Humanitarian Response by NGOs to the 2010 Haiti Earthquake: Expectations vs. Realities

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Abstract

A rising interest and participation from high-income countries in global health initiatives has been driven by increasing visibility and opportunities such as volunteering with non-profit organizations to provide healthcare. Thus, there must be a conscious effort to avoid further ingraining structures of inequality present in global health. This is particularly important in the context of Haiti's post-earthquake recovery and the role of international aid. This paper examines the impact of international non-governmental organizations (INGOs) on healthcare and maternal mortality in post-earthquake Haiti. Before the 2010 earthquake, Haiti was known as the "Republic of NGOs," yet the INGOs' interventions often proved ineffective. The wake of the earthquake provided an opportunity for progress but resulting efforts from INGOs fell short of expectations. Abuse of power, the exclusion of Haitian-led NGOs from funding, and inefficient project implementation further hindered progress in Haitian healthcare. This paper calls for ethical and equitable partnerships, Haitian-led development, and a shift toward self-sufficiency in international aid initiatives. In conclusion, this paper recommends aligning initiatives with host communities' needs, as well as exploring innovative changes to the healthcare system that most effectively meet Haiti's global health goals.

Keywords: global health, Haiti, foreign aid, partnerships, colonialism, natural disaster, medical emergency, NGOs, INGOs

Introduction

Haiti is known by most people around the world as "the poorest country in the Western Hemisphere," "the backyard of the United States," "the failed state of the first Black republic," examples of an extensive list of derogatory nicknames (1,2,3). Others prefer to call it "La Perle des Antilles" because of its natural beauty and the riches found throughout Haiti's lands and waters (4). The rise in popularity of global health as a practice has led to scholars and clinicians from high-income countries (HICs) looking for global health "opportunities." Said opportunities primarily involve professionals from HICs working with international organizations in low-and-middle-income countries (LMICs) to provide aid, though these opportunities are frequently harmful to the communities they intend to help. We must examine what happened in Haiti following the January 2010 earthquake to avoid repeating the same mistakes and emphasize the need for respectful and equitable partnerships with collaboration between Haiti and foreign aid organizations. To analyze the effectiveness of the relief efforts carried out after the earthquake in Haiti, this paper will review the relationship between Haiti and foreign aid such as aid provided by international non-governmental organizations (INGOs) prior to the earthquake, the expectations of INGO presence in Haiti, and the realities that ensued after the earthquake, specifically focusing on maternal and child health.

Background

Before exploring the influence and consequences of INGOs acting in Haiti, it is essential to know the country's colonial history and socioeconomic context. Prior to its independence, Haiti, formerly known as Saint-Domingue during its time as a French colony, supplied almost half of Europe's coffee and sugar (4). This was possible due to the unpaid labour of imported enslaved Africans to the island and their descendants (4,5). The former French colony gained independence in 1804 following the first successful slave revolt (4). The formerly enslaved people had successfully defeated the French armies at a point in time when colonialism was at its peak (4). The leaders of the Haitian revolution returned the Indigenous name of "Ayiti" to the land they reconquered from the

colonizers, emphasizing their new independent identity from European imperialism (4). After losing its most prolific colony, France imposed an independence debt on Haiti consequently leading to economic decline: a form of compensation for the lost revenues of white colonizers equivalent to 21 billion dollars today (6). Haiti paid this debt from 1825 to 1947 (6). The US further contributed to Haiti's decline through occupation and political manipulation throughout the twentieth century, depriving Haitian peasants of their lands and agricultural work, leading to mass emigration of Haitians (7). These are but a few instances where greater foreign powers have been at play to undermine Haiti's development and deepen its economic and political dependence on HICs such as the United States, France, and Canada. The "failed state" of Haiti did not fail alone; it was designed, shaped, and manipulated to uphold the social inequities seeded by colonialism, slavery, white supremacy, US imperialism, international support for past dictatorship and collaboration of the elite populations and the bourgeoisie (8).

Foreign Aid in Haiti

Before the earthquake, Haiti was already known as the "Republic of NGOs" (9), Global health practice in Haiti, referring to medical aid provided by foreign governments and organizations, became popular in the 1990s, and by 2009, there were thousands of INGOs involved. They had, and continue to have, omnipresent influences on Haiti's healthcare systems (9). Medical missions are a common practice of foreign aid intervention in Haiti that have been criticized for being ineffective and undermining the public and private health systems (8,9).

While emergency relief INGOs are essential for their ability to provide rapid aid, their short-term interventions often result in challenges for long-term development. For instance, temporary clinics set up by these organizations may provide immediate medical assistance, but their departure often leaves local communities unchanged, with persistent health issues and a void that is difficult for the local government to fill without proper preparation or coordination with the intervening organization (2,9). An example of such a void was seen in 2008 after hurricanes hit Gonaives in northern Haiti. Médecins Sans Frontières (MSF) erected a camp hospital but insisted on using their own staff, displacing the Cuban doctors already present. Once the state of emergency had passed and MSF departed, concerns arose regarding who would ensure the ongoing provision of healthcare services (2). However, it is important to recognize that MSF provides emergency medical humanitarian care, their mandate ends once the emergency is under control. Although their interventions were successful based on their own metrics and goals, the communities remained without adequate healthcare infrastructure (2). Despite this, organizations such as MSF, among others, would report that their intervention was successful to their stakeholders to justify the annual trips as well as the funds disbursed (9). The evaluations of these interventions are typically carried out by the same organizations whose interventions are being implemented – incentivizing organizations to report positive outcomes, resulting in biased reporting.

These evaluations use quantitative metrics with specific and limited indicators that do not consider the context and nuance essential to understanding health outcomes (9). This explains, in part, why little to no progress had been made in the country despite the increase in foreign aid and funding from INGOs to Haiti since the 1980s until the earthquake in 2010. The population continued to experience extreme poverty; thus the government could not sustain its own healthcare needs, resulting in a mass exodus of healthcare workers, and Haiti was still dependent on the "help" of high-income countries prior to the 2010 earthquake (2,9). However, it is important to mention that it is difficult to evaluate the impact of an intervention on the health sector because few health indicators, especially at a national level, can be directly linked to a specific intervention. This would require epidemiologic studies which have yet to be done. According to the World Health Organization (WHO), "health systems that can deliver services equitably and efficiently are critical for achieving improved health status" (10). This suggests that global health interventions should prioritize enhancing health systems and strengthening the building blocks of health systems while supporting nations in attaining sustainable gains. According to the WHO, the building blocks of health systems are service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership and governance (10). Before the earthquake, Haiti already had a fragile healthcare system due to extreme poverty, weak infrastructures, limited access to health centers and medicines, and a shortage of personnel and facilities, among other challenges (2,7,8). It is important to note that the impact of the earthquake compounded pre-existing challenges, making the recovery and reconstruction efforts even more difficult for Haiti.

Haitian Expectations of NGOs

The earthquake that struck the country on January 12, 2010, propelled Haiti into the global spotlight. International aid workers, particularly those working with NGOs, came to Haiti by the thousands (9). Everyone wanted to help and donate

through various means, including monetary donations, shipments of clothing and baby products, medicines, canned food, and more. The increased visibility of the hardships Haiti was experiencing held the promise of a new beginning. It was an opportunity to build a new Haiti with better infrastructures and strengthening governance and institutions to reduce the country's vulnerability to future disasters. It was also an opportunity for INGOs to collaborate and form partnerships with Haitian communities to build long-term sustainable development and to provide competent and comprehensive aid. It is safe to say that the expectations held by Haitian people following the earthquake were not met (11).

The Reality of Foreign Aid After the 2010 Earthquake

The biggest failure of foreign aid in Haiti following the earthquake is the cholera outbreak that began in the fall of 2010 after the arrival of United Nations (UN) personnel (12,13). It is important to note that cholera had never been documented in Haiti prior to this outbreak. Hundreds of thousands of Haitians became unhoused after the earthquake. Many had no other option but to seek refuge in the tent camps set up by international relief organizations or pack themselves into overcrowded and crude shelters (9,13). These environments were prone to infectious diseases due to the lack of sanitation infrastructure (9,13). However, the cholera outbreak that began nine months after the disaster did not emerge from the camps but appeared in an unlikely area in Haiti's Central Plateau (9,13). In 2018 it was estimated that the outbreak resulted in 10,000 deaths and over 800,000 infections (12).

Haitians are still dying from cholera today in 2023. These are preventable deaths as treatments such as intravenous hydration and antibiotics are widely available in wealthy countries (14). It would be unacceptable for someone to die from cholera in a HIC, yet the number of Haitian casualties due to cholera continues to be overlooked by the international community. This is a failure of foreign aid, and more specifically, it is a failure of the UN. Initially, the source of the outbreak was unknown. However, officials from the WHO downplayed the significance of determining the source or cause of the outbreak after the focus was shifted to the United Nations Stabilization Mission in Haiti (MINUSTAH) base of Nepalese origin located in the region where the outbreak had taken place (13). The UN denied their involvement in the cholera outbreak for several years despite the overwhelming body of evidence suggesting that the peacekeepers had contaminated the Artibonite River due to negligence occurring over several years (12). Despite Haitians' public outrage and actions against the UN and their personnel, the global community ignored their concerns. The UN only acknowledged its involvement years after the initial outbreak, emphasizing that they were not obligated to provide any form of reparations to anyone affected by the deadly virus they brought to Haiti (15). The demonstrated lack of accountability and responsibility by the UN is unfortunately representative of most NGOs acting in Haiti; in that they are not accountable to Haitians but instead accountable to the hands support them financially. The reluctance or apparent lack of urgency among WHO and UN officials to identify the source of the cholera outbreak, under the guise of avoiding attributing blame, is indicative of a failure to acknowledge responsibility and ensure accountability (9,12).

There were also many reported cases of foreign aid workers, particularly those associated with MINUSTAH, perpetrating sexual exploitation and abuse against local communities (16). Foreigners acting under INGOs fathered children and abandoned them (13). Again, despite the Haitian population's outrage, little to nothing has been done to hold perpetrators accountable for their actions. Foreigners abusing their powers and using Haitian communities for their own personal gain continues to deepen the mistrust that Haitians have towards foreigners. It only emphasizes the existing sentiment that Haitians hold against nations like the United States and France, who have continuing histories of exploitation.

INGOs failed in Haiti due to the lack of collaboration and coordination with the Haitian population. Between 2010 and 2011, two billion dollars USD were raised for immediate relief, of which less than one percent went to the Haitian government (17). International aid directed to the Haitian government has been notably limited. Donors exhibit reluctance in providing funds directly to the government due to perceptions of its lack of capacity to effectively manage finances and concerns regarding corruption (17,18). As a result, a significant portion of funds is channeled through non-state actors as donors tend to place greater trust in them, as has been the case for decades prior to the earthquake (16). The little funding that the Haitian government received was subject to harsh conditionalities and used as a mechanism of control by international donors who set their own priorities which do not always correspond to the country's needs (18). Any government acting under such limitations is extremely likely to fail its population.

Haitian-led NGOs were also excluded from these funds as 99% of the money raised for the earthquake remained in the hands of large INGOs, some UN agencies, private contractors,

the Red Cross, and US government agencies, to name a few (17,19). One would expect that the billions of dollars raised after the earthquake would result in significant change in a small country such as Haiti, yet little has changed. The money appeared to be diminished in a "trickle-down" effect as the funds were going through multiple layers of subgrantees before reaching the intended organizations responsible for implementing projects on the ground, projects which were often never implemented (9, 17). A myriad of projects were developed by undoubtedly highly skilled people from HICs that surely had Haiti's best intentions at heart but, regrettably, were not applicable within the Haitian context, highlighting another shortcoming of INGOs. Instead of financing people or initiatives unfamiliar with the needs of Haitian communities, thereby causing significant harm, INGOs should have collaborated with Haitians either through the Haitian government or by providing assistance to existing Haitian initiatives. INGOs would have seen a better return on their investment, as exemplified by organizations like Konbit Sante, which is generally well-perceived by the local community because they have a collaborative approach where they train and employ Haitian healthcare workers (9). Pierre Minn, an Associate Professor in the Departments of Anthropology and Social and Preventive Medicine at the Université de Montréal, describes the experiences of medical staff with foreign aid in his book *Where They Need Me* and notes that Konbit Sante is nearly always mentioned first by the staff. It is also referred to as the favoured partner of the Hôpital Universitaire Justinien, a significant hospital in Cap-Haitien, by its director. Konbit Sante is a US-based INGO acting in Cap-Haitien and works in partnership with Haiti's Ministry of Health and Population (MSPP) (9). Many international organizations prioritize short-term relief efforts, often neglecting their sustainability. In contrast, Konbit Sante prioritizes capacity-building initiatives aimed at empowering local actors and institutions and focuses on strengthening the Haitian healthcare system (9). Rather than directly administering treatments or having consultations with patients, Konbit Sante prioritizes other things such as infrastructure projects, logistical support for hospital leadership teams, and the education and training of Haitian clinicians (9). This approach enables Konbit Sante to contribute to the long-term sustainability of the healthcare system in Haiti, a goal that many international organizations may not prioritize due to their temporary relief-focused mandates. There lies the true success of an organization responding to the community's needs by including them in every step of a project's implementation.

After the earthquake, an estimated 3,000 to 10,000 unregistered INGOs were acting in Haiti (9). These organizations acted as parallel independent states setting up and imposing their own rules, causing the disempowerment of local actors, and weakening existing structures and organizations, all without producing any meaningful sustainable change (8). The problem is not necessarily the number of INGOs, but the fact that there was no collaboration or coordination between the organizations and the Haitian population. Effective collaboration entails engaging with local communities, understanding their needs, and involving them in decision-making processes. At the very least, consultation with the MSPP is necessary. Ideally, it would entail consultation with community healthcare workers to identify where the needs are and including their perspectives in designing the initiative. Unfortunately, these INGOs operated inefficiently, failing to prioritize strengthening the already weakened health systems in Haiti, resulting in temporary and superficial changes, and an apparent discrepancy between the inputs of global aid efforts, financing, and the observable outcomes.

Maternal Mortality

It is important to evaluate the impacts of INGOs on maternal mortality following the earthquake since both the Millennium Development Goal 5 and the Sustainable Development Goal 3.1, set by UN Member States (20), aimed to reduce the maternal mortality rate globally. However, little research has been done on maternal health in Haiti since the earthquake.

The Three Delays framework developed by Thaddeus and Maine (18, 21) can help improve understanding of maternal health in Haiti. The delays that contribute to maternal mortality are (1) the delay in deciding to seek medical care, (2) the delay in reaching the appropriate healthcare facility, and (3) the delay in receiving adequate care. Rapp explains that while this framework is helpful, it does not fully explain the dynamics and hierarchy between MSPP, NGOs, health practitioners and pregnant people, which Rapp describes as "shadow delays" (18). As such, "global health practitioners often opt for technical solutions" but do not take into consideration the "shadow delays" during the decision-making process thereby preventing the amelioration of maternal mortality (18, p. 8-9).

Several factors influence the Three Delays such as the lack of transportation, especially in rural areas. An organization can have the best intentions and set up practice in an already existing Haitian health center and train community healthcare workers. However, if a pregnant person living in a remote area in the mountains lacks transportation to reach the clinic, they are unlikely to make the journey as it will require walking for several hours. Instead, like 70% of women

living in rural areas in Haiti, a mother will give birth at home without the presence of a skilled birth attendant, thereby significantly increasing the risks of complications and death (18). This is only one example demonstrating how technical solutions drafted by INGOs that do not consider all delays, including the influence of contextual factors, and may not deal with problems the host population faces in an efficient manner. It is also why communication with Haitians is essential to understanding their needs. The absence of maternal health research in Haiti, conducted by relevant stakeholders such as local healthcare professionals, international organizations, and academic institutions, can be detrimental to the population. Without a thorough understanding of the situation on the ground and continuous assessments of needs, we cannot ensure that efforts remain appropriate and relevant (22). This can lead to the implementation of ineffective or inappropriate interventions that do not address the root causes of maternal health issues, leaving populations vulnerable to the same issues.

Conclusion

In conclusion, despite the difficulty of qualifying global health interventions as successes and failures for the reasons mentioned above, it is evident that the foreign aid to Haiti from INGOs and the UN after the earthquake was a massive and unforgivable failure. The world failed Haiti. It is of the highest priority for Haitian people to lead their own development, in contrast to a continued influx of INGOs. The Haitian population must initiate actions which are not directed by international institutions, organizations, or Haitian elites. This must be respected by any foreigner wishing to go to Haiti to fulfill their altruistic dreams. The realities that ensued after the earthquake exposed the need for respectful and ethical partnerships and collaboration between the host country's government, local actors, and foreign aid organizations. The goal of international organizations providing aid in any country should be the self-sufficiency of the local populations and to avoid patterns that lead to the dependence of lower-income countries on HICs. Proper research, including social science research and implementation research, should be done by people and organizations looking to implement their projects and initiatives in any community to avoid causing unnecessary harm. This paper's recommendation for anyone in search of global health opportunities is to ask yourself if you are needed, to research if what you intend to do is redundant, and if it is for your own benefit rather than catering to the needs of the host community. Moving forward, health systems research should explore innovative ways in which a healthcare system can incorporate public, private, and community-based methods at the same time – while promoting shared responsibility for meeting ambitious and equitable standards of care, global health goals, and patient satisfaction in all countries worldwide.

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The Neoliberal Globalization of Services Now Includes Nursing: The Exploitation of Low-Income Countries via Brain Drain

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Abstract

In response to rising nursing vacancies, many high-income countries are turning to low-income countries to recruit nurses into their healthcare systems, a process that has exacerbated global health inequities. This review challenges the dominant neoliberal worldview of achieving economic prosperity through a largely unregulated free market at the expense of population health – instead suggesting that high-income country governments should implement alternative local solutions rather than reinforce global health disparities through the exploitation of migrant nurses. In fact, increased nursing vacancies in high-income countries are the result of domestic nurse retention crises, not nurse shortages. The primary drivers of migration of nurses from low-income countries to high-income countries include remuneration, security, career prospects and job satisfaction. The Global South faces a collapse of healthcare systems due to scarcity and maldistribution of nurses, while nurses who relocate face exploitation in their receiving high-income country. The reliance of high-income countries on recruitment of nurses from low-income countries is an unsustainable mechanism for global healthcare.

Keywords: globalization, nursing shortage, retention crisis, health equity, migrant nurses, migrant healthcare workers

Background

High-income countries are recruiting nurses from low-income countries to fill their bedside vacancies. This 'brain drain' of nurses from low-income countries such as Nigeria, India, and Philippines, to higher income countries such as Canada and the United States, has characterized globalization in recent decades. Human capital flight, colloquially known as 'brain drain', refers to the departure of educated, trained health personnel from one country to another in search of better opportunities, such as higher pay, better standards of living, increased quality of life, and more stable political conditions (1). The neoliberal global economy has opened international borders for goods and labour, which now includes nursing. Over the past decade, the World Health Organization reports a 60% increase in the number of migrant healthcare professionals working in high-income countries (2). Additionally, the World Health Organization reports that 81% of the world's nurses work in three regions (the Americas, Europe, and Western Pacific), where only 51% of the of the world's population resides within (2). Unprecedented levels of exodus of healthcare workers, especially nurses, from low-income countries to high-income countries, have created a pressing global health issue with implications for population-level health outcomes. Moreover, the inequities in density and distribution of nursing personnel within low-income countries is exacerbated by this approach to filling nursing vacancies in high-income countries (3). This review explores the main drivers of the migration of nurses from low-income countries to high-income countries and the implications of this phenomenon. The brain drain of nurses is a pressing global health concern and its harms are disproportionately felt by low-income country populations, while also failing to address the root causes of the nurse retention crisis in high-income countries (4).

The Retention Crisis in High-Income Countries

High-income countries are claiming a nursing shortage; however, this issue is more accurately described as a nursing retention crisis (4). A 'nursing shortage' implies a lack of citizens with nursing credentials or too few students registered in the education streams. This is not the case. In Canada, according to the 2021 Labour Force Survey conducted by

Statistics Canada, the number of vacant registered nurse positions increased 85.8% from 2019 to 2021, despite a 2.5% net growth of nurses from 2020 to 2021 (5). There are enough nurses to fill these vacancies, but not enough Canadian nurses willing to work in the poor conditions which characterize many current nursing positions.

A few documented barriers to nurse retention in Canada include unsafe nurse-patient ratios and workplace violence. These are rampant issues in the nursing profession. Unsafe nurse to patient ratios causes reduced quality of patient care as well as documented increased likelihood of patient death, with a patient's odds of dying within 30 days of admission increasing by 7% for every additional patient added to a nurse's workload (6). In terms of workplace violence, the Canadian Federation of Nurses Unions reports that 93% of nurses experienced at least one form of violence at work in the past year, including verbal abuse, physical assault, threats of physical violence, bullying and aggression, and sexual harassment (7). Globally, 59.2% of nurses reported exposure to workplace violence in the past year, defined as any physically or non-physically violent incident where staff were abused, threatened or assaulted in circumstances related to their work (8). Taken together, barriers to nurse retention are the result of a poorly maintained health system in Canada.

Moreover, the nurse retention crisis in high-income countries is projected to worsen. Intentions to leave the nursing profession are at an all-time high. For example, the 2022 United States National Nursing Workforce survey found that 100,000 (2.8%) nurses have left positions since the COVID-19 pandemic, and that 800,000 (22.6%) more nurses plan to leave the profession in the next 5 years, excluding those who plan to retire (9). Similar trends were reported by Canadian nurses, with a 2021 survey conducted by the Canadian Federation of Nurses Unions finding that 19% of nurses reported intending to leave the profession in the next year and another 27% intending to leave their current nursing position in the next year (7). It is likely that the dissatisfaction with unsafe nurse-patient ratios and experience of structural and workplace violence has been compounded by the demands placed on nurses due to the COVID-19 pandemic. The COVID-19 phenomenon of praising nurses as 'heroes', coupled with governments simultaneously ignoring their calls for safe staffing ratios has compounded nurse burnout levels and their concerns with capacity issues, unable to provide adequate levels of care for their patients (4). Critical care nurses based in the United Kingdom, Australia, and North America report concern for unrealistic expectations and risks to workplace safety as a result of the pandemic heroism narrative (10). The framing of the issue by high-income country governments and health leaders as a nursing shortage is problematic as it allows these institutions to evade responsibility for the conditions of their workers.

Drivers of Migration

In general, the primary drivers of migration of nurses from low-income countries to high-income countries include remuneration, security, career prospects and job satisfaction (11). Interestingly, these drivers of migration do not differ across geographical regions in low-income countries (11). International organizations have described the main push and pull factors involved in migration and international recruitment of health workers. Push factors are those which motivate healthcare workers based in low-income countries to migrate out of their countries for work. Main push factors include absolute low pay or relative low pay, poor working conditions, lack of resources, limited career growth opportunities, economic instability, and dangerous work environments (12). Pull factors are those which draw in healthcare workers based in low-income countries to high-income countries, and these are reported to be higher pay, opportunities for remittances, better working conditions, better resourced health systems, and political stability (12). Specifically in Canada, the pull factors for migrant nurses are improved quality of life for their families, improved educational opportunities for their children, opportunities to advance their nursing education with specialty certifications and a higher income (13). As of 2019, 9% of the nursing workforce in Canada were migrants, an increase from 6.9% of the Canadian nursing workforce in 2007 (14).

The Globalization of Services and Exploitation of Migrant Workers

The neoliberal global economy has opened international borders for goods and labour, which now includes nursing. High-income countries are resorting to recruiting nurses from low-income countries to fill their vacancies. Concerningly, the nurses recruited from low-income countries are being recruited to work in the identical poor conditions which pushed out the existing nurses in high-income countries. Migrant workers are a vulnerable population at increased risk for exploitation, such as lower wages compared to their domestically trained counterparts, threats of deportation if they do not comply with excessive work demands, or delayed payment, all of which is further aggravated by the systemic racism they may face (4,7,8). Migrant nurses report discrimination, lack of recognition in comparison to non-migrant nurses, and limited opportunities for promotion (15).

The documented unsafe nurse-patient ratios and experience of workplace violence of the system will be burdened onto migrant nurses.

Compounded with poor work conditions, migrant nurses in Canada can also face complicated policy barriers to begin working, such as extensive skill and language requirements and lengthy, expensive licensing and registration processes (16). Internationally educated nurses may migrate to Canada due to various pull factors, such as better opportunities and renumeration, yet they instead face obstacles at every stage of the migration and relicensing process (17). As many as 47% of migrant healthcare workers who come to Canada for work cannot find employment in their profession (16). Issues in coordination are also to blame in the case of Canada's migrant health workers, as the immigration is incentivized and selected by the federal government. However, nursing employment is organized by the provincial governments, resulting in many migrant workers poached by Canadian incentive programs arriving in Canada and subsequently discovering their qualifications do not meet Canadian requirements (16).

The Collapse of the Healthcare Systems in Low-Income Countries

A key implication of this phenomenon is the collapse of healthcare systems in low-income countries due to loss of staff and expertise. The low-income countries disproportionately bear the cost of this exchange, while high-income countries stand to disproportionately gain. There is a persistent global maldistribution of nurses. According to the WHO's 2019 global health workforce statistics, high-income countries have approximately 12 nurses per 1,000 patients, compared to 1 nurse per 2,000 patients in low-and middle-income countries (18). For example, in 2020, the Americas had a ratio of 83 nurses per 10,000 people, while Africa had 9 nurses per 10,000 people (2). Moreover, the WHO's 2020 State of the World's Nursing report announced that nurse shortages are primarily in the African, South-East Asia and Eastern Mediterranean regions (2), such that an estimated 89% of the global nurse shortage is concentrated in low-and middle-income countries, and growth in number of nurses is not keeping pace with the population growth (2).

Furthermore, high-income countries are primarily recruiting nurses from these regions with the lowest-documented nurse to patient ratios (2). This is of critical significance as the reliance on this brain drain mechanism stands to deepen the global healthcare inequities, especially in relation to countries with the lowest numbers of nurses (4). Reliance on low-income countries for nurse recruitment leads to a collapse of their healthcare systems as they are left without adequate staff. In addition to aggravation of the existing workforce shortages, low-income countries face increased costs for healthcare, decreased access to care, and adverse population health outcomes (11,19). According to the Chief Executive Office of the International Council of Nurses, the risks are incredibly concerning; a low-income country may only lose a few specialist professionals to emigration, however this can be enough to end a specialized service for patients in a given country or region, resulting in severely decreased availability of care (17). The overwhelming loss of specialist expertise out of low-income countries as well as the extent of attrition of health care professionals is highly concerning as it compounds global inequities in access to health care.

Alternative Solutions

To address the problematic implications of the recruitment of nurses from low-income countries, various policy approaches have been proposed. These approaches encompass international agreements, domestic policies, and strategic interventions. In terms of international agreements, one such proposed solution is the introduction of a compensation mechanism where high-income countries would financially compensate the low-income countries from which they recruit workers (20). This compensation mechanism could be structured in two forms; either direct investment in educational institutions for nursing in the source country or general financial support to the source country to repay for their investment in human capital (to cover the invested cost of public nursing education for each migrant nurse) (20). The direct investment mechanism has been ongoing in the Philippines, whereby a high-income country interested to recruit nurses will fund private nursing schools for Filipino students intending to migrate upon completion of their nursing education (20). The latter form of bilateral financial agreements, general financial repayment, is less likely to be feasible (20). The human capital investment of a given low-income country in the public education of one nurse is a challenge to estimate and there are barriers to implementation of legally binding payments by high-income countries for each recruited nurse (20, 21). Throughout the evolution of various voluntary codes of best practices for international recruitment of nurses, the concept of financial compensation to low-income countries by high-income countries was replaced by the concept of mutuality (21). Rather than direct compensation, mutuality encompasses other trade-offs to balance the needs of the source and destination

countries, such as training exchanges (20, 21). Yet, in theory, a compensation mechanism may at least reduce the harms to the low-income countries caused by overwhelming loss of human capital investment in nursing education, compounded by loss of workers and expertise from the national health system (20, 21).

With regard to international health trade service agreements, the General Agreement on Trade in Services (GATS) treaty of the World Trade Organization (WTO) is a set of legally enforceable rules on trade in goods and services. However, they are only enforceable to members of the WTO who commit to modes of the GATS. Specifically, Mode 4 of the GATS pertains to the movement of people including the international mobility of health workers, including nurses (21). GATS commits WTO members to rounds of negotiations of their service sectors, in which members settle which service sectors they will commit to a higher level of liberalisation via GATS (22). The potential benefit provided by GATS on health care services is controversial (20). GATS may positively contribute to the international harmonization of nursing qualifications (20). GATS can also have positive economic impact for both high and low-income countries, as liberalization of the trade in services for nurses enables all countries to enter global markets, such as exporting of services abroad or to operate abroad (23). For example, low-income country economies may argue for increased freedom to work abroad since the associated remittances boost their economy (23). However, when it comes to health care services, experts warn against commitments to liberalist trade policy embodied by accepting remittances as this can seriously compromise health care quality and availability (24). Market competition for health care can exacerbate health inequities since public hospitals must compete with private. In low-income countries, the introduction of foreign private hospitals can recruit the most experienced healthcare professionals out of the public sector, compromising the number of professionals and level of expertise in the local public health care system, thereby reducing or removing the opportunity to access health care for those of lower socioeconomic status (24). The GATS is a step in the right direction for the equitable movement of people in health services, as global regulation efforts are integral, but it is not sufficient as it can reinforce inequities (20). There are opportunities for deeper, more equitable bilateral commitments related to health worker mobility, such as financial compensation to low-income countries from which nurses are recruited for high-income countries (21).

Voluntary codes of practice have evolved since adoption of the GATS. The 2010 WHO Code of Practice on the International Recruitment of Health Personnel serves as a core component of international, domestic and bilateral responses for the promotion of ethical principles in recruitment and retention of healthcare professionals (21, 25, 26, 27). The Code facilitates the strengthening of health systems, particularly low-income country health systems, by mitigating aspects of healthcare worker that may be detrimental (21, 25, 26, 27). Its main recommendations to member states include: ethical international recruitment by discouragement of active recruitment from low-income countries facing critical shortages of health personnel, health workforce development and health systems sustainability, fair treatment of migrant health workers, international cooperation, support to low-income countries, data gathering, and information exchange (25). Overall, the WHO Global Code of Practice emphasizes the importance of equitable access to healthcare services worldwide.

In low-income countries, non-financial incentives are effective strategic interventions against the mass emigration of nurses, which include training, study leave, and the opportunity to work in a team (20). Policy interventions may also be effective – specifically the replacement of traditional restrictive donation rules with more relaxed rules to allow donor money to be directed toward recurring health care costs such as wages (20).

The improvement of working conditions for nurses is another proposed domestic solution within high-income countries, achieved via policy and strategy interventions. This would stimulate the retention of trained local nurses as a means to address the root cause of the lack of nursing staff and the increase in vacant nursing positions. Local governments can implement evidence-based targeted solutions to ameliorate working conditions and to retain nursing staff: safe nurse to patient ratios, adequate wages, benefits, organizational support, and policy development to facilitate the reporting of workplace violence (20, 28, 29). In Canada, the government released a 2023 report stating strategies for nurse retention following the pandemic: Health Canada's Nursing Retention Toolkit draws upon evidence-based practice and lived experiences of nurses to call for immediate action (30). The Toolkit calls for safe staffing practices, flexible and balanced ways of working, and reduced administrative burden on nurses, in addition to other organizational adjustments (30). A joint report from the World Health Organization, International Council of Nurses, and Nursing Now (2020) recommends that countries who are over-reliant on migrant nurses focus on their self-sufficiency through investment in domestic retention and production of nurses (2). This is also an optimal solution to ameliorate the global nursing deficit

(4). The most sustainable approach to the lack of nurses in high-income countries is to fix longstanding systemic problems in their healthcare system by increasing the number of institutions providing safe working conditions.

Conclusion

The brain drain of nurses from low-income countries to high-income countries is a pressing global health concern which has been exacerbated in recent years. Adverse effects of the migration of nurses are disproportionately felt by low-income country populations, as this approach to low nurse retention in high-income countries is further worsening the global maldistribution of nurses (4). The communities of already resource-poor countries are burdened by increased costs for healthcare, decreased access to care, and adverse health outcomes (11, 18). The reliance of high-income countries on recruitment of nurses from low-income countries is an unsustainable mechanism for healthcare systems worldwide. To promote equity, it is necessary for all stakeholders to reinforce the implementation of the WHO Global Code of Practice. This review calls for two actions. Firstly, urgent global prioritization of preventative strategies against the unsafe nurse-patient ratios, and structural and workplace violence of nursing staff. Secondly, high-income countries ought to cease the unethical poaching of nursing staff from low-income countries. In sum, coordinated and synergistic work from both low- and high-income countries on their domestic safe working conditions for nurses will facilitate the recruitment and retention of nurses globally, thereby alleviating disparate global health inequities.

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