Realizing Rights:
The WHO Global Code of Practice on the International Recruitment of Health Personnel
Analysis with Nurses' Perspectives

A dissertation presented
by

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ABSTRACT OF DISSERTATION

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ABSTRACT

The World Health Organization (WHO) acknowledged the scope of the issues that undermine the development of sustainable health workforces when it promulgated the WHO Global Code (Code) of Practice on the International Recruitment of Health Personnel in 2010. The Code supplies a template for policy solutions to the global health worker crisis. Its recommendations are based upon four principles: 1.) to recognize the right of all people to the highest attainable standard of health; 2.) to acknowledge the right of skilled health workers to legally migrate in search of life opportunity; 3.) to employ a global policy approach to address the root causes and effects of health personnel disparity, and; 4.) to give special consideration to the needs of developing health systems. These four references embody an international consensus framework for health workforce policy that links health personnel to realization of the right to health, and well resourced to developing health systems.

In this dissertation an analysis of the Code’s literal and normative content is aligned with interview evidence obtained from internationally educated nurses (IENs) and health policy experts, to test its potential as a scaffold for nurse workforce policy that operationalizes its human rights framework. Guiding principles, offered by the Code, address the way society, governments and all stakeholders, should respond to the health system issues impacted by the unequally distributed shortage of skilled health workers. Its broad implementation direction does not, however, delineate the specific practices that respect, protect and fulfill the right to health. Nor does it supply a blueprint for policy that gives special consideration to the most needy. It acknowledges but does not resolve the policy tension of competing obligations to the freedom rights of nurses and the universal right to health.

The Code connects realization of the right to health, its central guiding principle, to the skilled health workforce. This supports the central argument of this thesis, that nurses are critical for fulfilling the right. Given this position, formal human rights governance obligations, directions and accountability mechanisms, derived from the International Covenant on Economic, Social and Cultural Rights (ICESCR) or domestic legislation apply to the responsibility to guarantee everyone access to nursing care.
The global nursing marketplace links wealthy and developing health systems. Vacancies in well resourced countries present opportunities that attract nurses, adding to the critical shortages seen in fragile systems and threaten realization of the right to health. Health outcomes align with the concentration of health workers; invariably regions with fewer health workers manifest poorer health.4

The Code echoes the ICESCR when it directs wealthy States to assist under resourced ones and to consider the effects of their health workforce policies on developing health systems. The right to health also imposes responsibilities toward the underserved. Although the Code explicitly cites the..."right to the highest attainable standard of...health", nothing in its text prescribes any compensatory remedy for right to health abuses that are exacerbated when nurses trained in poor countries deliver care in well resourced systems. Without correcting the long-standing wrongs that subsidize the nurse workforces of wealthy systems, at the expense of developing ones, it is unlikely that global solutions that realize the right to health for the underserved will be found. In addition to State duties, the Code directs that all stakeholders play a role in its implementation. Member States are left to, on their own or in collaboration, forge laws and develop policies that oversee the activities of stakeholders.

I propose a nurse workforce policy outline that uses the Code's guiding principles and objectives to operationalize human rights norms. The policy standards rest upon: 1) setting right to health as a core value: 2) accessing formal and informal accountability routes; 3.) using targeted incentives, specifically education and financial subsidy, to match the nurse workforce to health needs: and, 4.) sharing responsibility, research, resources, and best practices. Nurses and right to health are central to achieving the Code’s purpose.
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I dedicate this work to the nurses in critical health worker shortage areas. Through them fulfillment of the right to health can be realized.
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In 1946, the World Health Organization integrated the Right to Health alongside Civil Rights into its constitution: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” Preamble of the WHO Constitution 1946

In 2010 The World Health Assembly issued the WHO Global Code of Practice on the International Recruitment of Health Personnel in response to the deep concern that “the severe shortage of health personnel…. constitutes a major threat to the performance of health systems and the provision of health services…” Preamble to the WHO Global Code of Practice on the International Recruitment of Health Personnel 2010

Chapter 1: Health Workers, Health Outcomes
viewing the problem

Introduction and Overview

More than 60 years ago the World Health Organization (WHO) Constitution declared health a "fundamental " human right. The WHO defined it as “a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity”. Article 25 of the Universal Declaration of Human Rights (UDHR) identifies health as a right linked to overall wellness, stating “everyone has a right to a standard of living adequate for health and well-being of himself and of his family”. In 1966 the International Covenant of Economic, Social and Cultural Rights (ICESCR) recognized in Article 12 the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health". Although the right to health is amply recognized in formal and customary international law there is a gap between theory and practice when it comes to universally fulfilling it.

Globally, more than a billion people do not have access to basic health services. For example, the WHO estimates that 22 million infants worldwide do not receive required vaccines that are part of the WHO essential medication distribution program; 6.9 million children die from treatable or preventable diseases, such as diarrhea and respiratory infections, each year; while 48 million women give birth without a skilled attendant. The global life expectancy mean value is
67 years, which is significantly below the worldwide high of 83 years, but even more dramatically above the global low of 46 years, providing a statistical deviation that speaks to wide disparity. An inadequate cadre of skilled health workers, including nurses, contributes to the effects these statistics reveal.

Realizing the right to health raises challenges that laws and theories on their own have not solved. In this dissertation I explore the legal and historical basis for recognition of health as a human right. I develop the argument that nurses are essential for its realization. Without nurses to deliver care the required characteristics of the right to health cannot be achieved and progression toward full realization of the components of the right to health is not possible. The 2010 WHO Global Code of Practice on the Recruitment of Health Personnel (Code) supplies a common human rights guided structure for health workforce development, which I apply to policy recommendations for the nurse workforce.

Chapter 1 begins with a description of the difficulties that health systems face because of the global shortage of health workers. Wherever there are critical shortages of skilled health personnel, data confirms poorer health outcomes, and the greatest mismatch between human resources for health and burden of disease. The undersupply of nurses, which is exacerbated by their relocation from poor to wealthy health systems, further impacts health in fragile systems. The effects on health systems are set against a dynamic of the global nurse marketplace, which connects wealthy and developing health systems.

Chapter 2 lays out the legal and theoretical foundations for human rights, and, specifically, the right to health. A brief recounting of the history of human rights transitions to an exploration of its legal and political heritage, with specific focus on the right to health. The International Covenant of Social, Economic and Cultural Rights (ICESCR) provides the primary legal struc-
ture for the meaning of the right to health. The discussion of the right includes its legacy, a description of the required characteristics and core components of the right to health, the implications of the concept of progressive realization of social and economic rights to the right to health, acknowledgement of conceptual challenges and counter arguments to human rights, and an account of the distribution of duties and obligations to human rights realization. Examples of accountability and enforcement by domestic and international bodies demonstrate remedy.

Chapter 3 highlights the interface between the nursing profession and the right to health. In the care they deliver, nurses supply some of the essential core components and characteristics of the right to health, as defined in Comment 14, Article 12 of the ICESCR. I argue for nurses to be considered legally relevant components to meeting duties to progressive realization of the right to health. Examples of accountability mechanisms for human rights violations reveal potential remedy routes to address the effect of inadequate nursing care on the legal requirements to respect, protect and progressively fulfill the right to health.

Chapter 4 describes the methods used to acquire the empiric features of this work, which connect the theoretical model to the nurse workforce and the Code. I first describe the techniques employed to obtain interview data from ten internationally educated nurses (IENs) who were educated in low or middle-income countries (LMICs) but live or work in the United States (US). Their contributions furnished rich narratives, and responses to semi-structured questionnaire items. Content experts supplied focused interview information that lent relevance to issues surrounding health workforce policy. Interview data supplemented the document analysis of the Code.

Chapter 5 contains selected, concept analyzed, interview results, positioned alongside prior research concerning the migration of nurses. Responses describing the factors that drove
the IENs to migrate and to make career choices, add real life verification to policy sensitive proposals for developing the nurse workforce. IENs also indicated their perspectives on the meaning of the right to health to the nursing profession. Content expert interviews contributed, from their own viewpoints as clinical leaders, diplomats, health activists and regulators, to understanding the Code’s potential impact as a guide for global health governance in reference to nurse workforce development.

Chapter 6 consists of an article-by-article document analysis of the Code's text and meaning. The examination positions the Code's normative and literal elements alongside evidence gathered as interview data, and its theoretical foundations in human rights. The Code's policy guidance is based upon four principles: 1.) to recognize the right of all people to the highest attainable standard of health; 2.) to acknowledge the right of skilled health workers to legally migrate in search of life opportunity; 3.) to employ a global policy approach to address the root causes and effects of health personnel shortage and disparity, and; 4.) to give special consideration to the needs of developing health systems. The analysis of the document reveals its potential for applying the broad architecture of the Code to nurse workforce policy. Right to health unifies and strengthens the Code's policy platforms. The perspectives of IENs enlighten it. An addendum to Chapter 6 recounts the current evidence of Code implementation as reported by the WHO.

In Chapter 7, I discuss key empiric findings from the IEN interviews and Code analysis to lay a foundation for nurse workforce policy recommendations that operationalizes human rights norms. Integration of the right to health theoretical foundation, with the Code's directions and the empiric results supports recommendations that contribute to policy for nurse workforce development, expressly in critical shortage countries. In the discussion I address the usefulness
and limitations of using human rights as a standard when the policy conflicts emerge, such as meeting duties to competing rights, and setting priorities when resources are limited. I offer a structure for policy that operationalizes the human rights framework using the Code's guidance. Policy recommendations include: 1) setting right to health as a core value; 2) accessing formal and informal accountability routes; 3) using targeted incentives, specifically education and financial subsidy, to match the nurse workforce to needs; and, 4) sharing data, resources, and best practices.

This exploration of a new global health policy practice code draws attention to the link between nurses and realization of the right to health. Implementation of the Code focuses on the global dynamics of the skilled health workforce and directs that Member States coordinate their health workforce policy to consider its impact on human rights beyond State borders. Nurses, as vital members of the global health workforce, exert significant influence on realization of the right to health in all systems and, therefore, are my focus for operationalizing the guiding principles and objectives of the Code.

A. Global Health Disparity

1. Distribution of Health Workers and Health Outcomes

The inadequate global supply of skilled health workers, including nurses, is a threat to world health, social well being and to fulfilling the right to health as enshrined in international law. Identifying tangible elements that are required to fulfill the right to health can guide global health policy goals in a practical way. One target measure is the number of skilled health workers.
The WHO has set the minimum standard at a ratio of 23 skilled health workers, defined as nurses, midwives and physicians, per 10,000 people to meet basic health needs that include the health related Millennium Development Goals (MDGs) of 80% attended births and measles vaccination. These benchmarks also reflect core components of the right to health.

Skilled health workers contribute to the strength and stability of health systems and the delivery of health services. Using the WHO health worker to population minimum standard, there are 57 critical shortage countries (figure 1-1) where the ratio of health workers to population falls below the recommended minimum, jeopardizing their ability to fulfill the right to health for their citizens, or to meet MDG health and development targets. Most critical shortage countries are concentrated in Sub-Saharan Africa and Southeast Asia. Those with the largest deficiencies of health workers also carry the greatest health burdens (figure 1-2). For example, high maternal and infant mortality and childhood deaths from diseases such as diphtheria or polio, which can be prevented with vaccines, are almost exclusively seen in developing and under resourced countries.

Although there is a large global nursing workforce we find marked disparity in their distribution. The WHO Health Statistics Report of 2011 calculated a global force of over 28.5 million skilled health personnel. This computed to a worldwide mean of 29 skilled health workers per 10,000 people, an average ratio above the WHO minimum recommendation. Of the total, the largest professional group, nurses and nurse midwives, comprise about 70%-80%, over 19.5 million individuals, worldwide. According to the WHO, correcting the critical shortage deficiencies would require an additional 4.3 million skilled health personnel, largely nurses and midwives, in critical shortage countries alone. This estimate ignores the number needed to fill any
deficit other nations report, based upon their own, and generally considerably higher, reference points.

In comparison, the 34 Organization of Economic Co-operation and Development (OECD) countries record a ratio average of 30 physicians and almost 90 nurses per 10,000,\textsuperscript{13} about $5\frac{1}{2}$ times above the combined skilled health worker standard required to meet minimum health needs. In a staggering contrast, the ratio of nurses, alone, to 10,000 population in Tanzania is just over 2, in Afghanistan it is 5, while in the US, where the nursing shortage is also a concern, the ratio is 91.5\textsuperscript{14} per 10,000, more than 40 times higher than the nurse to population ratio in Tanzania. The disparity in remote areas of critical shortage countries may be even greater, since some of them fall far short of their reported national averages.\textsuperscript{15,16}

The skilled health worker shortage is a global concern that is made worse for poor countries by the loss of their health workers to wealthy States. Unfilled jobs in well resourced countries draw nurses to migrate to them. It should be noted that almost all OECD countries, including the US, also report shortages of nurses, based upon their own benchmarks. In the US health sector staffing is above the OECD average. Still, projections are that nursing workforce needs will increase. US Bureau of Labor Statistics data reported by the American Academy of Colleges of Nurses (AACN) Project, calculates that, with growth in the health sector, there will be jobs for an additional 1.2 million US nurses by 2020 to fill needs for expansion and replacement.\textsuperscript{17} The worldwide shortage of nurses is the backdrop for professional migration of internationally educated nurses (IENs), such as those interviewed for this dissertation. Job vacancies that attract health professionals to wealthy countries contribute to making it impossible to supply and maintain the health workforce in poor countries.\textsuperscript{18,19}
The density of health workers associates inversely with higher disease burden. Health worker deficit regions are marked by higher rates of death and disability from preventable and treatable causes. In 2011, the WHO and the WB data set on global deaths by cause and income level showed that worldwide 24.5% of deaths are a result of largely treatable or preventable causes; infectious disease, maternal or neonatal complications or poor nutrition. However, when WHO region and World Bank (WB) income strata separate the data, the distribution we see for preventable mortality is inversely associated with health worker density. In high-income countries, where health workers are plentiful, the rate of death from preventable and treatable causes is 6.6%. Contrast that with the rate of death from these therapeutically preventable conditions of 61.2% for Africa, where the critical shortage of skilled health workers is most acute. In Southeast Asia, where there are also critical health worker shortages, the percent of deaths resulting from these afflictions is 28.8. Citizens with access to skilled health professionals, nurses and physicians, are less likely, by a factor of ten, to succumb to preventable or treatable conditions.  

Figure 1-1. Source: WHO World Health Report 2006:Working Together for Health; http://www.who.int/whr/2006/media_centre/06_chap1_fig10_en.pdf
Falling below the minimum benchmark on health worker density is important because it is associated with a severe limitation of people’s prospects for health. Countries that fall below the WHO designated minimum ratio for skilled health workers record the poorest health outcomes in many areas, markedly so in those that require contributions from nurses and physicians, such as surgical interventions, maternal and infant mortality, and vaccine preventable infectious diseases. Higher concentration of health workers may also hold implications for sustaining the health workforce. Research in developed and developing health systems records higher staff satisfaction and greater professional retention, alongside better clinical outcomes, associated with nurse staffing ratios that are high relative to patient numbers.

2. The Link Between Health Workers and Health

When it comes to specific measurements of health the world wide disparity is staggering. In 2008, for example, more than 1000 woman died every day from complications of childbirth. Over 90% of the deaths occurred in the 75 poorest countries of the developing world. Most maternal deaths can be prevented by making basic health services such as prenatal care, attended deliveries and timely administration of medications to halt post partum hemorrhage accessible, all of which citizens in wealthy countries have routinely available. In developing countries giving birth is a time for a woman to face her mortality. In Sierra Leone a woman’s chance of dying each time she gets pregnant is 1 in 50. In 2008, a young girl in Niger stood a lifetime risk of 1 in 16 of succumbing to a maternal death, in Afghanistan the peril is even greater at 1 in 11. Mothers die giving birth at a rate of over 16 a day in Uganda. In contrast, lifetime maternal
mortality risk is measured at less than 1 per 48,000 in parts of the Europe. Maternal death is rare in well resourced health systems, but an accepted outcome in developing ones.

Preventable communicable disease statistics also reflect inadequate distribution of known remedies. All 1349 polio cases reported in 2010 originated in critical shortage areas of Sub Saharan Africa and Southeast Asia. This highly communicable virus has been eradicated in developed countries because of the availability of an effective, inexpensive immunization, and the personnel to distribute and administer it. African health workers comprise barely 3% of the global health work force but they need to treat patients suffering a staggering 25% of the world’s health burden with less than 1.3% of global health expenditure (figure 1-2). Common sense, simple arithmetic, and medical knowledge indicate that the extreme disparities are correctable, amenable to investment in and redistribution of resources. For over half a century we have known that an inexpensive, easy to administer vaccine will prevent polio and that routine maternity care will save mothers and babies. The cures are known, but the root causes of the global inequality of health remain inadequately addressed.

Elements, such as poor governance, lack of health system infrastructure, education barriers and poverty contribute to weak health systems. These also constrain the development of the skilled health workforce. Social and economic factors that do not prioritize the strengthening of health systems contribute to the dramatic disparity in the distribution of skilled health workers by limiting education and impeding practice, and thus hindering health care availability, especially for the disadvantaged.

Paul Farmer, founder of the NGO, Partners in Health, uses the term "structural violence" to describe the long standing, politically sanctioned, social policies that create barriers to the ability of the poor to enjoy the right to health. Economic decisions such as closing health centers
in rural areas because there are not enough nurses, not prioritizing development of the health workforce in critical shortage areas, or charging the indigent user fees for essential health services, fit his description. Many long standing structural arrangements, from unfair compensation plans for nurses that drive them from poor rural areas, to inadequate distribution of the scientific information needed for practice, conspire to impede health delivery to disadvantaged groups. When people are suffering and dying from preventable and curable conditions he would apply the label "structural violence".

"Structural violence is one way of describing social arrangements that put individuals and populations in harm's way...The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people." Paul Farmer

In an extreme comparison of nurse distribution, there are almost twice the number of registered nurses (RNs) employed at just one of Boston’s major hospitals as there are nurses and physicians combined in the entire country of Niger, which has a population of over 15,000,000. Figure 1-2 below displays the relationship between global health workforce and burden of disease. The association of a lesser density of health workers to greater disease burden is clear.
B. Global Nurse Workforce and Migration

The severe shortage of skilled health worker stems from many interrelated causes. The insufficient response to correcting deficiencies, makes access to adequate health services impossible for many. Domestic and international policies, such as prioritization of the use of international aid and loans, and lack of public accountability, alongside economic and social structural factors, such as weak domestic education systems, foreign loan repayment schemes, traditional practices that disempower women, and religious constraints, contribute to this effect. The global force of over 19 million nurses is a large component of the global health worker marketplace, and they are primary caregivers for basic health services in poorly resourced regions. Nurses are on the front line in health systems.

Nursing is a service profession that a country invests in by providing state subsidized education. In return for the investment it is reasonable to expect citizens to benefit from their service. Although inadequate training capability and pre career education are eligibility for nurs-
ing school acceptance issues that also need to be addressed as a part of sustainable solutions, another reason for the inability of States to increase their health workforces is the loss to emigration. \textsuperscript{18,40,41}

Nurses’ credentials and skills transfer across borders. The professional migration door is open to them and it swings invitingly from poor to wealthy health systems. Nurses from poor nations who apply for immigration often receive preferential selection for work visas, based upon needs for specialized skills in receiving countries. Professional attrition such as retirement, career change, and disability, along with migration make it impossible to sustain growth of the nurse workforce to meet needs in resource poor source countries.\textsuperscript{18,40,42}

Nurses migrate for a variety of personal and professional reasons, but regardless of the motivation, when their paths lead from under resourced to well resourced areas, fragile, developing health systems are left with fewer nurses. This can increase health system access disparity, and, in some cases, impede a State's ability to fulfill right to health duties to citizens. Wealthy countries often under produce health care personnel to meet their own work force needs, therefore, creating predictable, structural vacancies for nurses educated in poor countries to fill. The net effect is that nurses who are educated in poor countries emigrate to fill vacancies and deliver care in wealthy countries, while patients in developing systems are deprived of nursing care. This dynamic exposes the problem that inspired the drafting of the Global Code. Figure 1-3 below depicts this migration flow pattern. The dynamic makes the rich health system nurse wealthier at the expense of the poor. Essentially, the investment in nurse resources by developing countries subsidizes wealthy health systems.
The one way migration pattern underscores the need for global coordination in health workforce policy. Of the worldwide nurse cohort, about 3.5 million nurses, or almost 20%, are credentialed in the US. In contrast, the WHO calculates that only about half a million nurses, 2% of the global total, supply all low income countries combined.\textsuperscript{11} \textsuperscript{43}

Although global nurse workforce statistics are incomplete, collected data allows us to quantify the issue. From 1999-2007, 6% of Kenya’s already inadequate supply of nurses applied to emigrate, mainly to the US, Canada and UK, making it impossible to significantly increase the domestic nurse ranks through training,\textsuperscript{18} despite increases in nursing school enrollments. In 2010, Kenya’s chief nursing officer stated to a WHO inquiry that Kenya had the ability to train and graduate about 100 nurses each year. Since the health workforce is already severely under-supplied, and, nurses regularly leave the profession for reasons other than emigration, she projected that it would take “literally hundreds”\textsuperscript{44} of years to prepare a nurse work force that could meet the nation’s health needs. The dynamic that draws nurses from under resourced health systems, combined with the insufficient ability to develop or sustain the workforce, makes accessing basic primary health services a remote aspiration for many.
In 2008 Edward Mills, an HIV researcher from Canada, shocked the medical community when he titled an article in The Lancet “Should Active Recruitment of Health Workers from Sub Saharan be Classified as a Crime?”. Subsequently, in a 2011 British Medical Journal article, he further suggested, when looking at physician migration costs from Sub Saharan Africa, that compensation methods could be crafted to rebalance the cost benefit of physician migration, so the poor were not disadvantaged. The quotation below is from the 2008 Lancet article. He powerfully indicts recruiting agencies and the countries that approve and benefit from their activities.

"Active recruitment of health workers from African countries is a systematic and widespread problem ... and a cause of social alarm: the practice should, therefore, be viewed as an international crime. Recruitment of health workers from Africa is a structured initiative led by recruitment organizations, but clearly sanctioned by countries that then accept these placements, such as Australia, Canada, Saudi Arabia, the UK, the United Arab Emirates, and the USA. Active recruitment is considered unethical under many national policies, leads to negative health outcomes, and undermines the right to health as asserted in the Universal Declaration of Human Rights, various International Covenants, and numerous declarations and legally binding treaties including the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination Against Women."  

Mills links the recruitment of health workers to right to health violations, and he calls for compensation as a matter of justice. Mills’ perspective identifies wrongs that deserve remedy.

An added problem is that many nurses eligible for migration work visas to OECD countries are the most educated and experienced professionals, leaving new nurses, nursing assistants, and student nurses without mentors and instructors. The effect of the emigration of the most competent segments of the health workforce on capability to fulfill the right to health in source countries is unmeasured. The WHO world map (figure 1-1) depicts the global distribution of skilled health workers and displays the 57 countries experiencing critical shortages. The map does not show that some areas are dramatically undersupplied, well below the minimum bench-
mark. Others are left with the least educated or inexperienced nurses to provide services they have not been well trained to deliver, impacting the quality of care.

The global shortage of nurses and other skilled health professionals impact the function of health systems. WHO statistics show that where the concentration of health workers is lowest we find the poorest health outcomes.

Nurses are the primary skilled health professionals in the most underserved areas. Their departure from fragile health systems to fill nursing job vacancies in wealthy States makes it impossible for critical shortage countries, on their own, to make adequate progress toward developing their nursing work forces, or achieving global health targets. The wealthy enjoy the subsidized benefit of nursing care in which they did not have to invest, while citizens in poor countries are denied access to adequate care. Nurses play an important role in every health system.

The WHO’s threshold ratio for the number of skilled health personnel needed to achieve internationally established minimum health goals gives policy makers a measurable target for health workforce development. In a world where more than a billion people never even meet a health worker the current reality falls far short of the benchmark.
“The human rights community should take up the issue (the right to health) just as vigorously as it does extrajudicial executions, arbitrary detentions, and prisoners of conscience”. Paul Hunt, UN Special Rapporteur on the Right to Health

2: The Right to Health

*theory and legal foundation*

Introduction

Although the right to health is enshrined in international and domestic law, questions about the methods and contributions that assure its fulfillment remain unanswered. To achieve the right to “the highest attainable standard of….health” and supply the elements needed to realize it, requires more than laws, life saving cures and surgical procedures. Agreeing that health is a legal right doesn’t tell us exactly what elements comprise its fulfillment or who holds obligations and responsibilities to respect, protect and fulfill it. International law draws a picture of what the realized right should look like for everyone. Norms define how the right ought to be realized and protected.

The chapter begins with an overview of the political and legal heritage that supports health as a universal right that imposes responsibilities on States, organizations and individuals. The 17th century Enlightenment writings on natural rights inspired the calls for freedom and equality that resonated in the American and French Revolutions. Human rights were formally established in global governance in the mid 20th century with the endorsement of the Universal Declaration of Human Rights (UDHR), the creation of the World Health Organization (WHO), and, subsequently the dissemination of the two covenants, the International Covenant on Civil and Political rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Together, these comprise the International human rights framework. In the
late 20th century human rights emerged as internationally applicable forces in global governance, rather than a matter for domestic State concern alone.

Social, economic and cultural rights, which include the right to health, emerged as enforceable international law when the United Nations (UN) promulgated the ICESCR for ratification in 1966. This does not mean, however, that all aspects of right to health are fulfilled in all 160 States that have ratified it. The Covenant contains language, in Article 2, which makes it clear that States' duties do not require immediate fulfillment of all components of the right to health. When there are resource constraints compliance can be met through “progressive realization”. Exactly what comprises the progressive steps toward fulfillment is subsequently clarified in added Comments 3 and 14. However, certain aspects of realization of the right, such as non-discrimination and progression toward full realization, are always expected.

To fulfill the right to health defined and measurable elements are essential. The ICESCR designates essential characteristics of all human rights. Article 12, paragraph 2 also lists four health system components. General Comment 14 further details the core components, expanding the list to eleven interrelated elements. The core includes maternal and child health services, essential medications, social determinants, community health services, comprehendible health information, trained health workers, and other factors that assure equitable delivery of basic health services. When the core components of the right to health are not present the ability to enjoy health may be lost. Chapter 2 concludes with examples of the employment of accountability and enforcement mechanisms that have delineated the scope of right to health obligations to supplying essential medications and treatments, and analogously reference them as potential tools for developing and sustaining the nurse workforce.
A. Foundation of the Right to Health

_Everyone has the right to a standard of living adequate for the health, and well-being of himself and his family..._”. UDHR Article 25 1948

1. Political Movements and International Law

The trajectory of health as a fundamental human right and its global and State based legal heritage follows a traceable, historical route. The UDHR is generally recognized as the modern inception of global human rights.

Contemporary concepts that influence the health and human rights movement today, were formulated and codified in response to the shocking abuses of World War II; but the theoretical foundation was laid centuries earlier. John Locke, the 17th century Enlightenment thinker and physician, advocated social contract theory. His thoughts on “inalienable” rights, those fundamental rights to which all men are equally entitled, influenced Thomas Jefferson and the other framers of the US Declaration of Independence, the US Constitution and the Bill of Rights. Locke stated that certain rights are universal and inherent. They do not need to be determined by governments for people to be entitled to them. In his Second Treatise on Civil Government (1690) Locke referenced health when he wrote “All mankind...being equal and independent, no one ought to harm another in his life, health, liberty or possessions”.51 His work also influenced Rousseau, and others, in the 18th Century, who expanded his discussion of natural or innate rights. The ideals expressed in Rousseau’s work inspired allegiance to the right to liberty, equality and freedom that gave birth to the American and French Revolutions and later the US Civil Rights movement. They continue to serve as a foundation for civil society change worldwide. 52

Formal international recognition of health as a global political concern also pre dates modern times. In the early 20th century the League of Nations (LON) established the Health Or-
ganization, which collaborated with the Office International d’Hygiène Publique, a multinational organization that was established in 1907 to help deal with the spread of communicable diseases. Both bodies were precursors to, and formed a foundation platform for, the WHO. They enjoyed international support but little authority.

The nursing profession also has a formal heritage in global health. In the two world wars of the early 20th century nurses and other health professionals joined the military ranks to care for soldiers from all sides. Health science had advanced and nurses brought formal health interventions across borders. This era saw the birth of the United Nations (UN) and establishment of the WHO, and the formulation of numerous universal and situation specific declarations of human rights. In 1946 the UDHR integrated, in article 25, the right of everyone to “a standard of living adequate for … health and well-being ….including medical care” alongside civil and other human rights. Although the UDHR does not carry the force of formal law, in the 68 years since it was composed and promulgated it has assumed an influential place in customary law as a standard for civil society.

Subsequently the right to health was included in the ICESCR, which has been affirmed as enforceable international law, legally binding to ratifying States since 1976. Article 12 of the Covenant sets the standard for recognition of the right to health.

“The states parties to the present Covenant recognize the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

Article 12 goes on to broadly identify the steps Member States should take to achieve full realization of the right to health. These include provision of maternal and infant care, environmental improvements, prevention, treatment and control of infectious diseases and the providing medical services in the case of illness. The ICESCR made the right to health an established and
enforceable component of international law, and extended recognition of the right to a legal obligation for all States Parties. The right to health is formally included in numerous international governance documents. Subsequently added authoritative comments, General Comment 14, among others, elucidate the meaning of Article 12.

2. Human Rights Controversies

The view of human rights as evolving along the usually cited historically traceable route has detractors. In one alternative, Samuel Moyn proposes an anti-historical stand when he argues that human rights standards are mainly a recent development that cannot be directly drawn from Enlightenment thought or a response to the atrocities of World War II. He revises the theory of human rights origin when he proposes that the modern concept emerged in response to the ending of colonialism in developing nations in the 1960's, and the subsequent establishment of human rights as a pillar in US foreign policy in the 1970's. He writes that the "utopia" envisioned by contemporary human rights claims arose to counter disillusionment over the late 20th century failure to secure human dignity through national self-determination. He proposes that the contemporary vision of rights developed along a separate trajectory of thought, unrelated to earlier nationalistic declarations of political or natural rights. His basis for dismissing the historical continuum arises in part from a view of the differing political incentives for engaging human rights norms.

He is quoted as asserting that human rights arose, not from a political cradle, but seemingly "from nowhere". His claims point to a moral, rather than the legal foundation used in this dissertation. Moyn asserts that the rally cry of rights heard in the American and French revolutions were directed at building States, whereas, the modern human rights focus is primarily a re-
response to the repression of States. He uses this argument, that contemporary rights address a different political situation, as evidence that they do not share the same origin from a moral viewpoint. Human rights endow every citizen with entitlements, whether establishing the normative frame for new States or confronting abuses. Using the ideals for different purposes does not discount their intrinsic progression.

Regardless of its origins, the contemporary human rights framework has not controlled or eradicated cruelties that result from national self-determination in the name of rights, and they are still used as a basis for constitutions and codification in new or developing States. In Egypt, Syria, or South Sudan in 2013, for example, atrocities persist. At the same time, international human rights initiatives contribute to the guidance of leaders as they formulate the governance structure in the newly formed State of Somaliland, an example of contemporary human rights in nation building. Nor do human rights based foreign policies in the so-called "developed" nations consistently protect against rights abuses. 59 Although the context of human rights realization has evolved over time, its formal acceptance in contemporary global governance is clearly documented following World War II, in the WHO Constitution and UDHR, which were drawn up in the late 1940's.

All scholars do not see human rights as a utopian foundation for society. The French philosopher, Alain de Benoist, decries the totalitarianism of contemporary human rights as an example of the West's dominance in global governance. He claims rights, as defined in international law, lack the cultural nuances to make them equitable. In his view, the predominant human rights vision is not tolerant of minority differences, and can increase prejudice toward marginalized groups, whose beliefs do not conform. He challenges the authority of human rights platforms to dictate policy. 60
Clearly many global institutions are dominated by majority, liberal views, and his perspective reminds us that human rights policy should be scrutinized for upper class, Western or North, bias. Two principles embedded in the global human rights framework give the flexibility needed to recognize minority and cultural differences. The principle of progressive realization, which allows step-wise fulfillment of the right to health, also leaves room in setting progressive targets for cultural nuance because it calls for community involvement in health system planning. Compliance with realization of the right to health does not have to look the same everywhere, and can be adapted to circumstances that take culture, such as traditional birthing rituals or dietary restrictions, into account. Additionally, Human rights principles, those contained in the International Covenant on Civil and Political Rights (ICCPR) and ICESCR ask that the needs of the most disadvantaged are always recognized and respected, protected and fulfilled, and prioritized. Therefore, in theory, human rights governance principles, which enjoy broad international agreement, incorporate a defense to this argument.

These objections to the acceptance of universal human rights ideals because they are biased, and the controversy around their origin in political governance, do not directly address the right to health. Rights, including the right to health, redistribute power from authorities to individuals or communities. States hold duties to every individual, as a holder of rights. At least in theory being rights holders empowers the disenfranchised along with the privileged. Using the legal perspective, international human rights norms put enforcement power behind the claims of individuals whose rights are violated, irrespective of the foundation proposed. They provide accountability routes when markets and morality fail to do so.

The right to health, itself, also has detractors and has been challenged from a variety of theoretical perspectives. Paradigms, such as de Benoist's cultural relativist, or the libertarian
view, object to the imposed duties associated by the liberal egalitarian entitlement to the right to health, as proposed in international law. The relativist view notes that, although everyone is said to hold a claim to the right to health, the standard is, in fact, not equally applied, and its description may ignore priorities or beliefs of minority groups, while prioritizing the right of the individual. The relativist sees this as laden with the values of the wealthy and powerful. Relativist objections can, at least in theory, be dealt with by careful attention to processes, and respect for the criteria for realization of the right to health that safeguards the needs of the disenfranchised. An example, of a right to health priority that recognizes the needs of disadvantaged individuals and groups, would be elimination of all user fees for essential health services. The international human rights legal framework explicitly sets consideration for minorities and the disadvantaged as implementation priorities. The ICESCR along with other instruments of global governance that include the right to health, such as the Code, contain specific reference to meeting the needs of minority populations and including them in health system and development planning decisions.

Libertarian objections point to the application of forced duties and obligations, such as publically funded free health care for all. Libertarians argue that entitlement can be a disincen-
tive to people looking after their own health, leading to an unfair shared burden to provide for the health of others. This can impose a conflict if the libertarian feels his liberty right is violated when obliged to contribute to right to health responsibilities for others, or to comply with public health measures, such as state mandated vaccination programs. Libertarians call upon a balance of markets and beneficence to meet health needs. The market forces that libertarians suggest as a health system structure have not succeeded in making it efficient or affordable. There are arguments that suggest that when the poor, in any State, are not guaranteed access to health care
everyone pays for their poorer health. For example, if a person with acute abdominal pain delays seeking diagnosis until the appendix is ruptured or the hernia is strangulated, the cost and morbidity can increase exponentially. If poor children cannot develop to their potentials because of repeated bouts of inadequately treated and controlled infectious diseases, their ability to become productive society members is impeded. Society, including its objecting libertarian members, subsidizes the cost of denying the poor access to health care.

The libertarian view does not reject the idea of a right to health, but limits the State's duty to a negative one, to refrain from interfering with the health of individuals, and restricts any positive duty to protection of the right. Protection includes not impeding access. Libertarians can accept health protections such as vehicular safety laws or vaccination programs, as long as they are voluntary and don't interfere with liberty rights. Libertarians, for example, might support state sponsored measles vaccine programs, but would not agree that every citizen be compelled to participate. Although making compliance voluntary supports the freedom rights of the individual, from a communicable disease clinical view it puts the most vulnerable individuals at greater risk. Exercise of the freedom right in this case might interfere with fulfilling the broadly held responsibility to protect and respect the right to health.

Public health situations that raise this tension between conflicting rights are not new. Although the freedom right of the libertarian might be jeopardized, the community claim to public health measures is protected by public health statutes, at least in the US, not right to health, per se. Courts have ruled on the libertarian claim that unveils a conflict between the individual's freedom of choice, and the health of the community. Mandatory inoculations, testing or quarantine and have all been raised. Courts have generally favored protection of the public health over the civil right to freedom of choice. Admittedly, court decisions may reflect bias toward the
liberal egalitarian priorities of medical and public health ethics when they are adjudicated within the scope of public health law. The libertarian view might be incompatible with prioritizing the right to health as universal and fundamental from the perspective of responsibility to the health of others through taxation, and also from the vantage of the unresolved tension with autonomy and freedom rights.

3. Classifying Human Rights and Shared Obligations

Human rights are usually classified in two domains, which assign obligations and responsibilities for their fulfillment. They interrelate as civil rights and economic, social and cultural rights. Every person has a claim to rights in these two categories. States have the immediate duty to fulfill civil rights. Civil rights are termed negative rights, meaning the right should never be obstructed and is protected in law. States have an immediate duty to fulfill civil rights. Discriminating by not allowing certain individuals or groups to vote would violate the civil right to vote and the right to non-discrimination. Curtailing protected free speech, or free movement are also civil rights violations. States carry immediate civil rights duty to their citizens.

Social, economic, and cultural rights, such as the right to education or right to health, are positive, second generation rights. They require contributions, and may be fully realized gradually over time when there are resource limitations. For example, to fulfill the right to universal access to primary education the State needs to supply appropriate educational institutions. Developing the infrastructure for this can take time. Various component contributions to the right to health, such as basic primary health care, can also require long range contribution. Although some duties apply only to States for realization of social and economic rights, the responsibility
for their fulfillment and non interference, extends internationally to foreign governments and to
the private sector.

Human rights form a foundation for civil society and are embedded in the social progress
of individuals and groups from many perspectives. Today the right to health imperative has been
incorporated into numerous global and domestic governance documents as part of the comple-
ment of human rights that carry official State based, transnational, and societal authority. The
right to health is incorporated, employing complementary approaches, in The International Con-
vention on the Elimination of all Forms of Racial Discrimination (ICERD, 1965), the Conven-
tion on the Rights of the Child (CRC, 1990), and the Convention on the Elimination of all Forms
of Discrimination Against Women (CEDAW, 1979), as well as other international and domestic
instruments.\textsuperscript{3,64} Every UN Member State is now a signatory to at least one binding human rights
treaty that supports the right to health,\textsuperscript{65} indicating its acceptance as a defining consensus stan-
ard for global health policy. Although the US actively participated in formulating these formal
human rights documents and has signed CRC, CEDAW and ICESCR, it has not ratified them. In
the US, the process for ratification requires presidential signing and two-thirds senate approval.
Although consonant with US law for the most part, political factions object to the conceptual loss
of sovereignty that ratification might imply. The US has, however, ratified ICCPR, ICERD and
several other civil rights treaties.\textsuperscript{66}

Although the right to health is classified as a social, economic right its realization over-
laps with aspects of civil rights. For example, the right to health must be non discriminatory, a
civil right. Protection of the right to health for individuals also includes protecting social deter-
minants of health. The right to security and protecting features such as a safe water and food
supply, are also core components of the right to health as cited in the ICESCR and CRC.\textsuperscript{64}
The right to health is not realized in isolation from other rights. In 1993 the Vienna World Conference on Human Rights promulgated the Vienna Declaration and Programme of Action, which recognized the complementary and intertwined relationship between civil and social, economic and cultural rights. This means that for the first time fulfilling social and economic rights, such as the right to education or health, was formally recognized at a global human rights assembly, as a key to the fulfillment of civil rights, such as the right to freedom or to vote. It also means that certain aspects of all human rights, such as non-discrimination in their distribution and availability, were seen as components of civil society, safety, and security. Subsequently human rights were linked to development in the Declaration on the Right to Development, adopted by the UN General Assembly in 1986. It established that the importance of realizing rights was integral to achieving economic development goals.

Health is a foundation requirement for the exercise of other rights, such as the right to life, security and development. Health, like nourishment or education is a positive right. Unlike civil or political rights, its realization requires active contribution, which extends responsibility beyond State governments. The right to health imposes duties on States and others to respect, protect, and fulfill it. The duty to meet right to health obligations is generally assigned to States, Comment 14, added to the ICESCR in 2000, clarifies the responsibilities of individuals and private enterprise toward realization of the right to health. An example of health policies that include incorporating individual contributions to the right to health of others, is the program used to guarantee the distribution and administration of medicines to those with multi drug resistant tuberculosis (MDR-TB), instituted in Lima, Peru. Simply supplying State funded medication did not consistently get it where it was needed, putting individuals and groups at risk because of the contagiousness of the MDR-TB bacteria. Healthy community members, under health system and
NGO supervision, participated in the program for infected individuals by delivering essential curative medication to TB patients, and directly observing its administration. This technique protected every other member of the community from the disease. This is an example of fulfilling the right to health in one case (mandating free treatment, supplying an essential medication) and protecting it in another (designing policies to prevent the spread of disease) in a private/public partnership. 71

The ICESCR directs three specific legal obligations to the right to health; to respect, protect and fulfill the right. States are directed to respect the right by never interfering with its enjoyment. Respecting the right to health means keeping health services available, and providing the basic resources, including human resources, to assure non-discrimination in access. When available resources are not allocated to supply basic health services in poor rural areas, the right to health is not respected.

Protecting the right to health means States have the duty to adopt legislation that guarantees that health services are available and accessible without discrimination, and protected from interference by outside enterprise or individuals. 8 72 For example States may legislate free maternity or childcare. Besides instituting measures to protect citizens through legislation meant to guarantee services, States can also protect the right to health by preventing negative impacts from domestic or foreign enterprise practices on the social determinants of health, such as pollution or safety. They protect the right to health when they allocate foreign aid to secure the availability of basic health services and the resources to supply them.

The duty to protect also includes regulation of health professions, for example, ensuring licensed nurses are adequately educated before they are eligible to practice, and that they have access to appropriate health information. 73 We saw that some policy measures, such as manda-
tory vaccination campaigns that protect the right to health of citizens, can conflict with the freedom rights of individuals. A conflict between the freedom rights of health workers and the universal right to health is an underlying dilemma, recognized in the Code. Its guiding principles recognize the negative impact loss of health workers can have on fragile health systems, while also acknowledging the freedom rights of skilled health personnel to legally migrate. Protecting both is required.\textsuperscript{74}

The obligation to fulfill means that States give recognition to the right in appropriate legislative, administrative, budgetary, judicial, resource and other measures to progress toward full realization. At a minimum, progress toward full realization must always be made and services must be accessible without discrimination.\textsuperscript{75} Comment 14 of ICESCR gives shape to the right to health when it designates required characteristics and core components. The Comment stipulates that "the obligation to fulfill requires States \textit{inter alia} to take positive measures that enable.... individuals and communities to enjoy the right to health."\textsuperscript{3} This quotation is significant because it links the tangible, measurable elements of health systems, in addition to legislation, to the fulfillment of right to health obligations.

B. International Covenant on Social, Economic and Cultural Rights

"\textit{Health is a fundamental human right indispensable for the exercise of other human rights.}"
ICESCR Article 12, General Comment 14, 2000\textsuperscript{3}

1. Progressive Realization

The body of scientific knowledge has grown exponentially since the UDHR was penned at the end of World War II and ICESCR adopted in 1966. Alongside medical and scientific breakthroughs, the connections facilitated by globalization increase the ease of sharing and trans-
fer of knowledge, materials and health personnel, including nurses, across borders. The right to health, as set forth in the 1946 UDHR and the ICESCR, required further definition to be useful as a 21st century guide.

In 2000 General Comment 14 was added as authoritative clarification to Article 12 of the ICESCR to provide guidance on the application of right to health obligations. It recognizes that "since the adoption of the ...Covenants in 1966 the world health situation has changed" and ...the changes "created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12." Comment 14 details the extent, character and content of right to health realization.

Progressive realization is a defining notion of social, economic and cultural rights. In addition to respect and protection, it is progressive fulfillment that underlies realization of right to health obligations in resource limited settings. The concept of meeting obligations though progressive fulfillment is meant to prevent poor countries, and those with the ability to assist them, from viewing compliance as impossible. As a strategy for fulfillment of the right to health progressive realization can have vulnerabilities. It potentially gives States the excuse to do very little, and still claim they are compliant with the notion of progressive realization, since it only requires resource considered steps toward full realization, and States may claim no available resources that can be allocated to health.

However, under ICESCR, States are still obliged to take those steps. The constraints that limited supplies, skilled health personnel, or financial resources may place on the ability of a poor States to fulfill the right to health, do not relieve them of their obligations. No matter how poor, States are obligated to always respect and protect and take steps to progressively realize the right to health. They are directed, in Article 2.1 of the ICESCR, to the "maximum of its available
resources” and international assistance toward this end.\textsuperscript{50} Progressive realization, included in the ICESCR under Article 2, and clarified in General Comment 3 is referenced specifically to the right to health in Comment 14. \textsuperscript{77 50 3}

“The States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (article 2.2) and the obligation to take steps (article 2.1) toward the full realization of Article 12 (of ICESCR). Such steps must be deliberate, concrete and targeted toward full realization of the right to health."

The Comment goes on to direct that to fulfill their right to health responsibilities to progressive realization States should act independently and collaboratively.

“Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”\textsuperscript{3}

Meeting the obligation to progressively realize the right to health requires targeted deliberate steps toward full realization. Even though States are the signers of the Covenant and its amendments, Comment 14 clarifies the shared responsibility.

“All members of society—individuals, including health professionals, families, local communities, intergovernmental and non governmental organizations, civil society organizations, as well as the private business sector—have responsibilities regarding the realization of the right to health....”\textsuperscript{3}

Admittedly, States with limited resources need to prioritize the their distribution to the progressive fulfillment of their many rights obligations. States may claim they have no resources to contribute to progressive realization of the right to health, because their assets have been allocated toward the fulfillment of other rights, such as supporting the right to security through the State funded military. The assessment in international law of compliance with the efforts required by progressive realization is the reasonableness standard. There is also latitude in deciding what constitutes reasonableness, but it has been suggested that to meet the standard, progressive
realization strategies should be principled, usually interpreted as, at a minimum, non discriminatory. Reasonable effort also means it progressive realization strategies are evidence based, involve consultation with relevant parties, are transparent, and are subject to evaluation. Compliance with any of these can be argued on evidence in individual situations. Although having criteria for evaluation of complaints may not in itself stop States from using progressive realization as an excuse to do little, they show that the concept is not vacuous. Criteria exist that States and others can use as guidance to assess compliance or abuse.

Using progressive realization as a counter argument to the obligation to fulfill the right to health can oppose the spirit of the ICESCR stipulation of reasonableness. Although the precise effort required may be somewhat and qualified, there are criteria that the CESCR uses to evaluate a State's compliance. The CESCR investigates complaints when States use resource limitation, as an unjustified excuse for inadequate, or no effort toward fulfillment. The Optional Protocol to the ICESCR, its centralized complaint repository, provides further guidance. It has established a set of criteria that assess the obligation. The criteria progressive realization can be evaluated by measuring a State's efforts against the criteria. These include non discrimination, the use of evidence to make decisions, whether the issue is the absence of, or redistribution of available resources, the involvement of community and other entities beyond the State in progressive realization plan, and the availability of effective monitoring and accountability. The CESCR will investigate and monitor complaints and issue a remedy plan when progressive efforts are deemed insufficient based upon the criteria.

The global human rights framework also gives guidance about the character of resources. The CRC Committee issued a statement clarifying this definition from a right to health perspective. It declared, in 2008, that the reference to resources should be understood to mean more than
finances, but also the assets needed for progressive realization toward fulfillment of social and cultural right, including human resources along with technological, organizational and information resources. Meeting right to health progressive fulfillment obligations requires not only allocation of finances but also the range of items cited by the CRC.

Operationalizing a human rights based approach to health involves all stakeholders and nuanced policy. Whether States Parties are under resourced or self sufficient, all 160 ratifiers of the Covenant are legally held to the standards of progression toward fulfillment of the right to health. Under current conditions, the right to health cannot be fully realized by every country. That does not, however, negate the duty of States, along with individuals and private enterprise to make substantive, progressive, non discriminatory efforts toward full realization of the right, and to always respect and protect it. The obligation to protect can include passing and enforcing legislation that promises equitable universal health services, or protects citizens from regressive health effects such as pollution by industry or the luring away of nurses from areas of critical shortage by health workforce recruiters. Supplying sufficient skilled health workers to staff the centers needed to provide health services, requires more extensive education and investment contributions than passing legislation. Seeking and allocating foreign aid can support efforts.

While the exact components required to comply with progressive realization may vary with available resources, the ICESCR delineates minimal core components and essential characteristics for realization of the right to health. The core components give tangible shape to the concrete, targeted steps toward full realization. Resources, including human resources are indispensable requirements to the progressive fulfillment of most of the core components. For many countries international assistance will be essential if they are to meet minimum health worker and health service benchmarks, such as childhood vaccinations and maternity care. The WHO
minimum health worker ratio supplies a benchmark and can be regarded as a reasonable target toward progressive realization compliance.

2. Essential Characteristics of the Right to Health

Available, Accessible, Acceptable, Appropriate Quality

Fulfilling the right to health calls for action and translation of human rights legal and theoretical norms into the pragmatic language of health policy, that can be operationalized. The essential characteristics and core components shape the right to health. They provide authoritative policy guidance.

General Comment 14 refines the description and content of the actions and responsibilities that should always characterize the right to health. To meet right to health obligations health care should be available, accessible, acceptable and of appropriate quality. \(^3,5^4\)

The Comment supplies guidance in descriptive terms regarding these four central requirements that are fundamental to realization of the right to health. *Availability* means that the basic essential health services and health determinants are provided. Functioning health resources of sufficient quantity need to exist to protect the right to health of citizens. Although the exact nature of facilities will vary depending on a State’s resources and needs, the minimum standard is that maternal and child health care, primary health care, health facilities staffed with sufficient trained health personnel, clean water, basic health information and essential medications are available and affordable. \(^3,8^2\) Comment 14 explicitly cites the requirement for a sufficient number of appropriately skilled health workers as essential to meeting the requirement of availability.

*Accessibility* means that health services are open and all can use the facilities without any impediments. It requires non discrimination, along with physical, economic and information ac-
cessibility. This implies that the right is protected and non discriminatory when the facilities are open and physically and economically reachable with appropriate up to date health information accessible to health workers and clients. Non discrimination in the provision of resources is a key to meeting the required characteristic of accessibility.³

Acceptability means that the right to health is respected, that health services are equitably distributed to all regardless of their status in society, without prejudice. It means the right to health is protected from regressive effects of outside agents. To be acceptable a health system must show; respect for confidentiality, careful attention to research ethics, and respect for cultural, gender and age related needs. When disparities develop because of inadequate resources, or because programs disregard the values of minority groups, the acceptability criterion is not met.

Appropriate quality goes beyond the basic provisions of general access to health services to say that that “all health services must also be scientifically and medically appropriate…” and should include access to relevant scientific knowledge and therapies.³⁸³ Comment 14 states that meeting the criteria for health system quality "requires, inter alia, skilled medical personnel..." along with medical supplies.³ For health workers to maintain appropriate quality in the care they deliver they need to update skills and knowledge. The Comment also explicitly directs that there should be opportunity for the participation of citizens and health personnel in decisions related to the right to health. In addition to the supply of capital and human resources, compliance with the characteristics also demands access to relevant and reliable scientific knowledge and non-medical health determinants such as potable water, shelter, health education, security and nutrition.⁸²⁸⁴

Affirming the right to health, achieving the required health system characteristics, does not mean everyone will be healthy,⁸⁵ nor does it mean that all health care is free or conforms to
the ideals of distributive justice. However, meeting right to health responsibilities does mean that, for everyone, health systems, in broad terms, must meet the boundary criteria of being available, accessible, acceptable, and of appropriate quality. \(^3\) \(^53\)

3. Core Components of the Right to Health

Progressive realization intersects the tangible elements of the right to health through the core components. Despite the difficulty with forming a precise definition of the right to health or health, itself, there are tangible elements that can be quantified and minimum standards that Article 12 of ICESCR sets. Comment 14 expands the four components of ICESCR to eleven more specific health system elements that comprise “minimum standards of essential health related services...” \(^82\) needed to fulfill obligations to respect, protect and progressively realize the right to health. The core components of Comment 14 provide a template for translation of the elusive concept of the ICESCR’s “highest attainable standard of...health” \(^8\) into defined elements that can be implemented, enforced and measured. \(^3\) Regardless of resources all States hold the duty to demonstrate, at a minimum, progressive fulfillment of the core components. This duty includes the responsibility to assure that private enterprise and individuals do not interfere with them.\(^3\)\(^,82\)

The progressive realization standard, and the Comment 14 expansion of the core components, lends clarity that makes the realization of "the highest attainable standard..." reasonable. General Comment 3 makes the duty explicit by delineating the duty to progressive fulfillment. It directs that States must use their available resources, at a minimum, basic primary health care for all. \(^86\) Although some poor countries might not, on their own, be able to provide even basic health services, they can meet this obligation by seeking assistance and using aid to take targeted steps toward achieving fulfillment of the right to health for all citizens. \(^82\)\(^3\) The WHO has deter-
mined that a minimum number of skilled health workers are needed to attain the 80% mark on most of these essential health indicators listed in the abridged list of figure 2-3. Taking concrete and directed steps toward achievement of assessable measures of progress toward fulfillment of the core components is expected under the ICESCR. Governments and other entities can view progress toward these as criteria that are legal responsibilities as well as health system targets.

\textbf{Figure 2-1. Core Essential Components of the Right to Health}

- Comprehensive primary health care
- Access to essential medicines
- Reproductive health services including prenatal and delivery care
- Basic immunizations
- Enough food for adequate nutrition
- Accessible, affordable, equitably distributed and non-discriminatory health care services
- Safe water and hygiene
- Access to comprehensible important health information; including on health and human rights
- Adequate shelter
- Security and freedom from violence

\textbf{C. Operationalizing Accountability}

1. Responsibilities of State and Non State Actors to the Right to Health

Assigning shared responsibility for realizing the right to health calls for consideration from a variety of perspectives and involves an array of actors. Although effort toward full realization is required of States, the exact nature of their obligation is qualified by progressive realization. International and domestic codifications set norms to which nations, and the entities over which they have power, can be held accountable.

Realization of the right to health requires contributions in terms of services and materials. This implies responsibility to both legal, and less formal, requirements to respect, protect and fulfill the right. The legal duty to the right to health falls upon States, the treaty signatories, who then exercise their obligation to respect and protect the right through legislative, judicial and oth-
er means that impact citizens, health professionals and private enterprise. The responsibility is both domestic and international. States may codify the right in their constitutions, or through legislation operationalize it in regulation and policy. The exploration of what components comprise the right to health and who holds the duty to fulfill them bears implications for health policy formulation, accountability and enforcement.

The ICESCR and Comment 14 explicitly include reference to the responsibilities of non-State actors, including health professionals, toward the right to health. Countries reinforce the obligations of non state actors in their domestic legislation by incorporating the principles of international human rights law to their individual circumstances. An example of global application of international law to protect health, is the widespread acceptance of The Framework Convention on Tobacco Control (FCTC). This international treaty supports the right to "the highest attainable standard of...health". An FCTC treaty requirement is that the 177 States Parties promulgate domestic legislation that supports its principles. Tobacco companies have been held accountable in domestic courts in wealthy and poor countries for the impact of their activities on the health of individuals. Domestic laws and regulations that limit advertising, forbid free distribution, and prohibit youth sale of tobacco products, all protect health and hold business enterprise defendants accountable for offenses.

Reference to non-State actors extends the scope of the Covenant beyond the narrow reach on Member States' formal duties to the right to health. Although the international human rights framework cites their responsibility to the right to health, any legal sanction rendered generally results from measures that States adopt, such as laws or policies that regulate their activities, and enforce compliance. Although many poor States may not have the capacity to control the actions of large corporations, international law, also impresses the responsibility of cooperation on all
signatories. This suggests that States have a responsibility to investigate complaints and monitor the activities of the entities, over which they have power, for their impact on right to health realization outside their borders.^[53]

Health professionals can also influence right to health realization beyond the clinical care they deliver. Paul Hunt, former UN Special Rapporteur for the Right to Health spoke to the role of health workers toward health policy creation and its implementation.

"....Human rights can be an asset and an ally for... health professionals. It's going to help them achieve their profession objectives....The right to health is in the constitution of the World Health Organization and it is effectively in the Universal Declaration of Human Rights. The challenge is how to operationalize it, how to implement it. I'm a human rights lawyer. Human rights lawyers can't do that stuff. We need to have advice from, be guided by health workers if we are to implement the right. It is a partnership between the lawyers and the health workers and many others if we apply a human rights lens to the problem ... I think it will help us identify what has to be done and not just as good management not just as good medical practice but as a matter of legal obligation to which we should all be held accountable." ^[91] Paul Hunt 2012

The UN recognizes the effect corporations have on human activities. Private entities enact consequences on the rights of citizens far from their corporate offices. Business and private enterprise, ranging from health recruitment agencies, manufacturers of medical materials, educational institutions, pharmaceutical firms and a broad range of NGOs, among others, can impact realization of the right to health domestically and internationally. The UN issued direction for the responsibilities international business enterprises incur with respect to human rights. In 2008, John Ruggie, the UN Special Representative on Business, finalized the Respect, Protect and Remedy Framework, and in 2011 the UN published Guiding Principles on Business and Human Rights.^[92] Its principles assert that private businesses bear responsibilities to protect and respect the human rights of citizens, including international citizens, and to remedy abuses when they occur as a result of their practices. The UN has demonstrated commitment to holding transna-
tional industry and business enterprise accountable for actions that impact the realization of human rights. In 2011 the UN Office of the High Commission on Human Rights (OHCHR) appointed a global working group to disseminate and implement the Respect, Protect and Remedy Framework for business enterprises.\textsuperscript{93, 94} The responsibility of corporations to the right to health has been employed to delineate the obligations of pharmaceutical companies and health facilities with respect to distribution of essential medications and services.\textsuperscript{95} The guidelines for accountability and remedy apply to States and private business entities.\textsuperscript{92}

Besides the human rights responsibility placed upon States by the ICESCR, they hold other obligations to comply with international law to protect the health of those beyond their borders. Many WHO documents reinforce transnational obligations to health,\textsuperscript{96,97} such as, the WHO International Health Regulations (IHR) that carry the force of international law. IHR requires all Member States to report and institute protective measures when communicable diseases are at risk of international dissemination.\textsuperscript{63,98} The IHRs explicitly state that all Nations have the responsibility to act to protect health beyond their borders by reporting and controlling the spread of infectious agents.

\"The purpose and scope of IHR 2005 are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.\" (Art. 2, IHR 2005)\textsuperscript{99}

Since health workers are needed to comply with IHR requirements, it follows that States should also be concerned with the health workforce beyond their borders. Insufficient numbers of health workers threaten all countries when poor nations, with critical deficiencies, are unable to fully comply with the international regulations. Lawrence Gostin points out, that to protect their own health, it is in the self interest of wealthy nations to be concerned about health work-
force deficiencies worldwide, because when poor countries cannot contain infectious diseases at the early stages, and they are transmitted abroad, the adverse effects can reach to the wealthiest systems.

Though generally not operated for profit, NGOs engage in international activities that impact human rights. They often attract, and offer remuneration to, skilled health workers in countries they service. They also hold right to health responsibilities. The Commonwealth Medical Trust published a comprehensive guide for NGOs with regard to implementing policies that respect, protect and fulfill the right to health. The guide recognizes the effects NGOs, which often have limited time and scope of focus, have on realization of the right to health in the countries they service. They may influence the distribution of human resources by using incentives to mobilize them for the NGO's mission, thus, impacting care in the public sector. NGOs are directed to recognize the effect their operation has not only on consumers of health services, but also upon health workers, health systems and realization of the right to health.

States sign and ratify treaties, conventions, regulations and covenants, which comprise enforceable international human rights law. States then codify the international legal structure into their domestic legislation. Health is of interconnected global concern. Accountability to the right to health is not limited to governments. The responsibility to secure the right to “the highest attainable standard of ... health” for everyone is shared by States, individuals, non-state actors, NGOs, professional organizations and for profit enterprises. All are accountable to fulfill their legally recognized responsibilities.
2. Accountability and Adjudication

Governments hold legal power regarding protections of the right to health of their citizens. This also means States have an obligation to enforce domestic and international human rights laws and to hold those over whom they have power accountable. Civil society expects that those entrusted with power will protect the rights guaranteed by law. Globally, national courts have decided numerous cases on the basis of right to health violations, usually for individuals seeking specific remedies or treatments such as access to essential medicines, therapies or accommodations. There has been a spread of cases citing right to health violations since the 1990’s. 100,101

Court decisions affirm rights at a formal level but the evidence for generalized systemic change based upon right to health case adjudication is not consistent. At times court rulings for an individual, who claims a right to a particular therapy, will not extend to realization of the right to health for those who are not claimants. But, in other circumstances, decisions, such as the exposure of discrimination in basic health care for minorities, disadvantaged groups can benefit from court judgments. 61,101,102 Human rights arguments have been successful in obtaining affirmative decisions in countries, notably Brazil, Costa Rica, Argentina, India and South Africa, where the right to health is codified in national laws or constitutions. 89,101,103 Despite ostensible positive results there have been criticisms that court actions are a tool most often employed by the well off or best connected, and the benefits may not trickle down to the least advantaged. 103-106 In some countries, Columbia, Brazil and Costa Rica for instance, judges have heard literally thousands of cases brought by individuals claiming a right to specific health interventions. 100 53

Court decisions represent the ultimate formal sanction for right to health abuses but have not always resulted in benefits that improve the health of the most needy. Pursuing formal litiga-
tion is expensive and time consuming. In 2008 alone, courts in Sao Paolo, Brazil, ordered close to $2,000,000, for a variety of expensive drugs for individuals or small groups of claimants. Although successful claimants likely benefitted from the court decisions, the larger issues of access to basic care were not addressed. This appears to have resulted in not only a drain on Brazil's limited health resources, but also slants fulfillment of the right to health toward those with the resources to access the courts.

Octovio Ferraz examined right to health cases brought before courts in Brazil, a country that guarantees right to health, and access to all available therapies, in its constitution. His conclusion is that favorable right to health decisions for individuals increase health disparity. Courts, for example, have allocated large sums for expensive medications for a small number of plaintiffs, while cancelling vaccination programs for millions of children because of lack of resources. The ICESCR, Article 12 directs that "States have a special obligation to provide those who do not have sufficient means..." access to the health services they require. Court adjudications of right to health infringements toward individual citizens do not usually consider the latent effect of their decisions on the underserved, such as the cancellation of rural child vaccination programs.

The number of global right to health cases has increased but the societal effect of the decisions made for individuals in specific cases may not diminish health disparity. Many of the judgments have not been rendered in common law countries, leaving each decision resting on the individual case merits. When litigated, court rulings can clarify the contours of particular rights, such as the right to non discrimination in access, or the right to essential medicines, in their decisions, which can form a foundation for policy. Courts have not been examined as plat-
forms that enforce the need for an adequate supply of health workers to realize the right to health, except in one seminal case.

Recently the Constitutional Court in Uganda heard a case that spoke to a larger, underprivileged beneficiary base and stipulated deficiencies in skilled health worker care as right to health violations. The petition, which named care violations in two exemplary cases, was brought on behalf of the all mothers in Uganda. In Constitutional Petition 16, *The Centre for Human Rights and Development vs. Attorney General*, alleged a violation of the right to health, which is explicitly guaranteed in Uganda’s Constitution. Among the Petition's allegations it claimed that:

"...inadequate health worker resources for maternal health, specifically midwives......is an infringement of the right to health under Objective XX, XIV,XV and Article 8A of the (Ugandan) Constitution." Petition 16, Constitutional Court, Uganda

The “landmark” case is interesting because rather than claiming a right to the provision of a specific treatment, medication or procedure, the suit stipulated that the overall condition of maternity services, including shortcomings in nursing care, violated the rights of all Ugandans in a country where 16 women are said to die in childbirth everyday.

This case arises against the backdrop of appalling mortality and morbidity data, for mothers in Uganda. Empiric assessment indicates that for every one of those 16 daily maternal deaths, there are about 100 incidents of complications, such as obstetric fistula formation or gynecologic infections, which can impact a women’s ability to ever function normally. Because the right to health is explicitly acknowledged in Uganda’s constitution this violation was brought before the country’s Constitutional Court. Although argued on behalf of the two women who died without even basic nursing care while giving birth in State health facilities, the case cited the constitutional right of all mothers to *available and accessible* maternity care of *adequate quality*, in-
cluding adequate skilled health personnel, specifically nurses and midwives.

In June 2012, after multiple court delays, the Uganda Constitutional Court heard the case, but refused to rule on the merits, arguing that the case involved a non-justiciable “political question” – a health policy issue left to the discretion of the parliament and executive, rather than to the courts. The constitutional judge panel opinion stated that rendering a decision would breach the principle of separation of power between the legislative and judicial government branches.\textsuperscript{107} In its dismissal of the petition the Constitutional Court ruled solely on interpretation of the separation of powers question not on the allegations of the petition. In its definition of political question the court stated that the “political question doctrine holds that certain issues should not be decided by courts because their resolution is committed to another branch of government”.\textsuperscript{107}

The petitioners are appealing the ruling to the Uganda Supreme Court\textsuperscript{31,107,109,110} and have publically stated their intention to proceed to the continental African Court on Human and Peoples’ Rights in Arusha, if needed.\textsuperscript{109} In this case, we see that doctrines like jurisdiction authority and separation of powers can be deployed to defeat the broad realization of health rights. On the other hand, other courts including Africa courts in Kenya and South Africa have held that right to health cases are justiciable.\textsuperscript{111,112} Accordingly, there is hope that the initial conservative interpretation of judicial power and responsibility to adjudicate the constitutionality of health policy in Uganda will be reversed in the Supreme Court.\textsuperscript{110}

The Ugandan petition has garnered global support among legal activists, human rights groups and at least 50 private NGOs\textsuperscript{31} and has brought much attention to health system deficiencies. Among the shortcomings noted in the petition was inadequate nursing care. Nursing shortages are acute in Uganda and although public maternity care is free, its delivery cannot be realized because of deficiencies in health sector staffing and supplies.
The working conditions for nurses in Uganda are not unlike those experienced by nurses in most developing health systems. Investigations of professional attitudes reveal the dissatisfaction of Ugandan nurses with working conditions and education, contributing to lack of available skilled health care for mothers and babies. In one 2008 survey of Ugandan nursing students 70% expressed their desire to migrate after graduation because of poor working conditions. That rate of migration makes sustaining a stable nurse workforce impossible. Nurses cite low wages, which are government determined in the public health sector, and dismal working conditions as reasons for wanting to leave the profession or migrate. When interviewed one nurse involved in the maternal deaths cited in the Petition 16 case, said she was too “exhausted” to be able to care for all the mothers who needed her.

Despite the dismissal by the Constitutional Court, the Ugandan legislature has taken note of the staffing deficiencies stipulated in the Petition. The Parliament has responded with increased budget allocations that recognize the need to support development of the human resources for health. After several years of campaigning, health activists in Uganda have succeeded in winning legislated budget increases for expanding the number of health workers and increasing doctors’ salaries. Physicians, along with nurses, midwives, and anesthetists were among the groups targeted for increased government allocations. There are continuing efforts to increase the number of nurses and other health professionals being trained and in improving salaries and working conditions for other cadre of health workers. Although progress has been made at the legislative level, the funding release is behind schedule and in 2012 about 50% of skilled health worker vacancies remained unfilled and nurses complain they have not been paid. This case demonstrates, however, that linking the inadequate supply of nurses and other human resources to right to health adjudications can induce legislative corrective actions, even without the rende-
ing of formal court decision on the right to health issue.

3. Responsibility, Reparation and Intervention

Public and private entities have been held accountable to remedy human rights violations in national and international courts. Examples, range from population based reparations, to restitution for discrimination in health services, to awards for violations of an individual's right to health. Courts have cited governments and corporations.

European Courts have ordered reparations in response to human rights abuses, including violations of the right to health. In this first example, monetary damages were awarded on the basis of violation of the right to health when a prisoner experienced harm, while under State custody, because of lack of medical care. In this case, McGlinchey v the United Kingdom, the inadequate medical care of a prisoner resulted in a monetary award. Judith McGlinchy suffered from asthma and narcotic withdrawal while incarcerated. She died without medical attention. The European Court of Human Rights (ECHR) heard the case in 2003, and awarded her heirs 22,900 Euros for "moral damages". This recourse, using regional human rights courts to impose monetary reparations for human rights violations has not been explored for right to health violations caused by the loss of skilled health workers, exacerbating shortages in poor countries.

Courts have also recognized the right to health responsibilities of private enterprise. Although most successful right to health adjudications have named the State, or a public entity, such as a ministry of health, as defendant, in some cases non-state actors have been found to be accountable. Human rights activists have argued that access to essential medicines is a responsibility shared by the pharmaceutical firms that develop them, and the State in which they are distributed. The extent to which business enterprise can be held accountable under right to health
in courts remains unanswered, and is influenced by individual State codification of the right to health. Courts in Brazil are currently serving as a platform for adjudication of the question of shared responsibilities for patented medications. The issue of whether the State or the pharmaceutical industry is responsible for providing post clinical trial medication, as a right to health obligation toward research participants, remains undecided. It is under review in at least one ongoing case. 120

The Brazilian case, *Rio Grande do Sol (case number 1.001.032.528)*, manifests the convoluted web of corporate responsibility and national right to health laws in the courts. The Brazil Constitution guarantees the right to health. There are also domestic legislated guidelines that give human subjects in clinical drug trials the right to study drugs for as long as they need them after the trial is completed. 120 In this circumstance, a child participated in a study testing an HIV drug. When the trial ended, the patient's family sued the State for continuation of therapy. The question was whether this was an obligation of the State, under right to health, or the responsibility of the drug company that performed the trial. The company was found liable in the court, and subsequently, the decision was upheld on appeal. However, the company stopped providing the drug. The patient's parents then sued the State claiming that under right to health the State held the obligation to provide therapy.

During the lengthy trial period the State did provide the drug. The State then successfully sued the drug company based upon informed consent, which had included that the drug would be provided after the trial, as long as the participant needed it. According to the judge in that adjudication, both the State and the pharmaceutical company have the duty to protect the citizen's right to health, but in this case, the judge ruled that the State's duty was "subordinate" to that of the pharmaceutical company that sponsored the trial. The decision also affirmed that the responsibil-
ity of the pharmaceutical company does not cease with the end of the research trial. The pharma-
ceutical company appealed again and was held liable to damages to the State, as well as ordered
to provide the drug. However the case is still not over, since the company appealed to the Federal
Supreme Court; at the time of this writing, a decision is pending.\textsuperscript{120,121} Although the claims
which are specific to the well defined right to health legislation in Brazil, and a particular drug
trial, it does show that courts do not confine judiciable right to health responsibility only to
States. The ruling of shared responsibility for the right to health, demonstrated in Brazil's courts,
shows the potential scope of judiciable right to health obligations.

Cases brought to national courts claiming right to health violations are limited by the legal
justification of right to health in the particular country. Recognizing that some human rights is-
ues are international, or not judiciable domestically, the UN General Assembly adopted the Op-
tional Protocol Treaty to the ICESCR in 2008. It created a mechanism for complaints and in-
quiries at the international level for human rights abuses. The long awaited Protocol entered into
force in May 2013, lending a mechanism by which complaints of violations of any economic,
social or cultural right, including the right to the "highest attainable standard of ...health" can be
brought under international scrutiny.\textsuperscript{122} In Article 11.2, The Optional Protocol states:

"If the Committee receives reliable information indicating grave or systematic violations by a State
Party of any of the economic, social and cultural rights set forth in the Covenant, the Committee shall invite
that State Party to cooperate in the examination of the information and to this end to submit observations
with regard to the information concerned."\textsuperscript{122}

Alongside formal legislation and litigation, and not to be discounted as a mechanism for
enforcement, is the moral imperative established in global customary law to respect, protect and
fulfill the right to health. The UDHR has an established place in universally accepted customary
law, which often underlies policy. Article 28 concerns the right to social order and is often cited
as justification for international interventions. This is cited as rationale for humanitarian interventions.

"Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized." Article 28 UDHR 1946

Human rights violations have generated response, such as deployment of emergency personnel, generally peace-keeping personnel. Humanitarian interventions through non military UN agencies, for example The United Nations Childrens' Fund (UNICEF) or the UN Population Fund (UNFPA) distribute and deliver medical aid, usually in the form of supplies and medications, to those in need. Other interventions enlisted by individual States, and also authorized by the UN Charter, include economic and social sanctions against the State offenders in response to human rights abuses. Often the offenses that elicit sanctions are in the area of civil rights, such as the right to life violated by genocide, or monitoring when the right to vote or integrity of elections is threatened.

There is overlap between social, economic, and cultural rights and civil rights and the effect of sanctions on any one domain may overlap others. Sanctions for a grievous human rights violation may resonate in the health sector. For example, recent donor nation and World Bank (WB) actions to withhold scheduled aid funding for Rwanda in response to accusations of human rights abuses in Democratic Republic of Congo (DRC) conflict generated cuts in the Rwandan Health Ministry budget. Diminished allocations to the already underfunded public health sector resulted in significant reductions in the salaries of nurses and other health workers. The reduced aid funding did not necessarily effect military spending. Although the effect of sanctions on financial aid, or the impact of trade embargoes on human rights realization remains controversial, the publicity they attract does bring public attention to the behavior of offending individ-
uals, governments and private entities that can materialize as increased private sector support to
the health sector. 126

Conclusion

This chapter portrayed a legal and historical interpretation of the right to health. I set this
as a theoretical frame for interpretation of the Code and nurse policy recommendations. The
right's characteristics and core components have been defined, yet its realization is marred by
disparity. Enshrined in international law 3,7,8 64 it is a universal right to which everyone, without
discrimination, has a claim. 91 WHO health statistics tell us that the right is currently not ful-
filled in a quarter of the world's nations, based upon critical shortage of skilled health worker ra-
tios. 24

The right to health demands contributions and thus, levies accountability. Adjudicatory,
legislative, and social sanctions have been employed for enforcement with varying effects. With-
out accountability, right to health realization is unlikely to be universal. Developing and enfor-
cing policies that also supply the resources to fulfill the core components of the right to health,
gives all people the chance to flourish, to afford them the opportunity to enjoy living the healthi-
est life possible. Besides its appeal as the "right thing to do" from a humanitarian perspective, it
is required as a matter of law, to which all can be held accountable.

Comment 14 authoritatively clarifies the characteristics and components required to op-
erationalize the right to health. Achieving health targets, as measured by compliance with pro-
gressive realization of the core components, can seem overwhelming in developing health sys-
tems. But being under resourced does not relieve States of their obligations, or others of their re-
sponsibilities to assist, under right to health. To comply with the legal standards to respect, pro-
tect and progressively fulfill the right to health, systems need to demonstrate the required characteristics and maximum, targeted efforts toward fully achieving the minimum right to health core. This includes primary health care, maternity and well child-care, access to essential medications, and protection of the basic social determinants of health. Under current conditions, this cannot be accomplished by poor nations without assistance.

The right to health is a unifying principle with legal, moral and functional significance that provides a shared foundation for global health policy. An available, acceptable, accessible health system of adequate quality requires translation of the normative and theoretical arguments into actions on the global health front lines. In the next chapter I integrate my argument for the critical role of nurses in realization of the right to health into its formal legal structure.
"Without them (nurses), no vaccine can be administered, no life-saving drugs prescribed, no family planning advice provided and no woman can be given expert care during childbirth. Without skilled health workers, preventable diseases can easily become deadly," Dorcas Amoding, Manager Community Health and Information Network, Uganda, 2012

Chapter 3: Nurses and Realization of the Right to Health

their essential role

Introduction

Operationalizing right to health norms takes more than laws and good intentions. Global health inequalities are associated with the unbalanced shortage of skilled health workers. Invariably areas with the fewest skilled health workers, largely nurses and midwives, also demonstrate the poorest health outcomes. Now I build on the theoretical discussion of the right to health, and the portrait of health disparity, presented earlier, to connect the nursing profession to progressive realization of the right to health. The discussion begins by describing the functional nursing role in health systems, relative to the essential characteristics and core components of the right to health. Accountability and enforcement options for right to health responsibilities align with the argument for including nurses as essential elements required for fulfillment of the right.

The WHO calculates that in over a quarter of the world's countries the ratio for skilled health workers to population is so low that their capability to reach targets for basic health indicators is jeopardized. For some of the countries the shortage is considerably more severe than just missing the minimum target. Often in rural areas, where nurses provide all or most health services, health worker density falls significantly below the reported national averages. The 2010 WHO health workforce data (figure 3-1) illustrates that 36 of the critical shortage countries record a density of less than 50% of the minimum threshold.
This includes 16 countries reporting an average ratio of 5 or less skilled health workers per 10,000 citizens, only about 20% of the critical minimum. The International Council for Nursing (ICN) estimates that Sub Saharan Africa, alone, needs 600,000 more nurses, right now, and they need to be appropriately distributed to be able to deliver basic health care for everyone. The critical shortage of health workers, most acutely nurses, makes achieving health benchmarks or providing the core components of the right to health impossible.

Figure 3.1: Critical shortage of health workers.

\[\text{Density of doctors, nurses and midwives in the 49 priority countries}\]

\[\text{Critical threshold = 23 doctors, nurses and midwives per 10,000 population}\]

Source: WHO Global Atlas of the Health Workforce  
August 2010

A. The Role of Nurses to Realizing the Right to Health

1. Essential Characteristics of the Right to Health

Realizing the right to health means that health systems provide care that is characterized
by being available, accessible, acceptable, and of adequate quality. These describe the basic health services that the CESCR directs States to equitably provide all citizens. ³, ⁵³, ⁴³

In the previous chapter, right to health characteristics were broadly defined. Here I present the specific role of nurses and nursing care that contributes to guaranteeing the boundary characteristics of available, accessible, acceptable health care of adequate quality needed to assure meeting the duty to respect, protect and progressively realize the right to health.

Comment 14 explains that to achieve the available characteristic health facilities must be open and include, among other elements, a sufficient number of adequately trained and skilled health workers."³ This means that nurses, who are estimated to deliver 90% of care in poor areas,⁴³ are essential to making care available. Nurses keep rural clinics open and functioning. They examine patients, distribute medications and vaccines, provide skilled compassionate care, and delegate or supervise unskilled health interventions provided by families or community workers. The role nurses play in assuring that care is available goes beyond the established health facility, to the community. Without them, mothers cannot access safe maternity care, prenatal teaching, or local, often in home, monitoring; children are not immunized; emergency interventions are unobtainable; clinics don't function; medications are not distributed and administered; and basic primary health needs are not met. Without nurses care is not available.

Nurses contribute to making health care accessible. They manage community entry to the health system and form the link between highly skilled, referral interventions and basic access to primary care. In the public sector, nurses are State salaried and serve patients without regard to their ability to pay, providing care that is both physically accessible and affordable. Nurses function as mentors and educators for community health workers and they distribute health information to community members. Some countries, Sierra Leone and Uganda, for example, have
legislated free maternity and basic child health care in line with their codification of the right to health, but outcomes show us that only with sufficient nurse staff can this be realized. Without nurses the promise of free health care cannot be realized and the most well equipped donor funded facility will not be accessible. Additionally nurses are often the only skilled health providers in poor regions and are the link that can make health services accessible to the most disadvantaged.

Nurses are essential to acceptable care. They care for patients across the lifespan. A critical number of nurses are needed to keep health facilities open for equal access in remote areas. When nursing numbers fall below the critical threshold, it is the poorest citizens who miss out on health benefits, while skilled health workers are drawn to private clinics, to migrate, or to leave the profession. Without nurses, States cannot fulfill their duty to non-discrimination by providing acceptable care that does not victimize some citizens by denying them basic health care. Rural health systems are the most understaffed, which leads to disparities in the ability of the poorest, marginalized groups or those living in remote areas, to access the health system. Insufficient nursing care can result in de facto discrimination, which interferes with the duty to respect and protect the right to health. This is not acceptable.

In order for the health system to function at a level of adequate quality a sufficient number of appropriately distributed health workers need to be available, and they must be adequately trained, possess appropriate knowledge and skills, and have access to health information. State licensed nurses, including those with up to date specialty skills, such as maternity and infant care, are important to meeting health system quality criteria. Senior nurses are needed as mentors to students, beginning nurses and community health workers. Because the nursing profession is regulated, even in poor countries, minimum educational and competency criteria must be met to
gain professional recognition, establishing quality oversight. In addition to access to basic professional education, nurses need the resources and the appropriate specialty training that will allow them to function to meet health needs. There can be conflicts between the right to scientific information and individual patent or copyright protections of published material that skilled health workers need to update their practices. The ICESCR, in General Comment 17, also addresses the right to scientific knowledge and makes it clear that intellectual property and patent rights are subordinate to human rights. Meeting the criteria of adequate quality may require international contributions when educational resources in a poor country are limited. Skilled nursing care is essential to providing adequate quality health care.

Adequate quality also means providing sufficient resources for nurses to function. Frustration with job restrictions, either because of under staffing, over regulation, absence of information resources, or lack of functioning equipment and supplies, can drive nurses to leave poorly resourced health systems. States are advised to use resources, including seeking and allocating foreign assistance, to support the human, equipment, education and capital properties needed to make their health systems of adequate quality.

Nurses contribute to achieving all of the human rights characteristics required by ICESCR. They are essential to the provision of available, accessible, acceptable health systems of adequate quality. For health systems to meet the basic ICESCR criteria of progressive fulfillment of the right to health, they must display the four interrelated and essential characteristics: to be available, accessible, acceptable and of adequate quality. Without nurses health systems will not achieve these criteria.
2. Core Components of the Right to Health

States have an obligation to, at a minimum, progress toward supplying certain tangible core components with regard to fulfilling the right to health. Although the ability to fully realize all aspects of the right to health may be impacted by resource limitations, States assume fundamental obligations to provide at least a minimum level of equitable basic health service that everyone can access without discrimination. The expectation expressed in the ICESCR is that resources are allocated to continually progress toward full realization of all of the core components of the right to health. These include the elements of basic primary health care. Nurses are
just as important to providing the core components as they are to the essential characteristics of the right to health.

The extent to which States are obligated to provide the core components of the right to health is clarified in Article 2, Comment 3 of ICESCR. The duty includes "undertaking to guarantee" progressive fulfillment and "non discrimination" in the realization of designated components of social, economic and cultural rights, including the right to health. The elements include non-discriminatory basic health services, essential drugs, maternal and child health services, vaccinations, health education, nutrition and security. Nurses and nursing care contribute to provision of all of the ICESCR core components of the right to health. (figure 3-3) Since nurses are also the primary providers who care for the underserved, their presence protects against discrimination toward the poorest citizens' access to the core right to health components.

A robust cadre of nurses is essential for States to meet right to health obligations to progressive fulfillment and non discrimination stipulated in the ICESCR. Without nurses, legal obligations to progressively fulfill the components of the right to health are unlikely to be met. Taking this view they become a crucial element when accountability to the right to health is evaluated.
### Figure 3-3. Nurse and ICESCR Core Components of the Right to Health

<table>
<thead>
<tr>
<th>Core component</th>
<th>Example of nurse role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nondiscriminatory health services</td>
<td>Nurses provide most of the care for the disadvantaged, without them the poor can be discriminated against because health services are not available.</td>
</tr>
<tr>
<td>2. Nutrition, safe water, shelter and security</td>
<td>Nurses run infant feeding and weaning programs. Nurse run clinics and monitor for malnutrition. Nurses tend to be invested and trusted community members who are socially active.</td>
</tr>
<tr>
<td>3. Essential drugs</td>
<td>Nurses administer medications. No matter how many WHO medication supplies are donated without nurses they may not be given to patients, or used correctly.</td>
</tr>
<tr>
<td>4. Maternal-child care</td>
<td>Nurses (and midwives) are the primary maternal child caregivers. Without them international targets with regard to maternal and child health cannot be met.</td>
</tr>
<tr>
<td>5. Immunizations/infectious disease</td>
<td>Nurses administer vaccines as prevention, and in emergencies. Nurses diagnose infections; prescribe and administer antibiotics. and other therapeutic interventions, such as oral rehydration.</td>
</tr>
<tr>
<td>6. Health education</td>
<td>Nurses are community members who distribute health information, dispel myths, introduce evidence-based interventions and mentor other health workers.</td>
</tr>
<tr>
<td>7. Appropriate training for health personnel</td>
<td>Nurses need access to experienced mentors as well as educational materials and current evidence. Experienced nurses mentor new nurses and students. Nurses train and are the primary resource for community health workers and traditional birth attendants. Nurses with appropriate training can serve as right to health advocates.</td>
</tr>
</tbody>
</table>

### 3. Nursing Impact on Legal Human Rights' Legal Obligations

If we accept that nurses are needed to progressively realize the core components and essential characteristics of the right to health, it follows that the nursing workforce impacts a State's ability to comply with its legal obligations. States and other entities are obliged to always respect the right to health. Because nurses provide almost all primary health care in underserved areas,
if nurses are missing from rural clinics and community health centers, as they are in many poor
countries, access to even basic health care will not be equitable, and the legal stipulation to respect the right to health is not met. Additionally, Article 12 extends duties to "respect the right in other countries, and prevent third parties (over whom States have power) from violating the right." This requirement has implications for the responsibility States that benefit from recruitment of nurses hold to respect the right to health in source countries. This human rights principle holds transnational implications.

One way States may protect the right to health of citizens is by taking measures to develop and sustain their nursing workforce, since they are vital to supplying basic health services. When States fail to assure a supply nurses they may also fail to meet their obligation to protect the right to health, if citizens are left without available, assessable, acceptable, quality care.

Destination countries also can protect the right to health of the disadvantaged in source countries by regulating and monitoring the behavior of their health worker recruitment agencies and NGOs, and sanctioning offending activities, such as actively recruiting nurses who are under employment contracts in critical shortage countries. Comment 14, which includes explicit reference to the requirement to provide skilled health professionals, also directs that they be paid "...domestically competitive salaries". Under the duty to protect, States are also obliged to assure that nurses are adequately educated, competitively reimbursed, have access to relevant training and information, and that practice credentials are verified.

Meeting the progressive realization obligation involves planning and measuring progress. One quantifiable target is to progress toward building a workforce that meets the WHO minimum standard for the ratio of skilled health workers needed to supply basic health service. In practice, this means that States, experiencing shortages, take steps and allocate available re-
sources to increase and maintain their skilled health workforce to meet the WHO benchmark.

When nurses leave underserved rural areas to deliver care in wealthy systems, right to health compliance may be impacted in two ways. If clinics close because of lack of nursing staff, the patients there may suffer discrimination in access to health services, and realization of the right to health may regress. Discrimination and unjustified retrogression are hallmarks of right to health violations.

It follows that citizens cannot enjoy their right to health, and States cannot fulfill their human rights duties to their citizens, without the contributions of nurses. The responsibility to respect and protect the right to health applies to all countries and includes international responsibility. Falling below the WHO benchmark carries legal implications, because modest targets for the core components of the right to health will be unachievable. Recognizing the right to health legal implications of nursing care means it can be subject to the same human rights adjudication and enforcement proceedings as other recognized right to health core components, such as essential medications, non discrimination, health information, and therapies.

When nurses are viewed as vital to providing the required characteristics and core components of the right to health, developing, retaining and sustaining the nurse workforce becomes an obligation. Assuring that nursing care is available without discrimination is important for the health of citizens, but also underpins the legal requirement to respect, protect and fulfill the right to health.
B. Accountability to the Role of Nurses in Realization of the Right to Health

1. Adjudication; the Right to Nursing Care

Global health statistics, presented earlier, demonstrate that when countries do not meet minimum ratios for skilled health workers to population, health outcomes suffer. If we accept that nurses are crucial for the achievement of the required characteristics and for supplying the minimum core of the right to health, and that they comprise the largest percentage of skilled health workers, it follows that only with an adequate nursing workforce can States meet the legal obligation to respect, protect and progressively fulfill the right. The duty to never interfere with realization of the right to health applies to States, private enterprise and individuals. When nurses migrate or are recruited from critical shortage countries to wealthy ones, the net effect can be interference with progressive realization of the right to health. The global nurse market leaves poor countries subsidizing wealthy health systems.

The dynamic of the movement of nurses from areas that desperately need them to work in more desirable well resourced systems can uncover a human rights conflict between the freedom rights of the nurses and the right to health of citizens. If the nurse is not legally encumbered in any way she is cannot be considered legally responsible for any violation of the right to health, even though her decisions may have an impact on it. She is legally free to move within and out of her country. The obligation to the right to health of citizens, as well as freedom rights of nurses, falls upon States. They need to use resources to develop the nurse workforce and create incentives to keep them working where citizens need them. Prejudicially restricting the freedom of nurses to legally relocate, for example by arbitrarily denying them exit visas, would constitute an immediate human rights violation.
Although court action can represent the ultimate sanction for wrongs, lack of access to skilled health personnel has not generally been specifically cited in right to health adjudications. My argument is that because nurses are essential to providing the required characteristics and core components of the right to health, they become a factor for which States, and others, can be held legally accountable. Litigation is an under explored mechanism with regard to the obligation to supply a sufficient nurse workforce. Court resolutions can be time consuming, costly and sometimes apply to limited spheres of influence. However, having the public focus of litigation recognized as a mechanism in countries where right to health is codified can raise development of the skilled workforce as a priority.

Lack of nursing care is named as a component of the right to health violation in Constitutional Petition 16 brought on behalf of all mothers in Uganda, which was described in detail in Chapter 2. The case, *Center for Human Rights and Development vs. Attorney General*, cites the lack of nursing and midwifery care as factors that deprive Ugandan mothers of the core component of the right to health, essential maternity services. Although the petition was widely publicized and garnered international NGO support, after dismissal on a technical issue in the Constitutional Court, it remains legally unresolved, most recently when its scheduled hearing date was delayed by the Ugandan Supreme Court in late 2013. Even without a decision rendered, however, the case has had an effect. Parliamentary efforts to prioritize development of the health sector workforce have been passed in Uganda since the court case gained international attention. The relationship between skilled health workers and the legal duty to right to health realization, as codified in national and international law, can be identified and employed to spur positive health sector change through legislation and policy.
Global governance models give us some examples of other tactics for remediation and compensation that have been applied to remedy human rights abuses, and could also, analogously, relate to the right to health and the responsibility to provide nursing care. Specific examples of reparation awards and the court ordered accountability of private enterprise, which resulted in remedy compensation or remediation, were described in Chapter 2. Health workforce and business policies that facilitate the subsidy of wealthy health systems by nurses trained in poor source countries, contribute to longstanding insults to progressive fulfillment of the right to health. When nurses are recruited to wealthy States without replacement, the number of health providers in critical shortage areas diminishes. With fewer nurses available to equitably meet basic health needs in underserved areas, progress toward fulfillment of the core components can retrogress. We saw that regional and domestic courts have applied restitution, reparation and corrective sanctions when the rights, including the right to health, have been violated. Although, under progressive realization, all shortages of skilled health workers do not represent violations of the right to health, unjustifiable regression on the fulfillment of the core components is unacceptable. Remedy can take various forms, depending on circumstances. States need to integration accountability and enforcement mechanisms that strengthen the case for the remedy of critical nurse workforce shortages, when it is shown to impede progressive fulfillment of the right to health. Amnesty International emphasized the need for enforcement of remedy for abuses when they assessed the limited success of the roll out of the legally mandated free universal maternal health care in Sierra Leone:

"Without access to remedy human rights means very little. To be effective, all remedies must be accessible, affordable and timely. A remedy can be provided by a court or another institution that acts on complaints. International law entitles all victims of human rights violations access to reparations. Reparations require that, as far as possible, the consequences of the violation are corrected...including all or some of the following: restitution, rehabilitation, compensation, satisfaction and guarantee of non-repetition." 129,134  

Amnesty International 2010
2. Accountability: Nursing Profession and Human Rights

Professional nurses have human rights responsibilities. The human rights perspective reinforces the responsibilities of nurses and their professional associations to provide care that is non discriminatory, culturally appropriate, accessible and of high quality. Domestic and international nursing codes of ethics include the expectation that nurses respect human rights, including the right to health, in their professional conduct.\textsuperscript{135,136} Human rights adds a legal dimension to professional ethics. Jonathan Mann articulated the roles nurses and other health workers can play in advancing the right to health by bringing human rights ideals into their work. He called upon them to act as agents to advance the right to health. He suggests that they do something "practical, concrete, and immediate" to provide care where it is needed.\textsuperscript{137,138} Mann asked that health workers become activists, and he also cautions that they should never contribute to violations of the right to health.\textsuperscript{139} When nurses leave poor rural areas without access to health care to pursue opportunities in private clinics or wealthy destination health systems, their decisions impede health system function for people who are not their patients, extending their impact on right to health beyond the clinical care of their current patients. Besides being agents essential to translation of the core components and characteristics of the right to health into practice, nurses, individually, and as a profession, carry responsibilities to the right to health. National and international nursing professional societies include right to health, alongside other human rights, as a formal professional principle.\textsuperscript{135,140}

The nursing heritage in global health and human rights is also traceable to its professional inception. Women had cared for the sick for centuries, but the establishment of nursing as a profession is generally attributed to the work of Florence Nightingale, a 19th century British nurse,
social activist and researcher. Nightingale was from a wealthy family. She had a strong interest in science and also believed that the wealthy held a duty to help the poor. She practiced nursing internationally. Some of her most celebrated accomplishments occurred during the Crimean war where the remarkable contributions of her broad based health interventions drew praise and recognition from, not only her military countrymen, but also from the Sultan of Turkey. She insisted upon delivering care to everyone who needed it. Her legacy established an international foundation of caring for the sick and poor for the nursing profession\textsuperscript{141,142} that guides nursing professional practice codes today.\textsuperscript{135,143} Although she lived and worked almost a century before the formal UDHR was promulgated her professional standards reflected respect and protection of the universal right to health. Today, nurses participate in civil service, often conscripted service. When deployed by their countries they deliver care to anyone who needs it.\textsuperscript{55}

The nursing profession is based upon a foundation that respects human rights and has a heritage of service to the most needy. The former UN Special Rapporteur for the Right to Health called upon health professionals and health professional organizations to step beyond their view of health ethics to one that encompasses the legal force of human rights.\textsuperscript{144}

"Health professionals...nurses...and their professional associations have an indispensible role to play in the vindication of the right to health...they occupy a pivotal position to promote the right to health. Too often, however, their training encompasses ethics but not human rights. While ethics are vital, human rights are both vital and binding." \textbf{Paul Hunt 2004}

All professions, including nursing hold a social contract with society. Nursing practice is guided by codes of ethics that formally include references to global health and the right to health.\textsuperscript{136 135} The nursing position in health, however, goes beyond social responsibility and professional ethics to encompass their crucial legal position in the realization of the right to health.
3. Accountability: Conceptualizing Compensation Remedy

One mechanism to assess remedy for human rights violations, which could apply to the dynamics of the global nursing marketplace, is compensation when a loss is suffered. Potentially, if wealthy countries fairly compensated poor source countries for the loss of their skilled health personnel it would correct the "reverse foreign aid" that migrant health workers provide to wealthy health systems. Under supplied source countries unsuccessfully made a case at the WHO, during and after the drafting of the Code, for a recommendation for compensation for their loss to well resourced countries of fully educated skilled health workers.

Economic considerations dominate any discussion of the mechanisms for compensation for the loss of a nurse from a critical shortage country. Compensation requires placing a value on the loss. The loss of a nurse includes both the education investment cost, and also, the less easily quantified harm to health system function. Although the economic assessment can apply to any nurse migration, when the nurse has left a critical shortage country her uncompensated loss may also contribute to impeding progress toward fulfilling right to health duties.

Also relevant to remedy is identifying the beneficiaries. Compensation is generally awarded to those who sustain the loss. In the case of a nurse who migrates after State subsidized education, compensation from a receiving country might be directed to a public entity in the source country. Ideally revenue from compensation arrangements would be earmarked for developing and sustaining the nurse workforce. Generally poor nations subsidize the education for nurses, bearing the cost of development of the health worker product. A major reason that nurses flock to migrate is for improved working conditions. For this reason some suggest that compensation should not be paid to central governments, as that would reward them for their health workforce infrastructure policies that push nurses to migrate. The cycle of poor in-
vestment in health infrastructure driving the loss of skilled health workers, which further impedes health system function, and diminishes work satisfaction, pushing more nurses to leave the profession or migrate, is self-perpetuating. Wealthy receiving nations appear to have little or no incentive, under current conditions, to agree to monetary compensation arrangements.

It is expensive to educate a professional nurse for developing or developed health systems. In a 2006 article the reported cost of educating a basic nurse in Malawi was calculated at over $9000, while the entire education and training for a nurse midwife was reported at $31,726.26. In Kenya the cost to educate a nurse from primary school through professional licensure was calculated at over $43,000 in 2006. Of course, these education expenses are considerably below the investment needed to prepare a professional nurse in the US or other OECD countries, where the cost varies, but can amount to over $150,000 for the nursing professional segment of education, alone. Essentially, poor countries provide a subsidy, in the form of nurse education savings, to the wealthy.

In 2012, Mills, et.al., calculated the differential education cost of the migration of physicians working in the UK and USA from Sub Saharan Africa. They computed the total loss at approximately $2.17 billion, while the gain to the UK and US alone was greater than $3.5 billion. Comparable calculations are not available for the nurse workforce, but it is reasonable to assume the percentage subsidy, about 62% of the cost of health worker production, to wealthy economies, would be similar for IENs. Proponents of compensation arrangements call for, at a minimum, compensation tariffs on migrating nurses that cover educational costs for a replacement nurse. Compensation for education expenses alone would not solve current violations of the right to health, since educating a replacement nurse takes considerable time. Still, the funds could be used to support long term expansion of the nurse workforce for developing health systems.
Nations make decisions about the education of their health workforce. When they elect to recruit foreign educated nurses, instead of developing their own, there are transnational implications that extend beyond the financial, including the impact on the human rights of the neglected patients left without access to nursing care. Nurses educated in LMICs provide a ready supply of trained caregivers, who require less investment in time and money than educating new nurses would. The "reverse foreign aid" dynamic\(^{145}\) drains funds from already limited national budgets and impacts other areas of development.\(^{153}\) The economic loss for education has been measured in Malawi and Kenya, but the associated cost to the neglected health systems has not. Viewing the economic value of nurses solely as the investment value of their educations does not consider the broader short and long term impact of the loss of their service on health and health systems. The price poor countries pay is significant, and impacts not only health and human rights, but also development.\(^{46,67}\)

4. Accountability: Diaspora Contributions

Some have suggested that migration may be good for source countries. If skill and financial return results, it can support development.\(^{154,155}\) Globalization facilitates the ease of migration, including migration of nurses.\(^{131}\) They, like other skilled workers, migrate from poor to wealthy countries leaving professionally unfulfilling situations to find life opportunity for themselves and their families. Working in wealthy OECD countries increases the earning potential of a nurse trained in a low income country. Destination countries gain because nursing vacancies are filled without investment, and the nurses themselves may find professional, financial, and education opportunity. Despite the so called "brain drain", skilled professional migration also can benefit source countries, tangibly, through monetary remittances sent to families, and less tangi-
bly, because the success of migrants may motivate those remaining to also pursue skilled education.\textsuperscript{154} Counter arguments are equally compelling.

Although for some countries, such as The Philippines, nurse remittances are calculated as significant contributions to the economy,\textsuperscript{156,157} there is scant evidence of direct benefit, specifically from the remittances of migrant nurses, to realization of the right to health of the under-served in poor source countries.\textsuperscript{158} Research shows that remittances mainly benefit immediate family, and rarely subsidize health system development that contributes to realization of the right to health for the disadvantaged.\textsuperscript{152,158} Families, however, may use their financial gain from remittances to access health services. A 2009 American Journal of Public Health article studied the effect of remittances on receiving family health care in two Mexican villages. The authors reported some evidence that families, who had not previously had access to health insurance or services, did use remittances to buy health insurance and to access the health system. They also found that family members who already had health coverage from employment were unlikely to use remittances for health expenses. They did not report any specific information about nurses, who can migrate under NAFTA advantage to the US from Mexico, or indicate that the health infrastructure benefitted in any way. Their research focused on the effects on individual families.\textsuperscript{159} Their results corroborate the prevailing notion that remittances mainly benefit relatives. Revenue from remittances may, in some circumstances, improve health conditions and also provide other economic advantages for them.

A 2013 PEW Research Center Report recorded data related to migration and remittances. Its findings reinforce that the positive impact of remittances for poor, or critical shortage countries is minimal. Although the statistics focused on all migrants, not specifically nurses, the authors concluded that remittances had increased from 1993 to the present, but the disparity be-
between the share of money sent to middle income countries, and that earmarked for the poorest nations, had also widened. According to the PEW data the portion of total remittances sent to middle income countries has risen from 57% in 2000 to 71% in 2013. On the other hand low income nations receive a mere 6% of the remittance pool, with the remainder transmitted between wealthy States. 160 This current worldwide data indicates that remittances, defined as the monies sent to source countries by immigrants, 160 do not significantly impact the health systems’ ability to fulfill their obligations to the right to health in critical shortage countries.

In the current arrangements remittance funds do support the public sector in destination countries. When nurses migrate to OECD countries and earn wages, they become taxpayers in their adopted homelands. The portion of her wages a nurse earmarks for her family at home have already been taxed in the receiving country, where the revenue contributes to sustaining the public sector, including health resources. 161 If a nurse cannot transport money home herself, fees for currency exchange and fund transfer also benefit private industry in destination countries. 162

In addition to those involved in foreign money transfers, business interests and public institutions in destination countries can profit from the process of nurse migration. IENs pay thousands of dollars in fees to public and private entities. In the US, for example, these include, US Visa fee, Visa screen certificate, Commission on Graduates of Foreign Nursing Schools (CGFNS) application and testing, National Council on Licensure Exam (NCLEX) fee, English Proficiency testing, Board of Nursing licensure application and credential verification, and any fees private recruiters or employers may impose. 163,164 Contracts for IENs generally last for 2-3 years. Termination buyouts, if the nurse does not complete her contract, may be as high as 50,000 dollars. 164 The expenses paid by nurses who migrate add to the net revenue profits of private and public entities in destination countries.
Research on the economic and development benefits of migration do not specifically consider the effects nurse migration separately from the impact of migration of other skilled workers. Different types of migrants undoubtedly have different economic and social influences. The economists, William Easterly and Yaw Nyarko suggest that, on balance, skilled migration can benefit the poorest source countries. Their economic calculations suggest that remittances and other returns balance the loss of their skilled workers to low GNP source countries. Besides the economic gain from remittances, they propose theoretical positive effects on human capital development, inspired by the success of migrants, who might not find rewarding work in their home countries. They conclude their examination of skilled labor migration from Africa with the statement "...based upon our results, we think the brain drain is good for Africa." 

One problem with many studies, including Easterly's, is that they collect data about all skilled health workers without separating out the effect of the loss of their personnel on health systems or human rights. Skilled health worker density is directly linked to health and to realization of the right to health. The impact of the loss of some other classes of workers whose skills and knowledge would be wasted in poor source countries can be measured economically, but the impact the loss of nurses has on provision of the core components of the right to health in desperately poor countries requires reference to health metrics alongside financial ones. The effects of health on development are not considered in their model. Nor do they acknowledge the widening disparity indicated by the PEW data, which records a limited and increasingly disparate economic benefit to low income countries from remittances.

Economists also use employment opportunity arguments to calculate the value of skilled workers when they migrate. Factors, such as the lack of job opportunity in source countries, lose validity when applied to nurses, who are needed in all domestic health systems. Another poten-
tial benefit they put forth for the positive effect of migration of skilled workers on the economies of poor countries, is the inspiration migrant role models can have on future students to pursue higher education. In the case of medical personnel this inspiration has been shown to be a selection factor for professional education. Nurses and physicians in training cite choosing their profession because of the opportunity to migrate a health profession provides. This leads to the worrisome conclusion that students choose health careers for the very mobility advantage that negatively impacts developing health system workforces. In critical shortage countries health is directly associated with the density of skilled health workers, and health is vital to the development of the future leaders and workers in any economy.

Taking a more formally calculated approach to the contribution of skilled migrants, the economist, Jagdish Bhagwati has promoted a taxation system that places obligations on migrant workers, themselves, to those in their source countries. His scheme, called the Bhagwati tax, would have source countries levy taxes for wages earned abroad. His tax plan is loosely modeled on the US taxation model, which excludes all or most foreign earned wages from federal income tax, but still imposes Social Security and Medicare taxes on US citizens living and working abroad. Besides the revenue gain from taxation this could, in theory, encourage return migration of professionals, because of their investment in social programs from which they might benefit upon return. Although his plan has survived over 40 years of legal, economic and academic scrutiny it has proven very difficult to enact and has not had practical impact. The idea has generated more analysis and discussion than implementation. Among its operational difficulties is that it does not take into account the complex array of tax structures of source and destination countries that would have to be reconciled.
Bhagwati also encourages visa schemes that foster knowledge and skill sharing. Underlying his proposals is the idea that the benefits of migration could be more equitably shared. Economically based proposals, such as receiving country tax sharing, are mechanisms designed to better distribute the financial benefits of all skilled worker migration. Although they could contribute to development growth and more tightly tie migrants to their homelands, they do not address the current impact of the loss of nurses on the right to health or a State's ability to reach health targets.

Although, in theory, finances returned to poor countries through taxation of their emigrants, tax sharing from wealthy destination country wage taxation, or remittances could be directed to the development of health systems, there is no evidence of that happening. Diaspora remittances or institution of tax schemes alone do not appear to balance the human rights value of the loss of nurses, nor are they likely, on their own, to solve health workforce issues in critical shortage countries.

**Conclusion**

Nurses are crucial to respecting, protecting and fulfilling the right to health in any system. Without them the right is jeopardized because the ICESCR designated components and characteristics will not be achieved. At this point over 25% of the world's countries do not have the human resources for health to fulfill right to health obligations. The critical place nurses hold in realization of the right to health, as primary caregivers for disadvantaged groups, opens human rights remedy accountability mechanisms to those whose right to health is impacted as a result of the unavailability or loss of adequate nursing care. Realizing the right to health includes the obligation to establish the policy and legislative frames that can protect the right from third party
violations, and also furnish the resources to, without discrimination, progressively realize its fulfillment. Legislation alone is not always effective without access to formal accountability and enforcement avenues. Alongside other enforceable contributions, it is skilled health workers, including nurses, who make it feasible to fulfill the legal duties to the right to health.

I have argued that nurses are essential to operationalizing the progressive fulfillment of the core components and essential characteristics of the right to health. Governments in both source and destination countries, private enterprise and health professionals themselves are obliged to never interfere with realization of anyone’s right to health. When nursing care is viewed as crucial to the right to health, enforcement and implementation mechanisms that have succeeded in gaining pharmaceuticals, therapies and compensation for other human rights abuses also apply to correcting deficiencies in the nurse workforce.
“...to operationalize, ...implement it (the right to health) human rights lawyers need advice from, to be guided by, health workers...”

Paul Hunt; Former WHO Special Rapporteur on the Right to Health; speaking at Human Rights Day 2012.

Chapter 4: Methods: The IEN Sample and the Code Analysis

Introduction

Using more than one approach to view the same phenomenon expands the vision and understanding of a subject. Chapter 2 describes the human rights theory and legal basis for the right to health. An argument for including the role of the nursing profession and that of individual nurses as important elements of right to health realization comprises the content of Chapter 3. In this methods chapter, I describe the techniques used to develop an empiric base, using data collected in recorded nurse interviews, policy expert interviews, and a document analysis of the Code. I use the responses, analysis and narrative content to enlighten nurse workforce policy that is also based upon the broad framework that the Code supplies.

The observation that skilled health workers migrate from poor to wealthy countries has been viewed from a variety of perspectives, but there has been little or no research that examines the relationship between the attitudes and experiences of nurses who migrate and the impact of their migration on the fulfillment of the right to health. In this dissertation I apply data from three sources; narrative, open ended, semi-structured interviews with IENs from LMICs; consultation interviews with content experts; and a detailed document analysis of the Code to examine this issue.

Adding the perspectives of nurses, who have migrated from LMICs, to the previous analysis of the legal status of right to health and the role of nurses in its realization, augments understanding the nurse migration phenomenon. Qualitative analysis methods were used to assess
inputs. While exploratory methods help identify the best study and implementation approaches for questions, detailed document analysis drills down to the meaning of text. Interview findings are presented separately in Chapter 5, and then incorporated into the Code document analysis performed in Chapter 6. Outputs have been integrated with the previously presented theoretical knowledge and prior research, to contribute to solutions to the question: Can global nurse workforce policy use the Code to contribute to progressive realization of the right to health?

A. Study Design: Interviews

1. Interview Technique IENs

Exploratory semi structured interviews were conducted between April and November 2012. Ten nurses were recruited from a known and referral group of internationally educated nurses (IENs) who are now living or working in the US. The sample reflects non-probability, convenience chain sampling techniques. All interviewees met the selection criteria of having obtained their nursing education before emigration from their source LMIC countries.

All ten interviews of IENs were conducted face to face. Participants received an unsigned consent to keep (Appendix B) and were verbally apprised of its content and their rights, including the right to exclude information. The principle investigator, with advisor input, designed an interview guide (Appendix D) with open ended and demographic questions that gave the semi-structured interviews consistent content on key items. The guided interview questions and audio equipment was pilot tested on one subject before beginning the formal interview data collection. When new and significant information emerged during the process it was used to enlighten later interviews. This served as refinement, not essential content change, of the originally proposed interview format or data collection.
All the interviews were carried out in person, in English, by the principle investigator and were recorded using a portable Microtrack M-Audio II® device. Both audiotapes and note taking were employed for data collection. All recordings were transcribed and destroyed after transcription. Only the investigator on the study saw subjects' identifiable information. Collected notes taken contemporaneously or in response to audio review were coded with subject number only. Transcripts were securely stored by the investigator and were destroyed at the completion of the study data analysis.

Names and identifying characteristics of interviewees were redacted when integrated into results. Pseudonyms were used when attributing narrative and other identifying data was generalized, when appropriate, to protect identity. For example if an informant’s home country was Uganda the nurse’s name was changed and the source country name either changed or generalized to Sub Saharan East Africa.

2. Expert Interviews

The investigator also conducted interviews with eleven content experts between December, 2011 and February, 2013, to complement the other qualitative data and promote triangulation of information. Note taking alone was employed for recording information. Interviews were adapted to uncover background and policy focus specific to the subject’s realm of relevant expertise. Subjects included a US Ambassador to a low resource country, a minister of health and regional health minster for low resource regions, two NGO directors, the US medical director of Medecin Sans Frontiers, a nursing administrator in a low resource country, a human rights law scholar, a nurse global project manager and US health policy makers involved with the Code’s implementation. Any reference to material gained in these interviews is referenced as personal
communication or was independently verified from primary sources at a later date. Experts offered guidance and direction to the research focus and gave perspective to the current relevance of the Code. The content they provided supplemented other components of the research. Verbal permission to attribute responses to the individuals was obtained when appropriate.

3. Data Analysis of IEN Interview Content

Recurring themes were identified using inductive content analysis of IEN interview data. Themes emerged during transcription and review of interviews and written notes. Themes rather than the specific word content were the focus. For example, one of the themes that repeated in interviews was the motivation of IENs for career satisfaction. Although in some cases this meant higher salaries or better working conditions, and, in others it meant educational opportunity, the inductive thematic analysis identified both as “career or professional advancement/satisfaction”. Concepts expressed by the informants in response to selected questions, rather than specific responses were employed and collected on a checklist format (Appendix E). Coded themes extracted from the transcripts revealed repeated topics that made up patterns of experiences and attitudes. The investigator and a research assistant performed coding independently, then concurred on term designation.

4. Narrative Content

Interviews provided a source of first person stories, insights, and quotations as each IEN related his/her migration experience. Narrative bioethics is an approach that focuses on the personal in the exploration of bioethical questions. Techniques of “telling, comparing, and invoking stories” serve as tools to enhance reasoning. Narrative bioethics has been called “thinking
with stories”, rather than thinking about stories.\textsuperscript{176,177} Narrative, as both direct quotation and retelling, is used to illustrate and explain the analysis of the Code and its application to nurse workforce policy.

Narratives connect ideas and events in a clear order and give personal meaning to them.\textsuperscript{178} In formulating policy, IEN narratives give human reality focus and illustration to concepts that test and validate the relevance of the Code as a policy structure. Interviews contributed narrative quotations as well as contextual theme analysis of content. Using rich descriptions of complex human experiences, such as migration for a nurse, in the narrative bioethics method, can lend a deeper understanding to social issues.\textsuperscript{175,178,179} Policy relevant quotations that reinforce themes are interspersed among the findings and analysis. The verbatim recording of semi-structured interviews provided a rich source of data. Migration narratives of IENs are used to refute and illustrate the potential benefit and relevance of the Code as a policy structure.

5. Descriptive Sample Data

Descriptive data lends demographic context to the sampling. The purpose is to portray the features of the sample, not to infer characteristics of the population from which the sample was selected, or to make scientific predictions about the larger population. Demographic data includes characteristics of the IENs, such as, age, sex, country of education, highest educational degree earned, years in USA, and stated intention to return to source country to work as a nurse. These descriptions are meant to add relevant context to the narrative, qualitative data. Any inference is derived from qualitative data interpretation based upon the rich narrative interview content provided by participants.
6. Ethical Considerations

The Northeastern University Institutional Review Board (IRB) gave approval to conduct the study interviews of IENs, after review (Appendix B). Verbal consent was obtained from all prospective IEN participants prior to the interview meeting and each was given an unsigned consent (Appendix B) at the time of the meeting that delineated, among other provisions, the voluntary nature of participation, the right to withdraw from the study at any time and the observation of principles of confidentiality and redaction of personal identifiers. The principle investigator answered all participants’ questions. Each informant received phone and email contact information for the investigator and dissertation advisor.

Ethical considerations beyond those required by IRB approval influenced the conduct of this research. Recognition of authorship issues when “giving voice” to narrative content and applying context to quotes was carefully considered when representing or interpreting the interview data. The author was sensitive to ownership when using narrative content and made efforts to clearly distinguish between interpretation of interview responses and verbatim text. Every attempt was made to lend accurate context to subjects’ direct quotations.

B. Study Design: Analysis of the Code

The Code itself was subjected to formal document analysis. The evaluation of the Code called for review and assessment of its content and meaning. Document analysis is a process in which a text document is reviewed and evaluated systematically. This technique is used in qualitative research to triangulate data, combining sources of examination of data to study a subject from more than one standpoint. In this case, the detailed analysis of the document is used to balance and enhance meaning of the empirical evidence from IEN and content expert interviews.
Both expert and IEN interview content that relates to the Code and its usefulness as a basis for nurse workforce and migration policy is integrated, where it is applicable, throughout the Code analysis in Chapter 6.

Meaning and explicit reference uncovered in the document analysis revealed the Code's implementation relevance as a structure for nurse workforce policy that realizes the right to health. Analysis Findings are found in Chapter 6.

**Methods Summary**

The methods used for this exploratory, interdisciplinary study of a new global policy area complement each other and build on the theoretical right to health arguments. They yield perspective to the rich analysis by using diverse views of the same subject. Triangulated data integrates voices of nurses and content experts and semi structured interview concept analyzed responses, with detailed document analysis of the Code. These findings are later synthesized into suggested policy.

An interdisciplinary examination of the obligation to realize the right to health that includes health professionals is increasingly recognized as essential to creating global health policy. Paul Hunt, former UN Special Rapporteur for Right to Health spoke on International Human Rights Day, December 10, 2012. He emphasized the need for health workers’ involvement in right to health realization at all levels not just “as a matter of good management or medical care but as a matter of law to which we should all be held accountable”.

“I worked at a big hospital but we didn’t have the right supplies and I had to work overtimes ...and then I met some American tourists. One was a nurse and told me about nursing in America and... how she was in a nurses' union. I started to apply on the internet that week and here I am.” Charity, Jamaica


Chapter 5: Interview Findings

Interview data

Overview

The semi structured interview data presented in this chapter provided an opportunity for a group of IENs to contribute comparable information about their own migration experiences, and their attitudes toward the role nurses play in realization of the right to health. Content experts supplied additional information from their own areas of proficiency. The previous chapter described the methods used to collect, and techniques used to analyze, the data.

First, the IEN sample (table 5.1) is described. Individual characteristics are de-identified, when appropriate, to maintain confidentiality. This data supplies perspective on the individuals who participated in this study.

Next, theme concept analysis of responses to selected questions concerning migration is presented. Key findings, reflected in the self reported nurse experiences, augment the Code analysis, performed in the next chapter. Themes revealed in the interview data are collected in checklist format. These finding are discussed for particular relevance to the research sub-question; how can the perspectives and interpreted experiences of migrant nurses enlighten/contribute to nurse migration policy that supports human rights? Appendix E 1 -5 contains checklist data compilation. A brief discussion of the most relevant content obtained during expert interviews and communications are presented are integrated throughout.
A. Interviews with IENs

1. Participants

Table 5-1 below depicts the demographic characteristics of the 10 IEN subjects. All nurses were educated in LMICs and later migrated to the US. Five of the ten are from Africa with representation from East, West and South Africa. This source country distribution reflects the high proportion of countries on the African continent that fall into the critical shortage designation for density of skilled health workers, and thus, have significance for resolution of the research question. Of the estimated 8% of the US nursing workforce that is foreign educated about 80% are from poor countries of origin.\textsuperscript{131,181-183}

Ages of participants ranged from 33-55 years. The sample included eight females and 2 males. Both male participants are African. Although nursing in the US is a predominantly female profession with less than 6% of registered nurses being male, the sex distribution of nurses varies worldwide. In Spain about 20% of nurses are male, while in much of Africa more than 50% of the nursing workforces are men.\textsuperscript{184}

Published survey research has shown that immigrant nurses living in the US tend to be slightly more highly educated than their domestic nurse counterparts.\textsuperscript{182} The sample reflects previously reported higher education levels of immigrant nurses. Of participants only two IEN’s are not prepared at the bachelor’s degree level and three hold doctoral degrees. Two are clinical specialists and practice as Advanced Practice Registered Nurses (APRNs).

Of the 10 nurses interviewed only 2 expressed intentions to return to nursing employment in their countries of origin, and all who expressed a possibility of returning had stipulations
of teaching exchange, research focus or obtaining US citizenship that would influence their repatriation as nurses.

**Table 5-1: Description of IEN Participant**

** country of origin and age may have been changed to maintain confidentiality

<table>
<thead>
<tr>
<th>Subject</th>
<th>Education country**</th>
<th>Age**</th>
<th>Sex</th>
<th>Educational degree</th>
<th>Plan return to source country to work as nurses</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jamaica</td>
<td>39</td>
<td>F</td>
<td>RN diploma</td>
<td>No; maybe as volunteer</td>
<td>Visits home every 2 years</td>
</tr>
<tr>
<td>2</td>
<td>Democratic Republic of Congo South Africa</td>
<td>34</td>
<td>F</td>
<td>Diplomat infirmière Lycée</td>
<td>No</td>
<td>Not employed as nurse</td>
</tr>
<tr>
<td>3</td>
<td>South Africa</td>
<td>55</td>
<td>F</td>
<td>Bachelors RN PhD Health Policy RN Bachelors</td>
<td>Yes; currently teaching in South Africa and US No</td>
<td>Returned after apartheid OR nurse; recruited APRN;applying for US citizenship</td>
</tr>
<tr>
<td>4</td>
<td>Korea</td>
<td>39</td>
<td>F</td>
<td>RN diploma</td>
<td>No; maybe as volunteer</td>
<td>Visits home every 2 years</td>
</tr>
<tr>
<td>5. Cameroun</td>
<td>33</td>
<td>M</td>
<td>MS nursing</td>
<td>Yes; would like to return to teach APRNs</td>
<td>Visits home every 2 years</td>
<td></td>
</tr>
<tr>
<td>6. Georgia</td>
<td>33</td>
<td>F</td>
<td>PhD Nursing</td>
<td>Yes; research, not to stay</td>
<td>Visits home every 2 years</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Kenya</td>
<td>31</td>
<td>M</td>
<td>Diploma RN in Kenya; BSN in US</td>
<td>Maybe</td>
<td>Visits home every 2 years</td>
</tr>
<tr>
<td>8</td>
<td>China</td>
<td>51</td>
<td>F</td>
<td>DNS APRN</td>
<td>No</td>
<td>Visits home every 2 years</td>
</tr>
<tr>
<td>9</td>
<td>Nigeria</td>
<td>37</td>
<td>F</td>
<td>MSN, women’s health</td>
<td>No but visits yearly with family</td>
<td>Visits home every 2 years</td>
</tr>
<tr>
<td>10</td>
<td>The Philippines</td>
<td>46</td>
<td>F</td>
<td>BS Nursing</td>
<td>No; except as volunteer</td>
<td>Visits home every 2 years</td>
</tr>
</tbody>
</table>

2. Interview Concept Analysis:

a. Push and Pull

Interview responses from IENs revealed several distinct thematic patterns in areas that can be influences by policy. It is recognized that immigration of skilled workers is largely a consequence of factors in their countries of origin (push factors) and those in the receiving country (pull factors). Interviewees revealed these in their migration narratives and themes.
emerged. Opportunity factors, such as internationally located family members, and the effects of globalization also have been shown to influence health worker migration. Complete push and pull theme factor checklists are found in Appendix E checklists 1-3.

Most subjects reported influences in both domains, push and pull factors, and all reported more than one factor. Two main push themes emerged, professional/career advancement issues and personal or family issues. Deficiencies in job satisfaction and opportunity, themed as professional issues, predominated as factors that spurred nurses to leave their home countries. All interviewees except one from The Philippines, who had not worked as a nurse in her source country, reported employment experience related push factor influences. In total there were 25 items recorded as push factors by the 10 respondents with the majority, 60% of responses (15/25), theme coded as professional influences. This is depicted in fig 5.1 below.

"At home we worked long hours and there were never enough nurses or supplies. Sometimes we were not paid... Sick patients came and could not pay for medicine.... Here I had the chance to go back to school. When I graduate I will have a good job."

Christian N., Cameroun

Figure 5.1: Push Factor Citations of IENs. 15 of 25 responses indicated professional issues pushed nurses to leave source countries; 10 out 25 responses cited other personal factors.

Personal factors were also theme identified as a migration motivation. Although individual circumstances varied subjects generally cited the migration of another family member to the
destination country, or having a relative already living in the US who could ease migration adjustment. Family influences were interpreted as both push and pull factors depending on the context in which they were related. Interestingly, half of the sample group reported that they saw the open door for professional migration as an opportunity that being a nurse facilitated. It was mentioned or implied by five (50%) of the ten IENs as a reason for choosing nursing education in the first place. The contemporary ease of global movement and transferable skills nursing provided made migration seem feasible. In a State funded nurse education system this raises professional education selection questions that might bear policy relevance.

Pull factors from destination countries are often perceived to solve the very professional and life opportunity deficiencies that pushed nurses to migrate. The dominant theme concept expressed by nurses in this sample was again career/professional advancement and job satisfaction. Nine of the 10 respondents indicated that pull factors related to greater professional fulfillment influenced their migration decisions. US firms actively recruited only two of the nurses, although an additional three of the ten recalled accessing advertisements posted on line or in print for nursing employment abroad. Personal reasons, such as family already living in US or professional opportunities for a spouse, also pulled nurses to migrate and were the most important factor for several. One IEN, who had the opportunity to migrate to several other OECD countries to pursue higher education, indicated that the integration possible for immigrants in the US was a deciding factor.

“Even with an accent you can be an American.” Anna Y, Georgia

In total there were 22 responses cited as pull factors extracted from the 10 interviews. Salary was not explicitly mentioned by any of the IENs as an enticing factor, though it was mentioned as a push factor. The opportunity for education, and professional satisfaction and
career advancement, along with the opportunity to join a family member, predominated in the articulated pull influences. Of pull factors mined from interview content, 12 were checklist themed professional opportunity and 10 were considered personal motivations. For all nurses several interrelated factors influenced their migration decisions.

Figure 5.2: Pull Factors cited by IENs; Of 22 responses 12 were themed as professional while 10 were themed as personal.

Results of analysis of the push and pull influences on migrant nurses in this sample reveal that both push factors from source and pull factors of destination countries are at work, simultaneously. Many personal factors, such as a spouse’s opportunity for higher education at an American university, may not be amenable to policy change in the health sector. These influences on the migration decision rest on other aspects of life opportunity with the nursing profession acting only as an incidental facilitator. Some reported push and pull factors are potentially policy sensitive. The impact, for example, of human rights abuses that plague underserved health systems, and the regulatory and resource barriers to a fulfilling nursing practice could be adjusted with policy interventions that mitigate the drivers of emigration.

All ten subjects gave positive or semi positive responses when asked whether nursing was a good career, although five qualified their responses by indicating that one reason nursing is a good career choice for a young person in their country is because of the ease of migration for
skilled health workers. It has been suggested that the reputation of success for emigrant health workers can make them role models for future students, who then choose careers, such as nursing, to facilitate professional migration.  

b. Remittances

In an effort to uncover positive financial effects for source countries of migration of nurses to wealthy health systems, all respondents were directly asked if they sent remittances of cash or valuable commodities. Some economists suggest that the net financial balance can be positive for poor economies when skilled workers emigrate abroad for higher wages and return some portion of their earnings as remittances to their source countries. Research has also indicated that nurses may be more likely than many other professional groups to send generous remittances. In this sample five of the ten respondents, half of the sample, indicated they never had sent remittances home. Of the 5 nurses who answered the question about sending remittances affirmatively, three sent only money, one sent money and gifts and one sent or carried gifts, such as, expensive electronics that would be difficult for anyone to acquire in the home countries. All indicated these benefits fell directly to their own families, usually to parents. When questioned further, two of the respondents indicated that in their cultures children always contribute to their parents’ living expenses once they become employed, and that they would have been doing this, though on a lesser income, even if they had not immigrated to the US. (Appendix E-4)
c. IEN Perspective on the Right to Health

All subjects were asked specifically how nurses could contribute to fulfilling the right to health for everyone. The question was open ended. Their responses were concept analyzed in checklist form (Appendix E 5). Most indicated that the right to health meant non-discriminatory and high quality care delivered to individual patients. Their remarks included references such as “taking the best care of all patients”, “always giving good nursing care even for difficult patients”, “staying on duty even if you are sick or tired if patients need a nurse”, "Of course I take care of all patients, I am a nurse", and other comments reflecting the beneficent duty to care for the sick. These responses echo standards found in well-established nursing codes of ethics. Every subject included at least one reference to direct patient care as the way nurses contribute to realization of the right to health.

Responses that expanded the role of the nurse to express a broader social responsibility to right to health, beyond individual patient care, were expressed by 5 of the 10 (50%) IENs. These included recognition of obligations for the wealthy to contribute to health systems in poor nations, volunteerism, policy development participation and understanding of the WHO definition
of right to health. Although there were an array of different individual responses all 5 who gave public health concept categorized responses in the checklist coding indicated they also recognized an obligation of the wealthy to assist the poor when it came to matters of health. Two IENs felt easing migration would be a way for nurses to contribute to realization of the right to health. Subjects in the small sample did not demonstrate familiarity with the language of policy and global governance as it relates to the legal standing of the right to health. Only one IEN interviewee, who is a nursing professor, had ever heard of the Code. Likewise only one nurse, whose higher education included health policy, indicated knowledge of the WHO definition of health as a basis for a universal right to health. All respondents indicated that nurses’ fulfill human rights responsibilities in the context of the patient care they deliver, not as a legal responsibility. Sixty percent of their responses were content analyzed as direct patient care contributions. However, the subjects also seemed to grasp a larger worldview regarding the right to health. Despite not expressing direct knowledge of global public health governance documents, seven of the ten respondents articulated views reflecting a more global personal view of the right to health that included obligations of the wealthy toward the poor. The detailed checklist of responses is contained in Appendix E-5 and summarized in figure 4.

Figure 5. 4: The Right to Health: Nurse expressed meaning of the right to health.
Nurses in the sample displayed limited knowledge of the right to health as it is codified in international law, despite personal views that support its value, in concept, to patient care. This can potentially leave nurses at a disadvantage when trying to participate in the global health policy discussions and indicates the need for adjustments in nurse education policy if nurses are to serve as right to health policy advocates. Various expert reports concerning the nurse workforce have included the recommendation to include right to health and global health in nurse education curricula. 192-194

2. Expert Interviews

Selected experts were consulted before, during and after the formal IEN interviews. Although they arrived from a variety of disciplines, all had input into policies related to human resources for health and health system development. Their knowledge and understanding of policy issues enlightened the discussion of developing health systems, human resources for health, foreign aid and the Code. Their knowledge of the Code and its role in global health workforce policy was assessed. All policy makers, except a nurse manager at a district hospital in Sub Saharan Africa, were at least somewhat familiar with the Code. They recognized its potential impact for fulfillment of health rights beyond immigration reform. Several were involved in implementing the Code’s objectives or in data collection for WHO reports, and held insider knowledge of its development. There was a general acknowledgement among health policy experts that the issue of health worker migration and health workforce imbalances is an important one that requires cooperation among nations. Several indicated that there is a new awareness of this issue. Both the US Ambassador who was interviewed and the health minister for East African Community indicated that they had directives to strengthen the health workforce by allocating aid money to
human resource for health programs, principally educational efforts for physicians to acquire specialty training. They did not, however, attribute that change directly to implementation of the Code. 125,195

Conclusion

Findings from the 10 recorded IEN interviews provided rich narrative and focused data evidence that reflects the attitudes and experiences of a small sample of nurses who have migrated to the US from LMICs. Questions posed during the interviews were selected based upon considerations explored in the previous theoretical discussions and literature review. Evidence gathered in IEN and content expert interviews furnishes a limited empiric view of the migration and health workforce strengthening issues, which are the Code’s focus. The Code was drafted to serve as a template for skilled health workforce policy, including nurse workforce policy. Incorporating the perspectives of IENs into the development of nurse workforce policy can contribute to making that policy relevant for them. The document analysis of the Code, in the following chapter, incorporates the self-reported and analyzed experiences of IENs and expert opinion. This combination of data supplies the multi perspective, triangulated evidence used to synthesize nurse workforce policy in Chapter 7.
"...This is a gift to public health everywhere."
Margaret Chan, WHO General Director, May 2010, commenting on the unanimous approval of the Code by WHO Member States

Chapter 6: Analysis of the WHO Global Code of Practice on the International Recruitment of Health Personnel
...a global scaffold for health system development and health workforce policy

Overview: Background

Recognizing the impact the global shortage of skilled health workers has on health systems, the WHO assigned the task of developing a code of practice to guide coordinated global policy regarding health worker migration and recruitment to the WHA, in 2004. The result, the WHO Global Code of Practice on the International Recruitment of Health Personnel (Code) provides structure and guidance for international policy. Its scope expands policy direction to include health system strengthening, with a focus on human resources.

The non-binding Code of practice sets forth guiding principles and implementation objectives for health system development. Despite the fact that compliance with the voluntary Code is not judiciable, non-binding practice codes describe and delineate formally acknowledged political commitments between States, and carry substantial political and moral significance. They operationalize norms.

The identification of the need for a code of global scope, which addressed practices that influence the distribution of health personnel, arose out of recognition that the long standing shortage and uneven distribution of skilled health workers represented an interconnected problem that was amplified by their flow from poorly resourced to well resourced regions. Member States acknowledged that this was an issue that required international cooperation and collaboration to direct effective solutions. The unanimous approval by all Member States of the WHO
shows the international will to work together, and implies Member States intend to implement the Code, and that they also recognize its normative core, that realizing the right to health is linked to the health workforce.

This analysis of the Code evaluates it as a tool for design of nurse migration and workforce policy. Relevant political, policy, diplomatic, scholarship and nursing professional references to the Code, and their interpretation of its significance from their various vantages, contribute to a harmonized assessment. After a brief historical discussion of its development process, I will examine its Preamble and each of its 10 Articles. I analyze the Code using a systematic approach to its textual content and meaning with emphasis on its capacity to guide nurse workforce policy as a segment of health system strengthening.

A. Development of a Global Non Binding Practice Code

The Code represents only the second time in history, and the first since 1981, that the WHO has promulgated a non-binding code of practice of global scope. The previous example, the Code of Practice on the Marketing of Breast Milk Substitutes, has been effective at controlling dangerous infant formula marketing practices and continues to be relevant today. 206

The development process for the Code included the input of Member State representatives from health worker source and destination countries. Unlike many other international policy guides and frameworks developed at the UN or WHO, the Code was not created by a team of health lawyers or policy experts tasked to assemble and compose a focused document in isolation. It was written with input from representatives of all Member States, the community of interest, and human rights non-governmental organizations (NGOs). Unifying policy concerning was seen as vital for a solution to the interconnected global health workforce issues. The
Health Worker Migration Initiative was launched in 2007 and assigned responsibility to oversee the Code’s drafts. The Global Policy Advisory Council, a research based entity, and the politically influential Technical Working Group (TWG) of the WHO joined forces to provide leadership and direction that integrated scholarship, negotiation and politics. Input from the international community of interest was solicited at meetings and also during on-line open conferences.  

The drafters began by reviewing the impact of existing voluntary codes of practice related to the topic. These included the Commonwealth Code of Practice on the International Recruitment of Health Workers, The Pacific Code of Practice on the Recruitment of Health Personnel, The UK Health Service Code, and other similar politically limited documents. Any of these applied in restricted spheres, which impacted their effectiveness, while the Code was intended to supply global policy guidance.  

The drafters also considered comments from health professional organizations including the ICN and their nurse migration center, the International Center on Nurse Migration (ICNM), which focuses on the nursing profession and migration. The ICN, in affiliation with the World Dental Association, the World Pharmaceutical Federation and the World Medical Association, together called the World Health Professions Association (WHPA), commented on one of the final Code drafts. They issued a formal statement endorsing the Code to the WHO Executive Board. In it they also advocated that the Code include patient health outcomes as an objective and implementation assessment. This recommendation reflects the clinical focus of nursing and medicine, and their professional perspectives on realization of the right to health. The joint statement of the WHPA concluded with a Code endorsement that reflects a similar quality of
care value to that expressed by IENs in the interview sample, when asked to comment on the nursing role in realization of the right to health.

"The WHPA believes that the WHO code of practice will be an instrument for strengthening the capacity of governments to manage migration flows...and would strongly recommend a reference in the code to patients' outcomes and quality of care as an objective of the code. In conclusion we call upon governments and others to adhere to the WHO code...as a core component of national and global response to the challenges...." 209

Substantive differences developed among Member State participants in the drafting and negotiations. Poor African source countries expressed a desire for explicit language concerning enforcement and compensation for loss of their skilled health workforces. OECD nations, led by Canada, Japan, and the US, preferred the omission of any mention of compensation. They also lobbied for loosening of strict, “prescriptive”, reporting obligations. In the end, no direct recommendation for compensation was included. However, the Code does direct well resourced States to collaborate and assist poor countries, and to consider the impact of their policies on the disadvantaged. This is significant because it underlies the link that the global health workforce creates between wealthy and developing health systems, and indicates that health workforce policy influences the human rights of people beyond national borders. The requirement for regularly scheduled WHO reports to the WHA survived to the final document. 147,199

While the Code development negotiations were continuing the scope of the global health worker resource crisis was exposed and publicized at the 2008 Kampala Declaration and Agenda for Global Action (Kampala). It produced a set of strategies for their vision that “all people everywhere, shall have access to a skilled, motivated and facilitated health worker within a robust health system”. 210 The Kampala vision included development of a global code of practice for integrated policy, and served as an impetus to advance Code negotiations.
From 2008-2010 the drafters compromised as each section gained consensus acceptance. The Code drafting process involved staged negotiations of distinct areas of disagreement on practices, such as the reporting mechanism or compensation, and consensus agreement on the overarching human rights normative frame. Allegiances were usually along economic positions. When wealthy States, such as the US, EU, Canada and New Zealand dominated discussions, they pushed to remove any mention of compensation to source countries for loss of health personnel to migration or recruitment. African representatives, who were mainly high-level diplomats, were frequently silent. Norway and Brazil, both of which have strong explicit right to health stipulations codified, provided leadership in the negotiations and often spoke on behalf of poor nations, interpreting their issues into the human rights, right to health, agenda.

Discussions at the WHA, the legislative arm of the WHO, around how to strengthen the health systems of developing States centered on human rights issues, and the impact the distribution of human resources for health exerts on human rights. Both source and receiving countries aligned to support the human rights agenda that recognized the impact of the health workforce on the realization of the universal right to health. They also reinforced acknowledgement of the freedom right of health personnel to relocate, and to be treated fairly. Despite the potential policy tension around these competing rights, this platform, and its unanimous acceptance, demonstrates international solidarity around the Code's human rights normative core. Accepting fundamental norms has become an important feature of global health governance, as States recognize that tackling global health requires collaboration and standardized practices, with oversight.

Member States approved the right to health as a core principle, but there was on going controversy on some more specific points. In addition to their balking at any requirement for
compensation, Wealthy States continued to voice objections to the reporting requirements. On this issue several African States, namely, Zimbabwe, Botswana, Kenya and South Africa, united and their voices prevailed. The mandated WHO reports remained as the only enforceable monitoring aspect of Code. They keep the Code on the WHA agenda where it can be amended, and the results of implementation publically evaluated.

During the final stage of negotiations, a recommendation for financial compensation to source countries was introduced once again, and it appeared that wealthy nations would not sign on to the Code if compensation language were included. The representative from Brazil, who had previously spoken for compensation from destination countries to source countries, observed "the Code should not be held back by lack of agreement on compensation, and maybe, in the future, there could be meaningful discourse on compensation." The willingness of the Member States' representatives to compromise on issues that they felt could be resolved in the future, as evidence emerges, was a key to getting the document unanimously accepted. Code negotiations have been praised as an example of effective global health diplomacy.

All 193 WHO Member States accepted the Code's final draft on May 28, 2010. By signing onto the Code, they have entered a good faith agreement to comply with its recommendations in their own development of global health workforce policy. A section-by-section document analysis of the Code, with particular emphasis on its relevance to global nurse workforce policy, follows. It is enlightened, whenever applicable, by empiric data obtained in IEN and expert interviews.
B. Code Section Analysis

Preamble

“The Member States of the WHO...conscious of the global shortage of health personnel and....concerned that the severe shortage of health personnel, including highly trained health personnel....constitutes a major threat to the performance of health systems...stress that the WHO Global Code of Practice on the International Recruitment of Health Personnel (Code) be a core component of...responses to the challenges of health workforce migration and health system strengthening.”

The Code’s Preamble gives clear direction to Member States to use it to design policy around the challenges posed by the effects of health worker mobility on health systems. It links access to a skilled health workforce to health system strength. It explicitly cites the call put forth by the Kampala Declaration, which asked for the development of a practice code on this issue. Although the Code’s title includes the term “recruitment” the preamble, from the start, sets its more expansive scope: to address practices surrounding health system development.

This introduction establishes that the Code intends to influence policy beyond ethical business practices for recruitment of health workers. It calls for global cooperation to tackle the interconnected health workforce issues in a way that can strengthen health systems. It specifically references skilled health personnel, defined by the WHO to be nurses, physicians and midwives. These are the most mobile health workers and those requiring the longest and most intensive training.

Objectives: Article 1

“...to promote voluntary principles and practices taking into account rights, obligations and expectations of source countries, destination countries and migrant health personnel.”

Article 1 states the Code’s overarching objective, to act as a guide for international policy based upon voluntary principles. It explicitly directs Member States to use its architecture to
“improve legal and institutional frameworks” and “facilitate and advance” international cooperation and discussion on matters related to “ethical” health worker recruitment policy. It notes that any policy should contribute to health system strengthening, “with particular focus on the situation of developing countries.”

The explicitly stated priority to develop policy that supports poor health systems through health workforce strengthening means that wealthy States are directed to consider the health of people outside their borders when implementing policy and practices. This implies a normative mandate that directs wealthy countries to extend the reach of their health workforce concerns.

Although Article 1 only contains four one sentence objectives, it clarifies the purpose of the Code. It states that compliance with the Code’s principles is voluntary, and then goes on to express the need for the development of legal instruments by individual States, or development of multinational agreements among and between States. It promotes international cooperation with an emphasis on developing health system needs and consideration of rights.

When Article 1 recommends development of appropriate legal and institution systems related to health workforce issues, it implies that the Global Code objectives require national level governance action to issue policy that directs accountability. It places the obligation on individual States to promulgate binding legislation as might be appropriate and useful for fulfilling the Code’s objectives. For example, some destination countries are now subjecting health worker recruitment agencies to scrutiny using their own domestic oversight systems. Since the Code's promulgation in 2010, the US has begun the public/private partnership for oversight of health worker migration linking the monitoring resources of the National Center for Health Workforce Analysis and the certification process of the Alliance for Ethical Recruitment of Health Work-
ers.\textsuperscript{212} When applying for certification, an enterprise must include a statement that its practices take into account the effects of migration of health workers on source countries.\textsuperscript{212} 212

The Code also directs that rights and obligation, at the international, national and individual level, need to be considered in policy development, indicating that the Code’s implementation requires shared governance. Recognizing both citizens’ right to health and individual freedom rights of health workers delineates one of the conflicts revealed in nurse migration policy; namely, the conflict between the freedom right of a trained nurse to move to seek life opportunities in any country willing to welcome and employ her, balanced against the right to health of the citizens left behind without nursing care in poor countries. Who is responsible for right to health infringements caused by the exodus of essential health personnel from source countries is not always clear. The adverse effects may not be intended or recognized as directly attributable to any one entity. The Code indicates that remedies require international cooperation among States and private enterprise. It names assistance, especially technical and financial, as recommended interventions.

Although the Code links a robust skilled health personnel force to realization of the "highest attainable level of ...health" it does not directly claim that recruitment or migration causes violation of the right. Assessing accountability is nuanced and conditioned by the progressive fulfillment stipulation of the ICESCR and domestic codification of the right to health in domestic legislation. The Code does make it clear that policies should identify the interrelated roles played by States, individuals and private organizations and should consider their effects on the right to health of the underserved.

The Code objectives call for policy that protects human rights and fosters strengthening of poor countries’ health systems. Article 1 sets the tone for shared responsibility by stating, as
one of four globally applicable instructions, that the situation in developing health systems de-
serves special consideration. This thread extends from the Article 1’s objectives to future articles.
It also echoes the human rights Covenant framework found in Comment 14 that directs States
and other entities, including health workers, to give special priority to the most in need when it
comes to the right to health.

Nature and Scope: Article 2

“The Code...is intended as a guide for Member States, working together with stakeholders such
as health personnel, recruiters, employers, health-professional organizations, ...whether public or private
sector, including non governmental organizations, and all persons concerned with the international re-
cruitment of health personnel.” Code: Article 2.2

Article 2 expands the intended Code reach beyond the governments of Member States to
include other public and private organizations, professional societies and individuals. This is
significant because it directs governing bodies to recognize the behaviors of entities they have
power over, and to evaluate their conduct with regard to the Code's principles. This includes pri-
ivate health facilities, business enterprise, professional associations and health professionals,
themselves. This means that the Code asks organizations, businesses and individuals, along with
Member States, to act in accordance with its guidance. It alerts employers of nurses, nurses
themselves, and nursing professional and regulatory bodies that their practices are also consid-
ered within the Code’s scope and that all also carry responsibilities, to comply with global health
treaties, conventions and covenants.

The Code encourages States to use their authority to guide and enforce compliance of
other entities over which they have authority, for example, domestic nurse employers or health
recruiters. Instructions to monitor them with respect to human rights responsibilities are implied.
The US reporting authority at HHS included data gathered from professional regulatory bodies and foreign employee recruitment enterprises. Understanding the composition of the US nurse workforce is recognized as important to defining problems that drive the dynamics of nurse migration worldwide, and influence nurse staffing beyond the borders of the US. Inadequate domestic training capacity leaves nursing jobs unfilled, which creates the need to import nurses. In the US, gathering workforce data from nurse regulatory bodies is complicated because of the professional regulatory system that gives individual states the power to issue nursing licenses and promulgate professional practice statutes and regulations. Each decides which data to collect about applicants. Information is not standardized. Collecting standardized information from all state nurse regulatory boards would make national level investigation of the nurse workforce meaningful with respect to both local and global nurse workforce issues.

Article 2 addresses recruitment with respect to poor nations. It instructs that policy development should be directed toward the strengthening of health systems of developing countries and that certain practices, such as active recruiting of nurses from critical shortage countries, might warrant higher scrutiny and corrective action. Recruitment is not defined in the Code. Many health professionals initiate contact with health care institutions or recruitment agencies by responding to strategically positioned advertisements online or in print or by entering the key words, "nurse migration agency", in search public engines. IEN interviewees indicated that only two of the ten nurse subjects were actively recruited face to face. In one other case, a US employer recruited the nurse’s husband, who is a pharmacist. Six of the ten nurses in this sample recalled accessing migration agency assistance from direct online solicitation or advertisements in nursing publications. Immigration and professional qualification information is easily accessible online, therefore, not constrained by political borders. The Code does not define recruit-
ment or active recruitment in its User's Guide. It only asks that it be conducted "ethically" and observe applicable laws, leaving practices open to interpretation.\(^\text{74}\)

In Article 2 the Code extends its scope beyond Member States and recruiters, to the global community of interest, including international employers, migration assistance agencies, health workers and professional licensing boards. It directs all stakeholders to use the Code as a guide for policy that strengthens the health systems of developing countries. This expands the expectations of private agencies that assist migrating professionals to consider the effects of their practices on developing health systems. A Canadian survey of nurse recruiters, published in 2013, indicated recruiters did not know about codes of practice, and that their recruitment practice decisions were made based upon the receiving country's or the requesting hospital's needs. Encouragingly, the same group of Canadian recruiters stated that they saw a need for systematic domestic planning concerning human resources for health and for integrating broader ethical considerations. When given a list of policy interventions that might rectify the health workforce imbalance they indicated that "ethical codes on recruitment of health personnel from developing countries where there is a shortage" was the tool they felt would be most useful in designing solutions.\(^\text{216}\)

**Guiding Principles: Article 3**

"The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states." Code: Article 3.1

The Code’s eight Guiding Principles, which comprise Article 3, contain the nucleus of its normative content. They are the foundation on which to base health workforce policy. Article 3 links access to skilled health personnel to realizing the "right to the highest attainable standard
of... health”, and the health of people, to achievement of the development goals of peace and security. This section required significant, diplomatic negotiation during the drafting process because of the disagreement on the inclusion of recommendations for compensation for the loss of health workers. All Member States agreed on the fundamental importance of the universal right to health and the human rights of health workers. 

The principal guiding theme is that Member States base their policy initiatives on the universal human rights values that are at the Code’s core. In later articles the Code describes methods to accomplish this. The normative base of the Code includes direction: 1.) to respect human rights, including the right to health of all people and the rights of migrant health workers; 2.) to recognize the need for comprehensive and globally interconnected health worker policy that strengthens health systems; and 3.) to emphasize meeting the special needs of “vulnerable” countries when designing policy. The guiding principles of Article 3 ground the implementation of the Code in concert with established formal and informal human rights documents such as the UDHR, the ICESCR and the CRC.

The relationship between health and security is clearly stated as a guiding principle and rationale for the Code. In Article 3.4 the Code directs Member States to consider the right to health of people in source countries when designing policy. This is significant because it means States and others should evaluate the effects of their actions, even when unintended, upon the right to health of persons outside of a State's borders. They should, at a minimum, be able to describe the consideration they gave to the human rights of those populations. The article uses the language of international law, stating “...the right to the highest attainable standard of... health”, which links its essence and guidance to the pre existing governance force of the ICESCR.
The Code's strength derives from the moral significance of its guiding principles, specifically its human rights focus. Although not enforceable, non-binding global health documents occupy influential positions for global governance among States. Member States, using their own legislative authority, are advised to “take the Code into account when developing…health policies…” and the expectation is that those policies recognize their obligations under existing international and Member State human rights laws. This Article operationalizes broad human rights guidance for responsibilities that reach beyond national borders. It connects fulfilling those responsibilities to sustaining and developing an adequately skilled global health workforce.

For some nations their duty to their own citizens could oppose compliance with the Code's direction to always consider the effects of their health workforce policies on developing health systems. States hold duties to their own citizens. At times their domestic health needs might be more difficult to meet if health workforce policies favor poor States. Right to health duties could determine how much priority should be given to poor health systems. Under the right to health priority view, developing health systems who are struggling to achieve progressive realization of the right to health core components because of critical shortages of skilled health personnel, earn priority over the needs of well-financed systems filling job vacancies.

Article 3 makes it clear that the policy architecture of the Code extends beyond the morality of the recruitment of health workers, the so-called “brain drain”, from poor countries, to include health worker distribution imbalances within and among countries. Guiding principles, put forth in Article 3, do include explicit principles directed at active recruitment of health personnel from fragile health systems. It directs recruiters operate with “principles of transparency, fairness and promotion of sustainability of health systems of developing countries”, using reten-
tion, education and training strategies and the gathering and sharing of data. It suggests the need for oversight but does not offer any enforcement avenues. 217

In one of the Code's few specific practice directives, Member States are asked to facilitate policies that support circular migration, creating opportunities that encourage health workers, including nurses, who travel abroad for formal education or the acquisition of special skills, to return, and bring knowledge and skills to their source country’s health workforce. One way that source countries theoretically would benefit from the migration of their nurses after basic nursing education is if they return, enriched with new assets. 218 There are numerous impediments to this benefit in the current system ranging from visa restrictions to the inapplicability of the skills acquired abroad, which may not be relevant in developing health systems. Only 2 of the 10 nurses in the interview sample of IENs living and working in the US indicated that they would consider returning to their source countries to work or teach as nurses. One of them would only consider returning after being granted US citizenship, assuring reentry to the US.

Although acquiring new skills and returning to source countries to share them can theoretically benefit weak health systems, nurses in the sample expressed concern that they could not function in roles where they could use the full complement of their acquired skills. One nurse, who was working at an intensive care unit in a major teaching hospital in the US stated that she had been trained to care for patients using advanced techniques and monitoring not available in her home country.

"I studied hard to pass the critical care nurse certifying exam (CCRN) here, that would mean nothing in Nigeria." Ani, Nigeria

When health professionals do return from abroad with new skills the poor do not always benefit. In a study of Indian nurses, a significant number were found to return to their home State
of Kerala after gaining training and experience in better resourced Commonwealth or Gulf State systems. Their experiences helped them procure more desirable jobs in the rapidly developing Indian health system. Since "better jobs" usually meant working in the selective environment of major medical centers in large cities, their return may have had less positive effect on the health of the most disadvantaged than the return migration numbers indicate. In India, unlike in Sub-Saharan Africa, most nurses’ families pay tuition for their education. Graduate nurses are often encouraged to migrate, despite the shortage of skilled health personnel in poor rural areas, to contribute to re-payment of school debts and to gain valuable experience that assures better paying jobs when they return. Migration is officially encouraged, and return facilitated, because of the perceived financial and knowledge gain it can offer, despite the fact that the practice may interfere with the realization of national health goals, including fulfillment of the right to health of the poorest citizens.

When the right to health is jeopardized the Code brings notice to the effect on other development parameters. The Code’s guiding principle 3.6, links health to development and explicitly states that health workforce policy be integrated into a nation’s national development program. It draws the connection between the policies of wealthy states and the development of the health sector in source countries when it directs them to reduce their dependence on migrant health personnel.

"Member States should strive …to create a sustainable health workforce and work toward establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce …should be integrated within national development programmes." Code 3.6

Referencing national development programs extends the scope of policy based upon the Code to other interconnected arenas such as economics, education and governance. It is recognized that nursing vacancies that result from the escalating health needs of aging populations,
and insufficient domestic education investment in wealthy countries, create the job openings that make migration of fully trained nurses from poor countries a solution for wealthy health systems.\textsuperscript{182,203} Nurses in the IEN sample stated, in their migration narratives, that they were aware of vacancies before they initiated the migration process, in some cases before they began their nursing training.

The Code's guiding principles direct that policy consideration be given to the needs of the most vulnerable. Poor countries can adjust domestic health system development policy. It is remote rural areas that show the largest skilled health worker deficiencies. When health needs are unmet in poor areas development can stall. Policy in this area could include allocation of public budget resources for education of nurses, as well as development of pre-secondary education, especially in rural communities, to prepare students for health careers. It has been suggested that least advantaged rural children in poor countries might be easily integrated into their home communities, if they gain access to nursing education.\textsuperscript{152} Including incentives, such as pay bonuses, education or housing subsidies for nurses to remain employed in underserved rural areas, or for those who return to source countries after specialty training, has resulted in improved nurse staffing numbers in rural Senegal.\textsuperscript{16} Most poor health systems will require assistance to meet these policy objectives.

The Code also guides wealthy nations to maximize the positive effects of health workforce policy to support developing health systems and also the rights of health workers. This human rights duty of the wealthy toward the poor, echoes Article 2 of the ICESCR, which cites the duty for international cooperation to meet responsibilities toward the progressive realization of the right to health. Significantly, eight of the ten IENs recognized that the wealthy did hold obligations to the poor.
Reinforcing the language contained in international law strengthens the potential impact of the non-binding Code with regard to international assistance because the ICESCR makes it a responsibility. Allocation of funds has begun to include focus on human resources for health. Money earmarked to disease specific interventions is being redirected to contribute to specialty training of nurses who treat the designated conditions, such as HIV. The newly deployed Peace Corps modeled Global Health Service Partnership (GHSP) in East Africa, as well as specialty scholarships for physicians, have been funded in part by PEPFAR monies that were originally designated narrowly for single disease treatments. Expert interview data from a range of diplomats, health ministers and scholars supports this as an emerging priority. The US Ambassador to an East African country confirmed familiarity with the Code, as well as and support for the recently deployed US funded health mentoring Clinton initiative, Human Resources for Health (HRH).

One of the major reasons nurses leave their profession is low job satisfaction and impediments to career advancement. Health workers, especially nurses, from poor countries frequently cite infringement on their human rights, such as the right to security, decent working conditions and fair wages as push factors that spur them to leave under resourced health systems to seek better employment opportunities. Many of these arise form the cycle of poverty. One IEN gave voice to the conditions she worked under:

"We were always being be paid late or not at all...We never had enough nurses or assistants. I could not stay to care for patients who needed me because it was dangerous to walk home after dark in Kinshasa. I still think about some of those patients that ...I had to leave." Claudette N., DRC

We saw in Chapter 2 that development goals, such as security and safety, are also cited as core components of the right to health. Including strategies to correct deficiencies in these areas can help eliminate push factors that make nursing a discouraging and dangerous profession in
some poor countries. It is unlikely poor nations, such as Claudette's source country the DRC, have the resources to make these improvements without international contributions.

Article 3 provides the core normative structure for the more specific procedural directions that follow in later articles. They call the global community into the discussion of rights realization for populations and individuals everywhere. Nurses are important for fulfillment of the right to health for citizens and are mobile workers with transferable skills who also own the freedom right to move to seek secure meaningful, safe, fair employment. The human rights based norms of Article 3 shape a foundation for aspects of nurse workforce development. Improvement in working conditions, security, safety along with training and development support would diminish the potency of push factors for migration, as evidenced by responses from the IEN sample and reported in nurse migration research. Policies that recognize the rights of the health workers impact realization of the right to health.

**Responsibilities, Rights and Recruitment Practices: Article 4**

“Health personnel, health professional organizations, professional councils and recruiters should seek to cooperate fully with regulators, national and local authorities in the interests of patients, health systems, and of society in general.” Code Article 4.1

The rights and responsibilities laid out in Article 4 speak directly to the community of interest regarding recruitment practices and their impact on health systems. It recognizes the connections among stakeholders, health workers, legal authorities, educators, employers, States and private enterprise. It begins with Article 4.1 giving direct advice that they all collaborate in the interests of individuals and society. This article draws responsibility links among all parties involved in the phenomenon of nurse migration and development of sustainable health systems; private enterprise, governments, regulators, health worker employers and nurses themselves
Article 4 also describes the responsibilities of health workers with regard to the Code. It explicitly directs health workers and health recruiters to be "open and transparent" with regard to obligations to source countries, such as education subsidy contracts. Active recruitment may not always be easy to identify, or it can be blatant. One IEN participant described her migration incentive offered when her husband, who is a pharmacist, was actively recruited from his university appointment:

"An American company went to the school my husband attended. He is a pharmacist and was working as a teaching assistant there. When they realized I was a nurse they gave me contacts to help me get a license to work in the US. Now we both have good jobs and won't go back to Nigeria except to visit." Ani, Nigeria

Some nurses, who have been educated at State expense, are bound by service contracts to work for a designated period of time in the public sector of source countries. The Code directs nurses and recruiters to respect their service obligations and States to enforce them. Article 4 makes private enterprise, employers or employment agents aware of their responsibility to respect any agreements. Any enforcement would be left to Member States.

Migration assistance agencies offer important help for nurses who need to navigate the complicated credentialing systems of OECD countries. Although the Code discourages active recruitment of nurses from countries experiencing critical deficiencies in their health workforces, the nurses there also have the freedom right to relocate for fair employment and to pursue life opportunity. They would be at a disadvantage in seeking employment overseas if they were not able to access these services. This is an example of the conflict between protecting the right to health of citizens in critical shortage countries, and the freedom rights of nurses trained in poor source countries to migrate in search of life opportunity. In the interview sample of IENs included in this study, none recalled any service obligation connected to their education subsidy.
All remembered significant fees paid to recruiting, relocation assistance and credentialing agencies. Policy that protects rights without neglecting poor health systems or exploiting immigrant nurses will need integrated development and monitoring from source and destination country perspectives. Central oversight repositories, such as the one composed of agencies that adhere to the voluntary Code proposed at Georgetown University Law School, can help standardize monitoring of immigration practices at the national level.  

**Health Workforce Development and Health System Sustainability: Article 5**

"...the health systems of both source and destination countries should derive benefits from the international migration of health personnel." Code: Article 5.1

"As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce." Code: Article 5.4

Article 5 of the Code addresses the relationship between health system sustainability, development, and health workers. Its message links health workforce needs in source and destination countries and emphasizes the interrelated, shared responsibilities of both. The WHO links health to development when it states: "Better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive,..."  

Destination countries are asked to collaborate with source countries to support training of their health workforces. Education incentives have been cited as strong inducements for retention of health professionals. Reflecting this known driver of professional migration, six of the nurses in the interview sample pursued higher education after migration and named the opportunity for specialized instruction as a migration motivator. Published research supports supplying on going education opportunities as an effective retention strategy.
The Code advises that health worker migration policy benefit both source and destination countries. It calls for Member States to consider the effects their health workforce policies have on health workforce development outside their borders. One proposal is that wealthy States that benefit from the services of health workers trained in poor countries, forge bilateral or regional agreements that include schemes to compensate source countries for their losses. Naicker et al. reviewed the effects of health worker migration on source and destination countries. They calculated that source countries lose the cost of training and any productivity contribution to their health systems. Destination countries gain the health sector contributions of skilled health workers that they did not invest in training. In their article they suggest that compensation for physician loss could include the cost of five training years and "other compensation". Still they conclude that these modest financial remedies, even if they were distributed, would not address the root problem of underserved health systems with critical shortages of physicians and nurses. Although the lack of a compensation scheme disappointed some source countries the Code's compromised focus is on supporting health system development based upon human rights principles. States are left to, on their own or in collaboration, agree to remedy losses or access the accountability mechanisms of the global governance framework of the ICESCR.

The Code also acknowledges the benefits that education and training in wealthy systems can offer to health professionals, and to their source health systems if they return to share their knowledge. Wealthy countries are encouraged to develop education policies that maximize the ability of health workers to function to their potentials by supporting the training of health workers at home and abroad. One nurse in the interview sample has returned after the completion of her graduate studies in the US to teach nursing in her home country.
Article 5 describes strategies that echo those suggested in Kampala in 2008, such as, the emphasis on increased training capacity mutually supported by source and destination countries, developing an evidence based health workforce plan and devising measures to sustain and retain the skilled health workforce.\textsuperscript{210} The Code's directions, such as scaling up education, managing the health worker marketplace, and developing a sustainable workforce, apply to nurses. Several of the IEN interview subjects migrated specifically to pursue higher education that was not available in source countries. Their new skills and knowledge are not always matched to the needs of developing health systems. The absence of professional opportunity and inability to practice at the level to which a nurse is educated, among other factors, influenced their original migration decisions and also discouraged them from returning after higher education.\textsuperscript{226}

In a message aimed at source and destination States, Article 5.4 states “All member States should strive to meet their health personnel needs with their own human resources for health as far as possible.”\textsuperscript{2} Many wealthy states do not currently comply with this recommendation. By signing onto the Code, as all 193 WHO Member States did, they have agreed in principle to develop national policies that consider the effect of their domestic health workforce plans on fragile health systems, along with their own. The global nurse shortage, and the draw of unfilled positions in wealthy states is an important migration force. This is one root dynamic that facilitates migration of nurses.\textsuperscript{182} The role of domestic nurse workforce policy in destination States is explicitly recognized in this section of the Code as a component of the poor health system staffing in source countries. The Code directs coordination of source and destination country health workforce policies that can support the availability of a sustainable health workforce in both. The Code again links wealthy and poor States policy, to health care in fragile systems.
Data Gathering and Research: Article 6

“Member States are encouraged to establish or strengthen research programmes in the field of health personnel migration and coordinate such research programmes through partnerships...” 2 Code: Article 6.3

"An international comparative information base on health workforce mobility is needed but can only be developed through a collaborative, multipartnered approach." 227 WHO Code report 2013

Article 6 advises that valid policy planning and implementation for the global skilled health workforce require up to date multi national information. The WHO designed and distributed a data collection tool to Member States in an effort to standardize the recording of evidence and make it available in the WHO database 228 for policy planning and shared research. Recognizing that data about the nurse workforce is incomplete, even in developed systems, the Code asks for periodic report submission on its standard tool to establish baseline and trend information and to assess the effects of policies that implement the Code’s objectives. The 2013 first round of data collection established a starting point for further study of the Code implementation effect.

The creation of the global standardized tool and the regular reporting it promotes fills a gap in current information about individual national statistics and programs relative to health workers and their migration. With WHO oversight Member States are directed to report data that is “comparable and reliable…for ongoing monitoring, analysis and policy formulation”.2 The potential value of gathering the same data set for destination and source countries is that effects and interrelationships will emerge. The first national reports were due at the WHO in late 2012229 and every three years afterwards (figure 6-1). A report on the compilation of the national reports and the implementation of the Code was delivered at the WHA in June 2013. Representatives from each of the six WHO regional offices addressed global health workforce issues during the Code report session. The session began with a retelling of the Code history. The sum-
mary report was introduced with this statement “we ... require at least an additional 4.3 million health workers. Still, one billion people worldwide will never see a health worker in their life. So, three years after Code adoption and having the Code on the WHA agenda again: Let us take stock.”

The report is summarized as an addendum to this section.

Despite less than resounding participation success, the report process did proceed as planned and revealed progress and deficiencies. Article 6’s directions for data collection and submission are a major contribution of the Code that holds implications for the nursing workforce, and an opportunity for nursing participation. Although the Code’s non-binding status means that nations are not under enforceable legal obligation to submit reports, the WHO itself is required, under its own jurisdiction, to publically publish a summary of the submitted data, and to file reports every three years to the WHA. Code implementation progress is a formal, recurring agenda item. Developing a shared, standardized evidence base that includes accurate data as a rationale for policy formulation at the subnational, national and international levels can contribute to problem identification and assessment of implementation effects.

Even in well-resourced health information systems, data on nursing and nurse migration patterns is scant and scholarship is often based on estimates. For example, in the US individual state based boards of registration in nursing do not consistently ask for documentation about where a licensed nurse was educated, except in the state of initial licensure. In the 2012 report, the US national reporting authority cites the complex state based regulatory system as an impediment to gathering comparable, national data concerning professional regulation of both nurses and nurse recruiters. In generating the document the US Department of Health and Human Services (HHS) joined force with the privately managed Alliance for Ethical Recruitment to define strategies to standardize best practices. The US report reveals gaps in information. It has
also led to initiatives to gather more complete and consistent data at the national and state regulatory levels. 212

Countries with undeveloped infrastructure need assistance establishing their databases. In this section, as in earlier ones, the Code calls for assistance, cooperation, and engagement of stakeholders. One cooperative endeavor is the research partnership between the US Centers for Disease Control (CDC) and the Kenyan Ministry of Health. The collaboration developed an electronic nurse database that, for the first time, provides information on the components of the Kenyan nursing workforce. 41 All West African Health Organization (WAHO) countries have critical health worker shortages by WHO criteria, and lack health system infrastructure. In another successful partnership, Professor Kayode Odusota, a Nigerian physician working with the Health Worker Migration Policy Council of the Aspen Institute, has spearheaded regional use of an open source data tool that can be adapted for individual country needs. 232 The tools to develop an evidence base about health workers are emerging and cooperative endeavors show some success. Academic institutions as well as civil society research think tanks have a role to play.

The WHO Code has designed a system for regularly submitted, standardized, transparent progress and assessment reports from Member States. The development of a comparable database, open to international scrutiny, serves as a major source of monitoring and evaluation of the Code's implementation. 199 When resources are unavailable, the Code directs well-financed academic systems to collaborate with under resourced ones. The focus on developing a global evidence base for policy is an opportunity for shared research between source and destination country academic, civil society and professional organizations.
Information Exchange: Article 7

“Member States are encouraged to...promote the establishment or strengthening of information exchange on international health personnel migration and health systems...”

Article 7 delineates structure for the procedural aspects of data and information exchange. The article's title, Information Exchange, and text content make it clear that expectations go beyond the gathering of data by national reporting entities of Member States, to include sharing it domestically and internationally. Information collection and exchange includes relevant entities, such as businesses, professional associations, health professionals, and academic and research entities, as well as Member State authorities. It aims to establish a mechanism to collect and share data that shows trends in migration of health personnel, the effects of migration patterns on health systems, and the implementation of the Code. The WHO database reported through the WHO central authority, makes the information open and accessible. In addition to demographic data about their health workforces, Member States are also asked to report on laws and regulations relevant to the issue of health worker migration and Code implementation. Even well resourced systems do not have access to this information in a form that can be collated, shared and easily accessed. Development of a legal database, on matters involving the health workforce, will help coordinate and show due diligence toward the diverse global governance issues around human resources for health. Each Member State has been asked to assign a designated national authority that is responsible for submitting reports on the collected data to the WHO, every three years. (figure 6-1)

The first iteration of the WHO National Reporting Tool asked the international community to supply information about the scope of data currently available to record progress toward Code implementation. Collecting periodic standardized reports that are collated and made
transparently available, means that there is a structure to keep the issue of health worker migration on the agenda at both national levels, as reports are generated, and the international level, as they are assembled and made publically available. WHO and national reports also supply a shared repository for open data that researchers, including nurse researchers, can access. Reporting data identifies gaps for Member States to correct, questions needing further research, and identifies best practices. The reporting structure also uncovers under resourced countries research needs. Since the participation of poor countries in the first round of reports has been limited, the need for assistance in data collection, collation and analysis has been exposed. Information from under resourced, as well as destination, countries is essential to assessing Code implementation progress and generalizing results.

**Implementation of the Code: Article 8**

“*Member States are encouraged to publicize and implement the Code in collaboration with all stakeholders.*” Code: Article 8.1

“*Member States are encouraged to incorporate the Code into applicable laws and policies.*” Code: Article 8.2

Article 8 places primary responsibility for implementation of the Code on WHO Member States. Duties of dissemination, enforcement and integration into policies however are relevant to all stakeholders. Implementation guidelines also suggest that agencies actively recruiting nurses, or other health personnel, be monitored for compliance with the Code’s guiding principles with regard to the impact of their activities on critical shortages countries. States are directed to incorporate the Code into “applicable laws and policies”, and to assemble a legal database on issues related to the migration of health workers and health workforce development.
The Code directs that stakeholders, including health professionals, recruiters, public and private enterprises, professional organizations and governments, work individually and collaboratively to implement it. Several of this article’s sections refer specifically to recruiters and their monitoring, but it is also explicitly stated that regardless of the practices of others, each, individually, is expected to comply with the Code. Distributing information about the Code among the community of interest is seen as vital to operationalizing on the ground policy. In the 2012 interview sample of IENs in the US only one of the ten had even heard of the Code. The Canadian health sector recruiter survey data, mentioned earlier, demonstrated a low level of awareness of global governance, contained in documents such as the Code. The authors found evidence that recruiters did not generally consider the effect recruitment of nurses from poor countries had on developing health systems. In their conclusions they found the scope of recruiters' priorities to be influenced by local or client needs. The authors suggest a need for international or global oversight of health recruiters' practice. There is a need to increase awareness among stakeholders, including nurses and recruiters if policies relevant to them based on the Code are to be implemented.

Alongside States, right to health holds private enterprise, professional associations and individuals, including health professionals responsible to respect and protect it. Health professional employers and recruiters are advised to always consider human rights when incorporating the Code into their activities. Evaluation and monitoring of their conduct with respect to the impact of their business practices on the right to health of citizens, as well as the rights of recruited nurses, could be guided by the principles laid out in the Respect Protect and Remedy Framework, developed by the UN Human Rights Council, to set standards for human rights conduct of transnational corporations and businesses and discussed in Chapter 2. The framework goes be-
yond the Code's directions, to call for remedy of human rights abuses when they occur, even unintentionally, as a result of transnational business practices. 92

Many recruiters and employers of nurses are unaware of the Code’s content or their obligations with regard to it, and do not appear to have the vision to consider the right to health violations that are intensified when health workers depart. 216 Global governance will need to stimulate formation of local micro level policies. For example recruiters or nurse employers might be held accountable for the value of the education costs and subsequent health sector contribution loss of nurses recruited from critical shortage countries. The Code directs those involved in the hiring of health personnel to check for pre-existing binding service contracts and to respect them. However the Code stops short of obliging compensation or remediation for failure to comply.

The Code recognizes that data contained in private recruiter or migration assistance agency files contains key information for establishment of an evidence base. The balance between respecting the right to health of populations with the privacy and freedom of movement rights of nurses will require nuanced and flexible policy with central oversight. In Chapter 7 I discuss the potential policy tension and turn to the global human rights governance framework for guidance. Information on the practices of recruiting agencies is currently largely unavailable in Member State data repositories. 227

Article 8 includes explicit reference to facilitation of circular or return migration. Code implementation directions include developing policies that ease the ability of nurses to return to practice in source countries. This topic was also of concern to nurses in the interview sample. Visa re-entry limitations can interfere with optimal sharing of nurses' skills and talents. Member States are asked to evaluate the potential impact of return migration, assess the impediments to it, and report on the legal frames that pertain to it. Examination of current professional regulatory
laws, alongside migration/visa laws, may serve as a first step toward facilitating circular or return migration, which, in theory can benefit nurses, as well as, source and destination countries' health systems.

**Monitoring and Institutional Arrangements: Article 9**

“The World Health Organization should periodically review the relevance and effectiveness of the Code. The Code should be considered a dynamic text...” Code: Article 9.5

Article 9 addresses the central reporting obligations of the WHO and WHA. It is significant because the report structure fills a void. Required WHO reports collate and share National reporting Tool data. Generalization of the information depends upon a solid base of participation. Although non-binding on Member States, the WHO, itself, is obliged to report periodically to the WHA on the summary Code implementation. This complies with its institutional reporting obligations. In addition to the WHO Director General’s duty to furnish periodic reports to the WHA, Article 9 directs the WHO Director General to use the collected data to make policy and procedure recommendations, and to collaborate with international agencies such as the UN, the International Organization for Migration, the International Labor Organization, and relevant civil society entities and NGOs. This means that the issues related to the migration of health workers, and the state of global health workforce distribution should remain on the WHA docket. It also means that submitted data and its interpretation will be widely disseminated among the related global authorities and publically available on the WHO website. The WHO has published a timeline (figure 6.1) for report submission. The first WHO report to the WHA was presented and accepted in June 2013 at the 66th WHA. The addendum to this chapter summarizes the results.
One strength of non-binding global governance codes of practice is the potential to alter them as circumstances change. Article 9 also states explicitly that the Code’s text is dynamic and should be adapted to shifting conditions and needs. It is intended to evolve as evidence emerges. The Code's drafters recognized that the global health landscape is dynamic and included explicitly that “the code should be brought up to date as required.” This facilitates currency, while the code of practice format leaves the door open for additions or amendments to be made by the WHA, with Member State approval, without needing to construct and negotiate an entirely new document. One potential addition would be directing financial or service compensation or an obligation for compensatory support for nurse workforce development to countries with critical shortages of health personnel that lose nurses to migration. It might also mean providing incentives for development of the nursing workforce for the least advantaged, or national policies that lift visa restrictions for nurses who wish to periodically return to work in source countries.

**Partnerships, Technical Collaboration, and Financial Support: Article 10**

“International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries...that are experiencing critical health workforce shortage...such organizations and other entities should be encouraged to cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease specific interventions are used to strengthen health systems capacity, including health personnel development.” Code Article 10.2
Article 10, the last of the Code’s Articles contains only 3 sections. It reiterates the core principles of the Code, that implementation requires collaboration and assistance from a broad range of stakeholders, with focus on the needs of developing health systems. Wealthy nations are “encouraged to provide technical assistance and financial support” to strengthen developing health systems, especially those with critical skilled health worker shortages. Despite the softened voice of the Code's final draft, it reinforces the connections between the health policies of wealthy and developing States. In a rather specific directive it calls for allocation of disease designated program funds to be used for health system development, including human resource development. Many US funding programs, such as, PEPFAR or malaria eradication initiatives have focused upon specific diseases and progress has, at times, stalled because of the lack of skilled health personnel, including nurses, to execute program goals. In a change in US allocation policy PEPFAR funds are now being used to develop specialty health workers in areas related, not only to HIV, but also other associated chronic conditions.

Again the main message is that global health, and global health workforce development, connects low and high resource systems and requires flexibility, collaboration and shared contributions to achieve the objectives of the Code. Article 10 raises the discussion of using financial and other incentives for compensation from health worker receiving countries, to encourage health workforce development. The Code’s implied endorsement of proposals that encourage financial support “aiming at strengthening health system capacity, including personnel development...” suggests that policy avenues to address health workforce supply disparity should include financial assistance.
Education and wage incentives can be used to encourage health workers to stay in poorly resourced areas instead of as enticements that draw them to wealthy systems. USAID has published a survey tool that can be adapted to the setting in which it is used, to develop an evidence base on health worker incentives and their efficacy. Nurses in the IEN sample migrated for a variety of personal and professional reasons, but higher education and professional satisfaction dominated. Nurses felt that the opportunities they desired, the ones they saw reflected in the media, were simply not available in their home countries. Shifting this underlying motivator takes allocation of resources.

C. Summary

“The Code is a planting bed for many good seeds of change. Just read it again!” Amani Siyam, WHO Secretariat, WHA 2013

Codes of practice are frequently used instruments that recommend standards of behavior in particular areas, but proposing a practice code of global scope is rare, and has only once before has been issued by WHA. The WHO promulgated the Code in response to the acknowledged and long neglected issues resulting from the effects on health systems of the worldwide shortage of health personnel, and their unidirectional movement, which exacerbates their unbalanced distribution. Margaret Chan, Secretary General of the WHO called the Code “…a gift to public health…” when she announced that all 193 WHO Member States had voted in favor of it. The unanimous support it enjoyed, and its global human rights based foundation for health workforce development, holds promise for health system reforms that can benefit everyone. The Code’s objectives include ensuring that migration flows do not negatively impact health services
in source countries, while protecting the rights of migrant health workers. This draws analytical attention from nations to policy influences beyond their borders.

The Code's text links the health workforce, health system function, and realization of the right to health. It is well documented that migration of skilled health workers, especially nurses and physicians, from under resourced countries to developed systems, has resulted in widening of the functional gaps among health systems.\(^{199}\) It is the poorest who suffer the violation most. The Code also addresses this and directs that consideration is always given to the underserved, especially in critical shortage countries, when developing health workforce policy.

Although the Code may serve as a guide for long range and interconnected policy it does not enforce immediate remedy when the progressive fulfillment of the right to health is stalled due to the shortage of nurses or other health workers. It is broadly written and does not tailor policy direction to specific regions, health systems or professions. It does not detail a scheme that would compensate poor countries to remedy their loss of, either education investment, or health system function, that result when their skilled health professionals deliver care in wealthy nations. It does not provide incentives to encourage compliance by wealthy countries. It does not offer a mechanism to compel accountability of its implementation. Despite its lack of force on the issue of compensation and enforcement it does include moderately strong language directing financial and technical assistance.

As a voluntary Code, holding Member States to its implementation is not formally enforceable. The existing framework for human rights accountability does provide an avenue to monitor and remedy human rights violations. Although progressive realization compromises targets for the fulfillment of the core components of the right to health, it does not relieve States of the duty to take steps toward non discriminatory full compliance. The Code reporting tools and
on going WHO recommendations after their collation, provide some measure of accountability, along with evidence on which to base policy.

The Code's drafters noted that reconciling the loss of health personnel with fulfillment of human rights in poor countries, while honoring the workers' civil right to freedom of movement, requires collaboration among Member State governments, individuals and private enterprise. The Code’s architecture, supported by the global human rights framework, supplies a scaffold for policy in this area. Regulators, migration facilitators or recruiters, professional organizations, global health governance institutions and individual nurses have a role to play, alongside Member State governments, if nurse workforce policy is to fulfill the Code’s goal of benefitting source and destination countries’ health systems. Policy to resolve competing interests can operationalize the norms contained in the international human rights framework.

The Code is designed to be a dynamic document that can be improved and adapted, as circumstances change, and understanding is enhanced with evidence. Although non-binding, the good faith, official acceptance of the Code by all WHO Member States gives it persuasive leverage to expeditiously expect compliance from the global community. It publically links the health workforce to realization of the right to health and also to security and development. The Code formally raises the long neglected issue of human resources for health, and their impact on realization of the right to health, onto the global policy stage. Its international reporting strategy will keep it there.

C. Addendum: Code Report 2013

The first round of Code reports were due at WHO headquarters in December 2012. The WHO collated the submitted materials and presented the findings in June 2013, at the 66th WHA
session. Although the response was sub-optimal, its analysis gives further insight into the limitations resource constraints place upon developing systems.²²⁷,²³⁰

Eighty-five of the 193 Member States had designated a national authority but only 56 of them submitted reports, by the due date. Most reports originated from wealthy destination systems of Europe along with the US. The countries usually thought of as poor source countries in Africa, Pacific Islands, and Southeast Asia, contributed less than 30% of the data.²²⁷ This means that only slightly over 25% of WHO Member States made submissions, which are skewed to include mainly data from higher income States. This limits the generalizability of findings attributed to the results. The skewed response, however, does speak to the difficulty poor States have in developing a database and the absence of the infrastructure needed to assemble it. This makes the Code recommendations for technical support, including support for research and data analysis, an imperative for Code implementation. This first round of data collection was an assessment of the capability of Member States to implement the Code.

Of the reports submitted, even many wealthy countries conveyed incomplete data about their health workforces. In the qualitative response section the most commonly listed impediments to Code implementation were the difficulty of engaging stakeholders, such as the nursing profession or recruiting agents, in global health workforce issues. About half of the WHO Member States assigned a government agency, usually the ministry of health, as designated authority, and left the data collection and report generation to them.

The WHO national reports can reveal best practices, which others can emulate. Several examples of stakeholder integration did emerge as successful. Finland and Belgium designed programs to "better harmonize" the needs of stakeholders, by integrating them into the Code implementation process. Thailand, a source and destination country, successfully integrated the
Code into data gathering and health workforce development by assembling a multi-sectorial human resource partnership to oversee Code implementation among stakeholders. Most other reports were composed and submitted by a central government authority.

The reports also showed gaps in available data. Although greater than 60% of reports indicated that the country had a mechanism to assess competency and grant licensure for nurses and physicians educated abroad, a mere 11% had access to a database of laws and regulations related to recruitment and migration of skilled health workers. Even in wealthy destination countries the legal influences on health system function are not well coordinated and assessed.

Although there has been progress on the Code's aspirational objectives, it has been limited, and the submitted evidence does not include a large number of Member States. The Code text reiterates the recommendations for assistance, internationally coordinated actions and technical collaboration to guide health workforce policy. Without global comparative data, solutions will tend to be fragmented and skewed. The problems that arise because of the global under supply of adequately trained skilled health workers extend beyond staffing health systems to technical infrastructure issues. At this point the WHO has recommended a renewed commitment to the gathering of data and encouraged collaboration among Member States to that end.

We saw that nurses are essential to the progressive realization of the universal right to health. As the agents who translate health policy into healthcare, they can contribute by giving insight and leadership to nurse specific policy that supports the Code's aspirations. The Code cites responsibilities of health personnel in Article 4: "Health personnel, health professional organizations, professional councils and recruiters should ...cooperate fully with ...national and local authorities..." to use the Code as they take into account the highest attainable standard of health. In this nursing has an unrealized role to play.
"...When children are being killed because of a mosquito bite, and mothers are dying in childbirth, then we know that more progress must be made. Yet because of incentives - often provided by donor nations - many African doctors and nurses understandably go overseas, or work for programs that focus on a single disease. This creates gaps in primary care and basic prevention."
Barack Obama, Speech before the Ghanaian Parliament, July 2009

Chapter 7: Discussion and Policy Recommendations

designing nurse workforce policy

Introduction

In international forums, world leaders, such as President Obama, acknowledge the health impact of the global shortage of health workers. The Code's guiding principles and objectives tackle this complex problem. In this final chapter, I draw upon my findings from IEN and policy expert interviews, analysis of the WHO Global Code of Practice on the International Recruitment of Health Personnel (Code) and evidence described in previous research, to gauge the usefulness of the Code as a structural and normative foundation for nurse workforce policy that also considers the progressive realization of the right to health.

The Code links the skilled health workforce to its core guiding principle, the right to health. I integrate my argument, that adequate nursing care is an essential component of the required characteristics and core components of the right to health, to apply the objectives, guiding norms and implementation directions promulgated in the Code to policy recommendations. Where the Code's guidance, on its own, falls short, I turn to the international human rights governance framework to clarify accountability and resolve conflicts. The migration narratives of IENs add relevance to the human rights theoretical frame, and the Code's directions.

Part I of this discussion begins with of an interpretation of IEN interview evidence that assesses its policy implications and coherence with previous research. Besides the description of
migration motivators, such as professional dissatisfaction or the wish for further education, I include a discussion of IENs' responses that characterize the role they envisioned for nurses in fulfillment of the right to health. IENs expressed an acceptance of the nursing ethos that links the right to health to patient care, but were not familiar with its legal standing. IEN interview results illustrate policy implications of the Code and right to health.

Next, I summarize key points, derived from the Code analysis presented in the previous chapter, to interpret it as a steering template for nurse workforce policy that fits the criteria for progressive realization of the right to health. The Code's health system policy directions rest upon human rights norms. Its report structure, universal Member State affirmation, and global scope support its potential as global policy architecture. Criticisms of the Code, which potentially limit its influence, include its lack any reference to enforceable accountability, and the tension that can arise during implementation. It acknowledges but does not resolve policy conflicts, such as the possible struggle when fulfilling simultaneously, the competing freedom right of nurses and the right to health, or international and domestic health workforce demands. The international human rights governance framework supplements the Code to guide my exploration of these issues.

Part II synthesizes the evidence into policy recommendations. Here I propose pillars derived from the Code's human rights based foundation principles, and the characteristics of the nurse workforce. I recommend operationalizing the right to health as a central guiding norm for the development and protection of health systems. Based upon interview and analysis evidence, policy recommendations include, accessing human rights accountability and enforcement mechanisms, employing incentives to develop and maintain the nursing workforce needed for sustainable health systems, matching the characteristics of the nurse workforce to health system needs,
and international sharing of responsibility for resources and research. Strengthening health systems is a common goal and the responsibility of all entities, governments, private enterprise and individuals. When nurses are recognized as essential to realization of the right to health, nurse workforce policy becomes a vital consideration for any equitable, human rights based health system strategy.

**PART 1: Discussion**

**A. Relevance of Interview Results**

A limited segment of the body of research that explores the phenomenon of skilled worker migration focuses on skilled health workers and specifically nurses. Analysis of most of the published evidence identifies factors that drive migration, or it assesses the effects of migration on source or destination countries' health systems and economies, without directly considering the influence of health worker migration on the realization of the right to health. Although my sample is small, consisting of 10 IENs, their demographics (age, education, etc.), and stated migration motivations (professional dissatisfaction, desire for education and personnel issues, etc.) reflect the characteristics reported by other researchers for nurses who have migrated to the US, Canada and the UK. Chapter 5 contains more detailed collation of selected results.

1. **Why Nurses Don't Stay Employed in Underserved Areas**

Understanding why nurses leave professional employment in poor health systems can lead us to the interventions that might encourage nurses to work there. The content of narratives and responses of the interviewees in the IEN sample also reflects the complex balance between the mirror push and pull forces at work. As has been reported elsewhere, more than one element
was generally of influence to the IENs, and perceived pull factors, such as enhanced professional opportunity, were often understood to correct the push factor deficiencies of working in source countries.

Interviewees reported migration motivations that were similar to those described in skilled worker migration literature. These included both personal circumstances, for example, a family member living in the US to facilitate the move, and professional issues, such as, the desire for further education or better working conditions. More than one reported factor exerted influence for all of them. Even nurses, who had personal opportunity, for example, family contacts in the US, or the promise of employment for a spouse, also cited professional push factors, such as low job security or satisfaction. Nurses, like other skilled health workers, seek life opportunity and will be drawn to where they find it. A young male nurse from Cameroun describes the combined reasons for his choice to migrate.

"I finished nursing school in Bamenda and wanted to specialize in surgery. I worked at a good hospital there but had to take a job working nights in the medical wards and we never had enough staff or supplies. I always had the idea I could do better overseas. I was afraid I was forgetting all I learned in school... My cousin is a doctor in training in Maryland and my brother has also migrated...I knew my nursing credential would open doors. I came to the US without a job... I worked as a gardener in the summer... After I passed the exams and got a license I found a job working in a nursing home. I saved money and now I am in graduate school for my masters degree..." Christian, Cameroun

Career advancement through higher education is often a driving factor that influences the decisions of both physicians and nurses to migrate. Three of the ten nurses in the interview sample specifically cited their desire for further education, not available in their home countries, as a primary motivation for migration, while a total of six of the ten pursued bachelors or graduate degrees after settling to the US. The phenomenon of nurse migration has been implicated as a factor that impedes the development of nursing leaders in source countries, because the most ambitious and best educated are in demand worldwide.
nurses leave, their leadership potential is also lost. This may be significant when applied to the development of nurse workforce policy in source countries, because it can reveal an absence of nursing professional leadership. The departure of the most educated and talented nurses also leaves a mentoring void for junior nurses, passing the professional dissatisfaction driver of inadequate education and training opportunity, onto them.

Conversely, access to education and current information has been reported to increase retention of health workers in underserved areas. Small studies of nurses and physicians indicate that providing educational opportunities, and regular mentoring are the major features that they claim could keep them employed in fragile, rural health systems, or that would encourage their return to work there.241,225,226,242

Five of the ten IENs indicated that ease of migration was a factor in their career choice. Professional mobility has also been reported in research on physicians and nursing students in poor source countries.166,167,243 When talented young students choose their career paths to facilitate a move abroad, it indicates that policies around the skilled health workforce make this a more attractive option than domestic employment. Both dismal working conditions for nurses, and preferential selection based on criteria that favors those planning to migrate, such as arbitrary exam and financial measures that advantage wealthier students from urban areas, may be enabling this dynamic. Adjustments in the student selection criteria to include, setting admission standards that give preference to students from poor areas, awarding incentives to retain graduate nurses in the public sector, and involving communities in student selection, could increase the likelihood of meeting the health and development needs of underserved communities.200,244 Joseph's comments reflect this intent to migrate that precedes domestic employment.
"I never planned to stay working in Kenya. My uncle was living in Massachusetts. I knew nurses were needed in the US and England, so when I finished school I applied for a visa. Everyone in my school talked about going abroad to work. There are not many good jobs for nurses in Kenya. ...My parents encouraged me to find work in the US, where I could live with my uncle and that's what I did..." Joseph, Kenya

Pansy, who has been working as a nurse in the US for over 10 years, clarified that the intent to migrate was part of her life plan, and influenced her education choice.

"I always knew I wanted to leave China, so I studied English and nursing." Pansy, China

I developed the argument in Chapter 3 that nurses are essential components required for the progressive realization of the right to health. Integrating the human dynamic of the global nurse marketplace with the theoretical frame can guide functional policy.

2. IENs and the Right to Health

The IEN sample nurses' also furnished information about their attitudes toward and knowledge of the right to health. Each subject was asked, "How can nurses contribute to fulfilling the right to health for all?" They were also questioned to determine their familiarity with the Code. This information was gathered in an attempt to gauge their readiness for participating in global health workforce policy development based upon the Code. This data has not been previously reported.

All of the IENs all agreed that nurses play a role in fulfilling right to health, and they described it from the perspective of clinical care to individual patients. This reflects the standard taught in nursing schools and found in nursing codes of ethics and in scholarship. Sample responses indicated that nurses do recognize their professional duty to provide care for all patients, "even those who can't pay", but as a matter of professional ethics and social responsibility. They did not identify the right to health as imposing legal duties.
Lack of familiarity with the concepts of human rights law may be significant when advising nurses to be right to health promoters. We saw that Paul Hunt and Jonathan Mann have recommended that nurses become right to health advocates. Being unfamiliar with the concepts and formal normative content of human rights, such as the broad sharing of responsibility for its progressive realization, or the prioritization of the needs of the underserved, may limit nurses’ abilities to use right to health as a platform. Nurses, who understand the responsibilities and accountability imposed by human rights, can use legal arguments to compellingly bring the clinical reality of inadequate and inequitable health services, to those with power. Leveraging the legal force of their first hand experiences with regard to meeting right to health duties, can serve as an advocacy platform for workforce reforms, which in turn encourages retention of health personnel and can sustain stronger health systems.

Advancing arguments for an adequate supply of nurses, as a component of the respect, protect and progressive realization duties to the right to health, adds legal accountability to the tangible aspects of correcting health system deficiencies. This did not appear to be recognized by the sample nurses. Ani’s response below articulates the evidence the interviews revealed of IENs portrayal of the interface of nursing and the right to health. Although Ani recognizes that the poor do not have access to care, and that they deserve it, she does not appear to identify with any responsibility toward them if they are not her patients.

"We were taught in school that when we work as a nurse we care for all patients, even if they can't pay. To me the right to health means everyone can get health care for themselves and especially children... In Nigeria some clinics are expensive and don't treat the poor because they cannot pay. I would not want to work in public health centers because the pay is not enough and there are shortages. I had experience there as a student and knew I would not work in one. I was working in the university hospital but would not go back there to work as a nurse...As a nurse I care for any patient ..."  

Ani, Nigeria
From a different perspective all IENs were also asked, "Do the wealthy have an obligation to help the poor?" Eight of the ten agreed that the wealthy hold some duty to assist the poor, but only one extended that directive to mean helping patients in his home country. Christian's perspective is, if the wealthy help nurses, like himself, to develop advanced skills, the poor will benefit when he returns. It should be noted that he was the only one of the IENs who expressed an intention to return to clinical work in his source country and none suggested assistance was a legal responsibility of the well resourced.

"...the wealthy should help nurses in poor countries to come to the US for education. I finished nursing school and wanted to specialize...so I came here. I am in school now and will return to Cameroun after I am a US citizen...I am not sure if the wealthy should give money because it is not always spent the best way but they should find ways to help..." Christian, Cameroun

Comment 14, Article 12 of ICESCR clarifies that everyone, including health professionals, has responsibility toward the right to health. Nurses are generally well prepared to serve as care givers, and but have not developed their roles as the advocates that Paul Hunt envisioned them taking on. They are close to those who suffer as they deliver care, and are called upon to translate policy into health care practice. They see, first hand, the effects of policy on clinical care. Nurses leave low resource health systems because of health system features that result in unsafe or unsatisfying working conditions. Recognizing their essential role in realization of the right to health underscores the effects of labor and workplace policy on progressive fulfillment of the right.

Although not a scientific sample, the cohesion of the qualitative responses of the IEN interviewees with known data, gives validity to the content of their narratives. The one new focus area that is of interest, when using the right to health as a base for nurse workforce policy, is the response of the IENs regarding the right to health. Comment 14 (44e) describes the training that
is considered among the core components of the right to health and includes explicitly education for health workers on health and human rights. Since nurses identify their role as a duty to the individual rights of the patients under their care, they may not visualize realization of the right to health more generally, as a fundamental and universal right of the sick and well that is also a matter of law.

When designing nurse workforce policy that realizes the right to health, the discordance between the global governance language of policy makers, and the professional clinical focus of nurses, deserves mutual recognition. At the nursing leadership level, the ICN comments to the WHA concerning the early drafts of the Code also reflected the tension between clinical care and theory, in global governance. Although the ICN voiced official approval of the document, they asked that clinical outcomes be added to implementation evaluation criteria. The WHA Code drafters did not add this to the data collection document.

**B. Human Rights and the Code's Nurse Policy Implications**

**1. Shared Implementation Responsibility**

The Code’s ambitious agenda, analyzed in detail in Chapter 6, integrates four interrelated principles. Broadly, the recommendations that are most relevant for operationalizing the right to health in nurse workforce policy are, to integrate the shared responsibility to the right to health and the freedom right to legally migrate, while recognizing the global scope essential for solutions to the unbalanced health worker shortage and assuming the international responsibility to assist those in need.

The Code employs the norms set forth in the international human rights framework to guide policy directions. Its focus on a specific subject helps to refine the value of the human
rights framework for tackling the health system issues that intersect around the worldwide shortage of skilled health personnel. All WHO Member States agreed that this is a problem whose solution requires international collaboration. The Code echoes the ICESCR in its guidance when it explicitly cites recommendations for involving actors beyond State governments, always considering the needs of the underserved, and directing well developed economies to provide "financial and technical assistance". Its directions reflect the responsibility wealthy countries carry toward progressive realization of the core components of the right to health, under international human rights law.

Comment 14 voices authoritative clarification of shared responsibility toward core obligations, under the subheading "obligations":

The economically developed States parties have a special responsibility and interest to assist the poorer developing States ... the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" which enable developing countries to fulfil their core and other obligations..."

ICESCR Article 12, Comment 14, 40&45

Reflecting the ICESCR guidance, the Code, with reference to the development of the health workforce and health systems, articulates the shared responsibility standard in guiding principle 3.3.

"Developed countries should...provide technical and financial assistance to developing countries ... aimed at strengthening health systems, including health personnel development. "Code 3.3"

The Code was been widely disseminated after its promulgation among those responsible for health workforce policy development and implementation in Member States. All of the eleven policy experts interviewed for this work acknowledged that the shortage and poor distribution of health workers is an important problem of international scope. With one exception they were familiar with the Code. On the other hand, only one of the ten IENs had even heard of the Code, more than two years after it was published.
Among the Code's implementation directions is dissemination among the communities of interest. Evidence is it has failed to reach the ears of nurses. Both the responses of IENs in the sample and review of recent literature review substantiate this. Nursing Outlook, the official Journal of the American Academy of Nursing (AAN), devoted its first 2014 issue to the topic of globalization in the nursing profession. None of the articles mentioned the Code as a structure for nurse workforce policy, although many of the collected articles included policy implications for the global nursing community. Issues around standardization of nursing education and the effects of IENs on economies of source and destination countries were cited as prominent concerns, while the impact of the disparity of skilled health workers on the right to health was left unexplored. Nurses, even those academic leaders publishing in the one of the most scholarly nursing journals, do not seem to relate to the legal role nurses play in progressive realization of the right to health. Nor do the authors gesture, even in passing, to the potential global health workforce governance architecture the Code intends to standardize. Clearly there is work do to achieve the Code direction to include the community of interest, when it comes to the nursing community. Without integrating the health workforce into the development of policy reflecting the Code's objectives, it is unlikely to realize its potential.

2. Reporting Structure: Data

The Code incorporates a reporting structure that monitors participation in its implementation by States and others. This is its only formal accountability mechanism. The data requested on the standardized National Reporting Tool (Appendix F) includes information concerning the nurse workforce in Member States. Reports are commonly used monitoring tools in global governance. The ICESCR accountability structure requires regular reports.
WHO collated presentation to the WHA of Member State submissions makes the Code a living document with ongoing visibility. In the first round of voluntary reports barely 25% of Member States, mainly wealthy destination States, submitted the completed tool by the suggested due date, which leaves questions about the global applicability of the composite data.\textsuperscript{227,230}

The WHO first Code report on implementation, presented as an addendum to Chapter 6, has already produced evidence that poor countries need assistance to implement the Code.\textsuperscript{227} This outcome should not be viewed as a failure. It helps delineate the scope of the problems under resourced systems face, and confirms that support is needed for the Code's objectives to be implemented, not only for health workforce development, but also as technical assistance to even acquire the data on which to base policy. This is evidence directly linked to Code implementation that wealthy States can act upon, now. An evaluation criterion for compliance with national and international responsibility toward progressive realization of core components of the right to health, is the setting of benchmarks, and measuring progress toward targets, such as the critical minimum skilled health worker ratio.\textsuperscript{250} The Code report process has produced proof of need.

3. Code Criticisms and Human Rights Conflict

The most often recorded criticisms of the Code focus on the absence of any enforcement mechanism for its implementation, and its silence on recommendations for compensation when skilled health workers from poor States join wealthy systems.\textsuperscript{147,251} Potential struggles emerge when States are asked to prioritize rights and resources. Human rights, codified in the ICCPR and the ICESCR can guide nuanced solutions.

The global movement of health workers from poor to wealthy systems reveals a potential conflict between the civil right to freedom of movement and the right to health. The Code di-
rects respect for the freedom rights of skilled health workers, including nurses, to legally migrate. At the same time the departure of skilled nurses from critical shortage areas, where they are desperately needed, can negatively impact progressive fulfillment of the right to health of those left without access to nursing care. The question that arises involves prioritization of the co-existing rights, and accountability for their fulfillment.

Like the right to health, the right to freedom of movement is universal and fundamental. It is protected under Article 12 of ICCPR which states that "everyone within the territory of a State...have the right of liberty of movement ". Article 12 goes on to address cross border movement stipulating that "everyone shall be free to leave any country, including his own". Unlike the right to health, the right to freedom of movement imposes an immediate duty on States to allow citizens, including nurses, to freely relocate, but does not impose duties on destination States to receive them. Freedom rights are a domestic civil rights duty.

The right to health carries the obligation to always respect and protect it, but fulfillment can be satisfied progressively depending on circumstances. In this case, ICESCR assigns shared responsibility. Accountability to the right to health is both national and international. Regardless of resources, however, States hold fundamental obligations to apply every possible means to progressively supplying the core components, which include, among others elements, "essential primary health care", and to meet the continuing obligation to "expeditiously and effectively" move toward full realization. Non discriminatory essential primary health care requires an equitably distributed skilled health workforce, but progressive realization leaves the degree to which this resource need is met qualified by what is reasonable, considering available resources. Wealthy States share progressive fulfillment responsibility to those States that require assistance to meet their core right to health duties.
At the same time, destination countries require skilled health workers to meet the health needs of their citizens, and they often attract nurses trained in poor source countries to satisfy the demand. This can create a dilemma when the shared responsibilities, clearly expressed in the ICESCR for achieving the "highest attainable standard of... health" for all, conflicts with national health needs. The interconnected global nurse workforce market makes realizing the right to health more difficult for some governments.

The ICESCR does give guidance concerning the international implications of right to health responsibility. Article 2.1 directs that to enable States to meet core obligations, countries capable of providing international assistance, should do so. High income countries have the responsibility to assist, while low income countries should seek and use aid to strengthen their health systems. The right to health demands coordinated efforts to address the unbalanced flow of nurses and other skilled health workers.

Paul Hunt describes the nature of the international commitment as one of "do no harm". Wealthy States are called upon to respect and protect the right in other countries by their own actions, and by regulating the activities of entities over which they have power. Hunt's interpretation of this responsibility as one of "do no harm" is useful when evaluating the impact of the migration and recruitment of nurses, because it can reveal instances when progressive realization is impeded or becomes "retrogressive" because of the loss of nurses. By Hunt's standard, if harm is shown, the international responsibility to assist has not been met. Supplying a remedy for harm, as a matter of justice, is an argument advanced in favor of compensation. Although the Code does not include the controversial term "compensation", its substituted use of the terms "financial and technical support" carries implications of acceptance of integrating financial assistance solutions into Code implementation.
The Code's framers suggested that compensation schemes could be worked out bilaterally or regionally. At this point there is no evidence this is occurring as a part of Code implementation. It also does not offer any suggested mechanism, for example, leadership in world health governing bodies, or easing of visa restrictions, which would incentivize wealthy States or private enterprise to participate in assistance programs.

Another impediment to the generalized recognition of the Code's utility is its title, "The WHO Global Code of Practice on the International Recruitment of Health Personnel". This is perceived as implementation limiting nomenclature. The earlier in depth Code analysis revealed its intended scope is to serve as a scaffold for skilled health workforce policy that supports sustainable health systems. Although migration contributes to the critical nurse shortfall, the 4.3 million nurses needed now in developing health systems to meet basic health system benchmarks, far exceeds the number of nurses who migrate. Migration of health personnel is a symptom of larger health workforce problems. A group of global health activists in the EU has suggested that the Code be informally renamed "WHO Code of Practice on addressing the health workforce crisis".  

Since source countries have a civil rights obligation to the freedom right of nurses to legally leave, the onus for protection against the effects on health worker recruitment from poor countries falls on wealthy States. The Code asks that all consider the impact of the their health policies on source countries. Receiving countries should enforce and monitor this principle with recruitment agencies, immigration facilitators, and health worker employers. This could include designing compensation schemes, or personnel exchanges to meet responsibilities toward progressive realization of the core components. Recruiters and employers should always be moni-
tored in destination countries for their compliance with service contracts nurses may be obliged to fulfill.

The Code sets standards that operationalize human rights norms for nations' investments in health systems and the human resources that support them. It acknowledges but does not resolve policy conflicts. Its guiding principles recognize the nuanced engagement of the right to health with the freedom rights of health workers. The Code's implementation directions also reveal the potential tension that results when meeting the health system needs of wealthy states interferes with the right to health in poor source countries. Without giving specific directions it addresses these dilemmas with two general statements. The Code summarizes that health worker policy should mutually benefit both source and destination countries, and that the well resourced should provide financial and technical assistance to fragile health systems. Both directives reinforce the Code's inference that the global health worker crisis links wealthy and developing health systems.

**PART II: Policy Recommendations**

**C. Integrating the Code, the Right to Health and Nurse Workforce Policy**

Nurse workforce policy recommendations, that align the Code, the international human rights framework, and the characteristics of the nursing profession with the needs of health systems, comprise this final section. I briefly begin by discounting some frequently suggested practices that evidence predicts, either are not effective, or are counter to human rights principles. I follow with policy recommendations. In addition to setting right to health as a core guiding principle, the policy standards I propose include accessing formal and informal right to health accountability routes, employing targeted incentives, specifically education and financial subsidy,
matching nursing skills to health system needs, and collecting and sharing data, research and best practices.

1. What Human Rights Based Nurse Workforce Policy Should Not Do

Nurse workforce policy should not restrict the ICCPR protected right to free movement of nurses who wish to relocate. This includes nurses from critical shortage countries. States can only justify restricting this freedom in extreme circumstances, such as to prevent the spread of disease in a pandemic. The Code also explicitly supports the rights of skilled health workers to legally relocate "to any country willing to receive and employ them" in its guiding principles. This is a fundamental State civil rights duty. On the other hand, responsibility to realization of the right to health is shared, and subject to the loosely quantified and conditioned, progressive fulfillment.

The ICCPR does not place any obligation to receive nurse migrants on destination countries, however their policies that limit entry can also be seen as coercive. The argument against restricted entry is not based upon international law but lack of effectiveness. National and regional health worker recruitment codes of practice, precursors of the Global Code, have kept nurses from poor countries from entering certain regions, but have not succeeded in improving the nurse staffing ratios in under resourced source countries. The UK Code of Practice is an example of destination country coercive control over the entry of health workers from poor countries. UK recruiters agree to never bring nurses from the poorest African countries to work in the NHS. This is loosely enforced by removal of any offending agency's names from the official recruiter list used by health facilities. The restriction on recruitment and employment of nurses from developing countries seems both unethical, because it potentially discriminates
against the poorest nurses, and has been shown to be ineffective. A 2009 Human Resources for Health article reports that, although, after the UK Code was enacted, there was a decrease in the number of nurses immigrating to the UK from poor African countries, it did not mean they stayed to work in their source country. Nurses still left the poorest areas, but to work in neighboring countries or wealthy Gulf States, or they left the field entirely. There is no evidence that coercion persuades nurses to work in the most needy areas.

This dynamic underlines the Code's claim that the issues around health workforce development are global. The nurse marketplace makes bilateral or national restrictive policy initiatives ineffective at achieving the end goal of a more equitable distribution of health personnel. One of the IEN interviewees described her experience with recruitment to the US. Nurse migration may not be along an easily predicted straight path. Her story illustrates that a nurse whose education was obtained in a LMIC can migrate repeatedly and then initiate another move as a licensed nurse from a health system other than that of her source country. When she arrived in Boston, Pansy was considered a British nurse from the credential regulation standpoint that is recorded by US State Boards of Nursing.

"After graduation, I applied to take the exams for working in the US but it was expensive and they were not available in China. At the same time I just wrote to hospitals in England, and...one gave me a chance to work as a student nurse in the operating rooms. Even though I was fully trained and experienced I took that position. Sometimes I was not paid and the work was hard. I cried every night... but after one year of working as a student I was given a nursing position...A hospital from Boston came to an employment convention. I just got in line, spoke to them (the hospital recruiter)... because I now had the British credential and they needed nurses for the OR, they hired me. The hospital took care of all my paper work and getting a nursing license. I signed a contract for 3 years and eventually obtained a green card." Pansy, China

Another strategy that does not directly address the progressive realization of the right to health in critical shortage countries is to limit opportunity. The Code implies that reforming workforce policies in wealthy countries that under produce nurses for their health system needs,
will close the door to nurse migration. It recommends self sufficiency.\textsuperscript{2} Although this may be a reasonable domestic health workforce strategy, under current global nurse shortage conditions, decreasing employment opportunity in a few counties will not necessarily trickle down to sustain the nurse workforce in underserved areas. Undoubtedly, nursing job vacancies in the US do facilitate migration for nurses seeking professional relocation, but it is not the only destination.\textsuperscript{182} During the 2008-9 economic downturn, which temporarily resulted in less open nursing jobs in the US,\textsuperscript{256} nurses still left critical shortage regions. The global nurse workforce deficiency leaves many countries needing more nurses. The Gulf States and Japan are currently major destinations for nurses trained in LMICs.\textsuperscript{257 258,259} Closing the opportunity door in some countries, as a strategy to limiting migration from poor countries, is coercive. It is also ineffective, if the goal of policy is development of under resourced health systems and realization of the right to health for the disadvantaged.

In the interview sample only two nurses reported that they were likely to return to their home country, while six of the ten nurses stated they would never return to their source countries to work as nurses, because of the professional working conditions. Clearly effective policy interventions need to prioritize interventions that correct the deficiencies that drive nurses from working in critical shortage areas, rather than close opportunity doors to them.

"There are very few good jobs for nurses in Kenya. I would not want to work there as a nurse... Many of my classmates are doing other things now like working in shops." \textbf{Joseph, Kenya}

\section*{2. What Nurse Workforce Policy Should Do}

I began this work with a description of global health disparity, which pointed to the direct association between fewer health workers and poorer health outcomes. The WHO in-
icates that in critical shortage of skilled health workers areas, achieving the core components listed in Comment 14 is not possible. This evidence links the skilled health workforce with realization of the right to health. Assuring that an adequate number of nurses, with the appropriate skill set, are retained in health systems enables the capability to develop available, accessible, acceptable care of adequate quality health systems that progressively fulfill the core components of the right to health. This would mean that ideally all critical shortage areas design health workforce policies directed at increasing their ratio of skilled health workers to population to, at a minimum, show they are taking steps to reach the WHO target benchmark.

Of course, simply increasing the number of nurses and physicians cannot guarantee that the right to health is realized for everyone, or that everyone will enjoy good health, but without achieving that benchmark the right to health is de facto unfulfilled, because the required characteristics and core components cannot be achieved. Developing and sustaining the nurse workforce is crucial to any health system reform efforts, and to progressive realization of the right to health core. I recommend policy strategies to advance access to appropriate nursing care delivered in a robust health system. These recommendations are not perfect, and will not solve every issue around the health workforce crisis, nor are they the only useful approaches to dealing with complex health workforce issues. I draw upon the Code's guidance, in concert with the international human rights framework and insights from IEN's narratives, to match nursing care to the pressing needs of fragile health systems.

a. Hold Right to Health as a Core Value

The UN Office of the High Commission on Human Rights (OHCHR) premise that realizing the right to health is fundamental to the exercise of other rights and to the development of a
healthy, equitable society, underlies this work's policy proposals. Earlier I argued for recognition of the essential role nurses play in realizing the required characteristics and progressively fulfilling the core components of the right to health. Therefore, I set right to health as a normative reference for nurse workforce policy.

Countries may need to balance priorities when deciding how to distribute resources to fulfill all their human rights duties. The international human rights framework, along with the non-binding Declaration on the Right to Development and other treaties and frameworks, imparts guidance on the content of the right to health, and other human rights, and the actions required for fulfillment. The ICESCR directs States to include health as a component of their national development plans. Although ranking of rights is not found in the international human rights framework the "indivisible and interconnected " nature of rights is accepted. It follows that efforts toward the progressive fulfillment of one right, for example the right to health, often overlap with obligations to progressive realization of other rights, such as the right to development.

All human rights are fundamental and universal, but allocating resources requires that States set goals for achieving their human rights commitments. A State’s available resources influence the effort that is acceptable for progressive fulfillment. There are legal and pragmatic arguments to give high priority to the right to health in developing economies. Health is a desired outcome for everyone, and also underlies the ability to enjoy other rights, notably the right to development. Recent studies confirm that States that invest in health, and education, enjoy greater economic growth. The right to health is connected interdependently to the exercise of freedom rights as well as to other social and economic rights such as education and security. For example, child survival is a primary health indicator and child health care is included
in the core components of the right to health. Healthier children can attend school and achieve to their potentials, enjoying their right to education. Healthy children are more likely to survive to adulthood, graduate and become productive members of society who contribute to the economic growth of their communities. An educated productive workforce leads, ultimately, to greater development and stronger nations.\textsuperscript{67,69} In a cyclical arrangement, investment in health fosters economic development, which in turn can increase the ability of a society to invest in health.

Acknowledging that health contributes to the ability to enjoy other rights still does not tell us how much effort, possibly diminishing investment in fulfilling another right, is appropriate. Measurable targets are important to conceptualizing sufficient effort. Satisfying obligations and responsibilities to the right to health means that progress is being made toward fulfillment of the core components, employing targeted steps. The targeted steps to progressive fulfillment of the right to health need to be a part of a State's development plan. Although, in theory this may seem undefined, States are asked to set tangible goals and establish an assessable plan for progress toward realization of the right to health core components. Significantly international responsibilities toward progressive realization of the right to health core are also imposed under the ICESCR. Comment 14 clarifies that one criterion, to which there is accountability, is that unjustified regression on the provision of core components is unacceptable. This is the concept Paul Hunt termed "do no harm."\textsuperscript{250} When a State has difficulty progressively realizing its health goals it is advised to seek and allocate foreign assistance, and those with resources are advised to assist.\textsuperscript{247}

Health may be "fundamental" to the realization of other rights, but realizing the right to health encompasses more than health care. The UDHR definition of health includes well being, going beyond the absence of disease, and the ICESCR core components of the right to health in-
corporate social determinants along with health services. Therefore, not all resources allocated to realization of the right to health go toward improving health systems, in isolation. They may support core components such as clean water sources, health information, or community security, all reforms that evidence indicates will also encourage nurses to remain in a community. Any of these can contribute to progressive realization of other rights as well.

Setting right to health as a foundation for nurse workforce policy means that the impact of strategies, for example instituting curriculum changes in nursing programs, offering targeted scholarships to selected nursing students, adjusting criteria for admission to schools, or allocating foreign assistance, on the right to health is also considered. Significantly, the right to health extends notice to all States and other entities to assure that their health workforce policies and practices do not interfere with anyone's ability to enjoy his right to health, even if the effect is unintended. The Code echoes this guidance.\(^2\) This means that any State's nurse workforce policies, such as funding of nurse education scholarships, revising nurse practice regulation, or awarding of nurse workforce research funds, also consider the effects of those policies on the progressive realization of the right to health in underserved regions. Although international law does not give priority ranking to individual rights, it does prioritize the needs of the least advantaged.\(^{250,264}\) In critical shortage countries, where nurses supply most care, supporting development of the nurse workforce can be viewed as a component of progressive realization of the right to health, to which all carry responsibility.

b. **Integrate Formal and Informal Accountability Mechanisms.**

The non-binding Code of practice imparts policy direction that can operationalize the right to health with a specific focus. Human rights recognize shared principles that identify duty
bearers, and that convert citizens from consumers of services into holders of rights. Therefore, rights imply accountability. When implementation of the Code intersects right to health it can be argued that States, and others, should be held responsible for discharge of their obligations as a legal, not only a moral, duty. Recognition of nursing's position relative to obligations to the right to health implies access to the use of the accountability and enforcement mechanisms that international and domestic codifications allow. Examples of the use of formal and informal accountability procedures, presented in earlier chapters, were referenced analogously to the nursing workforce.

Obligations to the fulfillment of Social, Cultural and Economic rights, such as the right to health, are subject to progressive realization criteria, which confounds both accountability and its enforcement. Since available resources are the standard upon which compliance is evaluated, if States claim that limited resources impede their ability to fulfill right to health duties, it can slow progress toward realization. Progressive realization intends to make compliance reasonable and achievable, but it can also complicate the assessment of accountability to progress toward progressive realization goals, such as standards for an adequate nurse workforce.

The ICESCR provides guidance that ratifying States are expected to integrate into national policies. Comment 14 authoritatively explains that States always have immediate and universal duties to non-discrimination and to also take progressive, targeted steps toward fulfillment of core components of the right to health, while General Comment 3 delineates the duty to "minimum core components" under progressive realization. Targeted steps means that a State has a plan for progressive fulfillment of the core components that includes targets, such as the number of nurses or other skilled health professionals that can be measured as progress is assessed. It stipulates that States are expected to use every available resource to fulfill the minimum core of
basic primary health care.\textsuperscript{3,5,4,86} Nurses supply 90\% of basic health care worldwide, therefore an adequate cadre of nurses is essential to fulfilling this most elemental core component of the right to health. If, despite making every possible effort, resources still limit delivery of the minimum core of basic health care, States are advised to seek and use international assistance to meet this obligation. Comment 14 instructs well-resourced States to provide assistance to those struggling to supply the minimum core.\textsuperscript{3,247}

We saw that human rights gave a standard upon which source and destination Member States' health workforce interests coalesced during the drafting of the Code.\textsuperscript{199} Voluntary reports represent the Code's only accountability mechanism. Progressive realization leaves the exact nature and effort of the duty to right to health, vague, and possibly subject to the claim of no resources. In 2008, an ambitious study of global compliance with multiple right to health indicators, including the skilled health workforce, suggested that a major accountability indicator, which takes resources into account, is the evidence of planning and setting of measurable targets toward progressive fulfillment of the right to health.\textsuperscript{247} Along with other benchmarks, such as health system and health workforce metrics, compliance can be measured. If nurses are recognized as critical components of the right to health realization, metrics representing their distribution, such as staff ratios at rural dispensaries can be measured progressive realization targets.

Still, the conflicting and imprecise requirements of progressive fulfillment, reasonable as they may be, make strict appraisal of compliance difficult.

Required reports are the most commonly used assessments of the international human rights framework. At the national level, however, where the right is codified, courts may be accessed to enforce national laws. I discussed the uneven systemic effects of adjudications based upon the individual nature of the right to health, in Chapter 2. However, besides instances where
small numbers of individuals have gained access to expensive medications or therapies, there are examples of more broadly based interventions that impact groups of plaintiffs and implement aspects of the core components that involve the health workforce. Constitutional petition 16, which was discussed in Chapter 2, is one example of a case, though still unresolved, that cites the shortfall of nursing care as violating the right to health of all mothers in Uganda. 107

The European Court of Human Rights (ECHR) and the Inter-American Court have ruled in numerous right to health cases, often citing non-discrimination and imposing remedies that benefit groups of the disenfranchised. In one recent example, the ECHR imposed monitoring and report requirements on the government of Bulgaria (European Roma Rights Center v. Bulgaria, Collective Complaint 46/2007) to supply evidence they wereremedying discrimination in access to health services, suffered by the Roma population. Among other resources, they were required to document access to health workers. 61 In 2008 the Columbian Constitutional Court rendered a "landmark" judgment. It called for structural remedy of the entire health system and ruled that health personnel, as well as those affected, participate and accept responsibility for compliance.247,266,267 Recognizing the essential position nurses, and other health workers occupy with respect to achieving the required characteristics and progressively fulfilling the essential core components of the right to health, can give directions for remedy of human rights complaints.

It is unclear if critical shortage countries, suffering from resource limitations, can meet their right to health obligations without international support. Right to health accountability looks at what a State is doing, what effort it is putting forth, and whether the effort is equitably applied to all citizens. Broadly this encompasses the duty to non-discrimination in the progressive realization, commensurate with resources, of the core components and essential character of
the right to health. As argued in Chapter 3, nurses operationalize non discriminatory basic health care when their availability keeps clinics open and assessable for the poor and disenfranchised. Therefore they can be viewed as essential to compliance with the obligation to progressive fulfillment of the right to health.

Consequently, my argument that connects the nurse workforce to realization of the right to health supports the judgment that the responsibility to supply nurses, and to never interfere with the development of the nurse workforce in critical shortage areas, extends beyond the State health system. Interfering with these human rights obligations, even if the effect is not intended, can be subject, in theory, to the same accountability and enforcement mechanisms, such as adjudication, reparations and remediation, which have been accessed to correct other human rights abuses, including those that impact health. 100

c. Use Incentives to Improve Health Systems for the Most Needy

Incentives can change the balance of push and pull factors. 270 IEN interview evidence and prior nurse migration research show that nurses who graduate from training in under resourced countries do not see working in poor rural health centers, where the right to health is most in jeopardy, as professionally rewarding. They report poor resource allocation, barriers to full practice, the absence of advancement potential, and insecure living and working conditions. IEN responses are recorded in more detail in Chapter 5 and Appendix E. Some of the push factors including unfair pay scales or not being paid at all, outdated, poorly maintained equipment, inadequate supplies of medications, frustrating care situations, lack of career advancement opportunity and unsafe living and working conditions appear to be correctable if resources are made available.233,271
In small studies incentives show promise as tools for retention of skilled health workers in the most underserved regions. Physician workforce research indicates that relatively modest financial incentives, such as the promise of promotion to a higher salary grade, or school subsidy, can encourage service in rural areas after training. Other studies, which included nurses in Mozambique and Tanzania, showed that providing housing, regular ongoing professional training, access to early promotions, scholarships for family members, upgrading of health facilities and adequate supplies can all increase the likelihood a nurse will decide to accept a position working with the underserved and remain there. In a 2009 report from the Center for International Development, health system retention and performance in rural areas of Kenya, Rwanda, Uganda and Brazil were improved when nurses and other health workers were rewarded with financial or promotion performance based incentives. As mentioned earlier, there can be tension when States have many needs and limited resources about which programs to finance. Foreign aid and coordination of donor agency, volunteer and NGO efforts have funded most of the efforts referred to above. This is an example of using foreign assistance to progressively realize the right to health in poor communities by using incentives to increase the nurse workforce.

Along with the known push factor of difficult working conditions, nurses in the interview sample voiced the desire for further education as a migration motivator. Simply making educational opportunities, including access to mentors, available holds the potential for increasing satisfaction and retention of nurses. The US funded Global Health Workforce Partnerships is utilizing this model in a program that began in summer 2013 in East Africa. Experienced nursing mentors are partnered with students and nurse faculty members in rural and urban health centers. They provide formal education for students as well as mentoring for nurse faculty. Nurse volun-
teers serve for 1 or 2 year deployments. Measured outcomes are not yet available for this program but anecdotal reports have shown positive short term results. 38,222

Higher education is not available to nurses in most developing countries. Approaches such as pre-conditioned scholarships for advanced study in OECD countries, 273 easing return migration after completion of education, as the Code directs, and State subsidy of education with return work contracts can allow source countries to benefit from the education nurses pursue abroad. 244 To be an incentive to return or circular migration, higher education needs to prepare nurses for the work that is both needed, and possible to pursue, in source countries. Anna, for example, has earned her terminal degree but does not see a venue for her research in her home country. Her source country is a middle-income, not a critical shortage one, but still one in great need of nurse educators and researchers.

“ I graduated at the top of my class...hospital nursing is not a respected profession. My professors encouraged me to pursue a master’s degree and I enrolled in the program at my university. I did well in my research program and my professors pushed me to look into doctoral education. There were no PhD programs for nurses so I applied to several in Europe and the US. I was accepted into the program in Penn... and graduated with my PhD. When I first came I thought I was here for my education but after graduation I wanted to further my academic career in a way that would not be possible at home so I accepted a faculty position at a university. I feel this is where I belong." (Anna’s sister is also a nurse and is studying in the US.) Anna Y., Georgia

Wealthy destination countries' conduct might also be influenced by incentives. The Code does not suggest these, but providing benefits such as preferential access to natural resources or emerging market investment, eased visa restrictions, relaxation of import duties and granting leadership positions in global health governance bodies could influence their policy decisions. Incentives could motivate them to favor implementing the Code's objectives and fulfill the responsibilities cited in Comment 14 with regard to assistance for developing health systems, as a matter of their own self interest. Incentives have been shown to influence behavior of individuals and groups at all levels. 270,274
d. Match the Nurse Workforce to Health System Needs.

Nurses in the interview sample expressed frustration because they were not able to use the skills and knowledge they had acquired in their training programs. A contributing factor to lack of access to nursing care is that nurses' skills are under utilized. We saw that Anna did not feel she could succeed as a nurse researcher in her home country. Charity, the nurse interviewee who migrated from Jamaica to the US, cited the lack of routine monitoring equipment she had been trained to use with her cardiac patients, and Joseph found that in Kenya he could not work in the specialty area of his expertise. Ani related that her current role as an advanced practice nurse (APRN) specializing in critical care and women’s health would not be recognized, should she return, in her home country. Her skill and expertise would be desperately needed, but under utilized.

"We don't have APRNs. I would work as a general nurse. Here I can order medications for my patients and consult with the gynecologist if I need to. There I would not be allowed to make decisions I have been trained to make here...and I would not get any extra pay. Only physicians make decisions about treating patients and they tell nurses what to do and they are often not around anyway." **Ani, Nigeria**

Practice limitations add to job dissatisfaction for nurses, and result in skill and knowledge waste. Using resources, such as additional training, ongoing education, or matching nursing responsibility and skills to community needs can be steps toward progressive realization. Barriers to nurses practicing at their full skill and knowledge capability can be frustrating in developed, as well as, fragile health systems. However, in critical shortage countries obstacles to full nursing practice can impact more than health system efficiency or job satisfaction. They can jeopardize the right to health. In Kenya, for example, there are many unemployed nurses against a backdrop of rural health dispensaries that are not functioning because of the lack of skilled health professional staff.
Nurses educated in urban centers of developing health systems, or nurses who travel abroad for their educations, may not gain exposure to the knowledge and skills needed for practice in rural, underserved areas. All of the interviewed IENs graduated from programs based in urban centers in their source countries. These facilities are usually the best supplied, with both capital resources, such as cardiac monitors, medications and diagnostic materials, and with human resources, such as physician specialists and experienced nurses. When a student nurse graduates she may have only developed the expertise to work when these resources are available. Including mentored clinical experiences in rural health centers has been shown to encourage graduate nurses to function more comfortably, and to feel professionally fulfilled, in less well-resourced settings. Education reform policy interventions that have been tried or suggested to improve student skills and motivation to serve in the most needy areas include; pre conditioned service scholarships, involving members of the neediest communities in student selection, prioritizing student selection from poor communities, and adding clinical training that includes exposure to rural health, and the development of the skills needed there, as learning objectives.

All these hold the promise of developing a nursing workforce with the skills underserved communities need.

Regulatory reform can also contribute to the steps toward realization of the right to health. Over regulation can be a barrier to full practice that interferes with matching nursing skills to needs. In Kenya, for example, by law, even highly trained nurses cannot be the only clinical staff at a health dispensary without a physician present, until they have ten years of experience. Since there are not enough physicians to keep nurse staffed clinics open, this regulation leaves many in rural areas without access to basic care. Regulations often reflect idealized conditions, the policy maker's vision of how things ought to be. We saw that the perception of
practice limitations discouraged return migration among the sample IENs. One area of education reform that the treaty bodies include as a progressive realization responsibility, is that health workers, including nurses, have access to appropriate knowledge "including education on the topic of health and human rights". When nurses understand the legal responsibilities of States and others to human rights they can be better prepared to act as advocates in dialogue with policy makers.

No nurse in the interview sample mentioned any continuing or special education in rural health. There is survey evidence that shows that providing on going training in the skills and knowledge needed to function in underserved rural settings, then removing the barriers to fully practicing those skills, would counter the frustration and dissatisfaction that drives nurses from remaining in positions where the need is greatest. By way of example, a nurse who runs a dispensary in a remote village needs to be able to rapidly intervene if a parturient experiences hemorrhage. This is an aspect of essential maternity services to which all have a right. Student nurses at the urban training center are likely only taught to notify a specialist, physician or midwife, and then administer the medications they order. Education and regulatory interventions that match the training and skills of nurses to the needs of under resourced communities reflect the Code's guidance to always consider the effects of health policy on the right to health of the underserved. The international human rights framework sets this priority.

e. Share Responsibility for Resources and Research

The reality is that for many even basic health care is not available, because there are not enough skilled health workers, principally nurses, and resources limit the ability of poor countries to correct the deficiency. Using incentives to redistribute domestic skilled health workers, or
developing and facilitating the use of the needed skill set to deliver the core components of the right to health, may not be enough to correct existing shortages without foreign assistance.

Comment 14 instructs under resourced States that cannot immediately fulfill the right to health on their own using available resources, including seeking foreign assistance, to demonstrate progress toward full realization. Wealthy States are responsible to formulate policies that share resources to assist the underserved. Assistance can take many forms but it should always prioritize progressive realization of the core components of the right to health, when they are not being met. Aid can be monetary, such as health system directed support, or payment of compensation for benefits accrued when nurses migrate, or technical, such as grant funding that meets the need for research assistance to gather the data to achieve the Code reporting standard, or service, such as subsidizing teams of health providers to mentor nursing students and increase training capability. Although the Code directs the wealthy to provide financial and technical assistance it does not offer incentives for their compliance and does not contain any enforcement mechanism for non-compliance. Since States are the primary duty bearer for human rights realization, and progressive realization qualifies the effort required, it is difficult, or impossible, to judge when foreign entities do not meet their responsibilities to assist.

While enforcing accountability for the responsibility to assist is weak under international law, wealthy states can be influenced to collaborate in solutions as a matter of self-interest. Gostin gives the example of the need to globally control infectious disease as a potential motivator for the wealthy to invest in the human health resources of poor countries. Poor nations might have other incentives to offer to encourage assistance and resource sharing. For example, relaxed visa entry requirements for citizen nationals, such as the US-Rwanda arrangement, or removal of import duty fees for donated medical supplies, could encourage both nations and health pro-
professionals to engage in activities that support health education and services in poor countries. There are other possible business related incentives, such as preferential access to investment opportunity in emerging markets that could encourage reciprocal contributions to the right to health. Linking investment or other incentives to the progressive realization of the right to health is underexplored.

The Code suggests encouraging circular or return migration of health professionals, as a way that source countries can share in the knowledge and skills acquired by nurses who migrate. This sounds like an uncontroversial intervention that has the potential for positive effects on fragile health systems. Logistics can be daunting, since accomplishing it requires navigating complex, international visa and professional licensure issues, most of which were unavailable or unevaluated in the first Code report document. Legal issues are important to nurses who migrate. They were mentioned by all IENs when asked about their migration experience, and if they ever planned to return to work as nurses in their source countries. Four of the IENs stated that they viewed the complex visa regulations in source and destination countries as barriers to return migration. In one example a nurse returned to South Africa after completing her degree in the US. She cited legal issues that stemmed from the change in politics in South Africa as a determining factor that eventually allowed her productive return. Another IEN had joined the US Army reserves to hasten his route to US citizenship, which he felt would ease any visa impediments to return to the US, after service in his home country. Christian, who expressed a desire to train nurses in his home country of Cameroun, described his complicated visa situation.

"I am now on a student visa while studying for my degree. As a nurse I asked the hospital (where he trains) to sponsor me for a green card. Once I get it (permanent residency status) I will be able to travel to Cameroun and return, but there are still restrictions and I am afraid of not getting back to the US. I will apply for US citizenship as soon as possible." Christian, Cameroun
If personnel, skills and knowledge are to be shared for the benefit of the underserved, legal barriers need to be identified, clarified and amended to optimize their ability to facilitate, not impede, the movement of nurses. These reforms involve collaborative efforts from both source and destination countries. Legal data, such as nurse recruitment regulation, visa preferences or restrictions, and service contracts, among other laws that impact the global health worker marketplace, were cited as a primary missing pieces of evidence in the WHO's first Code report. When professional regulation or migration laws are amended their effect on right to health of citizens in source countries should be considered.

One of the criteria suggested for the evaluation of the actions and effort taken toward progressive realization is the setting of targets and gathering of assessment data. By making the shortage and unbalanced distribution of skilled health workers a global issue, the Code lays the groundwork for developing health workforce partnerships in research endeavors. Available information can guide setting of targets for the health workforce. The WHO designates a critical minimum of skilled health personnel to be 23 per 10,000, and we know that nurses comprise about 80-90% of health workers in developing health systems, therefore, a measurable target for the nurse workforce is to assure a distribution of about 20 nurses for every 10,000 citizens.

The concentration of nurses is a process measure that can be quantified and evaluated. It is a relevant marker for progressive realization compliance if the role I argued for nurses in realization of the right to health, and progressive realization of its core components, is accepted. Data collection concerning the nurse workforce is a suitable topic for interdisciplinary research and international collaboration. To assess progress for the care of the underserved, the data needs to be disaggregated, so that the impact of policy is not only reflected as a national average, but for its effect on equitable progressive realization of the right to health core in underserved regions.
The pressing needs of the poorest States make it unlikely they can allocate their scarce resources to data collection, and simultaneously meet progressive realization duties to the core components. International public private partnerships have successfully gathered nurse workforce data in developing health systems. Their methods can be replicated.\textsuperscript{41,232}

The Code's reporting structure directs regular submissions using a standardized tool and research guide for evaluation of workforce capacity, Code implementation and its policy impact.\textsuperscript{96} The development of a shared data repository holds potential for identifying both problems and best practices. Sharing standardized reports and research data, can give policy an evidence base. The WHO Code report recognized that national submissions did not generally contain input from the community of interest and this was identified as a generalized Code implementation shortfall. However, several countries, notably The Netherlands and Thailand, submitted 2013 reports to the WHO that demonstrated Code implementation through a sharing of efforts between the State authority, private enterprise, and individuals.\textsuperscript{227} These supply a rich opportunity for case based research that can identify and apply best practices that can be replicated.

Evaluation of nurse resource sharing projects, such as the Global Health Workforce Partnerships, mentioned previously and in the first US Code report,\textsuperscript{212} can identify the strengths and weaknesses of the program. All national partners to the nurse mentoring exchanges, need to be involved in assessment to share outcomes and perceptions of the program's effects. Integrating realization of the right of health into outcome assessment acknowledges the link between nurses and the right.

Setting target benchmarks is a component of progressive realization compliance.\textsuperscript{247} Lack of data is cited as an impediment to nurse policy development.\textsuperscript{227,280}  Accurate up to date information about the nursing workforce is limited, even in many wealthy countries, and very limited
or non existent in most poor countries. Projects to assess the current state of the nursing workforce, and to evaluate factors that lead to greater professional satisfaction, offer ideal partnership opportunities to share resources, and for nurses from source and destination countries to work together. A latent effect of doing research together to coordinate gathering nursing workforce data, is the experience developing researchers can gain by working with senior researcher mentors. A recent review examined the barriers to the use of evidence by policy makers. Among the major factors was the lack of integration of the researchers themselves into the policy making process. Nurse researchers can contribute to nurse workforce policy if they share and interpret results in dialogue with policy makers, as well as in discipline specific venues.

The Code makes the global shortage of skilled health personnel a global issue. Wealthy and developing countries share responsibility for the progressive realization of the right to health core components under international human rights law. Paul Hunt called for integration of health professionals into the development of right to health based policy.91

The International human rights framework ascribes the responsibility to assist the underserved to progressively realize the right to health when core components are unachieved. The Code calls for financial and technical assistance specifically focused at alleviating the effects of the global health worker crisis. Therefore, the link between wealthy and developing health systems involves a sharing of resources, and also the research knowledge needed to collect the data on which to base policy.
<table>
<thead>
<tr>
<th>What nurse workforce policy should do</th>
<th>Example interventions</th>
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</table>
| 1. Integrate the right to health      | ~Consider the effects on the right to health of any policy initiative.  
~Prioritize critical shortage areas for human resources for health development.  
~Recognize nurses for their essential role in progressive realization of the right to health in health policy.  
~All States consider the effects of their nurse workforce policy on the right to health in poor countries.  
~Set the WHO minimum health worker ratio as a target measure. |
| 2. Use Enforcement and accountability | ~Promulgate right to health legislation that applies specifically to the nurse workforce. (e.g. target staffing numbers, goals for meeting targets, pubic reporting of nurse workforce data)  
~Use domestic and international courts.  
~Use transparent reporting strategies.  
~Integrate the community of interest and make them aware of their responsibility to right to health.  
~Develop compensation agreements between States or other entities. (e.g. NGOs) |
| 3. Use incentives                     | ~Offer targeted pre conditioned scholarships to nursing students.  
~Provide mentored education and training for serving the underserved.  
~Provide housing supplements, early promotions, bonus pay, etc. to those working in critical shortage areas.  
~Offer incentives to wealthy countries for developing policies that contribute to the nurse workforce in critical shortage areas. (e.g. Award leadership positions in global health bodies for compliance, preferential resource contracts, visa preference, etc.) |
| 4. Match skills to needs              | ~Ask underserved communities to refer nursing students, and prioritize them for scholarships.  
~Integrate the skills needed for rural health into the learning objectives all nursing programs.  
~Remove regulatory barriers to full practice.  
~Make knowledge about health and human rights available to all health workers. |
| 5. Share responsibility for resources and research | ~Wealthy States accept their responsibility under right to health to provide assistance.  
~Deploy nurses from wealthy countries or subsidize nurses to serve in areas where the right to health is jeopardized  
~Redesign visa regulations to facilitate return/circular migration and sharing of the human resources for health.  
~Develop public/private research partnerships.  
~Support nurse mentors to serve in critical shortage areas  
~Supply technical assistance with data gathering and interpretation.  
~Involve nurses in integration of evidence into policy formation. |
"It must be asked who in the healthcare system will protect the vulnerable and what knowledge and resources are needed for that protection. If not nurses, then whom?"

Ann Pierce, health ethicist 2013.

Conclusion

This work presents policy recommendations based upon an integrated analysis of a recent global health practice code, applied to the nursing profession. I began asking if the Code could serve as a foundation for global nurse workforce policy that realizes the right to health. I conclude, "it depends". It depends how it is implemented and disseminated. It depends upon how it evolves in response to evidence. And it depends on how accountability to the link between nurses and the right to health is recognized, applied and enforced. To construct nurse workforce policy that realizes the right to health requires collaboration among, not only Member States, but also the communities of interest, including nurses themselves. At this early stage, implementation progress on the Code's objectives has been modest, and has not successfully included most nurses or many members the communities of interest.

The unanimous Member State approval of the Code, its global scope, universal human rights nucleus, and its visibility among health policy makers, give it great potential as a useful global governance policy tool. Its guiding principles operationalize the international human rights framework with reference to the global health worker crisis. The Code strategically links nurses, as members of the skilled health workforce, to realization of the right to health. Employing it as a policy scaffold applies human rights principles to the nurse workforce. Although the Code's objectives explicitly call forth the ICESCR defined right to health as a core goal, it does not contain any reference to accountability or enforcement of responsibility for its progressive realization. Right to health, however, does offer pre-existing accountability routes. Although cur-
rently under utilized with respect to the health workforce, these hold potential for monitoring of progress of the nurse workforce component of progressive realization of the right to health.

The Code has brought global governance attention to the worldwide shortage and unequal distribution of skilled health workers. It provides a framework for wide ranging cooperation to support development of the nurse workforce. It offers broad guidance that recognizes the link between wealthy and developing systems on issues surrounding the health worker shortage and health system development. Conflict resolution, enforcement and accountability can be reconciled using international human rights governance guidance.

Even without a prescribed enforcement mechanism, the Code does lay out a broad scaffold for collaborative health workforce policy. It is common in international governance instruments to omit accountability stipulations, and to leave enforcement to domestic codification. The Code reporting structure gives form to public monitoring that can generate responses both domestically and internationally. It will need better visibility among the communities of interest, including within the nursing profession, so that its strengths can be harnessed to develop the role of nurses in realization of the right to health, and guide policy solutions to the global health worker crisis.

Rwanda's Minister Binagwaho states that no health policy can do everything at once, especially when there are resource limitations. It is important, she says, to make progress, to include everyone, "leave no one out" when striving to realize the lofty goal of the UDHR and the ICESCR to guarantee everyone the right to the "highest attainable standard of... health and well being..." Code implementation, along with established human rights governance frameworks provides the scaffold upon which nurse policy can contribute to progressive fulfillment of the right to health.
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### Appendix A: Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>AACN</td>
<td>American Academy of Colleges of Nursing</td>
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<td>AAN</td>
<td>American Academy of Nursing</td>
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<tr>
<td>ANA</td>
<td>American Nurses Association</td>
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<tr>
<td>APRN</td>
<td>Advanced Practice Registered Nurse</td>
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<td>BMJ</td>
<td>British Medical Journal</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<tr>
<td>CERD</td>
<td>Committee on the Elimination of Racial Discrimination</td>
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<tr>
<td>CESCR</td>
<td>Committee on Economic, Social and Cultural Rights</td>
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<tr>
<td>CGFNS</td>
<td>Council on Graduates of Foreign Nursing Schools</td>
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<tr>
<td>Code/WHO Code</td>
<td>WHO Global Code of Practice on the International Recruitment of Health Personnel</td>
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<tr>
<td>COMMAT</td>
<td>Commonwealth Medical Trust</td>
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<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<tr>
<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<tr>
<td>Area falling below the WHO designated 23 health workers per 10,000 population</td>
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<tr>
<td>ECHR</td>
<td>European Court of Human Rights</td>
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<tr>
<td>FHCI</td>
<td>Free HealthCare Initiative (Sierra Leone)</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GHSP</td>
<td>Global Health Service Partnership</td>
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<tr>
<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<tr>
<td>GNP</td>
<td>Gross National Product</td>
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<tr>
<td>HHS/DHHS</td>
<td>US Department of Health and Human Services</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>ICESCR</td>
<td>International Convention on Economic, Social and Cultural Rights</td>
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<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant of Civil and Political Rights</td>
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<tr>
<td>IEN</td>
<td>Internationally Educated Nurse</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>International Human Rights Framework</td>
<td>ICCPR, ICESCR and UDHR</td>
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<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>HHS</td>
<td>Health and Human Services</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>HRSA</td>
<td>Health Resource and Service Administration</td>
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<tr>
<td>Term</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>Kampala</td>
<td>Kampala Declaration and Agenda for Global Action</td>
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<td>LMIC</td>
<td>Low and Middle Income Countries</td>
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<tr>
<td>LON</td>
<td>League of Nations</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MDR-TB</td>
<td>Multi Drug Resistant Tuberculosis</td>
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<tr>
<td>MSF</td>
<td>Medecins Sans Frontiers (Doctors Without Borders)</td>
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<tr>
<td>NAFTA</td>
<td>North American Free Trade Agreement</td>
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<tr>
<td>NCSBN</td>
<td>National Council of State Boards of Nursing</td>
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<tr>
<td>NCLEX</td>
<td>National Council Licensure Exam</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>NHS</td>
<td>National Health Service (of UK)</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>OHCHR</td>
<td>UN Office of the High Commission on Human Rights</td>
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<tr>
<td>PEPFAR</td>
<td>US President's Emergency Fund for Aids Relief</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group of WHO</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Childrens' Emergency Fund</td>
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<tr>
<td>UDHR</td>
<td>United Nations Declaration of Human Rights</td>
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<tr>
<td>WAHO</td>
<td>West African Health Organizations</td>
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<tr>
<td>US/USA</td>
<td>United States</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WHA</td>
<td>World Health Assembly</td>
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<tr>
<td>WHPA</td>
<td>World Health Professions Association (includes ICN)</td>
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</table>
Appendix B. IRB Approval and Unsigned Consent

NOTIFICATION OF IRB ACTION

Date: March 14, 2012  
IRB #: 12-02-40

Principal Investigator(s): Patricia Illingworth  
Janet A. Dewan

Department: Law and Public Policy  
College of Social Sciences and Humanities

Address: 371 Holmes Hall  
Northeastern University

Title of Project: Realizing Rights: WHO Global Code of Practice on the  
International Recruitment of Health Personnel: Cosmopolitan  
and Utilitarian Analysis with Nurses' Perspectives

Participating Sites: N/A

DHHS Review Category: Expedited #6, #7

Informed Consents: One (1) unsigned consent form

As per CFR 45.617(c)(2) Signed consent is being waived as the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required.

Monitoring Interval: 12 months

APPROVAL EXPIRATION DATE: MARCH 13, 2013

Investigator's Responsibilities:

1. The informed consent form bearing the IRB approval stamp must be used when recruiting participants into the study.
2. The investigator must notify IRB immediately of unexpected adverse reactions, or new information that may alter our perception of the benefit-risk ratio.
3. Study procedures and files are subject to audit any time.
4. Any modifications of the protocol or the informed consent as the study progresses must be reviewed and approved by this committee prior to being instituted.
5. Continuing Review Approval for the proposal should be requested at least one month prior to the expiration date above.
6. This approval applies to the protection of human subjects only. It does not apply to any other university approvals that may be necessary.

C. Randall Colvin, Ph.D., Chair  
Northeastern University Institutional Review Board

Nan C. Regina, Director  
Human Subject Research Protection

Northeastern University FWA #4630
If a surrogate is used to help recruit subjects for interviews they will say the following to prospective participants.

"Janet Dewan, a member of the Northeastern University nursing faculty and doctoral candidate in the Law and Public Policy program at Northeastern University is conducting research into the perceived experiences of nurses who have migrated from their native countries. Nurses who agree to participate will be interviewed. If you would be willing to consider participation in this research please contact the investigator, Janet Dewan MS CRNA at j.dewan@neu.edu or 617-373-3126.

Thank you
Northeastern University, Department: Law and Public Policy
Investigator Name: Janet A. Dewan MS CRNA, Doctoral Candidate; Advisor: Patricia Illingworth PhD JD
Title of Project: Realizing Rights: WHO Global Code of Practice on the International Recruitment of Health Personnel: Cosmopolitan and Utilitarian Analysis with Nurses’ Narrative Perspectives

Request to Participate in Research
You are being asked to participate in this research project because you are a nurse who has migrated from the country in which you received your basic nursing education. About 10 nurses are being asked to contribute to this research by describing their migration experiences and attitudes. This research is undertaken as part of completion of a doctoral degree in Law and Public Policy.

The purpose of this research project is to look at the factors that influence the migration of nurses and to explore ethical and human rights concerns that arise due to their migration. The experiences of nurses who have emigrated may be useful in understanding migration of nurses and its effects on the health care system or may lay a foundation for policy suggestions.

If you decide to participate the investigator will ask you some basic questions about yourself and your nursing and migration experiences. You will be asked to describe your experiences in your own words. The investigator will record your responses for transcription and analysis purposes only.

The interview will take approximately one hour and you will be asked to meet with the investigator at a time and place that you agree upon and that is convenient for you. As an alternative, if meeting face to face is difficult or inconvenient, the interview may be conducted over the telephone, at a time you and the investigator agree upon.

The possible risks or discomforts of the study are minimal. There is a small chance that you could experience discomfort when discussing prior events. If so, you may refuse to answer any question and the interview can be stopped at any time.

There are no direct benefits to you for participating in the study. However, your answers may provide us with insight into the migration experiences of foreign educated health care professionals.

Your part in this study will be confidential. Only the researcher on this study will see the information about you. No reports or publications will use information that can identify you in any way. Use of your responses in the research will be anonymous. All identifying information about you will be redacted. For examples name, age and country of origin will not be included as recorded. Each participant will be assigned a number and the interview transcripts will be securely stored without names attached. All interviews will be recorded and transcribed by the investigator. She will be the only person to know your identity. Transcripts will be securely stored by the investigator and destroyed at the completion of the study.

Your participation in this research is completely voluntary. You do not have to participate if you do not want to. Even if you begin the study, you may quit at any time. If you do not participate or if you decide to quit, you will not lose any rights, benefits, or services that you would otherwise have. You may also ask the investigator to eliminate or redact portions of your interview at any time.

You will not receive any pay for your participation and there are no anticipated costs to participation.

If you have any questions or concerns at any time before or after participation please contact the investigator, Janet Dewan MS CRNA (617-373-3126, j.dewan@neu.edu) or the dissertation advisor Patricia Illingworth PhD JD (p.illingworth@neu.edu).

If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4888, Email: irb@neu.edu. You may call anonymously if you wish.

You may keep this form for yourself.

Thank you, Janet Dewan MS CRNA.
Appendix C: WHO Global Code of Practice on the International Recruitment of Health Personnel

Preamble
The Member States of the World Health Organization,
Recalling resolution WHA57.19 in which the World Health Assembly requested the Director-General to develop a voluntary code of practice on the international recruitment of health personnel in consultation with all relevant partners;
Responding to the calls of the Kampala Declaration adopted at the First Global Forum on Human Resources for Health (Kampala, 2–7 March 2008) and the G8 communiqués of 2008 and 2009 encouraging WHO to accelerate the development and adoption of a code of practice;
Conscious of the global shortage of health personnel and recognizing that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services;
Deeply concerned that the severe shortage of health personnel, including highly educated and trained health personnel, in many Member States, constitutes a major threat to the performance of health systems and undermines the ability of these countries to achieve the Millennium Development Goals and other internationally agreed development goals;
Stressing that the WHO Global Code of Practice on the International Recruitment of Health Personnel be a core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening,
THEREFORE
The Member States hereby agree on the following articles which are recommended as a basis for action.

Article 1 – Objectives
The objectives of this Code are:
(1) to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel;
(2) to serve as a reference for Member States in establishing or improving the legal and institutional framework required for the international recruitment of health personnel;
(3) to provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments;
(4) to facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries.

WHO Global Code of Practice on the International Recruitment of Health Personnel

Article 2 – Nature and scope
2.1 The Code is voluntary. Member States and other stakeholders are strongly encouraged to use the Code.
2.2 The Code is global in scope and is intended as a guide for Member States, working together with stakeholders such as health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel.
2.3 The Code provides ethical principles applicable to the international recruitment of health personnel in a manner that strengthens the health systems of developing countries, countries with economies in transition and small island states.
Article 3 – Guiding principles

3.1 The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. Member States should take the Code into account when developing their national health policies and cooperating with each other, as appropriate.

3.2 Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed. However, the setting of voluntary international principles and the coordination of national policies on international health personnel recruitment are desirable in order to advance frameworks to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel.

3.3 The specific needs and special circumstances of countries, especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of this Code, should be considered. Developed countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development.

3.4 Member States should take into account the right to the highest attainable standard of health of the populations of source countries, individual rights of health personnel to leave any country in accordance with applicable laws, in order to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries. However, nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them.

3.5 International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing countries. Member States, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labour practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without unlawful distinction of any kind.

WHO Global Code of Practice on the International Recruitment of Health Personnel

3.6 Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce should be appropriate for the specific conditions of each country and should be integrated within national development programmes.

3.7 Effective gathering of national and international data, research and sharing of information on international recruitment of health personnel are needed to achieve the objectives of this Code.

3.8 Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries.

Article 4 – Responsibilities, rights and recruitment practices

4.1 Health personnel, health professional organizations, professional councils and recruiters should seek to cooperate fully with regulators, national and local authorities in the interests of patients, health systems, and of society in general.

4.2 Recruiters and employers should, to the extent possible, be aware of and consider the outstanding legal responsibility of health personnel to the health system of their own country such as a fair and reasonable contract of service and not seek to recruit them. Health personnel should be open
and transparent about any contractual obligations they may have. 
4.3 Member States and other stakeholders should recognize that ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions. 
4.4 Member States should, to the extent possible under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered. 
4.5 Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work. 
4.6 Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country. 
WHO Global Code of Practice on the International Recruitment of Health Personnel

4.7 Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis.

Article 5 – Health workforce development and health systems sustainability

5.1 In accordance with the guiding principle as stated in Article 3 of this Code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.

5.2 Member States should use this Code as a guide when entering into bilateral, and/or regional and/or multilateral arrangements, to promote international cooperation and coordination on international recruitment of health personnel. Such arrangements should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures. Such measures may include the provision of effective and appropriate technical assistance, support for health personnel retention, social and professional recognition of health personnel, support for training in source countries that is appropriate for the disease profile of such countries, twinning of health facilities, support for capacity building in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent.

5.3 Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country. 
5.4 As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific
conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible.

5.5 Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. Member States should undertake steps to ensure that appropriate training takes place in the public and private sectors.

5.6 Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population’s health needs. Member States should adopt a multisectoral approach to addressing these issues in national health and development policies.

5.7 Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas, such as through the application of education measures, financial incentives, regulatory measures, social and professional support.

WHO Global Code of Practice on the International Recruitment of Health Personnel

5

Article 6 – Data gathering and research

6.1 Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base.

6.2 Taking into account characteristics of national health systems, Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration, and its impact on health systems. Member States are encouraged to collect, analyse and translate data into effective health workforce policies and planning.

6.3 Member States are encouraged to establish or strengthen research programmes in the field of health personnel migration and coordinate such research programmes through partnerships at the national, subnational, regional and international levels.

6.4 WHO, in collaboration with relevant international organizations and Member States, is encouraged to ensure, as much as possible, that comparable and reliable data are generated and collected pursuant to paragraphs 6.2 and 6.3 for ongoing monitoring, analysis and policy formulation.

Article 7 – Information exchange

7.1 Member States are encouraged to, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and subregional, regional and international organizations, whether governmental or nongovernmental.

7.2 In order to promote and facilitate the exchange of information that is relevant to this Code, each Member State should, to the extent possible:
(a) progressively establish and maintain an updated database of laws and regulations related to health personnel recruitment and migration and, as appropriate, information about their implementation;
(b) progressively establish and maintain updated data from health personnel information systems in accordance with Article 6.2; and
(c) provide data collected pursuant to subparagraphs (a) and (b) above to the WHO Secretariat every three years, beginning with an initial data report within two years after the adoption of the Code by the Health Assembly.

7.3 For purposes of international communication, each Member State should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code. Member States so designating such an authority, should inform WHO. The designated national authority should be authorized to communicate directly
or, as provided by national law or regulations, with designated national authorities of other Member States and with the WHO Secretariat and other regional and international organizations concerned, and to submit reports and other information to the WHO Secretariat pursuant to subparagraph 7.2(c) and Article 9.1.

WHO Global Code of Practice on the International Recruitment of Health Personnel

6

7.4 A register of designated national authorities pursuant to paragraph 7.3 above shall be established, maintained and published by WHO.

Article 8 – Implementation of the Code

8.1 Member States are encouraged to publicize and implement the Code in collaboration with all stakeholders as stipulated in Article 2.2, in accordance with national and subnational responsibilities.

8.2 Member States are encouraged to incorporate the Code into applicable laws and policies.

8.3 Member States are encouraged to consult, as appropriate, with all stakeholders as stipulated in Article 2.2 in decision-making processes and involve them in other activities related to the international recruitment of health personnel.

8.4 All stakeholders referred to in Article 2.2 should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code. Recruiters and employers should cooperate fully in the observance of the Code and promote the guiding principles expressed by the Code, irrespective of a Member State’s ability to implement the Code.

8.5 Member States should, to the extent possible, and according to legal responsibilities, working with relevant stakeholders, maintain a record, updated at regular intervals, of all recruiters authorized by competent authorities to operate within their jurisdiction.

8.6 Member States should, to the extent possible, encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code.

8.7 Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel, and assess the scope and impact of circular migration.

Article 9 – Monitoring and institutional arrangements

9.1 Member States should periodically report the measures taken, results achieved, difficulties encountered and lessons learnt into a single report in conjunction with the provisions of Article 7.2(c).

9.2 The Director-General shall keep under review the implementation of this Code, on the basis of periodic reports received from designated national authorities pursuant to Articles 7.3 and 9.1 and other competent sources, and periodically report to the World Health Assembly on the effectiveness of the Code in achieving its stated objectives and suggestions for its improvement. This report would be submitted in conjunction with Article 7.2(c).

9.3 The Director-General shall:

(a) support the information exchange system and the network of designated national authorities specified in Article 7;

(b) develop guidelines and make recommendations on practices and procedures and such joint programmes and measures as specified by the Code; and

(c) maintain liaison with the United Nations, the International Labour Organization, the International Organization for Migration, and other competent regional and international organizations as well as concerned nongovernmental organizations to support implementation of the Code.

9.4 WHO Secretariat may consider reports from stakeholders as stipulated in Article 2.2 on activities related to the implementation of the Code.

9.5 The World Health Assembly should periodically review the relevance and effectiveness of the
Article 10 – Partnerships, technical collaboration and financial support

10.1 Member States and other stakeholders should cooperate directly or through competent international bodies to strengthen their capacity to implement the objectives of the Code.

10.2 International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organizations and other entities should be encouraged to cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development.

10.3 Member States either on their own or via their engagement with national and regional organizations, donor organizations and other relevant bodies should be encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition, aiming at strengthening health systems capacity, including health personnel development in those countries.

==
Appendix D. Interview Data Sheet

Number: __________________________

Interview data sheet

Realizing Rights: WHO Global Code of Practice on the International Recruitment of Health Personnel: Analysis with Nurses' perspectives

*Name ______________________________
*Date ______________________________
*Contact information __________________
* This information will be stored separately from question responses and destroyed after study completion
APPENDIX D: INTERVIEW GUIDE

Number___________

Demographics

Age: _________________________________

Country where you graduated from nursing school: _________________________________

Highest degree, specialty, if appropriate. _________________________________

Nationality _________________________________

Years in USA (or other OECD country)_______

Did you use a professional agent to facilitate visa acquisition? _________

Narrative Responses, open-ended semi directed questions.

1. Tell me the story of your migration?
2. Tell me about your nursing education? Who paid for it?
3. What factors influenced emigration? Was there one main factor?
4. What factors influenced your decision about destination country?
5. How long did you work as a nurse in your country of education?
6. Do you plan to return there to work as a nurse? Have you returned?
7. Do/Did you send remittances or gifts to your family? to anyone else?
8. Tell me about patient care in your country of origin? Do you think nurses emigrating affect the quality of patient care?
9. How are nurses viewed, treated in your country of origin?
10. What factors could have kept you working as a nurse in your country of origin? Or would make you want to return?
11. Is nursing a good career?
12. Have you heard of the WHO Global Code of Practice on the International recruitment of health Personnel?
13. Do you believe wealthy societies have obligations to the distant needy? What can they do?
14. How can Global health worker migration policy work best?
15. How can nursing contribute to fulfilling the right to health for all? What is meant by right to health?
16. What core minimum components you feel are essential to realizing the right to health?
Appendix E: Data Organization Checklists

1. Push Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>IEN</th>
<th>1</th>
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<td>*Danger</td>
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<td>Family matter</td>
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<td>Authority pressure</td>
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<td>Was reason for career</td>
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* CONCEPT THEME:* push factors related to nature of professional career/work environment

2. Pull Factors

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<td>*Better pay</td>
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<td>Spouse recruited</td>
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*CONCEPT THEME* * pull factors related to nature of professional career/work environment

3. Nursing is a good career

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<td>Equivocal or qualified</td>
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<td>x</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>*lets you migrate</td>
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4. Do/did you send remittances home?

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<tr>
<td>Yes</td>
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<td></td>
<td>* more in past when parents alive</td>
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<td>x</td>
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</table>

5. Attitude: Right to Health Concepts Checklist:

How can nursing contribute to fulfilling the right to health for all?

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<tbody>
<tr>
<td>Non discriminatory patient care</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Expand/support the role of nurse</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>Ease migration</td>
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<tr>
<td>*Return after education to LMIC</td>
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<td>x</td>
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<td>*Wealthy have obligations</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x*</td>
<td>x*</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>*Participate /contribute to policy</td>
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</table>

• CONCEPT THEME:::* Global public health criteria: population right to health
Appendix F: WHO Code National Reporting Instrument

Geneva
February 2012

Background

On May 21, 2010 the WHO Global Code of Practice on the International Recruitment of Health Personnel (the “Code”) was adopted by the 193 Member States of the World Health Organization. This ground breaking instrument marks the first time that WHO Member States have used the constitutional authority of the Organization to develop a non-binding code in thirty years.

The Code establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. The Code was designed by Member States to serve as a continuous and dynamic framework for global dialogue and cooperation to address challenges associated with the international migration of health personnel.

The Code encourages information exchange on issues related to health personnel and health systems in the context of migration, and suggests regular reporting every three years on measures taken to implement the Code. The reporting process is an integral component of the effective implementation of the voluntary principles and practices recommended by the Code.

To facilitate the reporting process under the Code and in accordance with the request of the World Health Assembly (Resolution WHA63.16) a series of consultations and discussions were conducted between June 2010 and November 2011, including consultation with Member States and other stakeholders concerned with the Code. Upon a number of reviews by experts, member states and regional offices, the document was further condensed into the National Reporting Instrument as a “kick start” country-based, self-assessment tool to monitor the progress made in implementing the Code. Comprising 15 questions, the instrument will enable WHO to examine the global status of health personnel recruitment and where possible assess the availability of data to explore time trends with inputs from governments and other stakeholders.

A key purpose of this instrument is to provide a simple, user-friendly method for governments and other stakeholders to use in monitoring the implementation of the Code. The common use of this method will facilitate participation as well as promote the comparability of data and regularity of information flow.

Submission of reports

To submit Reports, Member States are invited to directly complete the online reporting questionnaire via the following link: https://extranet.who.int/datacol/survey.asp?survey_id=1998. The deadline for submitting reports is 31st May 2012.

If technical difficulties prevent national authorities from filling in the online questionnaire, it is also possible to download it via the following link: http://www.who.int/hrh/migration/code/code_nri/en, to contact WHO Secretariat or, preferably, the Regional office (see Annex A), either by email or telephone or to complete it in a...
separate document, returning it to the WHO Secretariat or Regional office, either electronically or in hard copy.

3
Name of Member State:
Date National Report submitted:
If your country has designated a national authority (the “national authority”) responsible for the exchange of information regarding health personnel migration and the implementation of the Code as recommended by Article 7.3, please provide the following information:
Full name of institution:
Name and title of contact officer:
Mailing address:
Telephone number:
Fax number:
Email:
If your country has not designated a national authority, please indicate if your country intends to designate a National Authority in the future.
Yes No
In addition, please provide information on the national contact responsible for the preparation of this report.
Full name of institution:
Name and title of contact officer:
Mailing address:
Telephone number:
Fax number:
Email:

4
1. In your country, do equally qualified and experienced migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in terms of employment and conditions of work?
Yes No ..................... (If “No”, please proceed to Q(4))
2. Which legal mechanisms are in place to ensure that migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce? Please tick all options that apply from the list below:
2.a Health personnel are recruited internationally using mechanisms that allow them to assess the benefits and risk associated with employment positions
and to make timely and informed decisions regarding them?

2.b. Health personnel are hired, promoted, and remunerated based on objective criteria such as levels of qualification, years of experience and degrees of professional responsibility on the same basis as the domestically trained health workforce.

2.c. Migrant health personnel enjoy the same opportunities as the domestically trained health workforce to strengthen their professional education, qualifications, and career progression.

2.d. Other mechanism, please provide details if possible:

3. Please provide evidence of the legal mechanisms identified in Q(2) either as attachments or links to online files.

4. Has your country or its sub-national governments entered into bilateral, regional or multilateral agreements or arrangements addressing the international recruitment of health personnel?

   Yes No ………………….. (If “No”, please proceed to Q(6))

5. Please use Table A below to describe these bilateral, regional or multilateral agreements or arrangements:

   Table A Description of Bilateral, multilateral, regional agreements or arrangements

<table>
<thead>
<tr>
<th>Type of Agreement</th>
<th>Countries Involved</th>
<th>Coverage</th>
<th>Categories of Health workforce (choose all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Bilateral</td>
<td></td>
<td>1) National</td>
<td>1) Doctors</td>
</tr>
<tr>
<td>2) Multilateral</td>
<td></td>
<td>2) Sub-national</td>
<td>2) Nurses</td>
</tr>
<tr>
<td>3) Regional</td>
<td></td>
<td>3) Midwives</td>
<td>3) Midwives*</td>
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<td></td>
<td></td>
<td>4) Nurses/Midwives*</td>
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</table>
5) Other
   Please attach a document if possible
   Please provide a web-link if possible
   …e.g. (a) …e.g. (a) …e.g. (a)
Add as necessary…
* Please use this category only if the information available has no clear separation in reported numbers between the two cadres

6. Does your country have any (government and/or non-government) programs or institutions undertaking research in health personnel migration?
   Yes No ………………….. (If “No”, please proceed to Q(8))

7. Please use Table B below to provide the contact details for these research programs or institutions
   Table B Detailed information on research programs or institutions assessing health personnel migration
   Name of Program or Institution
   Name of contact person
   Contact details Web-link (if available)
   7.1
   7.2
Add as necessary……

8. Has your country taken any steps to implement the Code?
   Yes No ………………. (If “No”, please proceed to Q(10))

9. To describe those steps taken to implement the code, please tick all items that apply from the list below – the box can be ticked even if only some of the elements per step have been applied:
   9.a Actions have been taken to communicate and share information across
sectors on health worker recruitment and migration issues, as well as the Code, among relevant ministries, departments and agencies, nationally and sub-nationally

9.b Measures have been taken to involve all stakeholders in any decisionmaking processes involving health personnel migration and international recruitment.

9.c Actions are being considered to introduce changes to laws or policies on the international recruitment of the health personnel.

9.d Records are maintained of all recruiters authorized by competent authorities to operate within their jurisdiction.

6

9.e Good practices are encouraged and promoted among recruitment agencies.

9.f If other steps have been taken, please give more details:

10. Please list in priority order, the three main constraints to the implementation of the Code in your country and propose possible solutions:

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<th>Main constraints</th>
<th>Possible solution</th>
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</tr>
<tr>
<td>10.b1 10.b2</td>
<td></td>
</tr>
<tr>
<td>10.c1 10.c2</td>
<td></td>
</tr>
</tbody>
</table>

11. Has your country established a database of laws and regulations related to international health personnel recruitment and migration and, as appropriate, information related to their implementation?

Yes No .................... (If “No”, please proceed to Q(12))

11.1 Please provide details of the database reference or a web-link:

12. Does your country has any technical cooperation agreement, provides or receives financial assistance related to international health personnel recruitment or the management of and migration?

Yes No .................... (If “No”, please proceed to Q(13))

12.1 Please provide more information or evidence of agreements as appropriate:

12.2 Please provide more information or evidence of financial assistance provided or received as appropriate:

13. Does your country have any mechanism(s) or entity(ies) to maintain statistical records of health personnel whose first qualification was obtained overseas?

Yes No .................... (If “No”, please proceed to Q(14))
13.1 Please use Table C below to provide the contact details of each entity.

Table C  Contact details of mechanism(s) or entity(ies) maintaining statistical records of health personnel whose first qualification was obtained overseas

<table>
<thead>
<tr>
<th>Name of mechanism or entity</th>
<th>Contact details</th>
<th>Web-link (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.1b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.1c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add as necessary……</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.2 For the entity named in Q(13.1) please use Table D below to specify whether the information gathered include the following:

Table D  Description of the statistical information available on the internationally recruited health personnel

<table>
<thead>
<tr>
<th>Entity</th>
<th>Occupation category</th>
<th>Country of first qualification</th>
<th>Year of first recruitment</th>
<th>Age</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) Doctors</td>
<td>(1) Yes</td>
<td>(1) Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Nurses</td>
<td>(2) No</td>
<td>(2) No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) Midwives</td>
<td>(3) Midwives</td>
<td>(3) Midwives*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) Nurses/Midwives*</td>
<td>(4) Yes</td>
<td>(4) No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5) Other</td>
<td>(5) No</td>
<td>(5) No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13.1a
Add as necessary……

13.1b
Add as necessary…

13.1c
Add as necessary……

* Please use this category only if the information available has no clear separation in reported numbers between the two cadre

13.3 For the entity(ies) named in Q(13.1) which status best describes the possibility of accessing and sharing the information detailed in Q(13.2):

Entity Information-sharing status
(1) Information cannot be shared
(2) Information may be shared
(3) Sharing relationships not yet explored

13.a1 13.a2
13.b1 13.b2
13.c1 13.c2

14. Does your country have any mechanism(s) or entity(ies) to regulate or grant authorization to practice to internationally recruited health personnel and maintain statistical records on them?
Yes No ……..(If “No”, please proceed to Q(15))

14.1 Please use Table E below to provide the contact details of each entity.

Table E Contact details of mechanism(s) or entity(ies) regulating or granting authorization to practice to internationally recruited health personnel

14.2 For the entity named in Q(14.1) please use Table F below to indicate whether the information gathered include the following details:

Table F Description of information available on authorization and regulation of practice of internationally recruited health personnel

Entity
Occupation category
(1) Doctors
(2) Nurses
(3) Midwives
(4) Nurses/Midwives
(5) Other
Country of first qualification
(1) Yes
(2) No
Year of first recruitment
(1) Yes
(2) No
Age
(1) Yes
(2) No
Sex
(1) Yes
(2) No

14.1a Add as necessary……
14.1b Add as necessary……
14.1c Add as necessary……

* Please use this category only if the information available has no clear separation in reported numbers between the two cadres

14.3 For the entity(ies) named in Q(13.1) which status best describes the possibility of accessing and sharing the information detailed in Q(13.2):
Entity Information-sharing status
(1) Information cannot be shared
(2) Information may be shared
(3) Sharing relationships not yet explored
14.a1 14.a2
14.b1 14.b2
14.c1 14.c2
15. Please submit any other complementary comments or material you wish to provide regarding the international recruitment and management of migration of the health workforce that would relate to implementation of the Code.

Entity Contact details Web-link (if available)
14.1a
14.1b
14.1c
Add as necessary......