PUBLIC SERVICES INTERNATIONAL

The global union federation of workers in public services

The Open University

Impacts of Covid-19 on migrant health workers:

A REVIEW OF EVIDENCE AND IMPLICATIONS FOR HEALTH CARE PROVISION

Catherine Vaillancourt-Laflamme, Jane Pillinger, Nicola Yeates, Genevieve Gencianos, Gihan Ismail, Nashwa Ismail and Carlos Montoro

This work was supported by the UK Research and Innovation Fund [grant reference ES/W013193/1]. It does not necessarily reflect the opinions of the UKRI.

Papers in this series

Sarah Tipping, Vicky Murphy, Nicola Yeates, Carlos Montoro, Gihan Ismail and Nashwa Ismail (2022) *Migrant health worker deaths during Covid-19: a methodological exploration and initial estimates*. 10 September. Milton Keynes, UK/ Ferney Voltaire, France: The Open University/Public Services International.
DOI: https://doi.org/10.21954/ou.ro.00014b4b

Catherine Vaillancourt-Laflamme, Jane Pillinger, Nicola Yeates, Genevieve Gencianos, Gihan Ismail, Nashwa Ismail and Carlos Montoro (2022) *Impacts of Covid-19 on migrant health workers: a review of evidence and implications for health care provision*. 15 September. Milton Keynes, UK/Ferney Voltaire, France: The Open University/Public Services International.
DOI: https://doi.org/10.21954/ou.ro.00014b4d

Nicola Yeates, Jane Pillinger, Genevieve Gencianos, Catherine Vaillancourt -Laflamme, Nashwa Ismail, Carlos Montoro and Gihan Ismail (2022) *Policy responses to address risks of harm to migrant health care workers in times of Covid-19*. 20 September. Milton Keynes, UK/Ferney Voltaire, France: The Open University/Public Services International.
DOI: http://dx.doi.org/10.21954/ou.ro.00014b75

CC BY-NC-SA: This license allows re-users to distribute, remix, adapt, and build upon the material in any medium or format for non-commercial purposes only, and only so long as attribution is given to the creators. If you remix, adapt, or build upon the material, you must license the modified material under identical terms.

Layout and design by Blossom Carrasco

Cover Image
COVID-19 sample collection at a migrant workers' campsite in Bang Sue,Bangkok 31st October 2021 /WHO/Ploy Phutpheng

ABSTRACT

Migrant workers have been at high risk of contracting Covid-19 and experiencing adverse outcomes from it. This paper reviews research evidence from academic and grey literatures as regards how the pandemic has impacted on migrant health workers. Five principal factors stand out as exacerbating the risks to such workers: health workforce shortages; decent work deficits, including lack of social protection; discrimination, violence and harassment; absence of social dialogue, and changing patterns of international recruitment. These factors are interlocking and have highly consequential implications not only for the rights and welfare of those workers but also for the provision of universal health care and realising rights-based, people-centered sustainable development for all countries.

Key words: Covid-19, migrant health workers; health workforce; health services; pandemic; working conditions; social protection; violence; harassment; discrimination; recruitment; ethics.

Author details: Catherine Vaillancourt-Laflamme and Jane Pillinger are independent social researchers, based in Canada and France, respectively. Nicola Yeates is Professor of Social Policy, The Open University, UK; Genevieve Gencianos is Migration Programme Officer, PSI, France; Gihan Ismail is Associate Lecturer, Brookes University, UK; Nashwa Ismail is Lecturer in Education, Durham University, UK; Carlos Montoro is Learning Designer, The Open University, UK.

Address for correspondence: Nicola.Yeates@open.ac.uk (Principal Investigator)

Citation: Catherine Vaillancourt-Laflamme, Jane Pillinger, Nicola Yeates, Genevieve Gencianos, Gihan Ismail, Nashwa Ismail and Carlos Montoro (2022) *Impacts of Covid-19 on migrant health workers: a review of evidence and implications for health care provision*. 10th September. Milton Keynes, UK/ Ferney Voltaire, France: The Open University/Public Services International.
DOI: https://doi.org/10.21954/ou.ro.00014b4d

TABLE OF CONTENTS

LIST OF BOXES 5

LIST OF ABBREVIATIONS AND ACRONYMS 6

Section 1 Introduction 7

Section 2 Research method 9

Section 3 Health workforce shortages 10

Section 4 Decent work deficits 13

4(a) Working conditions: contractual issues, working hours and pay, wage discrimination and wage theft 13
4(b) Social protection and access to medical care 15
4(c) Occupational safety and health 15
4(d) Deskilling 17
4(e) Living conditions 18

Section 5 Discrimination, violence and harassment 19

Section 6 Absence of social dialogue and workers' voice 23

Section 7 Changes in recruitment practices and unethical recruitment 25

7(a) Changes in recruitment practices driven by the demand for health workers 25
7(b) Unethical recruitment 26

Section 8 Conclusions 28

References 29

LIST OF BOXES

Box 1 Risks faced by migrant health workers: trade unions' perspectives

Box 2 Evidence of health worker shortages before and during the pandemic

Box 3 Migrant health workers make up a significant percentage of the global health workforce

Box 4 There are inadequate numbers of health workers to meet the goal of Universal Health Coverage by 2030

Box 5 Repayment clauses

Box 6 Violence, harassment and stress faced by health workers

Box 7 International recruitment of health workers

LIST OF ABBREVIATIONS AND ACRONYMS

CGFNS	Commission on Graduates of Foreign Nursing Schools
CUPE	Canadian Union of Public Employees
EPSU	European Public Services Union
EU	European Union
GBD	Global burden of disease
HOSPEEM	European Hospital and Healthcare Employers' Association
ICN	International Council of Nurses
ICRC	International Committee of the Red Cross
IFH	International Hospital Federation
ILO	International Labour Organization
ITUC	International Trade Union Confederation
NNU	National Nurses United
OECD	Organization for Economic Cooperation and Development
PPE	Personal protective equipment
PSI	Public Services International
SDG	Sustainable Development Goal
TPVH	Third party violence and harassment
UAE	United Arab Emirates
UHC	Universal health coverage
UNISON	UK public services union
UK	United Kingdom of Great Britain and Northern Ireland
USA	United States of America
WHO	World Health Organization
WMA	World Medical Association

Section 1 Introduction

The COVID-19 pandemic has demonstrated the essential role of universal healthcare systems in promoting public health, economic development and social resilience. The maxim that there is "no health without a workforce" (WHO, 2014) speaks afresh to the importance of having sufficient numbers of skilled workers in the right place, at the right time, to deliver appropriate lifesaving services on a scale and in a form matching demand for them. Healthcare workers have been at the forefront of the delivery of vital services throughout the pandemic. Hundreds of thousands of health and social care workers, both migrant and non-migrant, lost their lives treating people infected by the SARS-COV-2 virus. The World Health Organization (WHO) estimated 80,000 - 180,000 deaths of such workers occurred from Covid-19 between January 2020 and May 2021, with a central population-based estimate of 155,500 deaths (WHO, 2021). Pillinger, Gencianos and Yeates (2021a) estimated that as many as 36,000 migrant health workers around the world lost their lives to Covid-19 over the same period. Both of these worldwide estimates significantly under-count the actual death tolls across the duration of the pandemic (see Tipping, Murphy and Yeates et al. (2022) for further discussion).

Beyond the loss of life, a growing base of research evidence charts the multidimensional impacts of the Covid-19 pandemic on health workers and on health services provision. Remarkably little of this focuses specifically and in detail on how the pandemic has impacted on migrant health workers. This is an oversight. Not only do migrant (foreign-born and/or foreign-trained) health workers constitute a significant share of the health workforce across Organisation for Economic Cooperation and Development (OECD) countries (OECD, 2020)[1], but there is evidence to suggest that migrant workers have been at high risk of contracting Covid-19 and experiencing adverse outcomes from it due to their concentration in 'frontline' roles in parts of the service sector designated as essential and required to continue to work during the pandemic (Nazareno et al., 2021; Pillinger, Gencianos and Yeates, 2021a; 2021b; 2021c; WHO, 2022a; WHO, 2022d; see also Box 1). This, combined with the fact that work-related ill health and injury are relatively common among international migrants (Hargreaves et al., 2019) and that exposure to occupational health hazards is very high for workers in the health sector (Joseph and Joseph, 2016), provides the imperative for focusing on the impacts of the pandemic on migrant health and care workers. Only when all workers are able to work in safe and decent conditions can the availability and quality of health care delivery be guaranteed.

1 The precise proportion varies among OECD countries. Indicatively, however, nearly 25% of all doctors in the OECD are born abroad and 20% are trained abroad. Regarding nurses, about 16% are foreign-born and more than 7% are foreign-trained (OECD, 2020a).

BOX 1 RISKS FACED BY MIGRANT HEALTH WORKERS: TRADE UNIONS' PERSPECTIVES

A survey of trade union perspectives and responses to COVID-19 by Public Services International and the Open University (Pillinger, Gencianos and Yeates, 2021a, 2021b, 2021c) found that migrant health workers, most of whom are women, are playing a critically important role on the front-line of health care services during the pandemic, but bear a disproportionate burden of Covid-19. This burden impacts on their rights at work, health, wellbeing and survival:

- 78.7% of public health services unions responding to the survey said that the pandemic negatively impacted on the rights of migrant workers.
- Over half (54%) of unions reported that migrant health workers experienced significant negative impacts on their health and wellbeing, including fatigue and burnout.
- Nearly one-half (47.8%) reported that migrant health workers had poor access to, and in some cases were denied, access to safety protections such as personal protective equipment and necessary training.
- 40% reported problems associated with short-term contracts and employment insecurity.
- One-third (32.4%) reported an increase in violence and harassment, which was frequently targeted at migrant health workers especially of Asian origin or heritage.
- 27% reported that migrant health workers had only unpaid sick leave when they were infected with Covid-19. This is even though Covid-19 is a significant occupational risk for migrant health workers on the front-line of care.
- 27% reported that migrant health and social care workers had higher levels of illness and death from Covid than their non-migrant colleagues.

This paper discusses five main factors exacerbating migrant health workers' risks of infection and fatality from Covid-19 during the pandemic. They are: health workforce shortages; decent work deficits; discrimination, violence and harassment; absence of social dialogue and workers' voice, and changing international recruitment and unethical recruitment practices. These are discussed in Sections 3 to 7, which are followed by concluding comments.

Section 2 Research method

Hybrid review methodologies were used to systematically search for and assess sources of academic and 'grey' literature on the impacts of the pandemic on migrant health workers. Initially, scoping review methodology was used to search broadly and systematically for studies and data in three global languages - English, Spanish and Arabic. This multi-lingual methodology was designed to increase the ethno-linguistic reach and inclusivity of our literature review. Our review of academic studies covered all disciplines to gain the broadest range of evidence. We used content analysis methodology to extract data of interest and to assess the methods and findings of diverse studies and publications.

Interviews undertaken for this research were conducted with international organisations, employers, trade unions and non-governmental organisations. The identity of the interview participants has been withheld on the grounds of privacy and confidentiality. All interviews were conducted remotely due to the health crisis and travel restrictions.

Further information on the research method, including inclusion and exclusion criteria, is available at https://fass.open.ac.uk/research/projects/CRaR.

Section 3 Health workforce shortages

The Covid-19 pandemic has revealed major weaknesses and profound inequalities in health services globally, threatening already-fragile health systems in many parts of the world. These have been compounded by a systemic shortage of health workers (WHO, 2021; WHO, 2022a, 2022d; Jato et al., 2022). The availability of a sufficient number of skilled and motivated health workers in the right place at the right time is central to the effectiveness of any health system. Three WHO global pulse surveys (August 2020, April 2021 and February 2022) confirm that in most Member States

> ...a lack of available health workers is the largest constraint to ensuring the continuity of essential health services during the pandemic, including the delivery of COVID-19 tools (vaccines, diagnostics and therapeutics). (WHO, 2022e, para 5, p.2)

Workforce shortages in high-income countries have led to much higher levels of international recruitment and migration in recent years (see Box 2). Prior to the Covid-19 pandemic, in OECD countries a 60% increase in the international migration of doctors and nurses had taken place in the last decade (OECD, 2019; Yeates and Pillinger, 2019). The critical importance of this issue led to a raft of global policy developments, international calls for action and high-level strategies being drawn up prior to the pandemic by the WHO and other international organisations, including the UN High Level Commission on Health Employment and Economic Growth and the WHO's own Global Strategy on Human Resources for Health: Workforce 2030 (WHO, 2016b; WHO, 2022a; Yeates and Pillinger 2019). Allied to these developments have been calls from Public Services International (PSI) (PSI, 2020a, 2021; Pillinger and Yeates, 2020), amongst other organisations, for priority to be given to strengthening public health care services.

BOX 2 EVIDENCE OF HEALTH WORKER SHORTAGES BEFORE AND DURING THE PANDEMIC

Even before the pandemic hit, health worker shortages were increasing across the world, with demand for health workers being expected to double by 2030. Covid-19 amplified the global shortage of health care workers, adding to existing critical staffing problems.

- In 2016 there was an estimated shortage of 18 million health workers by 2030, mostly in low- and lower-middle income countries (WHO 2016a; Pillinger and Yeates, 2020). The projection of 18 million made in 2016 was revised by the WHO to 15 million in 2022 and 10 million in 2030, although these estimates were based on pre-pandemic data (WHO, 2022a).
- In the nursing workforce, there is an estimated global shortage of 5.9 million nurses, and nearly all of these shortages (89%) are concentrated in low- and lower middle-income countries of the African, South-East Asia and Eastern Mediterranean regions (CGFNS, 2022:4; WHO, ICN and Nursing Now, 2020:3).
- On top of an estimated pre-pandemic need for 30.6 million more nurses to reach the goal of universal health coverage (UHC), the most recent ILO estimates flag up a further shortfall of 13 million nurses (ILO, 2022b:17).

- For doctors, meeting the recommended WHO threshold of 20.7 physicians per 10,000 population to reach 80 per cent of UHC by 2030 is also unattainable. In 2019 the world already needed 6.4 million more doctors (GBD 2019 Human Resources for Health Collaborators, 2022).
- In 2019, 132 of 204 countries and territories included in the Global Health Data Exchange Database struggled with physicians and nurses' workforce shortages (GBD 2019 Human Resources for Health Collaborators, 2022).
- Evidence of staffing shortages collected in the UK by UNISON's, the UK public service trade union representing health workers, in its Safe Staffing Forum (UNISON, 2021) shows 40,000 nurse vacancies in the NHS. Half of all respondents to the UNISON survey did not have enough staff on their shift to deliver safe, dignified and compassionate care. One in six workers surveyed believed patient safety was compromised on their shift. More than a third said there were not enough staff to deliver safe care.

The pre-pandemic shortage of healthcare professionals has been exacerbated by the impact of COVID-19. Many tens of thousands of health professionals have died, others are now long-term ill; and of those who have 'held on' for the first year or more of the pandemic, many are now exhausted and will have to step down to less demanding roles, take respite, step away to work in other sectors, or retire. Those who remain at work report increasing levels of stress, and an increasing propensity to consider leaving their job or profession (ICN, CGFNS and Buchan, 2022: 4). According to the International Council of Nurses (ICN), it is likely that in countries where the impacts of COVID-19 have been significant, there will be further short-term reductions in the immediate domestic supply of nurses because some workers will have burned out and will be absent for a short- or long- term period. Others will reduce their working hours or will retire early (ICN, 2020). For example, in the USA, it is estimated that around 40% of the workforce will leave their jobs in the following five years (Hare Bork et al., 2020). This is a very significant challenge in the light of ageing workforces in many countries.

Among health workers, migrant health workers represent a substantial and increasing number of the global health workforce (see Box 3). They are pushed away from their low- and middle-income countries of origin by the chronic under-investment in public and health infrastructures and pulled towards high-income destination countries by the vacancies there generated by decent work deficits (Yeates and Pillinger, 2019; Pillinger and Yeates, 2020; WHO, 2016a, 2016b; PSI, 2020a).

BOX 3 MIGRANT HEALTH WORKERS MAKE UP A SIGNIFICANT PERCENTAGE OF THE GLOBAL HEALTH WORKFORCE

- Around 23% of the nursing workforce and 25% of doctors in OECD countries are migrant workers (OECD, 2020a: 2).
- The 2020 State of the World's Nursing report estimated that 3.7 million nurses (13% of all nursing personnel worldwide or 1 in every 8 nurses) were born or trained in a country other than the one in which they are employed (WHO, ICN and Nursing Now, 2020).
- The percentage of foreign-born or foreign-trained health personnel varies significantly by region and occupation. Up to 80% of nurses and physicians in six high-density Gulf countries are migrant workers (WHO, 2022c). Migrant nurses account for 26% of the nursing workforce in New Zealand, 25% in Switzerland, 18% in Australia and 15% in the UK (Llop-Gironés et al., 2021).

The fact that migrant health workers make up a significant percentage of the global health system workforce highlights how dependent many countries have become on migrant health workers. In a recent publication, the OECD concluded that,

> [t]he COVID-19 pandemic revealed once more that foreign-trained nurses are key assets for health systems in many OECD countries. Along with bringing into the spotlight the important role and dedication of frontline health workers, the pandemic has further highlighted the deeply embedded challenge of staff shortages as well as the significant contribution that migrant nurses make to the health workforce. (OECD, 2021:15)

The pandemic led some countries to develop strategies to increase international recruitment, for example, for critical care nurses (Omaswa, 2020). Many of these countries affected by COVID-19 relied on recruitment of migrant workers, sometimes by simplifying recruitment procedures, visa requirements and recognition of qualifications (ILO, 2020a; OECD, 2020; Pillinger and Yeates 2020). Data and time limitations of this present research study mean that it is too early to show the extent of international recruitment during the pandemic in ways that also take into account travel and other restrictions on mobility during the pandemic.

COVID-19 made visible the consequences of the interdependence between countries, health systems and labour forces. However, global health worker shortages are compounded by global health inequalities in access to health care and in provision of adequate numbers of doctors, nurses and other health professionals (see Box 4).

BOX 4 THERE ARE INADEQUATE NUMBERS OF HEALTH WORKERS TO MEET THE GOAL OF UNIVERSAL HEALTH COVERAGE BY 2030

- More than half of the world's population lacks access to essential health care. The goal of universal health coverage by 2030 is in jeopardy as health worker shortages worsen (WHO, 2022a). In Africa, which faces the largest burden of disease in the world, 36 out of the 57 countries listed by the WHO in its World Health Report (2006) faced a human resources crisis in their healthcare systems (WHO, 2006).
- High-income countries have nearly 12 times as many people employed in the health sector compared to low-income countries. The USA and the UK have 682 and 664 health workers per 10,000 people, respectively. In Africa, on average, just 57 workers are employed in the health sector per 10,000 population (ILO, 2020a).
- Forty-seven countries facing 'pressing' health workforce challenges related to meeting the goal of UHC are included in the WHO's Health Workforce Support and Safeguards List (WHO, 2020).[2] The countries listed, 33 of which are in Africa, have a UHC Service Coverage Index that is lower than 50 and a density of doctors, nurses and midwives that is below the global median of 48.6 per 10,000 population.
- By 2020, there was a shortage of health care professionals reported in most European union (EU) Member States, leading to higher levels of work pressure and stress during the pandemic than would otherwise have been (European Commission, 2020; EPSU, 2022a).

2 The List identifies countries with the most pressing UHC-related health workforce needs, and towards which support and safeguards should be targeted.

Section 4 Decent work deficits

4(A) WORKING CONDITIONS: CONTRACTUAL ISSUES, WORKING HOURS AND PAY, WAGE DISCRIMINATION AND WAGE THEFT

Many of the hardships faced by migrant workers stem from the precarity embedded in their contractual arrangements. The pandemic hit at a time when non-standard forms of employment were on the rise. These include fixed-term work, temporary work, temporary agency work, dependent self-employment and part-time work. In a pre-pandemic report, the ILO noted a trend in some countries to replace permanent public health services employment with fixed-term contracts, and to use outsourcing for certain types of work (ILO, 2018: 178). These non-standard forms of employment that emphasise 'flexibility' give rise to decent work deficits such as job insecurity, lower pay and gaps in social protection (ILO, 2022a; 2022b). As a result, migrant health workers can be more easily made redundant. This may have pushed some, during the pandemic, to accept working conditions below acceptable standards (for example, accepting to work in the absence of adequate personal protective equipment (PPE) in fear of losing their jobs and other entitlements in their country of employment if they refused).

In some countries, for example in the USA, the systemic lack of investment in public healthcare systems, has, over the years, contributed to a poor working environment and dire working conditions, and pushed health workers, including migrants, into ever-more precarious private agency work. Although these temporary employment agencies can initially offer slightly more attractive rates of pay, they also make it very difficult for health workers to organise and seek future improvements to their workplace and working conditions. A trade union representative, interviewed for the purpose of this research explained that:

> All these issues are tied to the migration question…employers are looking for more nurses to exploit. We want nurses to migrate, [but] to come and live in the US and work and migrate and not be exploited, because it [exploitation] is worse for everyone (Interview, trade union representative, North America).

In a further interview, a European trade union spokesperson highlighted the issue of 'repayment clauses' inserted into some migrant health workers' contracts (see Box 5). This provides powerful evidence of how employers are circumventing the 'No Recruitment Fees' policy adopted by the ILO in 2016 (ILO, 2019a). While many recruiters publicly claim that they do not charge recruitment fees, there is actually a hidden ''repayment clause' -which can be worse and more punitive than recruitment fees.

BOX 5 REPAYMENT CLAUSES

Repayment clauses have been used by some employers to force migrant health workers to remain at their service for a determined amount time, or risk otherwise having to pay a substantial sum of money before being allowed to resign (*The Observer, 30 July 2022*). Repayment clauses are used by employers to recoup initial recruitment costs incurred through international recruitment.

This research found that repayment clauses could be as high as £14,000, which represents a weighty portion of migrant health workers' wages. As a result, repayment clauses have tended to keep migrant health workers in potentially exploitative workplaces as they often cannot afford to leave (see also *The Guardian, 27 March 2022*). The presence of such clauses in migrant health workers' contracts may explain why, during the pandemic, some migrant workers accepted more hazardous working situations.

Unprecedented pressures have been experienced by health workers, including long working hours and insufficient rest periods linked to global health workforce shortages (ILO, 2022a:152). Information from the interviews carried out for this research indicates that migrant health workers have been particularly vulnerable to long working hours schedules, which may be the result of their more precarious contractual status rendering them more vulnerable to pressure by their employers.

Observers have noted the paradox of millions of healthcare professionals, including migrant ones, being laid off from private medical institutions while other emergency staff in public health services were working excessively long hours (Fadel et al., 2020). In the USA, for example, non-emergency nurses and doctors were laid-off just as the pressure on emergency health services heightened. This shows, according to the PSI, that health emergencies and pandemics are best addressed by public health care systems under democratic control, with powers to ensure allocative effectiveness of health workforces on fair terms in support of comprehensive and inclusive health services (Pillinger and Yeates, 2020; PSI, 2020a, 2020b).

In addition, migrant health workers face vulnerability due to wage discrimination linked to where they undertook their training. For example, in France although migrant doctors have been on the frontline of the pandemic, 'each receive the equivalent of half the salary of a French doctor, because they obtained their degrees from outside the European Union' (Alyehawai, 2020). Some migrant health workers do not have access to the same degree of wage protection as their non-migrant colleagues. As one trade union leader from Asia noted, employer wage theft (such as not paying for overtime) became commonplace among migrant health workers during the height of the pandemic:

> In the Middle East [migrant health workers] don't have the same level of protection and access to health services if they contract Covid-19. Some of the hospitals are short of staff, they don't give compensation for the extra work they do. There is also wage theft, which is when they are underpaid, not paid, and not given benefits they should be entitled to. Covid was used as an excuse in some countries to not pay health workers or give them benefits, so [they] used migrant workers to save money. (Interview, trade union representative, Asia)

A 2020 ILO report on the migrant pay gap found that migrants earn on average nearly 13% less than their non-migrant colleagues in high-income countries (ILO, 2020c:1). This gap existed prior to the pandemic and had been increasing over the previous five years. The report pointed to a significant skills mismatch and institutionalised discrimination. Migrant workers earn less than similarly qualified nationals within the same occupational category. They are more likely to work in lower-skilled and low-paid jobs that do not match their education and skills, which may point to discrimination during the

hiring process. Higher-educated migrant workers in high-income countries are also less likely to attain jobs in higher occupational categories (ILO, 2020c).

4(B) SOCIAL PROTECTION AND ACCESS TO MEDICAL CARE

COVID-19 has also revealed weakness in some countries' social security systems and how difficult it might be for migrant workers, even migrant health workers, to access protection afforded to others in the country. The lack of universal coverage of sickness benefits has been identified as a major challenge to the success of virus containment strategies. The ILO reports that in some countries, national social security systems impose eligibility criteria linked to nationality in ways that exclude migrant workers from benefits. In some cases, migrant workers may be covered by separate arrangements under the direct responsibility of their employer, or may not be afforded coverage at all (ILO, 2022a:181). In the USA, migrant health workers are prone to be disadvantaged by migration policies that create a hostile environment generally, and, specifically, limit their access to benefits or comprehensive medical insurance in the case of Covid-19 infection, disability and death (Roy, Solenkova and Mehta, 2021; Obinna, 2021; Aktas et al., 2022; Zaidi, Dewan and Noricini, 2021; Kierster and Vazquez-Merino, 2021).

The ILO further reveals how the COVID-19 crisis has shed light on significant coverage gaps, not only in access to health care but also in terms of sickness benefit. This leaves health workers, including migrant health workers, who may be in non-standard forms of employment, or self-employed, excluded from social protection. This lack of coverage from income protection measures and employment security when migrant health workers fall ill creates an incentive to go to work while unwell. Not only does it increase risks of virus transmission but also the risk of impoverishment of those affected by the disease and their families (ILO, 2020b: 8). As a case in point, migrant health workers in the UK must pay up to USD500/£400 (Mueller, 2020; Pillinger and Yeates, 2020) to have access to the very healthcare service they are themselves providing. This exclusion is a direct result of their visa denying them any recourse to "public funds", including healthcare services. In its 2022 Health Care Service Group Conference, UNISON notes that many migrant health workers face impoverishment as a result of this policy (UNISON, 2022:18). In central Asia, a trade union leader noted that:

> in the Middle East [migrant health workers] don't have the same level of protection and access to health services if they contract COVID-19. We heard that some health workers are sent home if they contract COVID and they are left alone to recuperate with no support. (Interview, trade union representative, Asia)

Migrant health workers' fear of being deported if they report infection or prolonged illness of themselves or their families acts as a significant deterrent to reporting, as does death of a family member (Roy, Solenkova and Mehta, 2021; Bhaskar et al., 2020; Obinna, 2021; Kierster and Vazquez-Merino, 2021).

4(C) OCCUPATIONAL SAFETY AND HEALTH

The literature reviewed for this paper highlights alarming failures in access to PPE and infection control systems, such as COVID-19 tests, for health workers, including migrant workers (ILO, 2022a:152; Trullàs, 2020; Jamal, 2020; Yousef, 2020; Gasana et al., 2021) and associated psychological strains (Saleem, 2021). Anecdotal evidence indicates how health workers, including migrants, had to suffer the indignity of buying and wearing adult diapers, because their workload pressures prevented them from taking toilet breaks; nor could they afford to waste their PPE as no change was available (Interview, trade union representative, Asia). Nurses from many countries have reported that the distribution of the PPE is based on medical hierarchy rather than the needs of health workers. In interviews with trade unions and NGOs for this research, migrant health workers, many of whom were working in direct contact with COVID-19 patients, reported they faced additional difficulties of actually accessing PPE beyond those experienced by their non-migrant colleagues. This PPE hierarchy was also replicated with the administration of vaccines in countries such as the UK, Italy and Spain (Llop-Gironés et al., 2021), possibly slowing the immunisation of migrant health workers.

Interviews carried out in this research have also indicated anecdotal reports that migrant health workers may be at a greater risk of contracting COVID-19, particularly due to additional vulnerabilities they face in their employment:

> ...they can't say no to being assigned to Covid wards and in the most serious cases, maximum working hours are being exceeded. In the US, [American-born] nurses can refuse to be assigned to high-risk Covid wards, but Filipino nurses can't do this because they are worried about their job security, because they are on visas with conditions and short term contracts. (Interview, trade union representative, Asia)

Côté et al (2021) point to a concern about migrant workers' lack of knowledge about their occupational health and safety rights, which may rationalise a sense of distrust in the protection measures that are put in place by employers to prevent their infection and death from Covid-19. A similar observation about those workers' mistrust of employers was made in relation to Arabic-speaking countries that pointed to systemic discrimination in health systems which pushed migrant health workers to the frontline of COVID-19 and strongly dissuaded any concerns they may have from being voiced: 'Those professionals live in "fear" of losing their jobs and being "judged" if they speak frankly. The alternative is to continue working despite the dangerous roles they perform' (London Araby, 2020).

With substantial evidence showing that the pandemic led to further pressures on already short staffed and overstretched health care systems, a significant increase in psychosocial risks and stress caused by heavy workloads, burnout and third-party violence and harassment propelled many health care professionals leaving or consider leaving their jobs (Hare Bork et al., 2022; *Nursing Times*, 2021; UK Parliament Health and Social Services Committee, 2022; see also Section 5, this paper). This situation has exacerbated the already-critical problem of staffing shortages in many countries, including an ageing workforce, making it difficult to build sustainable and resilient health care systems, particularly in preparation for future pandemic emergencies.

In a European context, EU-OSHA (2022) data shows that workers in the health and social work sector are exposed to a wide range of occupational safety and health (OSH) risks related to the COVID-19 pandemic, including psychosocial risks such as exposure to traumatic events, high workloads, caring for people at the end of their lives, the need to work intensively and continuously multitask, undertake shift work, work alone, lack of control over work and burnout. According to EU-OSHA (2022) there is a need to strengthen links between this sector and public health policy and to resolve staffing shortages, improving pay and conditions, and protect the workforce from violence

and harassment. Taking into account the vulnerabilities faced by migrant health workers, it is likely that migrant health workers will not only experience these risks in a heightened form, but will have little choice but to endure them. Such additional pressures on the health care systems and stress on health workers are likely to result in a greater propensity for staff to leave their jobs.

The urgency of addressing this problem is reflected in a Joint Statement of a group of international health and medical NGOs, including the global union for the public services, Public Services International (PSI), issued during the WHO Regional Committee for Europe in 2022. This called on governments to:

> ...provide all healthcare staff and healthcare students with a safe working environment and adequate mechanisms to prevent any type of violence so as to decrease the risk of exhaustion and burnout for all healthcare professionals, and to deploy all necessary means to protect the physical and psychological integrity of our colleagues during this pandemic and beyond. The health sector should be, and must remain, a safe and attractive place to work. (WHO Regional Committee for Europe, 2021: 1)

4(D) DESKILLING

Working conditions are also affected by the deskilling of health workers and particularly as the pandemic-induced demand for additional healthcare professionals in the health sector of many countries has been mirrored by a similar demand in the social care sector of many OECD countries. The social care sector (made up of lower-skilled home-based and residential care for vulnerable adults and children, including people with disabilities and older people) is one of the sectors where health workers face significant exploitation, lack of protections and lower rates of unionisation. The sector includes workers that have formal education, such as nurses, and workers without any formal training. Care workers are often women and migrants (ILO, 2020e). Many European countries depend heavily on migrant workers to perform social care work in a sector where there were severe staffing shortages even before the pandemic (Rodrigues et al., 2012; Fasani and Mazza, 2020). Workers in this sector may also face specific challenges linked to their migration status, including discrimination and unequal treatment in employment, wages and occupation compared with their non-migrant colleagues (OECD, 2022).

In the UK, for example, in an attempt to improve the image of the sector as being 'women's work', the care industry has raised its standards for the skill levels of carers (partly due to recent legislation such as the Care Standards Act of 2000), driving out the traditional workforce (which is less formally educated) and profiting from migrant skilled labour, especially former nurses who have care expertise and need little intensive training (IOM, 2012:42). Nurses sometimes migrate, only to encounter institutional barriers that prevent the conversion of their qualifications, leaving them in poorly remunerated occupations in ancillary roles (in hospital laundry, cleaning) or in social care where they are not able to use their education or skills (ILO, 2022d:375; IOM, 2012: 37-51). The Migration Policy Institute (MPI) observed that, in the USA, foreign-born health-care workers overall were more likely than their native-born peers to work as nursing assistants, personal care aides, and home health aides. MPI noted that 38% of foreign-born women and 19% of foreign-born men worked in these occupations, compared to 22% and 14% of USA born women and men, respectively (Batalova, 2020).

Skilled healthcare professionals in countries like the Philippines and India, are lured by recruitment companies into jobs requiring lower qualifications presented to them as an entry point to a bright future in Europe (Yeates and Pillinger, 2019; IOM, 2012). Given the increasing needs for care workers,

there are risks that nurses trained abroad are recruited as social care workers in various destination countries and, unable to utilise their skills and qualifications, they become deskilled. In an interview conducted in the context of this research, a North American nurses organisation explained that the recruitment of educated, yet unlicensed nurses, tends to drive wages down for the entire profession.

4(E) LIVING CONDITIONS

Due to a range of pre-existing vulnerabilities such as higher incidence of poverty, overcrowded housing conditions, migrants, including migrant health and social care workers, have paid a high price during pandemic. Living conditions (out-of-work risks) have featured prominently in academic research studies (Bui et al., 2021; Rostila et al., 2021; Nasol and Francisco-Menchavez, 2021; Tazyeen et al., 2021; Đoàn et al., 2021; Jaljaa et al., 2022; Nazareno et al., 2021; Kierster and Vazquez-Merino, 2021). Thjs issue has been spotlighted in the Gulf countries where overcrowded living conditions significantly elevate migrant workers' risks of Covid-19 infection and transmission (Saudi Digital Services, 2022). Migrant workers are also a group with a higher use of public transportation, which is an infection risk in times of pandemic (ITF, 2020). Socio-economic disadvantage (Bhaskar et al., 2020; Obinna, 2021; Rostila et al., 2021; Tazyeen et al., 2021; Đoàn et al., 2021; Freier and Espinoza, 2021) and ethnic and racial marginalisation (Côté et al., 2021; Murphy et al., 2020; Rostila et al., 2021; Hamadah et al., 2020; Aktas et al., 2022; Jaljaa et al., 2022; Nazareno et al., 2021; Oikelome, Breward and Hongwu, 2022; Aldridge et al., 2020) as experienced by migrant workers generally and migrant health workers specifically across several domains of living conditions have been foremost themes of all studies found.

Section 5 Discrimination, violence and harassment

Evidence from international and European organisations, professional bodies, employers, industry and regulatory bodies and unions point to a significant increase in both discrimination and third-party violence and harassment (TPVH) against health workers (see for example, ICN et al., 2022; ILO, 2019b, 2020d, 2021; UN, 2020; UN Women, 2020; EU-OSHA, 2022). Migrant health workers' vulnerabilities due to employment and visa insecurity and working on the front-line mean that they are frequently and disproportionately affected. These issues were exacerbated by the lack of emergency preparedness of health care systems and lack of PPE in the early days of the pandemic, and in many countries the long-standing problems of chronic underfunding of services (WHO Council on the Economics of Health for All, 2021). Health workers, including migrant health workers, have encountered high levels of stigma and discrimination, as well as verbal and physical violence and harassment, for example, due to popular perceptions that they may be vectors for transmission of the COVID-19 virus or because of a worrying increase in anti-vax verbal abuse and aggression towards health workers (ILO, 2022a:433; ICN et al., 2022; Pillinger and Yeates, 2020; EPSU et al., 2022). Violence and aggression, also driven by racism, from patients and family members frustrated with poor quality care arising from staffing shortages during the pandemic placed further acute pressure on already-overwhelmed and under-staffed health workforces in many countries. A devastating side effect of the pandemic has been racialised and xenophobic attacks and discrimination against Black, Asian and minority ethnic professionals (Bauomy, 2020; Pillinger, Gencianos and Yeates, 2021a), and migrants more generally, many of whom are healthcare professionals. Sources of violence and prejudice arose from within and outside the health care system.

Although data points to a generalised increase in TPVH against all health workers regardless of country or setting, data is limited on risks faced by racialised and minoritised health workers and migrant health workers (NNU, 2021; UNISON, 2021; Pillinger, 2017; Pillinger, Gencianos and Yeates, 2021). However, evidence shows that racialised and minoritised workers, including migrant workers, generally experience higher levels of violence and harassment in the world of work (ILO, 2016; ILO, 2020d; Pillinger, 2017). The data in Box 6 gives a picture of evidence of heightened levels of violence and harassment in the health sector both prior to and during the pandemic.

BOX 6 VIOLENCE, HARASSMENT AND STRESS FACED BY HEALTH WORKERS

- A global survey of violence in the hospital sector (ICN et al., 2022) highlighted the 'persistence of violence against health personnel...with a higher frequency of incidents after the coronavirus pandemic started' (p.1). Nearly 60% of the respondents perceived an increase in reported cases of violence against health care workers since the beginning of the pandemic. The survey shows that violence against health care workers affects all organisations, private and public, regardless of their country's economic and security situation. The survey also reported various initiatives to tackle violence such as security, safer work environments, care for staff mental health and well-being, and addressing gaps in communication and coordination.

- In the PSI and the Open University survey (Pillinger, Gencianos and Yeates 2021a, 2021b), one-third (32.4 %) of unions stated that violence and harassment had increased during the pandemic; and over half (54%) of unions reported that migrant health workers experienced significant negative impacts on their health and wellbeing, including fatigue, burnout and violence. A further one-third of unions had given priority to introducing new measures to address the increase in violence and harassment, which was frequently targeted at migrant health and social care workers. Overall, the survey found that migrant health workers were disproportionately affected by the pandemic because of employment insecurity and limited access to health and safety protections, PPE and paid sick leave, making them more vulnerable to violence, harassment and heightened levels of racist and anti-migrant harassment.

- Anti-Chinese sentiment is at its highest in 15 years, at 60% in the USA and 67% in Canada. Similar trends are observable in Western Europe and in the Asia-Pacific region (Silver, Devlin and Huang, 2019).

- Prior to the pandemic, as many as 42% of workers in direct contact with the public in Europe had experienced TPVH and that levels of TPVH grew significantly during the pandemic (EU-OSHA, 2022).

- A survey of over 2,000 nurses by the UK public service union, UNISON, reveals that sexual harassment in healthcare had become 'normalised', with 60% of nurses reporting that they had been sexually harassed either by patients or colleagues; however, nearly three-quarters did not report these incidents (UNISON, 2021).

- In a poll by the Canadian Union of Public Employees (CUPE, 2021), one third of surveyed workers were considering leaving the profession as a result of stress, increased workloads, long hours and an increasingly aggressive working environment; over two thirds reported they faced increased violence from patients and their families (Brophy et al., 2021).

- A study in the health sector in Brazil, Chile, Colombia, El Salvador and Peru (PSI and Kommunal, 2020) found that 80% of health workers interviewed had suffered some form of harassment. The report called for tripartite social dialogue, the promotion of bipartite occupational health and safety committees, the adoption of procedural protocols, risk assessments and strengthened labour inspection systems.

- In Denmark, immigrant nursing students from Eastern Europe, Iran, Pakistan, Africa and Asia have faced significantly higher risk of being bullied in colleges compared to their native counterparts (Llop-Gironés et al., 2021).

- While not exclusively targeted to migrant health workers, examples of incidents of violence include 70 cars of healthcare workers outside the hospitals in one Italian city being damaged overnight, and, in Mexico, cases of physical and verbal assaults on health workers, including nurses, inside and outside hospital facilities, as well as while making home visits to assess patients, and on their way home (Llop-Gironés et al., 2021).

- While more health providers are bound by national laws on ending discrimination and violence at work, worryingly, the State of the World nursing report indicates that only just over a third of countries (37%) reported measures in place to prevent attacks on health workers (WHO, ICN and Nursing Now, 2020: xvi).

Rising levels of racism have brought to the fore the need for better recognition of the intersections of gender and socio-economic inequalities, with those of migration and 'race' in providing and receiving health and social care services (Pillinger, Gencianos and Yeates, 2021b). In the USA, National Nurses United has called for improved data collection to identify and address racial disparities during the COVID-19 pandemic (NNU, 2020a). NNU's own research showed that Filipinos make up 4% of nurses in the USA, but 31.5% of nurse deaths from COVID-19 (NNU, 2021). African Americans and other minority groups in the USA are disproportionately affected by death from COVID-19. For example, in Chicago 40% of deaths from COVID-19 have been of African Americans, even though African Americans represent only one-third of the population (Pillinger, Gencianos and Yeates, 2021b).

Uncertainty and lack of full information around COVID-19, as well as more general discourse reflecting political and economic tensions (such as those between China and the USA when the pandemic broke out (Bauomy, 2020); remnants of the Brexit debates in the UK (Mueller, 2020); the arrest of a high profile Chinese Huawei official in Canada (Silver et al., 2019); or more generally racialized narratives in France (Helies, 2021) - have generated additional fears about foreigners, including people of Asian origin, many of whom are providing healthcare services. The stigmatisation of and discrimination against migrants have been exacerbated by misinformation and fake news in the media (IOM, 2020; Huang and Liu, 2020). The Asian Pacific Policy and Planning Council in the USA has documented 1,500 discriminatory and xenophobic incidents in the country in one month (March - April 2020). Civil rights violations involving workplace discrimination, being barred from businesses and transportation or being refused a service made up almost ten per cent of all incident reports, with women being twice as likely to face such risks (Asia-Pacific Policy and Planning Council, 2020).

Similarly, Asian health workers face discrimination due to a unique combination of their racial background and their occupation of roles that bring them into direct contact with COVID-19-exposed patients (Cheng and Ma, 2022; Huang and Liu, 2020). Interestingly, our review of Arabic literature found that information available in destination countries blames migrant workers, including migrant healthcare workers, especially those who come from high infection rate countries such as India, for the introduction and transmission of COVID-19. Countries such as UAE, Iraq, Jordan and Morocco recorded a highly transmissible Covid-19 variant, termed 'Indian Covid-19' because it is said to have been spread by Indian emigrants (RT Online, 2021). According to Alhussein (2020) overseas doctors and nurses in Saudi Arabia are seen as primary transmitters of 'Corona' to the world, with some experts in this disease explaining that Covid-19 will likely be transmitted through these health workers when they return to their country. In Algeria, the spread of Covid-19 to Algeria was said to have come from returning health workers employed in France (Derar, 2020).

Conversely, information available in Arabic source countries on migrant health workers tend to explain the fact that their nationals caught COVID-19 by reference to the poor working and living conditions in destination countries. According to AFP (2020), Qatar, which is the home to more than two million migrant workers, has one of the highest rates of coronavirus infection in the world, with (at the time) 18,000 cases among a population of just 2.8 million. More than 25% of people tested for the virus the week of the test, the vast majority of them migrant workers, were found to be infected.

Migrant health workers face greater risk of prejudice and discrimination in both their personal and professional lives. A survey conducted by the Canadian Union of Public Employees (CUPE) reported an increase of COVID-19-related racism targeting health workers in the Canadian province of Manitoba. Most significantly, while only 1% of health workers who did not identify as Asian reported experiences of racism during the surveyed 1-month period, a staggering 20% of Asian health workers reported racism during the same time frame (Cheng, 2020; Reimer, 2020). Research indicates that these repeated aggressions, made worse by the lack of acknowledgement by authorities, are linked to incidences of burnout and the desire of health workers to abandon their jobs. Further, these issues have been linked to the quality of care that migrant health workers are able to provide.

Furthermore, systemic discrimination (London Araby, 2020) and lack of job security explains why migrant health workers are unable to refuse jobs with the highest exposure on the front line of the COVID-19 response. Reporting on data from a survey of the UK's National Health Service workforce, UNISON reports that 'higher proportions of frontline staff are Black', although it did not specify what proportion of such staff may be migrants (UNISON, 2022a:28). Overall, 34.7% of NHS staff were redeployed into COVID-19 areas whereas 49.2% of staff 'from other ethnic groups' were redeployed into such areas (cited in an interview with an employer representative). UNISON remarks that 'in the workplace many [migrants] continue to face racism, wider discrimination and unfair employment practices' (UNISON, 2022a:19). The *New York Times* postulates an hypothesis that the disproportionate mortality rate of migrant doctors during COVID-19 may be rooted in practices where locally-born 'doctors have largely dominated the prestigious [medical] disciplines while foreign doctors have typically found work in places and practices that are apparently putting them on the dangerous front lines of the coronavirus pandemic' (Mueller, 2020). UNISON further observed that black and minority ethnic workers with post-COVID-19 syndrome have been subject to particularly punitive handling of leave entitlements 'due to systemic racism' (UNISON, 2022a:14). It concludes that COVID-19 'has highlighted the long-term impact of racism on people's physical and mental health, leaving them more vulnerable to COVID-19' (UNISON, 2022a: 26).

In a highly feminised workforce, particularly in nursing, gender discrimination disproportionately impacts on women's opportunities, advancement and pay. Nurses in particular face direct and indirect discrimination, sexual harassment, vertical and horizontal occupational segregation and gender pay gaps (ILO, 2022a; NNU, 2020b). For example, women in the health and social care sector earn 24% less than men, representing a much larger gender pay gap than in any other economic sector (ILO, 2022c). Furthermore, the UN (2020) has drawn attention to the role played by women in the pandemic. Given that women represent almost 70% of health workers, not only are they much more likely than male health workers to be infected with Covid-19 (Hierrezuelo Rojas et al., 2021; Poblete Umanzor et al., 2020; Trullàs et al., 2020) (largely because they tend to be deployed on the frontline), and to die from that infection (Ares-Blanco et al., 2021), but the discrimination they face is compounded where intersecting multiple grounds of discrimination are present, such as sex, age, 'race' and national origin (ILO, 2022a: 439). In this respect, those with a Black or minority ethnic background, particularly low-profile health occupations, were disproportionately impacted by Covid-19 due to racial discrimination (Côté et al., 2021; Obinna, 2021; Đoàn et al., 2021; Oikelome, Broward and Hongwu, 2022) and lack of peer support in their health facilities (Bhaskar et al., 2020; Obinna, 2021; Nasol and Francisco-Menchavez, 2021; Aktas et al., 2022; Nazareno et al., 2021; Simmons, Rodrigues and Szebelhelyet, 2021; Gasana et al., 2021).

Section 6 Absence of social dialogue and workers'voice

Social dialogue, including workplace cooperation and collective bargaining, is critical for enabling stakeholders in the health system to play an active role in responding to the COVID-19 outbreak (ILO, 2020b:6; ILO, 2020g; Pillinger and Yeates, 2020; Pillinger, Gencianos and Yeates, 2021c). Interviews carried out for this research from public bodies, international organisations and trade unions underline the importance of having the freedom to express concerns, for example, around occupational safety and health or refusing work that health workers believe will endanger themselves or others, as well as their right to organise and participate freely in dialogue, and that these are important principles that must be upheld, even in emergency situations such as the COVID-19 pandemic. In its Employment and Decent Work for Peace and Resilience Recommendation, 2017 (No. 205)[3], the ILO is clear that social dialogue is an effective way to increase the coordination needed in times of crisis. Given the important role played by women in delivery healthcare services, the voice of women, including women migrant health workers is paramount. Social dialogue is essential to building resilient health systems, and therefore has a critical role both in crisis response and emergency preparedness (Pillinger and Yeates, 2020; Pillinger, Gencianos and Yeates, 2021c).

In a recent report on the application of ILO nursing labour standards across its member states, the ILO observes that although the *formal right* of nursing personnel to establish and join organisations of their own choosing and to bargain collectively exists in most of its member states, some countries still limit the legal protection afforded to health workers if and when they want to exercise their right to freedom of association (ILO, 2022a:398). In some cases, health workers' 'essential workers status' may deny some nursing and medical personal the right to freely form and join a trade union, and or make it difficult to join or form their own advocacy organisations, given their sometimes precarious employment status or – in the case of agency workers - their convoluted relationship with their employers. The ILO adds that the *effective exercise* of health workers' right to organise is particularly weak, especially for those employed in the private sector.

This finding echoes evidence from PSI (Pillinger and Yeates, 2020) and highlights that certain employment practices, including outsourcing, precarious forms of employment and recourse to 'service contracts', have a 'chilling' effect on the effective exercise of freedom of association by nursing personnel in both the public and private sectors (ILO, 2022a:398). As many migrant health workers operate under these non-standard forms of employment, many would face difficulties in exercising these internationally-recognised rights. PSI has also observed that there may be a significant aspect of gender discrimination in such denial, with some employers declining to employ male nurses due to the belief that they are more active than women nurses in unions and advocacy for improved working conditions through collective bargaining (ILO, 2022a: 399). Interviews with trade union representatives carried out for this research reveal that, in exploiting the shortages and uncertainty created by the pandemic, some employers have attempted to divide unionised health

3 The Nursing Personnel Convention (No. 149) and Recommendation (No. 157), 1977.

workers and migrant health workers by luring them to leave their stable employment for precarious, yet better paid, short-term contracts that do not allow them to join a trade union organisation (Interview, trade union representative, North America).

In a post-COVID scenario involving future pandemic planning, governments should invest energy and resources into building better and more resilient public health systems. Essential to this is the participation of healthcare workers' organisations in policy dialogue, including those representing migrant workers. However, a recent global survey of emerging post-COVID-19 dialogue processes indicated the intentions of some governments to limit workers' participation in formal dialogue. Healthcare workers' involvement in COVID taskforces in many countries 'has been negligible or null in coordinating and supervising the governments' efforts to monitor, prevent, contain, and mitigate the spread of COVID-19' (Llop-Gironés et al., 2021:7).

Translating the dissatisfaction of health workers at the handling of the pandemic, a representative of the WHO interviewed for this research revealed that after two years of pandemic 'there is a lot of dissatisfaction amongst the global health and global care worker associations and communities', and that at least 75% of the organisation's Member States have experienced industrial unrest in the sector since 2020. Recent analysis by the European Public Services Union (EPSU) (2022b) found that in the first six months of 2022 there was unprecedented strike action and mobilisation by trade unions across Europe as dissatisfaction associated with staffing levels, burnout, pay levels, working hours and conditions of work grew.

Section 7 Changes in recruitment practices and unethical recruitment

7(A) CHANGES IN RECRUITMENT PRACTICES DRIVEN BY THE DEMAND FOR HEALTH WORKERS

Travel restrictions and border closures have impacted on staff recruitment in the sector, leading many countries with an increased demand for health staff to consider different ways of continuing to recruit overseas health workers (Pillinger and Yeates, 2020). In Switzerland, for example, where a third of all nurses working in Swiss hospitals are foreign-trained, the government was 'forced to negotiate with its neighbours to allow health workers to continue to cross the border to work' (CGFNS, 2022: 36). These difficulties prompted the European Union to call on Member States 'to facilitate the smooth border crossing for health professionals and allow them unhindered access to work in a healthcare facility in another Member State' (ILO, 2022a: 385). More worryingly perhaps, accounts have emerged of nurses being stranded in destination countries needing the assistance of their national nurse association to be safely repatriated (Llop-Gironés et al., 2021; ITUC, 2020a).

Despite greater investment in recruiting additional health workers, whether in-country or from overseas, temporary measures have been instituted on an emergency basis, rather than with a view to the long-term sustainability of the health care system. As one research participant from an international organisation interviewed for this study said:

> What we have seen is that COVID-19 has fuelled increased economic demand for increased migrant health workers in the global north, and economic demand has driven investment into the COVID response, with more funding in the system for recruitment and wages. Over 80 jurisdictions had changed their regular frameworks for licencing to practice enabling recruitment, and licencing to practice were loosened up for retirees, students and migrants. Some jurisdictions – 15 countries - put in place restrictions...to enable professionals to get permission to leave and travel somewhere else, plus travel restrictions were in place. Competition for resources has taken place.

In the midst of the drive for overseas health workers in country-level measures to increase surge capacity, the Vice President of Zimbabwe said countries that engage in international recruitment owe Zimbabwe USD$100 million in recompense for the nurses taken out of the country. This intervention resurrects a long-standing policy debate about the merits of recruiting countries paying compensation to source countries in recognition of the latters' loss of public investment in educating and training skilled health workers (Yeates and Pillinger, 2019). According to our interview with a representative from the WHO, Zimbabwe is a particular case as the migration push factors have been as strong as the pull factors, with recent inflation eroding salaries by as much as 30%. As a result, as many as 20% of Zimbabwean nurses have left the country during the pandemic.

In addition, travel restrictions imposed during the pandemic, meant that migrant health workers faced long periods of separation from their families abroad, either because they were prevented from taking paid or unpaid leave from work or because of travel restrictions and quarantine requirements upon return. The harsh attitude toward family reunification, for example in the UK, has also contributed to health workers being isolated from their families (Interviews, health care authority and trade union, Europe; see also Llop-Gironés et al., 2021).

7(B) UNETHICAL RECRUITMENT

The COVID-19 pandemic created an immediate and urgent demand for more healthcare workers to boost surge capacity at a time of existing staff shortages. As an immediate response, many OECD countries resorted to international recruitment of healthcare personnel (CGFNS, 2022). This impacted directly on the health systems of lower-income source countries equally struggling with their own pre-existing shortages and the pandemic needs, as well as putting healthcare migrants at higher risk of unethical recruitment given the speed at which recruitment drives were being organised.

For a number of years after adoption of the WHO's Code of practice for the ethical recruitment of health personnel that aimed to ensure health equity across countries (WHO, 2010), the risks associated with international recruitment of health personnel, especially from countries where there are critical workforce shortages, has been a continual concern. These countries face the most pressing health workforce challenges in meeting the Sustainable Development Goal of universal health coverage (UHC) by 2030, and a minimum density established under the SDG index threshold of 4.45 doctors, nurses and midwives per 1,000 population. The outward migration of health workers hampers the ability of source countries to deliver health services. A Dutch NGO highlighted in an interview with the research team the relevance of the WHO Code to the pandemic response, but also pointed out that the Code's voluntary nature renders it too weak to respond to current challenges (Interview, NGO, Europe).

At the 2022 World Health Assembly (WHA), the WHO's highest governing body, governments were urged to increase their efforts to comply with the Global Code (WHO, 2022d). The WHA acknowledged the recommendations from the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code in 2020, notably 'to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration and to safeguard the rights of all health personnel' (WHO, 2022d:49). This gives specific attention to the 47 countries identified on the WHO Health Workforce Support and Safeguards List (WHO 2020; see footnote 2) as being at risk of severe harm from recruitment of health workers to work abroad, as well as to the importance of collecting and reporting data on international health workforce migration. The introduction of the precautionary and safeguarding principle is intended to avoid situations arising that lead to unprecedented levels of migration of health workers, and the potential for this to lead to inter-state conflict, as cited above in the example from Zimbabwe. As stated in a research interview with a senior member of an international organisation, in relation to Zimbabwe:

> This is unprecedented, we have never seen such level of outward migration. If there is a level of COVID-19 vulnerability for services to be provided and address the backlog of care, then those vulnerabilities will be addressed under the support and safeguards list to prevent unethical recruitment.

BOX 7 INTERNATIONAL RECRUITMENT OF HEALTH WORKERS

- The pandemic has heightened the risks to population health and health service provision associated with international recruitment (CGFNS, 2022:30). Even before the pandemic, the scale of the international flow of nurses was large and growing. In 2019, more than 550,000 foreign-trained nurses were working across 36 OECD member countries.
- This was a marked increase on the 460,000 recorded in 2011 (OECD, 2019; ICN, CGFNS and Buchan, 2022:37). The number and/or share of foreign-trained nurses in the nursing workforce has increased particularly rapidly in Belgium, France, Germany and Switzerland, with a steady growth also occurring in Australia, New Zealand, Canada and the USA (CGFNS, 2020:37).
- The UK is now recruiting from a list of more than one hundred countries, some of which were off-limit prior to the 2021 revision of the NHS Code of Ethical Recruitment (Interview, trade union, Europe).
- A recent report by CGFNS describes some of the international recruitment measures adopted by several countries. Some of these countries are known to depend on international recruitment, but others are new to it (CGFNS, 2022: 38; see also Yeates et al., 2022 in this series).

In some cases, ethical recruitment conditions have been severely compromised, putting migrant workers at great risk. The urgent call for immediate intervention to recruit foreign doctors and nurses in some cases took place without following up the standardised measures to ensure that immigrants are eligible for health insurance (Abdelsalam, 2021). For example, in Italy, according to Alhamdid (2020) where more than 77,000 migrant health workers were recruited from around the world, calls mounted for the implementation of legislative procedures to conform with health insurance regulation for those immigrants. According to Gingia (2020), 1,500 Syrian doctors and 1,000 Palestinian doctors were recruited to work in Europe during the pandemic, health workers who in otherwise times of peace in their countries would have no doubt contributed to their own country's health care (citing Maguid, 2020).

As the corollary of the above, some countries, such as the Philippines, a country with a historically high rate of outward migration of healthcare workers, have also actively tried to stop international outflows of nurses on the basis that their skills were required at home. Measures taken to forbid the migration of health workers at the beginning of the pandemic were since dropped (Chipman-Koty, 2021).

Not only does the increased demand for internationally-recruited health workers impact on the healthcare system of source countries, but it also increases the risk that migrants will be misled by recruitment processes designed and carried out on an emergency basis (ILO, 2022a:375). For example, an interview with a Europe-based trade union carried out for this research highlighted that pre-departure information was not always provided to intending migrant health workers. This means they arrive in their country of employment without knowledge of national labour laws, including, in the case of the UK, the 'repayment clause', and their rights at work.

Section 8 Conclusions

This paper has reviewed a wide range of available evidence from academic and grey literatures showing that multiple risk factors have compounded extant vulnerabilities of migrant health workers and increased their risk of contracting and dying from COVID-19 compared with their non-migrant colleagues and/or the population at large. These exacerbating factors fall into five principal categories: health workforce shortages; decent work deficits, including lack of social protection; discrimination, violence and harassment; absence of social dialogue, and changing patterns of international recruitment. This cluster of factors, all relating directly or indirectly to working conditions, have exacted a heavy toll on migrant health workers and have resulted in severe, frequently fatal, threats to their health and welfare. We have shown how the pandemic changed international dynamics of health labour movement, weakened health care systems in many countries least able to sustain losses of health workers, and exacerbated harms to migrant health workers due to decent work shortfalls, social protection gaps, increased violence against migrant health workers (especially those of Asian origin or heritage) and compounded harassment and discrimination. The significant worsening of working conditions has been consequential for the rights and welfare of migrant health workers as well as for the provision of universal health care. Although these risks were present pre-pandemic, it cannot be doubted that the pandemic posed a serious threat to realising rights-based, people-centered sustainable development for all countries and peoples worldwide.

The weight of evidence affirms that the migratory status of health workers is linked to systematic health risks. These risks emanate from the social organisation of health-sector workforces and their working conditions at sector and workplace levels as well as from public policy frameworks and interventions across a wide range of sectors and issues. Continued attention is required to address the unevenly-distributed risks across the health workforce as a whole, not only in times of pandemic but also during 'normal' times. From a research perspective, there remains much to learn about how those risks are structured, by age, health status, occupation, migrant status, country of origin, certainly, but also by institutional environment (e.g. hospitals vs. community settings; public vs private sector), the degree of worker organisation (e.g. unionised vs. non-unionised workforces), the quality of working conditions and the extent of social protection coverage. From an advocacy and reform perspective, the maxim that no-one is safe until everyone is safe – migrant or not - is of immediate and obvious relevance here. This is not just a matter of global health security, but of social justice. The universally-accepted principle of fair and ethical treatment, as concretely established in provisions on ethical recruitment, decent work, fundamental rights at work and health workforce and health systems strengthening, must be the bedrock of actions in support of universal health care and rights-based people-centered sustainable development for all countries worldwide.

REFERENCES

Abdelsalam, S. (2021) 'Italy: Calls For The Employment Of "Foreign" Doctors To Confront The Corona Pandemic', *Muhajer News*, https://www.infomigrants.net/ar/post/28461 (Accessed 9 May 2022).

(AFP) Agence France Presse (2020) 'Migrant Workers "Begging" In Qatar Due To An Epidemic "The World Still Does Not Know"', *Araby News,* https://www.bbc.com/arabic/inthepress-52586168 (Accessed 9 May 2022).

Aktas, E., Bergbom, B., Godderis, L., Kreshpaj, B., Marinov, M., Mates, D., McElvenny, D., Mehlum, I., Milenkova, V., Nena, E. and Glass, D.C. (2022) 'Migrant workers occupational health research: an OMEGA-NET working group position paper', *International Archives of Occupational and Environmental Health,* 95, pp. 765–777. https://doi.org/10.1007/s00420-021-01803-x (Accessed 7 April 2022).

Aldridge, R., Lewer, D., Katikireddi, S., Mathur, R., Pathak, N., Burns, R., Fragaszy, E., Johnson, A., Devakumar, D., Abubakar, I. and Hayward, A. (2020) 'Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data', *Wellcome Open Research*, 5, p.88. https://wellcomeopenresearch.org/articles/5-88 (Accessed 9 April 2022).

Alhamdid, T. (2020) الجيش-الأبيض-يخوض-حربا-على-كورونا-ليبقى-الوطن-بصحة-وعافية. محليات. ['The White Army is fighting a war on 'Corona' to keep the homeland healthy'], https://alrai.com/article/10530587 (Accessed 29 March 2020)

Alyehawai, K. (2020) ريبورتاج: الأطباء الأجانب في فرنسا بالصفوف الأولى لمواجهة فيروس كورونا رغم تفاوت الامتيازات المهنية [Reportage: Foreign doctors on the frontline in France to respond to the COVID-19 pandemic in spite of disparities in professional privileges], *France 24*. Available at: https://www.france24.com/ar/20200421-%D8%B1%D9%8A%D8%A8%D9%88%D8%B1%D8%AA%D8%A7%D8%AC-%D8%A7%D9%84%D8%A3%D8%B7%D8%A8%D8%A7%D8%A1-%D8%A7%D9%84%D8%A3%D8%AC%D8%A7%D9%86%D8%A8-%D9%81%D9%8A-%D9%81%D8%B1%D9%86%D8%B3%D8%A7-%D8%A8%D8%A7%D9%84%D8%B5%D9%81%D9%88%D9%81-%D8%A7%D9%84%D8%A3%D9%88%D9%84%D9%89-%D9%84%D9%85%D9%88%D8%A7-%D8%AC%D9%87%D8%A9-%D9%81%D9%8A%D8%B1%D9%88%D8%B3-%D9%83%D9%88%D8%B1%D9%88%D9%86%D8%A7-%D8%B1%D8%BA%D9%85-%D8%AA%D9%81%D8%A7%D9%88%D8%AA-%D8%A7%D9%84%D8%A7%D9%85%D8%AA%D9%8A%D8%A7%D8%B2%D8%A7%D8%AA-%D8%A7%D9%84%D9%85%D9%87%D9%86%D9%8A%D8%A9 (Accessed 29 August 2022).

Ares-Blanco, S., Astier-Peña, M.P., Gómez-Bravo, R., Fernández-García, M. and Bueno-Ortiz, J.M. (2021) 'Gestión de los recursos humanos y estrategias de vacunación en atención primaria en Europa en la pandemia COVID-19' [Human resource management and vaccination strategies in primary care in Europe in the COVID-19 pandemic], *Atención Primaria* 53(10), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8188304 (Accessed 25 April 2022).

Asia-Pacific Policy and Planning Council (2020) 'In One Month, STOP AAPI HATE' Receives almost 1500 Incident Reports of Verbal Harassment, Shunning and Physical Assaults', Los Angeles, US: Asia-Pacific Policy and Planning Council. http://www.asianpacificpolicyandplanningcouncil.org/wp-content/uploads/Press_Release_4_23_20.pdf (Accessed 29 August 2022).

Batalova, J. (2020) *Immigrant Health-Care Workers in the United States*. MPI Spotlight. Washington DC, Migration Policy Institute. https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2018 (Accessed 29 August 2022).

Bauomy, J. (2020) 'COVID-19 and xenophobia: Why outbreaks are often accompanied by racism', *Euronews*, 6 March. https://www.euronews.com/2020/03/05/covid-19-and-xenophobia-why-outbreaks-are-often-accompanied-by-racism (Accessed 25 August 2022).

Bhaskar, S., Rastogi, A., Menon, K.V., Kunheri, B., Balakrishnan, S. and Howick, J. (2020) 'Call for Action to address equity and justice divide during Covid-19', *Front Psychiatry* 11:559905.

Brophy, J., Keith, M., Hurley, M. and McArthur, J. (2021) 'Sacrificed: Ontario Healthcare Workers in the Time of COVID-19', *NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy*, 30(4), pp. 267–281.

Bui, H.T.T., Duong, D.M., Pham, T.Q., Mirzoev, T., Bui, A.T.M. and La, Q.N. (2021) 'Covid-19 stressors on migrant workers in Vietnam: Cumulative risk consideration', *International Journal of Environmental Research and Public Health*, 18(16), p. 8757.

(CGFNS) Commission on Graduates of Foreign Nursing Schools (2022) *Passport2Liberty Opens Ukrainian Nurse Migration to United States*. 22 July. Philadelphia, USA: CGFNS International. https://www.cgfns.org/passport2liberty-opens-ukrainian-nurse-migration-to-united-states/ (Accessed 22 August 2022).

Cheng, B., and Ma, J. (2022) 'The other pandemic: COVID-19 as a catalyst for hate against Asian health care workers', *British Columbia Medical Journal*, 64(4), pp. 182-184.

Cheng, W. (2020) 'Locsin Says Nurses with Existing Contract Abroad May Now Leave', *ABS-CBN News*, 13 April. https://news.abs-cbn.com/overseas/04/13/20/nurses-with-contracts-abroad-exempted-from-poea-ban-due-to-coronavirus-covid19-luzon-lockdown (Accessed 22 August 2022).

Chipman-Koty, A. (2021) *How COVID-19 Has Impacted Philippine Medical Worker Recruitment*? ASEAN Briefing, 26 October. https://www.aseanbriefing.com/news/how-covid-19-has-impacted-philippine-medical-worker-recruitment/ (Accessed 22 June 2022).

Côté, D., Durant, S., MacEachen, E., Majowicz, S., Meyer, S., Huynh, A-T., Laberge, M. and Dubé, J. (2021) 'A rapid scoping review of Covid-19 and vulnerable workers: Intersecting occupation and public health issues', *American Journal of Industrial Medicine*, 64(7), pp. 551-566.

Derar, F. (2020) انتشار فيروس كورونا في الجزائر مصدر فرنسا [The spread of the Corona virus in Algeria is from France], *Aljazayer*, https://aljazair1.dz (Accessd 25 March 2020).

Đoàn, L., Chong, S., Misra, S., Kwon, S. and Yi, S. (2021) 'Immigrant communities and COVID-19: strengthening the public health response', *American Journal of Public Health*, 111(S3), S224-S231.

(EC) European Commission (2020) *Analysis of shortage and surplus occupations*, Directorate-General for Employment, Social Affairs and Inclusion, Luxembourg, Publications Office. https://data.europa.eu/doi/10.2767/933528 (Accessed 7 June 2022).

(EPSU) European Public Services Union (2022a) *Pay and staffing: six months of action by health and social care unions*, Brussels, BE: EPSU. https://www.epsu.org/sites/default/files/article/files/Action%20in%20health%20and%20social%20services_0.pdf (Accessed 10 August 2022).

(EPSU) European Public Services Union (2022b) *Staff shortages in health increase across Europe*, Brussels, BE: EPSU. https://www.epsu.org/article/staff-shortages-health-increase-across-europe (Accessed 10 August 2022).

EPSU, HOSPEEM, CEMR, CESI, EUPAE, ETUCE, ETF, UITP, ETNO (2022) *The role of social partners in preventing third-party violence and harassment. Report of Webinar 3: Third-party violence and harassment and the role of risk assessment,* Brussels, BE: EPSU https://www.epsu.org/sites/default/files/article/files/Report%20-%20TPVH%20Webinar%203%20-%20Risk%20assessment%20-%2025%20October%202021.pdf (Accessed 10 July 2022).

(EU-OSHA) European Union information agency for occupational safety and health (2022a) *Human health and social work activities – evidence from the European Survey of Enterprises on New and Emerging Risks (ESENER),* Bilbao, ES: EU-OSHA. https://osha.europa.eu/en/publications/human-health-and-social-work-activities-evidence-european-survey-enterprises-new-and-emerging-risks-esener (Accessed 10 July 2022).

Fadel, L., Stone, W., Anderson, M., and Benincasa, R. (2020) 'As Hospitals Lose Revenue, More Than A Million Health Care Workers Lose Jobs', *National Public Radio*, 8 May. https://text.npr.org/852435761 (Accessed 22 August 2022).

Fasani, F. and Mazza, J. (2020) *Immigrant Key Workers: Their Contribution to Europe's COVID-19 Response,* Brussels, BE: European Commission briefing note. https://knowledge4policy.ec.europa.eu/sites/default/files/key_workers_covid_0423.pdf (Accessed 25 August 2022).

Freier, L.F. and Espinoza, M.V. (2021) 'COVID-19 and immigrants' increased exclusion: The politics of immigrant integration in Chile and Peru', *Frontiers in Human Dynamics*, 3:606871. doi: 10.3389/fhumd.2021.606871

Gasana, J., Al-Ahmad, B., Mudga, S., Kamel, M., Zoughool, M., Vainio, H., Hazeem, L., Altourah, M., Buqammaz, M., Safar, A., Al Hajri, S., Ateeq, A., and Alfajjamet, S. (2021) 'Healthcare workers and exposure to Covid-19: survey and training in Kuwait', *Teikyo Medical Journal*, 44(6), pp. 3313-3329.

Gingia, N. (2020) هل يعيد كورونا الاعتبار للأطباء المهاجرين؟ [Does Corona restore consideration to immigrant doctors?] MCD International, 17 May. https://www.mc-doualiya.com/articles/ (Accessed 9 April 2022).

(GBD) Global Burden of Disease 2019 Human Resources for Health Collaborators (2022) 'Measuring the availability of human resources for health and its relationship to universal health coverage for 204 countries and territories from 1990 to 2019: a systematic analysis for the Global Burden of Disease Study 2019', *The Lancet*, No 399, https://doi.org/10.1016/S0140-6736(22)00532-3

Hamadah, H., Alahmad, B., Behbehani, M., Al-Youha, S., Almazeedi, S., Al-Haddad, M., Jamal, M.J.. and Al-Sabah, S. (2020) 'COVID-19 clinical outcomes and nationality: results from a Nationwide registry in Kuwait', *BMC Public Health*, 20, 1384. https://doi.org/10.1186/s12889-020-09490-y.

Hare Bork, R., Robins, M., Schaffer, K., Leider, J.F. and Castrucci, B.C. (2022) 'Workplace Perceptions and Experiences Related to COVID-19 Response Efforts Among Public Health Workers - Public Health Workforce Interests and Needs Survey, United States, September 2021–January 2022', *Morbidity and Mortality Weekly Report,* 71, pp. 920–924. http://dx.doi.org/10.15585/mmwr.mm7129a3 (Accessed 22 August 2022).

Hargreaves, S., Rustage, K., Nellums, L.B., McAlpine, A., Pocock, N., Devakumar, D., Aldridge, R.W., Abubakar, I., Kristensen, K.L., Himmels, J.W., Friedland, J.S. and Zimmerman, C. (2019) 'Occupational health outcomes among international migrant workers: a systematic review and meta-analysis', *The Lancet Global Health*, 7(7): e872-e882, 1 July, 2019. Doi: https://doi.org/10.1016/S2214-109X(19)30204-9

Helies, K. (2021) 'En France, la pandémie de Covid-19 a mis en lumière un «racisme anti-asiatique ambiant' [In France, the Covid-19 pandemic has highlighted 'ambient anti-Asian racism'], *Le Parisien*, 8 July, https://www.leparisien.fr/societe/covid-19-une-pandemie-revelatrice-dun-racisme-anti-asiatique-ambiant-08-07-2021-3KK7W5DRO5GW3NO354HE2NECEI.php (Accessed 30 August 2022)

Hierrezuelo Rojas, N., Fernández Gonzalez, P., León Gilart, A., Johnson Valenciano, S. and Cordero Castillo, F. (2021) 'Principales características clínicas y epidemiológicas de trabajadores de la salud diagnosticados con COVID-19 en Santiago de Cuba' [Main clinical and epidemiological features of healthworkers diagnosed with COVID-19 in Santiago de Cuba], *MEDISAN*, 25(6), p. 1324.

Huang, J. and Liu, R. (2020) 'Xenophobia in America in the Age of Coronavirus and Beyond', *Journal of Vascular and Interventional Radiology,* 31, pp. 1187–1188.

ICN (International Council of Nurses) (2020) *COVID-19 and the international supply of nurses*, Geneva: ICN. https://www.icn.ch/system/files/2021-07/COVID19_internationalsupplyofnurses_R (Accessed (9 August 2022).

(ICN) International Council of Nurses, CGFNS International and Buchan, J. (2022) *Sustain and Retain in 2022 and beyond: toward a global nursing workforce and the Covid-19 pandemic*, ICN and CGFNS. https://www.icn.ch/system/files/2022-01/Sustain%20and%20Retain%20in%202022%20and%20Beyond-%20The%20global%20nursing%20workforce%20and%20the%20COVID-19%20pandemic.pdf (Accessed 29 August 2022).

(ICN) International Council of Nurses, International Committee of the Red Cross (ICRC), International Hospital Federation (IFH) and World Medical Council (WMC) (2022) *Violence Against Health Care: Current practices to prevent, reduce or mitigate violence against health care*, https://www.ihf-fih.org/download_doc_file.php?doc=e86a004c2d4dfe2341080e1f2bd8e3b2 (Accessed 29 August 2022).

(ILO) International Labour Organization (2016) *Final report. Meeting of Experts on Violence against Women and Men in the World of Work*, 3–6 October 2016. Geneva: ILO.

(ILO) International Labour Organization (2018) *Care work and care jobs for the future of decent work*. Geneva, ILO. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf (Accessed 30 August 2022).

(ILO) International Labour Organization (2019a) *General principles and operational guidelines for fair recruitment and Definition of recruitment fees and related costs*. Geneva: ILO. https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/publication/wcms_536755.pdf (Accessed 29 August 2022).

(ILO) International Labour Organization (2019b) *Ending violence and harassment in the world of work*, Report V(1), International Labour Conference, 108th Session. Geneva: ILO.

(ILO) International Labour Organization (2020a) *COVID-19. Are there enough health workers?* Geneva: ILO. https://ilostat.ilo.org/covid-19-are-there-enough-health-workers/ (Accessed 29 August 2022).

(ILO) International Labour Organization (2020b) *COVID-19 and the health sector*, ILO Brief. https://www.ilo.org/sector/Resources/publications/WCMS_741655/lang--en/index.htm (Accessed 26 August 2022).

(ILO) International Labour Organization (2020c) *The migrant pay gap: Understanding wage differences between migrants and nationals*, Geneva: ILO. https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/publication/wcms_763798.pdf (Accessed 22 August 2022).

(ILO) International Labour Organization (2020d) *Ending violence and harassment in the world of work*, Policy Brief. ILO ACTRAV. Geneva: ILO.

(ILO) International Labour Organization (2020e) *COVID-19 and care workers providing home or institution-based care,* ILO Sectoral Brief, Geneva: ILO. https://www.ilo.org/sector/Resources/publications/WCMS_758345/lang--en/index.htm (Accessed 29 August 2022).

(ILO) International Labour Organization (2020g) *Social dialogue key to combating COVID-19*, Policy Brief, Geneva: ILO. https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---dialogue/documents/briefingnote/wcms_743640.pdf (Accessed 22 August 2022).

(ILO) International Labour Organization (2021) *Global trend analysis on the role of the trade unions in times of Covid-19: a summary of key findings*, Geneva: ILO.

(ILO) International Labour Organization (2022a) *Securing decent work for nursing personnel and domestic workers, key actors in the care economy*, International Labour Conference 110th Session. Report III (B), Geneva: ILO.

(ILO) International Labour Organization (2022b) *Discussion on the General Survey Securing decent work for nursing personnel and domestic workers, key actors in the care economy*, Geneva: ILO. https://www.ilo.org/ilc/ILCSessions/110/committees/standards/cas-reports/WCMS_848032/lang--en/index.htm (Accessed 29 August 2022).

(ILO) International Labour Organization (2022c) *The gender pay gap in the health and care sector. A global analysis in the time of COVID-19*, Geneva: ILO. https://www.ilo.org/global/publications/books/WCMS_850909/lang--en/index.htm (Accessed 29 August 2022).

(IOM) International Organization for Migration (2012) *Crushed hopes: Underemployment and deskilling among skilled migrant women*, Geneva: IOM. https://publications.iom.int/system/files/pdf/crushed_hopes_3jan2013.pdf (Accessed 30 August 2022).

(IOM) International Organization for Migration (2020) *Stigmatization & discrimination: COVID-19 Analytical Snapshot #6*, 20 April. https://www.iom.int/sites/g/files/tmzbdl486/files/documents/covid-19_analytical_snapshot_6_-_stigmatization_and_d (Accessed 30 August 2022).

(ITUC) International Trade Union Confederation (2020) *Covid-19 and migrant workers' rights*, June, Geneva: ITUC. https://www.ituc-csi.org/covid-19-and-migrant-workers (Accessed 7 July 2022).

(ITF) International Transport Forum (2021) *Covid-19 and Transport: A Compendium*, Paris: OECD Publishing.

Jaljaa, A., Caminada, S., Tosti, M.E., D'Angelo, F., Angelozzi, A., Isonne, C., Marchetti, G., Mazzalai, E., Giannini, D., Turatto, F., De Marchi, C., Gatta, A., Declich, S., Pizzarelli, S., Geraci, S., Baglio, G. and Marceca, M. (2022) 'Risk of SARS-CoV-2 infection in migrants and ethnic minorities compared with the general population in the European WHO region during the first year of the pandemic: a systematic review', *BMC Public Health*, 22(143). Doi: https://doi.org/10.1186/s12889-021-12466-1.

Jamal, S. (2020) الأطباء المسلمون في بريطانيا.. أبطال ضحوا بحياتهم في معركة كورونا [Muslim doctors in Britain. Heroes who gave their lives in the Battle of Corona] Aljazeerera. https://www.aljazeera.net/ (Accessed 8 April 2022).

Jato, D. M., Maila, B., Asombang, M.W. and Hassa, H.K. (2022) 'COVID-19 and Public Health in Africa: a call for new Perspectives in Health System Strengthening', *Journal of Preventive and Rehabilitative Medicine*, 4(1), pp. 3-13. https://journals.unza.zm/index.php/medicine/article/view/727 (Accessed 30 August 2022).

Joseph B. and Joseph, M. (2016) 'The health of the healthcare workers', *Indian Journal of Occupational and Environmental Medicine*, 20:71-2.

Kierster, E.and Vasquez-Merino, J. (2021) 'A virus without papers: Understanding COVID-19 and the impact on immigrant communities', *Journal of Migration and Human Security*, 9(2), pp. 80-93.

Llop-Gironés, A., Santillan-Garcia, A., Cash-Gibson, L., Benach, J., and Zabalegui, A. (2022) 'COVID-19 and the global need for knowledge on nurses' health', *International Nurse Review,* 169, pp. 196-200.

Llop-Gironés, A., Vračar, A., Llop-Gironés, G., Benach, J., Angeli-Silva, L., Jaimez, L., Thapa, P., Bhatta, R., Mahindrakar, S., Scavo, S., Nar Devi, S., Barria, S., Alonso, S. and Mireia Julià (2021) 'Employment and working conditions of nurses: where and how health inequalities have increased during the COVID-19 pandemic?', *Human Resources for Health*, 19, 112.

London Araby (2020)) لماذا يموت الأطباء المهاجرون ببريطانيا بمعدل أعلى من البيض؟ [Why is death rate of immigrant doctors higher than among white doctors in the UK?], Araby 21, https://arabi21.com/story/1270545/%D9%84%D9%85%D8%A7%D8%B0%D8%A7-%D9%8A%D9%85%D9%88%D8%AA-%D8%A7%D9%84%D8%A3%D8%B7%D8%A8%D8%A7%D8%A1-%D8%A7%D9%84%D9%85%D9%87%D8%A7%D8%AC%D8%B1%D9%88%D9%86-%D8%A8%D8%A8%D8%B1%D9%8A%D8%B7%D8%A7%D9%86%D9%8A%D8%A7-%D8%A8%D9%85%D8%B9%D8%AF%D9%84-%D8%A3%D8%B9%D9%84%D9%89-%D9%85%D9%86-%D8%A7%D9%84%D8%A8%D9%8A%D8%B6 (Accessed 01 September 2022).

Maguid, T. (2020) 'Coronavirus...Doctors with Borders?', *France 24*, https://amp.france24.com/ar/20200430-فيروس-كورونا-أطباء-بدون-حدود (Accessed 9 May 2022).

Mueller, B (2020) 'Eight U.K. Doctors Died From Coronavirus. All Were Immigrants', *New York Times*, 13 April 2020. https://www.nytimes.com/2020/04/08/world/europe/coronavirus-doctors-immigrants.html (Accessed 30 August 2022).

Murphy, C., Noonan, N., O'Toole, E., Plunkett, P., Colgan, M., Canning, C., Martin, Z. and Hennessy, M. (2020) 'Covid-19, when fourteen days are not enough-A case series of affected healthcare workers', *Clinical Case Reports*, 9(4), pp. 1876-1881.

Nasol, K. and Francisco-Menchavez, V. (2021) 'Filipino home care workers: Invisible frontline workers in the covid-19 crisis in the United States', *American Behavioral Scientist*, 65(10), pp. 1365-1383.

(NNU) National Nurses United (2020a) *Sins of omission: How Government Failures to Track Covid-19 Data Have Led to More Than 1,700 Health Care Worker Deaths and Jeopardize Public Health*. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0920_Covid19_SinsOfOmission_Data_Report.pd (Accessed 30 August 2022).

(NNU) National Nurses United (2020b) *Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity*. https://www.nationalnursesunited.org/campaign/deadly-shame-report (Accessed 30 August 2022).

(NNU) National Nurses United (2021) *Sins of Omission: How Government Failures to Track Covid-19 Data Have Led to More Than 3,200 Health Care Worker Deaths and Jeopardize Public Health*. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0321_Covid19_SinsOfOmission_Data_Report.pdf (Accessed 30 August 2022).

Nazareno, J., Yoshioka, E., Adia, A., Restar, A., Operario, D., Choy, C. (2021) 'From imperialism to inpatient care: Work differences of Filipino and White registered nurses in the United States and implications for COVID-19 through an intersectional lens', *Gender, Work & Organization*, 28, pp. 1426–1446.

Nursing Times (2021) *Nursing shortages contributing to emergency-level burnout, warn MPs,* https://www.nursingtimes.net/news/workforce/nursing-shortages-contributing-to-emergency-level-burnout-problem-committee-08-06-2021/ (Accessed 30 August 2022).

Obinna, D.N. (2021) 'Confronting disparities: Race, ethnicity, and immigrant status as intersectional determinants in the Covid-19 era', *Health Education & Behavior*, 48(4), pp. 397-403.

(OECD) Organization for Economic Cooperation and Development (2019) *Recent Trends in International Migration of Doctors, Nurses and Medical Students*, Paris: OECD Publishing https://doi.org/10.1787/5571ef48-en (Accessed 30 May 2022).

(OECD) Organization for Economic Cooperation and Development (2020) *Contribution of migrant doctors and nurses to tackling COVID-19 crisis in OECD countries*, 13 May, Paris: OECD Publishing, https://www.oecd.org/coronavirus/policy-responses/contribution-of-migrant-doctors-and-nurses-to-tackling-covid-19-crisis-in-oecd-countries-2f7bace2/ (Accessed 25 August 2022).

(OECD) Organization for Economic Cooperation and Development (2021) *International migration and movement of nursing personnel to and within OECD countries - 2000 to 2018 : Development in countries of destination and impact in countries of origin*, Health Working Paper No. 125, Paris: OECD Publishing. https://www.oecd.org/health/international-migration-and-movement-of-nursing-personnel-to-and-within-oecd-countries-2000-to-2018-b286a957-en.htm (Accessed 30 July 2022).

(OECD) Organization for Economic Cooperation and Development (2022) *The unequal impact of COVID-19: A spotlight on frontline workers, migrants and racial/ethnic minorities*, Paris: OECD Publishing. https://www.oecd.org/coronavirus/policy-responses/the-unequal-impact-of-covid-19-a-spotlight-on-frontline-workers-migrants-and-racial-ethnic-minorities-f36e931e/ (Accessed 30 July 2022).

Oikelome, F., Broward, J. and Hongwu, D. (2022) 'Immigrant health care workers from developing countries in the US: antecedents, consequences and institutional responses', *Equality, Diversity and Inclusion*, 41(2), pp.157-181.

Omaswa, F. (2020) *COVID-19 exposes a global scramble for health workers*, Health Worker for All Coalition https://www.healthworkersforallcoalition.org/features/2020/6/4/covid-19-exposes-a-global-scramble-for-health-workers (Accessed 04 May 2022).

Pillinger, J. (2017) *Violence and harassment against women and men in the world of work. Trade union perspectives and actions*, Geneva: ILO. https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---actrav/documents/publication/wcms_546645.pdf (Accessed 30 April 2022).

Pillinger, J. and Yeates, N. (2020) *Building Resilience Across Borders: A Policy Brief on Health Worker Migration*, Ferney Voltaire, France: Public Services International.

Pillinger, J., Gencianos, G., and Yeates, N. (2021a) *What we know about their situation. Migrant health and social care workers during the Covid-19 pandemic*, Factsheet 1, Ferney Voltaire/Milton Keynes: Public Services International-The Open University.

Pillinger, J., Gencianos, G., and Yeates, N. (2021b) *Trade union response to the challenges faced by migrant health and social care workers. Migrant health and social care workers during the Covid-19 pandemic,* Factsheet 2, Ferney Voltaire/Milton Keynes: Public Services International-The Open University.

Pillinger, J., Gencianos, G., and Yeates, N. (2021c) *Building the trade union agenda', Migrant health and social care workers during the Covid-19 pandemic*, Factsheet 3, Ferney Voltaire/Milton Keynes: Public Services International-The Open University.

Poblete Umanzor, R., Saldías Peñafiel, F., Sabatini Ugarte, N., Vite Valverde, A., Ceriani Bravo, A., Schaffeld Pernas, S. Letelier Saavedra, L.M., Gran Scheuch, J.I. and Rabagliati Borie, R. (2020) 'Infección respiratoria aguda por coronavirus Sars-CoV-2 en personal de salud. Implementación de un programa de detección precoz y seguimiento de casos en un hospital universitario' [A surveillance system to detect COVID-19 infections in health care workers. Experience in 209 cases], *Revista médica de Chile*, 148(6), pp. 724-733.

(PSI) Public Services International (2020a) *COVID-19 Emergency – PSI priorities and perspectives*. Ferney Voltaire, PSI. https://publicservices.international/resources/news/covid-19-emergency--psi-priorities-and-perspectives?id=10694&lang=en (Accessed 30 June 2022).

(PSI) Public Services International (2020b) *Nurse Manifesto: No going back*, https://peopleoverprof.it/campaigns/sign-on-to-the-nurses-manifesto---no-going-back?id=10773&lang=en (Accessed 30 August 2022).

(PSI) Public Services International (2021) *Covid-19 Emergency – PSI priorities and perspectives*, Ferney-Voltaire, PSI. https://publicservices.international/resources/news/covid-19-emergency--psi-priorities-and-perspectives?id=10694&lang=en (Accessed 30 August 2022).

(PSI) Public Services International and Kommunal (2020*) Violencia y Acoso en el Mundo del Trabajo con Perspectiva de Géneros*, Ferney-Voltaire, France: PSI.

Reimer, W. (2020) 'Coronavirus: CUPE survey reveals anti-Asian racism towards Manitoba health-care workers', *Global News*, 14 April. https://globalnews.ca/news/6816668/cupe-survey-anti-asian-racism-manitoba-coronavirus/ (Accessed 30 August 2022).

Ricardo, R., M. Huber, and G. Lamura, G. (eds.) (2012) *Facts and Figures on Healthy Ageing and Long-term Care Europe and North America*, European Centre for Social Welfare Policy and Research. https://www.euro.centre.org/publications/detail/403 (Accessed 30 March 2022).

Rodrigues, R., Huber, M. and Lamura, G. (eds) (2012) *Facts and Figures on Healthy Ageing and Long-term Care*, Occasional Reports Series 8. Vienna: European Centre for Social Welfare Policy and Research. https://www.euro.centre.org/publications/detail/403 (Accessed 30 June 2022).

Rostila, M, Cederström, A., Wallace, M., Brandén, M., Malmberg, B. and Andersson, G. (2021) 'Disparities in Coronvirus disease 2019 mortality by country of birth in Stockholm, Sweden: A total population-based cohort study', *American Journal of Epidemiology*, 190(8), pp. 1510-1518.

Roy, K., Solenkova, N. and Mehta, P. (2021) 'A wasted opportunity during a pandemic: The foreign medical graduates in the USA', *Journal of Immigration and Minority Health*, 23, pp. 1364-1368.

(RT) Russia Today Online (2021) 'To which Arab countries did the Indian mutant infiltrate Corona?', *Arabic World News*, https://arabic.rt.com/middle_east/1229031 (Accessed 9 May 2022).

Saleem, J. (2021) 'Experiences of frontline Pakistani emigrant physicians combating COVID-19 in the United Kingdom: a qualitative phenomenological analysis', *BMC Health Services Research*, 21, 291.

Saudi Digital Services (2022) العمالة الوافدة في دول الخليج تدفع الثمن الأكبر لوباء كورونا[Migrant workers bear the brunt of Coronavirus pandemic in the Gulf], *Arabic Guardian*, https://www.alquds.co.uk/%d8%a7%d9%84%d8%ba%d8%a7%d8%b1%d8%af%d9%8a%d8%a7%d9%86-%d8%a7%d9%84%d8%b9%d9%85%d8%a7%d9%84%d8%a9-%d8%a7%d9%84%d9%88%d8%a7%d9%81%d8%af%d8%a9-%d9%81%d9%8a-%d8%af%d9%88%d9%84-%d8%a7%d9%84%d8%ae%d9%84 (Accessed 01 August 2022).

Silver L, K., Devlin, K., and Huang, C. (2019) *People around the globe are divided in their opinions of China*, Washington DC: Pew Research Center. 5 December. https://www.pewresearch.org/fact-tank/2019/12/05/people-around-the-globe-are-divided-in-their-opinions-of-china/ (Accessed 30 August 2022).

Simmons, C., Rodrigues, R. and Szebehelyet, M. (2021) 'Working conditions in the long- term care sector: A comparative study of migrant and native workers in Austria and Sweden', *Health and Social Care in the Community*, November, pp.1-12 https://doi.org/10.1111/hsc.13657

The Guardian (2022) 'Trapped and destitute: how foreign nurses' UK dreams turned sour', 27 March, https://www.theguardian.com/society/2022/mar/27/trapped-and-destitute-how-foreign-nurses-uk-dreams-turned-sour (Accessed 29 August 2022).

The Observer (2022) *MPs demand end to repayment clauses in contracts of overseas health workers*, 30 July, https://www.theguardian.com/society/2022/jul/30/mps-demand-end-to-repayment-clauses-in-contracts-of-overseas-health-workers (Accessed 01 August 2022).

Tazyeen, S., Khan, H., Salma Babar, M. and Lucero-Prisno, D.E. (2021) 'Foreign workers in the Middle East during Covid-19', *International Journal of Health Planning and Management*, 1(6). https://doi.org/10.1002/hpm.3403

Tipping, S., Murphy, V., Yeates, N., Montoro, C., Ismail, G. and Ismail, N. (2022) *Migrant health worker deaths during Covid-19: a methodological exploration and initial estimates*, 10th September. Milton Keynes, UK/Ferney Voltaire, France: The Open University/Public Services International. DOI: https://doi.org/10.21954/ou.ro.00014b4b

Trullàs, J.C., Vilardell, I., Blascod, M., and Herediae, J. (2020) 'COVID-19 en trabajadores sanitarios del Hospital Comarcal de Olot (Girona)', *Revista Clínica Española*, 220(8), pp. 529-531.

(UK) United Kingdom Parliament Health and Social Services Committee (2022) *Workforce burnout and resilience in the NHS and social care* https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/22/2202.htm (Accessed 30 August 2022).

UNISON (2021) 'Majority of nursing staff have experienced sexual harassment at work, survey shows', London: UNISON https://www.unison.org.uk/news/2021/06/majority-of-nursing-staff-have-experienced-sexual-harassment-at-work-survey-shows/ (Accessed 30 August 2022).

UNISON (2022) *2022 Health Care Service Group Annual Conference. Preliminary Agenda*, 25-27 April, ACC Liverpool. London: UNISON. https://www.unison.org.uk/content/uploads/2022/01/Preliminary-Agenda-2022.pdf (Accessed 30 August 2022).

(UN) United Nations (2020) *United Nations General Assembly resolution* 75/157 (2020) *on women and girls and the response to the coronavirus disease (COVID-19)*, New York: United Nations. 23 December. https://digitallibrary.un.org/record/3896017?ln=en (Accessed 30 March 2022).

(UN) United Nations Women (2020) *COVID-19 and Ending Violence against Women and Girls*, Issue Brief, New York: UN.

(WHO) World Health Organization (2006) *World Health Report 2006. Working together for health*, Geneva: WHO.

(WHO) World Health Organization (2010) *WHO Code of Practice on the International Recruitment of Health Personnel*, Geneva: WHO.

(WHO) World Health Organization (2014) *A Universal Truth: No Health Without A Workforce*, Geneva: WHO

(WHO) World Health Organization (2016a) *Working for health and growth: Investing in the health workforce – report of the High Level Commission on Health Employment and Economic Growth*, Geneva: WHO.

(WHO) World Health Organization (2016b) *Global Strategy on Human Resources for Health: Workforce 2030*, Geneva: WHO.

WHO World Health Organization (2020) *Health Workforce Support and Safeguards List 2020*, Geneva: WHO. https://www.who.int/publications/m/item/health-workforce-support-and-safeguards-list (Accessed 30 August 2022).

(WHO) World Health Organization Council on the Economics of Health for All (2021) *Financing for all: increase, transform, redirect*, Council Brief, No. 2. https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/who_councileh4a_councilbrieffinal-no2.pdf?sfvrsn=bd61dcfe_5&download=true (Accessed 30 June 2022).

(WHO) World Health Organization (2021) *The impact of COVID-19 on health and care workers: a closer look at deaths*, Geneva: WHO.

(WHO) World Health Organization (2022a) *Global Strategy on Human Resources for Health: Workforce 2030: Reporting at Seventy-fifth World Health Assembly*, https://www.who.int/news/item/02-06-2022-global-strategy-on-human-resources-for-health--workforce-2030 (Accessed 30 August 2022).

(WHO) World Health Organization (2022b) *Human resources for health WHO Global Code of Practice on the International Recruitment of Health Personnel: fourth round of national reporting: Report by the Director-General*, Geneva: WHO https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_14-en.pdf (Accessed 30 August 2022).

(WHO) World Health Organization (2022c) *Global health and care workers compact technical guidance compilation*, Geneva: WHO https://www.who.int/publications/m/item/carecompact (Accessed 30 August 2022).

(WHO) World Health Organization (2022d) *Resolution WHA74.14 Protecting, safeguarding and investing in the health and care workforce*, Geneva: WHO https://apps.who.int/gb/ebwha/pdf_files/WHA74-REC1/A74_REC1-en.pdf (Accessed 30 August 2022).

(WHO) World Health Organization (2022e) *Human resources for health Working for Health: Draft 2022–2030 action plan*, Report by the Director-General, Geneva: WHO. https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_12-en.pdf (Accessed 22 August 2022).

(WHO) World Health Organization Regional Committee for Europe (2021) *Joint Statement for the 71st session of the World Health Organization Regional Committee for Europe* (agenda item 3 COVID-19 lessons learned: getting ready for the next pandemic), Geneva: WHO. https://www.who.int/europe/publications/m/item/psi-cpme-efn-ensa-efma-wfot-humatem-ifa-efa-eurocam (Accessed 30 August 2022).

(WHO) World Health Organization, International Council of Nurses (ICN) and Nursing Now (2020) *State of the world's nursing 2020: investing in education, jobs and leadership,* Geneva: WHO.

Yeates, N., and Pillinger, J. (2019) *International Health Worker Migration and Recruitment: Global Governance, Politics and Policy*, Abingdon and New York: Routledge.

Yeates, N., Gencianos, G., Pillinger, J., Vaillancourt-Laflamme, C., Ismail, N., Montoro, C., and Ismail, I. (2022) *Policy responses to address risks of harm to migrant health workers in times of Covid-19*, 15th September. Milton Keynes, UK/Ferney Voltaire, France: The Open University/Public Services International. DOI: http://dx.doi.org/10.21954/ou.ro.00014b75

Yousef, K. (2020)) قضية الطبيب المصري تسلط الضوء على تأشيرات موظفي القطاع الصحي في بريطانيا. . ['The case of the Egyptian doctor sheds light on the visas of health sector employees in Britain] https://www.alaraby.co.uk/society (Accessed 09 April 2022).

Zaidi, Z., Dewan, D. and Norcini, J. (2021) 'International Medical Graduates: Promoting Equity and Belonging', *Academic Medicine*, 95(125), p.S82-S87.