically, all the claims being made…are basing it on pure, maybe on ad hoc or anecdotal, but really not on any systematic data.

Another official also commented on the problems associated with the lack of comparability of data:

> The difficulty [is] that data is collected from different sources and ministry of health, they might collect data only from health sector, but health workers are working in other sectors and this data is not collected. Some countries have separate data collection from public sector and private sector and usually we don't have complete data because private sector is not providing data. We have also a lot cases of when people are working in health sector in the public sector and we have double counted numbers.

The WHO has suggested that there is an urgent need to develop coordinated, comparable and comprehensive data, provide technical cooperation in building health information systems and improve national capacity to address health workforce issues need to be rectified through technical cooperation and assistance (WHO 2013). Recommendations for a centralised EU-wide data and information collection system (OECD/WHO 2010; Tjadens, Weilandt and Eckert 2012) have a potential for transferablity in a global context. A global system, as suggested by Mackey and Liang (2013), for matching migrant health workers with destination countries could be provided through an ILO database of healthcare employers, recruitment companies and migrant health workers in order to provide a single point for recruitment and for ethical and effective pre-qualification, registration and migration processes. This presupposes comparable data and the establishment of a global system for recognition of qualifications.

This data is crucial for health labour planning. Although the global economic crisis has impacted on health spending and reduced staffing levels in some countries, skilled HRH migration will continued to increase in OECD countries. Part of the problem is current shortages are driven by a lack of supply due to decisions taken five or ten years ago, leading

one respondent to pose the question, "what is the impact of the current crisis on training decisions now that might have an impact on the supply in five or ten years when the economic condition will be different?"

The OECD has previously suggested the importance of identifying good practices in HRH migration policies at national level and evaluating their transferability (OECD 2008: 11). However, the value of a wider approach that examines global contexts has been reiterated by the IOM. Its research on the professional mobility of health workers makes recommendations for better systems to assess the effectiveness of HRH in underpinning sustainable health care systems: "Further research into the global market of health workers to increase better understanding of global developments beyond national strategies in order to better respond to and manage national and local human resources for health" (Tjadens, Weilandt and Eckert 2012: 174).

Section 4. Challenges for the global governance of HRH migration

This report has documented diverse responses and interventions on HRH migration and located them in the context of wider contemporary global policy initiatives and debates. At one level, these initiatives reflect the definition of HRH migration as a global issue requiring a multitude of coordinated and integrated responses at global, regional and national levels. While the need for coordinated and integrated responses is well understood - policies implemented in one region or country can have significant enabling or destabilising effects in other regions or countries – there is much less consensus among the institutions we examined as to what would constitute such responses. Beyond the differences that arise from diverse mandates and perspectives of the many organisations examined here, the considerable challenges for multilateral organisations in managing the combined goals of the right to access to health care in source countries with the right of people to migrate and the right to decent work need to be emphasised. As one respondent aptly stated:

> Migration of health professionals is at the junction of the right to mobility, right to health and right to decent work…It is about finding an acceptable compromise between the rights and obligations of migrant workers, employers and governments based on sound research findings.

A key challenge is how coordination of responses can be instituted in the complex and multifaceted arena of HRH migration, since multilateral organisations have different missions and work within different normative frameworks inside and outside of the UN system. We

conclude this report by drawing attention to four overarching challenges which stand out in discussion on the global governance of HRH migration.

- ***Coordinating public policies across migration and health***. Health policy and HRH planning domains and ministries are often separate from other domains and ministries covering immigration, public service modernization, finance and development aid. These are developed and governed by separate legal frameworks that rarely coalesce and which operate in separate policy and institutional domains at national, regional and global levels. Human rights principles that embody both the 'right to health' and the 'right to migrate' can be severely impeded in this context. This is relevant to how HRH is situated in the context of current policy debates about migration for development. It also raises important questions about how the ILO normative framework (on decent work, the principle of equality and rights in enshrined in labour migration conventions and the ILO Multilateral Framework on Labour Migration) and the ethical recruitment principles enshrined in the WHO Code are compatible with national, regional and global migration management developments.

- ***Situating problems of HRH in source countries in the broader context of unequal economic and social development***. The absence of a global regulatory governance framework for shared global responsibility and ethical recruitment raises questions about the extent to which destination countries (as well as source countries) are prepared to cede legal sovereignty over migration policy and in relation to specific health policy and HRH goals. In the light of the continuing global economic crisis, many destination country governments are under increasing political pressure to restrict inward migration; related to this is the impact of austerity measures to reduce spending on national health programmes and on development aid budgets. This pressure comes at a time when shortages of skilled workers are likely to continue, if not become even more acute, in the foreseeable future.

- ***Visibilising HRH migration in the evolving global development agendas***. There are many competing priorities in the current discussions about the post-2015 development agenda and it is uncertain whether HRH migration–relevant issues that were not originally included as core MDG goals (such as migration, employment and decent work and HRH/health care systems) will explicitly feature in the new development framework, and if they do how they will be expressed. Related to this are on-going debates within multilateral organisation on a) HRH migration and the centrality of HRH

to building health systems and UHC, b) the role of migration for development, and c) the role of global trade agreements in the quest for development. Questions about the emerging role of global trade agreements and HRH migration, and the role of development aid and assistance and whether development strategies can be focused on HRH migration issues, will be foremost among debate in the future. This in turn raises important questions about global shared responsibility for tackling poverty and under-development, and through this how HRH across a whole health system can be strengthened and resourced in order to address the push factors to migrate as part of efforts to realise universal health care.

- ***Strengthening global alliances and networks on health worker migration***. Multilateral organisations are promoting cooperation between relevant stakeholders and through multi-stakeholder partnerships in addressing HRH migration in source and destination countries. Alliances and participation in global programmes has involved the participation of government ministries, employers, trade unions, health professional regulatory bodies, recruitment companies and international organisations in policy dialogues. Different stakeholders bring different perspectives into policy formation and can hold multilateral organisations and governments accountable for commitments made. Global alliances and networks have also been crucial to building global responses to HRH migration amongst multiple stakeholders. One challenge is how positive forms of multistakeholder engagement at national, regional and global levels can be sustained and strengthened. This includes the question of what role is to be played by global alliances such as GHWA in the monitoring of the WHO Code and other codes and global commitments, and in keeping issues of HRH migration on global policy agendas across a range of institutional policy domains. It also raises the question as to what will be the sources and forms of global institutional leadership to emerge in the wake of the recent restructuring of the WHO's HRH unit.

ANNEX 1. Data sources and methods

We gathered comprehensive research data on the policy responses and initiatives of twelve international organisations and policy fora with regard to highly skilled health worker migration. These are listed below, in alphabetical order:
- European Union
- Global Forum on Migration and Development
- Global Health Workforce Alliance
- International Labour Organization
- International Organization for Migration
- Organisation for Economic Cooperation and Development
- Pan-American Health Organization
- UN Global Migration Group
- UN High-Level Dialogue on Migration and Development
- World Bank
- World Health Organization
- World Trade Organization

Resource constraints on this research project necessitated a strict prioritisation of which organisations and fora were included in this research. The organisations included have a discernable presence in the field. Within the UN system, priority was given to WHO and ILO as UN specialist agencies, and to UN migration-specific groups (UN GMG, UN HLD-MD). Other UN programmes and agencies of potential relevance, such as UNDP, UNICEF, UNHCR and UNFPA, were not covered. With the exception of the EU and PAHO (as an international public health agency as well as the regional branch of the WHO in the Americas), the project did not cover regional organisations, commissions, development banks, or consultative fora. The project was not concerned with unilateral initiatives projected internationally, such as through international development assistance, or country-based initiatives. However, country-based initiatives and fora in which multilateral organisations have a major stake (whether as a funder or participant) are mentioned where of they are of direct, immediate and significant interest to this report.

This report is based on research evidence gathered from primary and secondary sources as set out below.

<u>Consultations with senior policy officials</u>: the project was commissioned to undertake recorded telephone interviews with up to fifteen senior policy officials working in multilateral organisations. The interviews aimed to elicit: (a) perceptions of the causes and consequences of highly skilled health migration for source countries; (b) the ways in which given organisations are responding to those issues through operational, research, policy development and partnership initiatives, and (c) upcoming and future initiatives (Appendix 4, Interview Guide). The interviews supplemented our analysis of documentary sources (see below), extended knowledge of current and emerging policy responses, and provided additional contact information. In practice, the interviews tended to focus on policy responses and initiatives (areas (b) and (c) above) as interview time was limited and many of the respondents' specialist expertise lay in these two particular areas.

Research informants were identified on the basis of our expert knowledge of staff in these organisations, targeted web searches and recommendations. These contacts were refined and extended through email and telephone contact, using snowballing-style methods, over several months. The overwhelming majority of contacts recognised the importance of this project and

to the invitation to participate in the research. Others proved more challenging. In some instances, no reply was forthcoming despite repeated attempts and follow-up calls.

Nearly all interviews were conducted via a recorded telephone interview on a one-to-one basis using digital technology. For a minority of research informants, a different approach was taken, following their preference to converse via email, or to participate in a joint interview with colleagues with complementary expertise from different parts of the same organisation. In three cases, notes were taken due to the failure of recording technology. Telephone interviews lasted between 40-70 minutes and were transcribed. Informants were given the opportunity to clarify between statements that reflected their personal views and those that represented those of the organisation for which they work, and to add and/or amend any statement during the interview itself or subsequently. Respondents were given the opportunity to review the interview transcript (or notes) after the interview.

In a further round of consultations, each of the respondents was given an opportunity to review and comment on the draft report. This was an opportunity for the respondents to correct any factual inaccuracies, provide any additional information they deemed relevant, and confirm whether or not they wished to be named as respondents in the final version of the report. Eight respondents engaged with this round of consultations, six of whom positively confirmed within the time frame that their names could be included in the report. Those that agreed are as follows, listed in alphabetical order: Carmen Carpio (Senior Operations Officer – Health, World Bank - Latin America and Caribbean Region); Charles Godue (Project Coordinator, Human Resources for Health, Area of Health Systems based on Primary Health Care, Pan American Health Organisation); Barbara Rijks (Migration Health Programme Coordinator, International Organisation for Migration); Mubashar Sheikh ((former) Executive Director, Global Health Workforce Alliance); Federico Soda (Head of Labour Migration & Human Development, International Organisation for Migration); Catherine Vaillancourt-Laflamme (Chief Technical Adviser, ILO-Decent Work Across Borders Project, International Labour Organisation). We thank all respondents for their time and consideration given to discussing the subject of this research with us.

Ethical protocols were developed in accordance with the ethical codes for research of the funding council (Canadian Institutes of Health Research) and the University of Ottawa, and were strictly adhered to throughout the duration of the project. Information about the project, including data protection protocols, was supplied in advance, and consent agreements were elicited from the respondents. To ensure anonymity of the officials interviewed, neither the name of the official nor the organisation they work for are attributed to quotes included in this report. The statements and views expressed in the interviews cited in this report reflect those of the officials we interviewed and are not those of the organisation.

Secondary analysis of policy and research documents: we undertook a comprehensive review of policy and research literatures on global HRH migration. We focused on official documents such as reports (annual, thematic or special/ad hoc reports), quasi-technical documents (e.g. guides and handbooks), Minutes, Notes, Resolutions and formal statements that represented a substantive engagement with the issue of HRH migration whether or not it was the main subject of the document. Research papers, working papers, and evaluation reports that were prepared by external consultants but published by the organisation were excluded as although these do not represent official policy. In addition to the official policy documents included in the References list, about double that number were consulted but as they did not include sufficiently substantive relevant coverage to merit inclusion in this analysis.

In addition to this review of policy documents by the organisations included in this study, we conducted a comprehensive literature review of policy-relevant research on the subject of

global health worker migration policy and governance. This included literatures, whether published as articles in scientific journals or as policy research reports, conducted by academic researchers and advocacy movements and groups (e.g. trade unions, non-governmental organisations, health workforce associations). It spanned the intersecting areas of global migration, global health and global development. The sources that directly informed this report are listed in the References List.

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