Addressing Gender Equity in International Health Workforce Migration Policy and Practices

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Abstract

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Gender equity in the health workforce has been gaining attention in recent years as evidence emerges of gender discrepancies in leadership opportunities, pay, and decent working conditions. While increased attention to gender equity in the health workforce generally is encouraging, gender differences may be particularly inequitable for one critical group, the migrant health workforce. In many wealthy countries, internationally educated health professionals, which for the purpose of this study we will refer to as migrant health workers, comprise a quarter of the health workforce. Still, research on gender and health workforce issues either focuses exclusively on the domestic workforce or makes no distinction between the two groups.[1, 2] Some case studies from India, Canada, Australia, and the United Kingdom have attempted to describe effects of gender inequity in association with international health workforce migration, but data are still limited.[3, 4, 5, 6] Consistent annual increases in international health workforce recruitment over the past 30 years has led to a maldistribution of the global health workforce, 70% of whom are women.[7] It is therefore critical that national governments consider the intersection between

health labor migration and gender equity, and develop migration policies that help to transform the status of women in the workforce rather than exploit them.

In this qualitative study, we explore how health labor migration and gender inequity interact to affect working conditions for the global health workforce. Bilateral agreements between governments or other actors are increasingly common policy tools used to facilitate health workforce migration. These agreements, in addition to being non-binding, fail to address the role of gender inequity in international recruitment. In focusing on the barriers to gender-equitable bilateral agreements, we found the particular issue of deskilling (when a health worker practices below their skill level) is common among female migrant health professionals and may fuel the leadership gap and gender pay gap in the health workforce.[3, 8] On the other hand, migrant health laborers may benefit from reduced occupational segregation in nursing by drawing more men into the profession who seek pathways for migration, although this trend is highly context-specific. We found a varied effect on decent working conditions; female migrant health professionals may experience better working conditions in their destination country, but higher levels of discrimination and bias due to their migrant status. Finally, a lack of transparency, accountability, and monitoring mechanisms all inhibit the development of gender transformative bilateral agreements. We offer a set of recommendations for key stakeholders to better promote gender transformative health labor migration policy and practices.

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List of Acronyms

BLA	Bilateral Labor Agreement
CSO	Civil Society Organization
GEH	Gender Equity Hub
GHWN	Global Health Workforce Network
HRH	Human Resources for Health
ILO	International Labor Organization
IOM	International Organization on Migration
MOU	Memorandum of Understanding
OECD	Organization for Economic Cooperation and Development
OSCE	Organization for Security and Cooperation in Europe
PSI	Public Services International
RN	Registered Nurse
UN	United Nations
WGH	Women in Global Health
WHA	World Health Assembly
WHO	World Health Organization

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Abstract

Gender equity in the health workforce has been gaining attention in recent years as evidence emerges of gender discrepancies in leadership opportunities, pay, and decent working conditions. While increased attention to gender equity in the health workforce generally is encouraging, gender differences may be particularly inequitable for one critical group, the migrant health workforce. In many wealthy countries, internationally educated health professionals, which for the purpose of this study we will refer to as migrant health workers, comprise a quarter of the health workforce. Still, research on gender and health workforce issues either focuses exclusively on the domestic workforce or makes no distinction between the two groups.[1, 2] Some case studies from India, Canada, Australia, and the United Kingdom have attempted to describe effects of gender inequity in association with international health workforce migration, but data are still limited.[3, 4, 5, 6] Consistent annual increases in international health workforce recruitment over the past 30 years has led to a maldistribution of the global health workforce, 70% of whom are women.[7] It is therefore critical that national governments consider the intersection between health labor migration and gender equity, and develop migration policies that help to transform the status of women in the workforce rather than exploit them.

In this qualitative study, we explore how health labor migration and gender inequity interact to affect working conditions for the global health workforce. Bilateral agreements between governments or other actors are increasingly common policy tools used to facilitate health workforce migration. These agreements, in addition to being non-binding, fail to address the role of gender inequity in international recruitment. In focusing on the barriers to gender-equitable bilateral agreements, we found the particular issue of deskilling (when a health worker practices below their skill level) is common among female migrant health professionals and may fuel the leadership gap and gender pay gap in the health workforce.[3, 8] On the other hand, migrant health laborers may benefit from reduced occupational segregation in nursing by drawing more men into the profession who seek pathways for migration, although this trend is highly context-specific. We found a varied effect on decent working conditions; female migrant health

professionals may experience better working conditions in their destination country, but higher levels of discrimination and bias due to their migrant status. Finally, a lack of transparency, accountability, and monitoring mechanisms all inhibit the development of gender transformative bilateral agreements. We offer a set of recommendations for key stakeholders to better promote gender transformative health labor migration policy and practices.

Background

In May 2010, the 63rd World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO Code) to address health workforce shortages in low and middle income countries created, in part, by migration to rich countries.[9] By 2030, this shortage is expected to reach 18 million health workers worldwide.[7, 10] Health workforce shortages disproportionately affect the world's poorest countries, as their healthcare professionals are most likely to immigrate for higher pay and better working conditions abroad. The WHO Code, only the second Global Code of Practice ever adopted by a World Health Assembly, promotes the ethical international recruitment of health workers by commitments to limit recruitment from countries with critical health workforce shortages.[9]

In 2018, Member States and independent stakeholders contributed to the third round of national reporting on the relevance and effectiveness of the Code, which revealed two important developments in health workforce migration.[11] First, the increasing international mobility and migration of health personnel; and second, 39 Member States, or roughly 50% of reporting countries, report the use of bilateral, multilateral or regional agreements on international recruitment of health workers.[11] In total, 77 distinct agreements were communicated to the WHO, 65 of which were reportedly informed by the Code recommendations.[11] Prior to the 2018 round of national reporting, there was no formal monitoring of negotiated agreements on international recruitment of health workers. Importantly, no assessments were conducted of how and if Member States were incorporating the Code guidelines into these agreements.

International health labor migration has continued to rise in the years following the Code and many countries are experiencing a shift in the composition of their healthcare labor force. For example, in Sweden from 2000 to 2015, foreign-trained physicians went from 14% of all physicians to 27%.[1, 2] In Germany and France, this proportion more than doubled over the same

time period.[2] Similarly, foreign-trained nurses made up 15% of the total nurses in 2002 but over 25% in 2015 in New Zealand.[1, 2] Many countries have high proportions of migrant health professionals, including Israel, Ireland, and Norway, where foreign-trained physicians made up 58%, 39%, and 38.1% of total physicians in 2015, respectively.[1, 2] In Switzerland and the United Kingdom in 2015, foreign-trained nurses comprised 18.7% and 14.4% of the total nursing workforce, respectively.[1, 2]

This growing dependence of rich countries on migrant health labor undermines the strength and resilience of health systems in low-income countries. Bilateral labor agreements (BLAs) have been gaining recognition over the past 15 years as a tool to mitigate the negative effects of international health worker migration on source country health systems.[8] These agreements can facilitate return migration under a mutually agreed upon set of conditions.[12] BLAs are defined by the International Labor Organization as "formal agreements or memoranda of association to ensure that migration takes place in accordance with agreed principles and procedures."[13] When done right, BLAs facilitate international cooperation and can designate the party responsible for migrant social protections, ensuring access to information on immigration law, migrant job screening, and more.[14, 15] Importantly, most countries that engage in health workforce recruitment choose to negotiate a less formal and non-binding type of BLA, called a Memorandum of Understanding, or MOU.[13]

A 2018 report by Public Services International (PSI), however, stresses the current approach to BLAs are mostly transactional business agreements with a focus on the interests of employers, while failing to emphasize the social and labor rights of migrants.[16] In theory, BLAs may offer a policy tool to promote ethical recruitment for the individuals involved. In practice, these agreements likely further exacerbate the maldistributed global health workforce by facilitating migration that largely ignores ethical recruitment principles, and may even promote gender inequity and undermine workers' rights.[16]

Global data on health care workforce migration rarely are disaggregated by gender, making it difficult to conduct a comprehensive gender analysis of the migrant health workforce. However, research shows female nurses are the largest health worker migrant group globally, and more female health professionals migrate than males.[17] Studies by Walani, Adhikari, Ryan and others have found gender plays a role in the migration decisions made by health workers.[5, 17] For example, societal gender norms may discourage female migration, while at the same time,

gendered social networks increase awareness of migration opportunities for female health workers.[17] Further, the gender of a migrant health worker will influence her working conditions in the destination country.[5, 10, 17, 18, 19]

Despite awareness of how gender influences both migration decisions and the migration experience, there remains a significant lack of global research on gender equity in health workforce migration policies and practices.[7, 10] According to one study from 2015, “unequal treatment in recruitment and employment, faced by Internationally Educated Nurses (IENs) is one of the most serious issues related to global migration of RNs.”[5] Initial case studies have found female migrant health workers face multiple and simultaneous gender-specific challenges when it comes to international recruitment. For example, female migrant health workers may experience deskilling (when a health worker practices below their skill level) and “double or even triple discrimination, disadvantage, marginalization and vulnerability” owing to migration status, gender, and ethnicity.[3, 8]

Concurrently with the third round of Code reporting, the Gender Equity Hub (GEH), a thematic hub under the WHO’s Global Health Workforce Network (GHWN), published an extensive review of gender equity in the health workforce.[7] This study found women make up 70% of the global health workforce, but only 25% of the senior leadership positions. Further, the gender pay gap in the health sector is worse than in other sectors, as much as 26% greater.[7] Additionally, there is significant occupational segregation by gender that varies by country, but on a global scale “[women] are mostly concentrated in nursing and midwifery professions, while far fewer are physicians.”[7] Finally, female health workers disproportionately face workplace discrimination, bias, and harassment.[7] Some of the key drivers of these inequities include gender stereotypes, discrimination, and harmful norms that leave women with less power and decision-making ability than their male colleagues.[7] Although this report did not analyze gender equity by migrant status, its findings highlight the need for HRH policies that advance women’s status in the health workforce.

Women in Global Health defines gender transformative approaches as seeking to “promote gender equality and achieve positive development outcomes by

transforming unequal gender relations in order to promote shared power, control of resources, decision-making, and support for women's empowerment."[20]

Given the significance of gender in health professionals' labor migration experiences and the widespread gender inequity in the global health workforce, it is reasonable to observe that health labor migration policies reflect the gendered dimensions of health labor migration. Nevertheless, the negotiated BLAs and MOUs on labor migration "largely ignore gender issues and lack gender-sensitive monitoring mechanisms."[21] The International Labor Organization (ILO) and WHO have both acknowledged the importance of gender considerations in health workforce policy, as evidenced in their recent reports, working papers, and policy guidance on gender and health labor migration.[8, 19, 22] Still, without significant evidence of how health workforce migration and gender equity interact, these recommendations are difficult to implement.[20]

As international health workforce recruitment continues to grow, policy makers and gender experts call for evidence of ethical international recruitment practices and gender equity in health workforce recruitment policies and practices.[7, 8, 10, 14, 21, 23] To fill this knowledge gap, this study examines the gender-related aspects of health workforce migration and seeks to understand the current barriers to crafting and implementing gender transformative BLAs.

The principal aims of this study are to explore the relationship between international health labor migration and the four types of gender equity in the health workforce (the leadership gap, gender pay gap, occupational segregation, and decent work) as outlined by the Gender Equity Hub of the WHO GHWN. We will explore the reasons why gender considerations have been neglected in health labor migration BLAs, as these policy documents provide the framework for international recruitment in many countries. This manuscript concludes with recommendations for both governments and independent stakeholders to promote gender equity in their health workforce migration policies.

Methods

This cross-sectional descriptive study uses qualitative data from in-depth key informant interviews, extensive literature review, and policy content analysis of BLAs and MOUs on health workforce recruitment.

First, we conducted an extensive literature review in three electronic databases to identify evidence of gender inequity in health labor migration and to identify best practices for gender transformative policy. The search included only English publications and publication dates after January 2009 - when the first draft of the WHO Code was submitted to the 124th session of the WHO Executive Board.[24] After identifying 237 responsive black and grey literature, we screened the publications using secondary inclusion criteria that reduced the number of papers to 78. The publications were coded in an Excel spreadsheet and organized by the Gender Equity Hub's four themes (leadership, gender pay gap, occupational segregation, decent work) plus policy development. The full search parameters are listed in Table 1.

Table 1: Literature Review Parameters for investigating the relationship between types of health workforce gender inequity and health workforce migration

Dates of search	April 2019-July 2019
Databases	PubMed, Google search, WHO Code Reporting Tool
Inclusion criteria	Published between 2009-2019; English version available;
Search terms	"gender" AND (health workforce migration OR health workforce recruitment OR bilateral labor agreements OR memorandum of understanding OR migrant health worker); "health workforce migration" AND (gender equity OR gender analysis OR gender pay gap OR leadership OR harassment OR gender discrimination OR bias OR deskilling OR gender policy); "brain drain" AND (gender equity OR gender analysis OR gender pay gap OR leadership OR harassment OR gender discrimination OR bias OR deskilling OR gender policy)
Articles responsive after search terms	237
Secondary inclusion criteria for screening	Abstract or executive summary indicates the publication distinguishes between health workforce migration and other labor migration, focuses on the formal care sector, examines differences between male and female migrant health workers
Responsive articles after abstract screening	78

Wemos, a global health research and civil society advocacy organization in the Netherlands, provided access to many of the key informants interviewed. After extensive

communication, key informants were identified based on their areas of expertise and purposively selected to gain distinct perspectives on gender equity and health workforce migration.
The lead author (KF), while based at Wemos, conducted interviews with 19 key informants from 10 countries from July-September 2019. Interviews were conducted both in person (n=7) in Amsterdam, NL, and Geneva, CH, and using the online video conferencing services Skype and Zoom (n=12). Of the 46 stakeholders contacted for participation in the study, 19 agreed to participate, yielding a 41% participation rate. In total, 4 WHO employees, 1 IOM employee, 4 administrators from international recruitment agencies, 5 international health workforce experts, 2 gender experts, 2 labor union representatives, and 1 migrant health professional were interviewed.

The interviews were semi-structured and participants were asked 8-12 questions, with follow-up questions. Informants were asked about their own experience and understanding of the gendered dimensions of international health workforce migration, the BLA negotiation process, and the opportunities for including gender in international health workforce migration policy. All interviews were conducted in English and the researcher took detailed notes of the participants responses, asking participants to repeat certain statements for direct quotes.

The interview notes were *a priori* coded – codes were developed before data analysis – for the presence of four central themes of gender equity in the health workforce; the leadership gap, occupational segregation, decent work, and the gender pay gap. *A priori* coding was used for this research specifically to evaluate the effect of health labor migration on the WHO's four subthemes of gender inequity. To identify themes surrounding gender in health workforce migration policy, interview notes were coded using an inductive approach. Inductive coding allowed the researchers to examine the perspectives of stakeholders with varying levels of expertise to study the similarities and differences in insights. (citation for that?)

Interview notes were hand coded using highlighters and post-it notes for recurrent patterns and divergent perspectives. Model quotes were coded and sorted into themes to identify similarities and differences between stakeholder groups. We used a single coder (KF), recognizing this as a limitation of our data analysis.

In addition to the qualitative data provided by interview responses, we supplemented our data set with findings from a policy content analysis of 11 BLAs and MOUs and the WHO Code. For this analysis, we adapted a gender policy analysis toolkit from the WHO, "Checklist for

Assessing the Gender Responsiveness of Sexual and Reproductive Health Policies," in Appendix B.[25]

Research expenses were partially covered by a grant from Wemos. The Human Subjects Division at the University of Washington approved this study (Study ID Number: 00007669).

Findings

To explore the relationship between health workforce migration and gender equity in the health workforce, we asked key informants how the following four themes (determined in advance of analysis) interact with health labor migration: 1) decent work, 2) the leadership gap, 3) occupational segregation, and 4) the gender pay gap. We also considered the challenges to incorporating gender considerations into bilateral agreements and asked key informants about their own experiences and understanding of the BLA negotiation process. The following section outlines our findings.

1. Migrant health professionals face disproportionate bias, discrimination and harassment, thus diminishing "Decent Work" experiences

Decent work refers to a workplace that is free from bias, discrimination and harassment, including sexual harassment.[7] For this study, we focused on gender-based bias, discrimination and harassment, and how this interacts with labor migration. Female health workers are more likely to face discrimination, bias and sexual harassment in the workplace than men.[5, 7, 26] Our research indicates workers who bear an additional identity as "migrant" most likely face increased workplace discrimination, harassment, and bias; therefore female migrant health workers likely also face additional discrimination.[1, 3, 5, 8] Our key informants also commented on the dynamics that can undermine decent work:

> *"[Women] are more likely to encounter issues like harassment and discrimination and much less likely to speak up about them than men. This happens for a variety of reasons, but the effect is that women are in less powerful positions within the workforce. Then add to that that the worker might be on a long-term contract and their visa is tied to their job and this leaves people very vulnerable to harassment." (Recruitment Specialist)*

> *"The gender issues are complex and multiple. There is an issue about what happens to decent work, physical protection against sexual violence against women who are moving. And particularly when midwives and nurses move, this has a huge impact on the women health workers and nurses left behind." (Gender & Health Workforce Specialist)*

One recruitment specialist explained the complexity of the intersecting identities of gender and migrant status:

> *"…what is more difficult is when they are a migrant health worker and they get harassed or face indecent working conditions and then they can't leave or change jobs easily because they have a contract. They can of course file a formal complaint and go through the process with their staffing firm, but the practical reality is that it's really scary and women often aren't believed. If they don't want to go through this whole complicated and challenging process and 'create waves,' and there really isn't a process for leaving, so they're stuck." (Recruitment Specialist)*

Another key informant explained their personal experience with discrimination in the United States as a migrant health worker, which influenced their productivity:

> *"No one said it directly to me, but my colleague told me it's because I am a Muslim woman and because I wear a hijab. And it is not very welcome in the positions I was in. One of my colleagues mentioned that because my name is not a white name, this could be the reason I wasn't successful." (Female migrant physician, USA)*

2. Deskilling as a result of labor migration exacerbates the leadership gap

Deskilling decreases pay and leadership opportunities for women both in their destination countries and after their return home, which has implications for the leadership gap in global health. When deskilling occurs on a larger scale, and disproportionately to female health workers, the effect on gender equity in the health workforce is tangible. Our literature review confirmed that women experience the most harm from deskilling, but further research is needed

to understand the extent of deskilling on a global level.[3, 5, 17, 18, 27] Several key informants (n=7) acknowledged deskilling resulting from health labor migration:

> *"We have nurses that have worked in ICU and are highly skilled but have accepted positions in home care or long-term care because it's opened the door for them to come to the United States." (Healthcare Recruiter, USA)*

Although deskilling occurs across genders, it is likely that this phenomenon is more common among female health workers as the most common deskilling happens from nursing to home health care, as one informant explained:

> *"When women work abroad they often experience deskilling. Especially female nurses, they often work below their skill level as home care workers." (Health Policy Consultant)*

One key informant described their personal experience with deskilling, as she was currently not practicing in her medical specialty:

> *"Women are working way below their qualification! This is my experience in the United States as well. I love what I'm doing but I feel like I can do more and provide more... Especially when people are asking for doctors that speak their language." (Female migrant physician, USA)*

On the other hand, when return migration of health personnel is effective, which is what BLAs and MOUs are designed to facilitate, it can improve gender equity in global health leadership. Professional development opportunities may be available in the destination country not available at home:

> *"The added potential with migration is that women will be increasing their skills that they have and if it's done well, should be able to return home and be more in line for leadership and decision-making positions than they were when they left, which will*

> *increase diverse perspectives in decision-making." (Gender & Health Workforce Specialist)*

However, most stakeholders interviewed agreed that deskilling is a reality for many migrant health workers, and female nurses in particular. This results in long term implications for career advancement and leadership development opportunities for women health workers.

3. Migration opportunities draw health workers to non-traditional professions, affecting occupational segregation

When asked how labor migration may influence occupational segregation in the health sector, several key informants (n=4) described migration pathways and incentives for nurses may bring more men into the nursing profession:

> *"Where countries have made it easier for their health workers to migrate, like in the Philippines and India for example, then we see more men moving into nursing because they knew that as nurses there are more opportunities to migrate. I don't have numbers, but I know in India there were male doctors who then retrained as nurses because they could migrate more easily as nurses than doctors." (Gender & Health Workforce Specialist)*

> *"The nursing profession gives a migration path that some males do not have in other professions. From an immigration perspective, a nurse can get to the United States faster than an IT professional. We have heard of doctors that have changed positions to nursing to get to the U.S. faster because they can get a visa faster as a nurse." (Healthcare Recruiter, USA)*

While more men may enter the nursing profession as a result of labor immigration policy, our key informants were unaware of any cases of women entering male-dominated medical professions following migration.

4. Challenges to gender equity in international health workforce recruitment agreements

The most apparent challenge in assessing gender considerations BLAs negotiations is the inherent lack of transparency and visibility during the negotiating process, as well as the obscurity of the documents themselves. These policy documents vary greatly in their scope, goals, and formation, which further complicates analysis and comparison. Of the 77 BLAs reported to the WHO, we located only 9 online, and were granted access to two additional texts by a Ministry of Health, after months of investigation. Several key informants (*n=5*) cited lack of transparency as a major barrier to promoting gender, or any human rights, through BLAs:

> *"It's really difficult when you're working in this industry to find information about bilateral agreements. It's not really well documented and we don't have the time for that kind of research." (Healthcare Recruiter, USA)*

BLAs on health worker migration are typically negotiated between government Ministries. Independent stakeholders, like civil society organizations, labor unions, and recruiting agencies, are rarely involved in this process. Our key informants noted that the closed negotiations limited accountability in health workforce recruitment:

> *"A lot of these agreements, when they're negotiated, don't have much labor representation, there's not really unions or other stakeholders at the table. So the driver is rarely the practices on the ground for the worker." (WHO Employee)*

Our key informants also identified the lack of independent stakeholder or civil society engagement in the BLA development process as a barrier to promoting gender equity through BLAs, as there are no monitoring mechanisms outside of the government:

> *"A lot of those bilateral agreements are not followed through; they're not seriously monitored at all. They're there, there might be a project but then governments change and there is no follow through." (Health Policy Consultant)*

With so little access to negotiated bilateral agreements, it was difficult to conduct a thorough gender assessment of the documents and their negotiation processes. Of the eleven total BLAs we obtained and analyzed, none (*n=0*) mention gender or any aspects relating to gender equity in the health workforce. According to the Organization for Security and Cooperation in Europe (OSCE), BLAs lack gender-specific provisions because policy makers fail to conduct gender impact assessments or gender evaluations.[21] In 2009, the OSCE published a Guide on Gender-Sensitive Labour Migration Policies (see Appendix C), which provides specific guidelines for "engendering" labor migration policies. The OSCE argues that if BLAs underwent gender impact assessments prior to implementation, "it would be possible for them to take into account the specific vulnerabilities inherent in female-dominated sectors."[21] Although the OSCE guide is not specific to health workforce migration policies and was developed for the European context, it notes that gender-specific provisions "need to be taken into account and anchored in the negotiated text."[21]

5. Civil society organizations as independent observers of international recruitment

Another theme that emerged from data analysis was the role of civil society organizations in ensuring migrant health workers' rights are protected. Our informants noted that CSOs are an important external resource when migrant health workers experience challenges with their recruitment agency:

> *"We do evaluations with our migrant nurses to check on their wellbeing and working conditions. We make sure they are being treated ethically and fairly." (Recruitment Specialist)*

Particularly, labor unions have the potential to ensure migrant health workers labor rights are protected, but the extent to which they represent migrant workers is blurred. Migrant health workers often find themselves without representation, falling outside of the scope of both their home country and host country's labor unions:

> *"Participation of migrant workers in professional associations is key. It is currently unclear if they have representation in local unions." (WHO Employee)*

One interviewee noted the important role that dispute resolution procedures could play in improving the accountability of BLAs:

> *"Having dispute resolution mechanisms that are confidential and ensure lack of retaliation are critical. These mechanisms are helpful for all workers, regardless of gender, but women are more vulnerable to this kind of workplace discrimination." (Recruitment Specialist)*

However, most of our informants were unaware of these independent reporting mechanisms existing in their country. Our key informants highlighted the important role CSOs could play in reporting and dispute resolution:

> *"Civil society can work with migrant health workers and give them a place to report any violations. They can be an external resource for migrant health workers outside of their employer for them to ask questions about their contract, for example." (WHO Employee)*

CSOs are in the unique position of interacting directly with the migrant health workers in their countries, the recruiting agencies, and the national government, which means they often have a deep understanding of international recruitment in their country. They may be able to provide an important gender lens to health workforce recruitment that governments and recruiters typically neglect.

Discussion

This qualitative study examined how migrant health laborers experience gender inequity in their destination countries, and whether WHO Code-informed bilateral labor agreements are playing a role in mitigating these problems. We identified several areas of potential intersection where global migration may exacerbate gender inequities and other areas where global migration may pose an opportunity to improve gender equity, such as through BLAs. However, we found significant evidence that international health workforce migration interacts with gender equity

problems in the health workforce, suggesting further research is needed to provide policy-relevant evidence at national and regional levels.[3, 5, 10, 17, 18, 19]

When health labor migration is governed effectively and equitably, it has the potential to provide new leadership opportunities to female health workers. However, our research indicated that deskilling resulting from migration likely occurs on a global scale and more frequently among female-dominated professions, such as nursing. This mass de-skilling prevents large numbers of women from progressing into leadership roles with decision-making power, expanding the gender leadership gap in the health workforce.

Our research indicates health workforce migration may diminish occupational segregation in nursing, which could reduce gender bias and discrimination in the field. When more men join nursing, it weakens gender stereotypes that contribute to segregation.[7] However, men hold a disproportionate share of leadership positions in nursing, so a more gender balanced nursing workforce could mean fewer leadership opportunities for women.[28] In addition, our literature review and key informant interviews did not produce clear findings on whether migration brings women into higher paid professions like surgical care, which could reduce the gender pay gap and occupational segregation.

During our interviews, key informants were unable to provide substantial information on how the gender pay gap interacts with health worker migration. However, deskilling as a result of labor migration likely exacerbates the gender pay gap in the health workforce in destination countries, because migration disproportionately prevents women from advancing in their careers, earning promotions, and seeking higher pay. The lack of sex-disaggregated data on the health workforce prevents a thorough gender analysis of pay gaps in the health workforce, which is further complicated by the limited research on migrant health workers employment experiences.

The WHO Code encourages national governments to sign bilateral, multilateral and regional agreements on health workforce recruitment, leaving it to the states to negotiate agreements that uphold the migrant health worker's rights. However, the lack of formal guidance on how to negotiate BLAs that advance human rights leaves it to the discretion of Ministry negotiators to operationalize the recommendations made in the WHO Code. While the OSCE Guide on Gender-Sensitive Labour Migration Policies offers many valuable recommendations, it is not specific to the health sector, it was developed for European contexts, and it does not include any gender and HRH specific challenges. Gender assessments are critical tools for

closing the knowledge gap and ensuring migration policies are gender transformative, although they are currently absent in BLAs on health labor migration.

Our research also found bilateral agreements in their current state do not acknowledge the gender-specific motivations, needs, or challenges faced by migrant health professionals. This gender neutrality suggests the bilateral agreements have not been viewed as a vehicle for promoting gender equity. National governments have both the power and responsibility to promote gender equity through their international policies and they can achieve this by following the recommendations outlined in the OSCE guide. At the very least, improved accountability and formal social dialogue in BLAs and their negotiation processes would allow for the participation of gender experts who would bring a gender equity lens. Additionally, health workforce recruitment practices require greater monitoring and support from national governments if they are ever going to promote gender equity in the health workforce.

Finally, this study considered civil society organizations' role in ensuring migrant health workers' rights are protected, as they often serve as independent observers of government actions and policies. We found that third party complaint mechanisms, which provide migrant health workers with somewhere to report violations without fear of retribution, are critical for ensuring accountability of BLAs and protecting workers rights. The strength of civil society varies from country to country, but non-government organizations often interact with migrant health workers on a more personal level than the government. Labor unions in particular can ensure migrant health worker labor rights are protected, although the extent to which they enthusiastically represent migrant health workers varies. CSOs can also provide an important gender lens to health workforce recruitment that governments and recruiters typically neglect, as they are in the unique position of interacting with government, labor unions, health workers, and employers, and have a deep understanding of the situation in their country.

Limitations

This research did not investigate the domestic care sector, but home care workers comprise over 50% of the health labor market.[7] Domestic care, a female-dominated profession, and domestic care labor migration is widely unregulated although frequent gender-based discrimination and labor rights violations are cited in this sector.[7, 29] The WHO Code is limited to addressing the recruitment of skilled health professionals (doctors, nurses, pharmacists, laboratorians, etc.), and

for that reason we chose to remain in the scope of Code. However, if the domestic care sector was included in this research, it is likely that we would see a greater negative effect on gender equity from these migration practices.

Another limitation of this research is that BLAs were selected through a convenience sample of the full-text documents that are publicly available and we recognize there may be a discrepancy in the available BLAs and BLAs that are restricted. Finally, the health worker perspectives gained in this research were limited to one migrant health professional working in the United States and this presents only one, highly specific experience of international healthcare recruitment.

Finally, this study used only one coder (KF) to analyze the interview notes for themes, which we recognize as a limitation of this study.

Recommendations

The aim of this study was to explore the ways in which international health workforce migration intersects with the four subthemes of gender equity in the health workforce, as outlined by the Gender Equity Hub of the WHO. We then sought to identify why gender considerations have been neglected in the BLAs on health labor migration, as these policy documents provide the framework for international recruitment in many countries. Using this understanding, we have developed some recommendations for both governments and independent stakeholders to promote gender equity in their health workforce migration policies:

Recommendation 1: Open up the process of negotiating bilateral health workforce migration agreements to include a role for gender advocates and observers, and make all the agreements available publicly through a single WHO portal.

Gender equity in health workforce migration is only possible if gender considerations are included in the policies that facilitate their recruitment. Gender experts and advocates must be included in agreement negotiation processes, although there is currently no room at the table for independent stakeholders. Without an open and transparent process, there is no way to ensure gender equity in health workforce recruitment policy development. Additionally, we recommend Member States upload their negotiated BLAs involving the health workforce to the WHO Code

reporting portal, to allow for improved accountability and gender-sensitive monitoring and evaluation.

Recommendation 2: consider publishing checklists or principles crafted by advocates and civil society organizations to guide the formation of gender transformative bilateral agreements specific to the health sector, and even consider the value of publishing model language for bilateral agreements.

One key challenge to the development of gender transformative migration policy is the lack of guidance on how to do so effectively. CSOs can develop guidelines that could form the basis for independently assessing each agreement using a "report card" or other assessment system.

Recommendation 3: Conduct audits and reviews of BLAs to look for how well equity is advanced, including gender equity

To reduce gender inequity in the health workforce, governments could routinely conduct gender-specific evaluations and assessments of their health labor force, especially in relation to the migration status of health workers. Gender audits or evaluations might include a gender impact assessment conducted during the policy formulation phase, gender-sensitive indicators in the monitoring and evaluation mechanisms, and gender trainings for BLA implementing staff. Such reviews should inform the bilateral agreement negotiations.

Several resources are available for planning gender-responsive evaluations (see Appendix A) but they all require adaptation for use in the varying contexts of health workforce migration.

Recommendation 4: Provide third-party advocacy, monitoring, and reporting mechanisms for migrant health workers

We recommend local CSOs serve as a third-party support system for migrant health workers, labor unions ensure they are representing migrant workers, and all CSOs work to include a gender lens in their monitoring and evaluation activities.

Recommendation 5: Invest in research

Our final recommendation for all State and non-State actors in health workforce migration is to invest in further research on how migration status intersects with gender equity to influence

working conditions, and consider the role of policy makers in shaping this phenomenon. There is extensive literature on the importance of gender inequity in the health workforce, but we are missing critical research on migrant health workers' gendered experiences and how to effectively incorporate gender into health worker recruitment policies. Case studies can provide detailed accounts of the gender-specific aspects of labor migration for health workers.

Conclusion

As international health workforce recruitment increases, female migrant health professionals make up an increasing percentage of local health labor forces. However, the existing literature surrounding gender equity in the health workforce rarely makes a distinction between migrant and domestic healthcare staff, although we know these workers have vastly different employment experiences. Using an in-depth literature review and key informant interviews, we explored the relationship between international health workforce migration and gender equity in the health workforce. We also considered the challenges to gender transformative health workforce migration policies, which include a lack of accountability and transparency in BLAs, lack of formal monitoring mechanisms for BLAs, and limited research and evidence surrounding gender equity and health labor migration. Our research found that female migrant health professionals face high levels of discrimination in their migration experiences, due to their overlapping identity as a "migrant" in the destination country. Additionally, migration status likely increases gender-based discrimination and harassment because the health worker's ability to remain in the destination country, and speak out against discrimination, is contractually bound to their job. Although both male and female migrant health workers likely face discrimination based on their migration status, this identity overlaps with gender to create a unique and intensified form of discrimination for women.

In summary, it is our recommendation that all stakeholders in this process actively promote gender equity in health workforce migration. This includes involving gender experts and advocates in the agreement negotiation process, civil society organizations serving as independent watchdogs of health worker recruitment, and conducting gender-specific audits of existing agreements.

Appendices

Appendix A: Resources for Gender-Responsive Evaluations

Title	Date	Produced by	Intended Use
UN-SWAP 2.0: Accountability framework for mainstreaming gender equality and the empowerment of women in United Nations entities[30]	Nov. 2018	UN Women	By UN agencies for internal gender mainstreaming
Resource guide on gender issues in employment and labour market policies[31]	2014	ILO, Employment Policy Department	For ILO experts & national policy makers to embed gender in national policy frameworks
Gender mainstreaming for health managers: a practical approach[32]	2011	WHO: Department of Gender, Women and Health	For health program managers conducting gender mainstreaming trainings
Guide on Gender-Sensitive Labour Migration Policies[21]	2009	OSCE	OSCE States to include gender in their labor migration policies and procedures
Guidance for addressing gender in evaluations[33]	May 2018	IOM, Office of the Inspector General	By IOM for internal gender mainstreaming in M&E processes
Checklist for Assessing the Gender Responsiveness of Sexual & Reproductive Health Policies[25]	2010	WHO: Regional Office for Europe	For health program managers to assess how gender is integrated into their health policies

Appendix B: Checklist for Assessing the Gender Responsiveness of Health Policies

From the WHO Regional Office for Europe's "Checklist for Assessing the Gender Responsiveness of Sexual and Reproductive Health Policies"[25]

Suggested questions for stakeholders:
Is gender important for the implementation of the policy? If yes, why?
Was gender considered during the planning of the policy? How?
Were gender experts involved in the development of the policy?
Are groups of men and women representing different vulnerable population groups involved in the implementation of the policy? If yes, how?
Have you attended gender capacity building events during the implementation of the policy?
Suggested questions to examine policy objectives for their attention to gender considerations:
Is gender addressed in objectives/results/actions? On which level?
Are there aspects of the goals and objectives that will be affected by local gender relations, roles, or identities?
Is the policy addressing the needs of vulnerable population groups including men and women of difference ages, ethnic groups, and socioeconomic status?
Do actions consider how differences in participants' sex, age, socioeconomic status, and ethnicity might affect their ability to control resources, voice opinions, make decisions, or access information and services?
What are the social, legal or cultural taboos or obstacles that might prevent women or men from participating in the action?
Suggested questions for data and evidence:
Is the policy based on the analysis of sex disaggregated data?
Are there actions oriented to collecting evidence on gender inequities?
Suggested questions for monitoring and evaluation:
Are indicators disaggregated by sex, ethnic group, age, and socioeconomic status?
Are baseline data collected on women and men of different ages, socioeconomic status, and ethnicity?
Are there specific indicators to measure changes in gender relations, access to services and resources, and power?
Does the policy have a systematized way for collecting and analyzing the information on a regular basis?
Does the monitoring and evaluation framework include what to do when monitoring and evaluation data reveal gender inequities?

Appendix C: OSCE Guide on Gender-Sensitive Labour Migration Policies[21]

From section 3.1.2: Engendering Bilateral Labour Migration Agreements

During the negotiation process of bilateral agreements:
Make gender impact assessments an integral procedural component.
Include the participation of gender advisers with expertise on labour migration.
Include gender-specific, non-discrimination and rights-based clauses in order to enhance policy coherence
Acknowledge female-specific vulnerabilities by establishing protection measures.
Implement a complaint mechanism for harassment or discrimination.
Create protective provisions for sectors not covered by national labour law.
Provide for appropriate healthcare and social security benefits.
Establish common agreed on criteria for the recognition of skills and qualifications.
Consider the possibility of portability of retirement pensions, social security and health benefits.
Pre-departure and on arrival:
Provide gender training to those selecting migrant workers in order to ensure a fair and transparent selection process.
Disseminate information on legal migration opportunities and migrants' rights and obligations.
Provide information on arrival on national immigration and labour laws, the social welfare system, information on complaints mechanisms and contact details of counselling organizations, professional organizations and trade unions, etc.
Protective measures during the stay in the country of destination:
Provide gender training to administrative staff implementing bilateral agreements.
Strive to provide equality of wages and work conditions.
Examine possibilities of family reunification for longer-term migrant workers.
On return:
To ensure higher return, consider the option of repeat migration.
Allow for the renegotiation of contracts regarding working conditions and remuneration in the case of repeat migration so that new skills gained can be considered.
Consider policies that allow for conversion of temporary work permits to permanent work permits.
Implement a gender-sensitive monitoring mechanism during the review process.

Source: OSCE, 2009.

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