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# Human Trafficking and Other Labor Risks in the Healthcare Sector

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Verité

# Human Trafficking and Other Labor Risks in the Healthcare Sector

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# 1. Introduction

### *1.1 Objective*

This report provides an overview of the risks of human trafficking, including forced labor,[1] in the healthcare sector globally, including the United States. In some cases, the report also discusses other serious labor abuses as indicators of conditions or practices in the working environment that contribute to workers' vulnerability to forced labor. Healthcare is one of the main sectors in which workers are highly vulnerable to forced labor, because migrant workers,[2] who are at particularly high risk for related exploitation, participate in the healthcare workforce in significant numbers.

The objective of this report is to raise awareness of the forms that forced labor may take in the healthcare sector, as well as the structural causes and the combination of factors that may bind workers to their jobs. The intended audience for these findings includes government and industry actors seeking to strengthen their human rights due diligence approaches to manage the risks of forced labor, as well as workers and their advocates, civil society, and consumers.

Healthcare entities operate within an increasingly stringent regulatory environment that demands proactive measures to prevent human trafficking. Federal legislation such as the Trafficking Victims Protection Act, the Tariff Act of 1930, the Trade Facilitation and Trade Enforcement Act of 2015, the Countering America's Adversaries through Sanctions Act, the Uyghur Forced Labor Prevention Act, as well as relevant regulations like the Federal Acquisition Regulation and various state-level requirements, establish clear expectations for businesses to monitor and address trafficking risks within their operations and supply chains.

Healthcare sector entities also face compelling business reasons to implement robust due diligence

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[1] **Note: The United States recognizes two primary forms of trafficking in persons: forced labor and sex trafficking. For the purposes of this report, several terms are used such as "trafficking in persons," "human trafficking," and "forced labor." In this report, these terms refer to a crime whereby traffickers exploit and profit at the expense of adults or children by compelling them to perform labor.**

[2] In this report, the term migrant worker refers to a person who migrates, or has migrated, from one country to another, with a view to being employed by someone other than him/herself, including any person regularly admitted, as a migrant for employment, and/or to seek temporary or permanent residence in another country. This definition is aligned with ILO Convention C097 – Migration for Employment Convention (Revised), 1949 and the U.S. Department of Homeland Security's Office of Homeland Security Statistics.

systems. The reputational damage from association with trafficking operations can result in immediate loss of contracts, particularly with government agencies and major corporations that have adopted zero-tolerance policies. Furthermore, the operational disruptions caused by trafficking-related investigations can significantly impact service delivery and customer relationships, while the financial costs of remediation and legal proceedings can be substantial.

The focus of this report is on labor supply chains and the work performed by foreign migrant workers, subcontracted workers, and otherwise vulnerable workers. Guiding frameworks used to benchmark practices and conditions in this sector include, but are not limited to:

- ILO Convention 29 – Forced Labour Convention, 1930
- UN Guiding Principles on Business and Human Rights
- Responsible Sourcing Tool's Base Due Diligence Toolkit

***1.2 Scope***

This report examines the recruitment, contracting, and management of labor, including outsourced workers, across the healthcare sector. Workers comprising the sector include a wide range of health professionals and associate professionals, personal care workers, and health system support staff, as well as those involved in the upstream manufacture and distribution of healthcare supplies.

The main focus of this report is on workers who tend to be more vulnerable to exploitation: those who have jobs with worse conditions and less protection, like nursing assistants, home healthcare aides, environmental (cleaning) and food services workers, as well as those who have migrated or traveled internationally for work and equipment supply chain workers. Any worker with one or more of the vulnerabilities described in this report can become a victim of forced labor. Attention is given to research indicating acute vulnerabilities faced by migrant, seasonal, and subcontracted workers (workers who are supplied by third-party providers), who are often exposed to deceptive recruitment, debt bondage, excessive working hours, retention of identity documents, and unsafe working and living conditions.

### *1.3 Context and Methodology*

#### *1.3.1 Risk Factors, Risk Indicators, and Analytical Framework*

The healthcare sector includes a wide range of occupations spanning highly specialized, well-regulated clinical roles to lower-skilled and lower-paid service and care positions and supply chain labor. As in many industries, certain workers are more vulnerable to forced labor risks than others, particularly where employment arrangements limit workers' ability to decline or leave a job in order to protect their welfare. Verité's research has found that the greatest risk of forced labor emerges at the intersection of worker vulnerability and employment practices, including recruitment systems, which exploit that vulnerability. Across healthcare providers and supply chains, there are often overlapping characteristics of work and workers at this intersection, such as those in low-paid, low-skilled, dirty, dangerous, and demeaning ("Three D") jobs; subcontract workers and workers hired through third-party intermediaries; migrant workers; workers compelled by severe economic drivers; and workers in state-imposed forced labor.

This report examines both socio-demographic and employment practice-related *risk factors*, which contribute to worker vulnerability, and *risk indicators* or signs, which help identify cases of forced labor. Risk factors and risk indicators have overlapping elements and causes. To help contextualize the many indicators highlighted by the research on this sector, Section 3 organizes them into the four most common **risk factors** that underlie them:

- The involvement of labor contractors, recruiters, agents, or other middlemen in the labor supply chain
- Workers experiencing precarious employment and/or precarious residency status (including migrant workers)
- Workers experiencing poverty, marginalization,[3] and the absence of alternative income options
- State-imposed forced labor programs

[3] The ILO Global Guidelines on the Prevention of Forced Labour Through Lifelong Learning and Skills Development Approaches notes that people most at risk of forced labor are those that are vulnerable and includes marginalization among the common characteristics of vulnerability, along with suffering discrimination on the grounds of age, ethnicity, disability, gender, migration status, race, religion, or sex, etc. leading to social and economic exclusion or marginalization.

The **indicators** of forced labor found in the healthcare sector are:[4]

- Deceptive or fraudulent recruitment (regarding nature and terms of the job and/or the working and living conditions)
- Hazardous or degrading working conditions
- Onerous working hours or work schedule
- Inability to terminate employment
- Abuse of vulnerability

### *1.3.2 Sources of Information and Criteria for Inclusion*

Sources of information for this report include a broad range of publicly available materials, including civil society publications, journalistic investigations, academic research, and government reporting. These sources were used to identify documented or credible allegations of labor exploitation across healthcare service delivery and related healthcare supply chains, including clinical settings, long-term care environments, home-based care, outsourced support services, and the manufacturing of healthcare products. We note that the absence of documentation (e.g., research or investigative reports) pertaining to certain geographic locations, workforce categories, or types of healthcare organizations does not signify low risk or the absence of risk and, conversely, more information does not necessarily mean the risk is higher.

Further, allegations were not required to meet a legal or prosecutorial threshold to be included in the analysis, and not all findings presented here meet the legal definition of human trafficking. Labor exploitation occurs along a continuum, from fair, safe, and legal work in which employment is freely

[4] The ILO Forced Labour Convention, 1930 (No.29), defines forced labor as "all work or service which is exacted from any person under the threat of a penalty and for which the person has not offered himself or herself voluntarily." To support front line actors in the identification of situations of forced labor, ILO Indicators of Forced Labor - 2025 Revised Addition includes 11 of the most common signs observed in forced labor cases. They comprise situations that qualify as the menace of any penalty (also called coercion) and the absence of voluntary consent, or the ability to withdraw that consent, in other words the workers' freedom to leave the job. (To meet the threshold of forced labor, a situation must have some a *combination* of these two types of abuse.) The 11 indicators do not map exactly to the ILO 's earlier, more granular 2024 *Hard to See, Harder to Count: Handbook on Forced Labour Surveys*, which describes 22 circumstances commonly giving rise to involuntary work or qualify as forms of coercion. The list of indicators here are drawn from both these ILO documents as well as Verité's research for this report.

chosen, to situations characterized by a combination of involuntariness and coercion.[5]

## 2. Overview of the Healthcare Sector

### *2.1 Background*

The global healthcare industry encompasses a wide range of services delivered through hospitals, nursing homes, diagnostic laboratories, pharmacies, and outpatient care facilities. These healthcare institutions are supported by an extensive network, including pharmaceutical, medical device, and equipment manufacturers and distributors; chemical suppliers; and technology providers. Workers in job categories considered to be most vulnerable due to lower levels of training, lower pay, and higher potential for exploitation – like home health aides, personal care attendants, nursing assistants in residential facilities, hospital support staff, and direct care workers in long-term care settings – are the focus of this report.

These vulnerable occupations are the primary focus of this report's analysis of forced labor risks within the healthcare industry. In addition, forced labor has been documented in conjunction with the production of certain kinds of medical supplies (e.g., gloves) and equipment. Equipment involved in healthcare provision is also at risk for forced labor at the level of primary inputs such as metals (see the Mining sector report and Steel commodity report for more information), electronics (see the Electronics and Electrical Products sector report for more information), and certain chemical supply chains.

The healthcare industry represents about 10 percent of the gross domestic product (GDP) of most developed nations.[6] That said, there are significant disparities in national spending on healthcare, with 141 governments spending less than 5 percent of their GDP on public healthcare.[7] In the United States, healthcare spending was approximately 18 percent of the national economy, reaching USD 5.3 trillion in

[5] For operational forced labor indicators of involuntariness and coercion developed by the ILO, please refer to the International Labour Organization's *Hard to See, Harder to Count: Handbook on Forced Labour Surveys* (2024). The presence of an indicator alone does not necessarily confirm a legal finding of forced labor, but signals elevated risk, especially when multiple indicators are present simultaneously.

[6] OECD. *Health at a Glance 2025: OECD Indicators.* OECD. 13 Nov 2025.

[7] Human Rights Watch. "New Data Exposes Global Healthcare Funding Inequalities" *Human Rights Watch,* 10 Apr 2025.

2024, or roughly USD 15,474 per person.[8] This represents a significant acceleration from 2012 levels,[9] driven largely by greater demand for healthcare services and the increasing intensity of care required for an aging population. The OECD projects that per capita spending on healthcare globally will continue to grow through 2030.[10] In many economically developed countries, this growth is linked to a global demographic shift characterized by increased longevity and the aging of the "Baby Boomer" generation.

The global healthcare workforce has expanded significantly over recent decades. While the World Health Organization (WHO) reported approximately 60 million health workers in 2010, the WHO National Health Workforce Accounts estimates the global total was 115 million workers in 2024.[11] Approximately 65 million are categorized as professional health service providers, while the remaining 50 million are in management, administrative and technical support roles, reflecting shifts towards more administratively complex healthcare systems.[12]

In the United States, employment growth in the healthcare sector has outpaced most other industries, with over 8 million jobs added between 2014 and 2025. This workforce is currently distributed across several primary sub-sectors, with ambulatory healthcare services employing 9.4 million, hospitals employing 5.5 million, social assistance employing 4.4 million, and nursing and residential care facilities employing 3.2 million.[13] The most dramatic growth is occurring in lower-wage, direct-care positions, with approximately 3.7 million home health and personal care aides employed in 2024, as well as 1.3 million nursing assistants and approximately 42,000 orderlies.[14] Overall, the healthcare and social assistance sector is projected to add roughly 2.1 million jobs by 2032, or about 45 percent of all new job gains in the U.S. economy.[15] However, there is a significant shortage of available healthcare workers relative to demand. For example, the U.S. Health Resources and Services Administration (HRSA) estimates a national shortage of approximately 78,000 full-time Registered Nurses (RNs) in 2025, with

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[8] Centers for Medicare & Medicaid Services. *NHE Fact Sheet.*

[9] Centers for Medicare & Medicaid Services. *NHE Fact Sheet.*

[10] Lorenzoni, Luca et al. *Healthcare Spending Projections to 2030*. OECD, 23 May 2019.

[11] World Health Organization. WHO (2024): *National Health Workforce Accounts (NHWA) Data Portal*.

[12] World Health Organization. WHO (2024): *National Health Workforce Accounts (NHWA) Data Portal*.

[13] United States Bureau of Labor Statistics. BLS (2025): *Current Employment Statistics (CES).*

[14] United States Bureau of Labor Statistics. BLS (2025): *Current Employment Statistics (CES).*

[15] US Bureau of Labor Statistics. *Employment Projections*. 2024.

some projections of a 100,000 RN gap by 2038.[16] One result of such shortages, across a number of healthcare worker categories, is increased demand for foreign workers, many of whom will be recruited and placed by third-party labor agencies. The National Health Service (NHS) in the United Kingdom currently faces a staffing crisis characterized by high vacancy rates for both medical and non-medical personnel. Factors such as stagnant salaries and a heavy backlog of care have contributed to domestic staff retiring or seeking employment abroad, which has led to an increased reliance on international recruitment to maintain operations. [17] NHS in Wales, for example, recruited over 400 overseas nurses within a single year to address these service gaps. [18] Similarly, Canada has experienced record highs in health sector job vacancies since the 2019 Coronavirus pandemic, reaching over 100,000 open positions. These shortages have resulted in documented bed closures and disruptions to healthcare delivery across various provinces. [19]

### *2.2 Labor Supply Chain*

The shortages described above have already fueled a steady rise in migration of healthcare workers globally, mainly from lower-income to higher-income countries, including to the United States. According to the WHO, the number of migrant doctors and nurses working in OECD countries has increased by 60 percent over the last decade, with foreign-born professionals now making up one in five doctors and nurses across the 38 member nations.[20] In the United States, these figures are even more pronounced; as of 2025, foreign-born professionals account for approximately 26 percent of physicians and surgeons and 16 percent of registered nurses.[21] The demand has created a migration pipeline from countries like Fiji, Jamaica, Mauritius, and the Philippines, where the potential for international

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[16] Health Resources and Services Administration (HRSA): *Health Workforce Projections Dashboard. 2024.*

[17] Khan, Z. (2023). "The emerging challenges and strengths of the National Health Services: A physician perspective." *Cureus, 15*(5).

[18] Khan, Z. (2023). "The emerging challenges and strengths of the National Health Services: A physician perspective." *Cureus, 15*(5).

[19] Tomblin Murphy, G., et al. (2022). "Investing in Canada's nursing workforce post-pandemic: A call to action." *FACETS, 7*, 1051-1120.

[20] World Health Organization. *International Platform on Health Worker Mobility*.

[21] "New Research: Foreign-Born Workers Make Key Contributions to U.S. Health Care." *National Foundation for American Policy,* 19 Nov 2025.

employment remains a primary motivation for students entering medical and nursing programs.[22] The Philippines is a particularly notable example, having institutionalized the training of healthcare workers specifically for the global market. The country remains the world's leading exporter of nursing labor, with a record 28,258 Filipino nursing graduates taking the U.S. licensure examination (NCLEX) for the first time in 2024.[23]

Healthcare workers such as these are placed in jobs in foreign countries through both outsourced recruitment and direct hiring. Labor agencies have played a dominant role in the international labor market, acting as intermediaries to navigate the complexities of recruitment, job placements, visas, work permits and other documentation, and relocation, including in the healthcare sector, as described in greater detail in Section 3.1 below.

### *2.3 Jobs and Workforce Characteristics*

The healthcare labor market includes a wide range of occupations that differ in training requirements, scope of practice, and regulatory oversight. The International Labour Organization (ILO) and the WHO's international classification of health workers is a widely recognized classification system that helps define the main healthcare roles. Physicians have the most specialized medical training and full authority to diagnose and treat. Some work in technical specialties, while primary care doctors focus on prevention, chronic illness, and coordinating care. Advanced practice clinicians, such as nurse practitioners, physician assistants, and nurse anesthetists, are licensed professionals who can often diagnose, prescribe, manage ongoing health problems, and perform some procedures. They complete advanced training and work in many healthcare settings.[24] Registered nurses provide direct patient care, monitor health, coordinate services, and educate patients in hospitals, clinics, and community settings. Their roles vary widely, from bedside and specialty care to public health, and licensure defines their

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[22] OECD. *Health Workforce.*

[23] "28K Filipino Nurses Took First US Licensure Exam in 2024." Philippine News Agency, 26 Jan 2025.

[24] Bureau of Labor Statistics. *Healthcare Occupations*.

World Health Organization. *Classifying Health Workers.* 2019.

scope of practice.[25]

Allied health professionals include many non-physician specialists, such as pharmacists, physical therapists, mental health clinicians, speech-language pathologists, dietitians, audiologists, optometrists, and radiology professionals. Most need substantial education, clinical training, and a license or registration.

Health associate professionals do more technical and supportive clinical work, usually with additional supervision. This group includes Licensed Practical Nurses (LPNs), medical and dental technicians, lab and radiology assistants, pharmacy technicians, Emergency Medical Technicians (EMTs) or ambulance staff, and medical assistants. Personal care workers help with daily living and basic health needs. This includes Certified Nursing Assistants (CNAs), home health aides, and personal care aides, who assist with things like bathing, mobility, eating, and routine monitoring in nursing facilities, assisted living facilities, and private homes.[26]

Health system support personnel keep healthcare settings running. They include cleaning staff, food service workers, records and health information staff, clerks, and patient transporters. Their work supports sanitation, paperwork, logistics, and day-to-day operations, whether employed directly or through contractors. [27]

Physicians, specialists, and other highly autonomous licensed practitioners are generally at lower risk of severe labor and human rights abuses than workers with less autonomy, lower wages, or more limited bargaining power. While difficult working conditions can occur across the healthcare workforce, RNs, LPNs, personal care workers, and support personnel are more likely to face hazardous working conditions, irregular hours, and, in some cases, limited workplace protections. Their greater exposure to workplace hazards and forced labor risk is discussed in the following section.

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[25] Bureau of Labor Statistics. *Healthcare Occupations*.

World Health Organization. *Classifying Health Workers.* 2019.

[26] Bureau of Labor Statistics. *Healthcare Occupations*.

World Health Organization. *Classifying Health Workers.* 2019.

[27] Bureau of Labor Statistics. *Healthcare Occupations*.

World Health Organization. *Classifying Health Workers.* 2019.

## 3. Forced Labor and Other Labor Rights Risk Factors Associated with Healthcare Sector

Forced labor in the healthcare sector has been documented extensively around the world. For example, the U.S. Department of State's *2025 Trafficking in Persons Report* noted evidence of forced labor (or the risk[28] of forced labor) in the healthcare services or supplies sectors in the following 32 countries: Antigua and Barbuda, Argentina, Bahamas, Barbados, Brazil, Canada, China, Germany, Guatemala, Guyana, Haiti, Honduras, Hong Kong, Italy, Jamaica, Kuwait, Malaysia, Maldives, Mexico, Panama, Portugal, Qatar, Saint Lucia, Saudi Arabia, Saint Vincent and the Grenadines, Suriname, Taiwan, United Arab Emirates, United Kingdom, United States, Uruguay, and Venezuela.[29]

The following sections discuss common factors, also called drivers, and employment practices identified across many geographic locations, including the countries listed above, where risks and situations of forced labor in the healthcare sector have been identified. These factors and practices are often interrelated and can compound each other.

### *3.1 Involvement of Labor Contractors, Recruiters, Agents or Other Middlemen in Labor Supply Chains*

The global healthcare infrastructure is critically dependent on international labor, with wealthier nations increasingly filling lower-paid and high-demand support roles through migrant workforces.[30] While these workers are essential for system stability, their vulnerability to abuse is often exacerbated by the use of third-party recruitment and staffing agencies. These agencies can serve a legitimate function by helping foreign healthcare workers and employers navigate licensure, visa sponsorship, relocation, placement, and integration processes that are often complex, expensive, and multi-year in nature. The practices of some labor recruiters or other third-party intermediaries who recruit, hire, and/or manage workers are known to increase the risk of, and in some cases create situations of, forced labor.[31] These practices

[28] Risk of or vulnerability to forced labor in the hospitality sector, as opposed to documented evidence of forced labor, is indicated by the inclusion of "(risk)" following the country in which the risk or vulnerability was reported.

[29] U.S. Department of State. *2025 Trafficking in Persons Report.*

[30] World Health Organization. *WHO report on global health worker mobility.* WHO, 2024.

[31] A 2023 information memorandum from HHS's Office on Trafficking in Persons reviewed 13 federal cases alleging forced labor of health professionals, including 3 criminal prosecutions and 10 civil lawsuits. The memo found that the alleged traffickers

include deceiving workers about the nature, conditions, location, pay, and/or duration of the job; charging recruitment fees; withholding identity documents; and isolating workers at or near work sites.

Using migrant nurses as an example, these intermediaries manage the complex logistics of licensure and visa processing but frequently implement restrictive contracts that limit a worker's autonomy and legal recourse upon arrival in the host country.[32] International hiring follows three main models. In direct recruitment, the employer conducts the hiring itself and is the employer rather than relying on a recruitment firm as a broker to place a worker in a job. That said, middlemen may have been involved with facilitating other aspects of the worker's travel. In the placement model, third-party agencies recruit nurses abroad and manage testing, visa processing, and travel, but the nurse becomes an employee of the hospital or facility once placed. In the staffing model, the recruitment firm typically performs the same duties as in the placement model but remains the nurse's employer and "leases" nurses to facilities on an hourly basis.[33] This can generate more revenue than the placement model because the agency continues collecting fees for each hour the nurse works, rather than receiving a single placement fee.

When labor intermediaries are involved in recruitment, migrants are more likely to face recruitment fees, including fees that are illegal under applicable law or inconsistent with fair recruitment standards.[34] Debt owed to recruiters is combined with threats of deportation or reporting to immigration authorities; these practices create a culture of intimidation and can potentially lead to situations of debt bondage. In these working environments, workers are less able to raise concerns or grievances about issues such as unsafe environments, harassment and abuse, or underpaid wages.

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were staffing agencies, recruiters, hospitals, or nursing homes using staffing agencies, and that all 13 cases involved foreign national health professionals, with coercion commonly linked to recruitment promises, visa sponsorship, debt, breach fees, and restrictive contract terms.

U.S. Department of Health and Human Services, Office on Trafficking in Persons. *Federal Cases Involving Forced Labor of Health Professionals*. Document no. OTIP-IM-23-01. 17 Feb 2023.

[32] Eaton, Julian et al. "The Negative Impact of Global Health Worker Migration, and How It Can Be Addressed." *Public Health* 225: 254–257. Dec 2023.

[33] Pittman, Patricia et al. *U.S.-Based International Nurse Recruitment.* Academy Health, Nov 2007.

[34] International Labour Organization. *Global Study on Recruitment Fees and Related Costs: Second Edition*. Geneva: International Labour Office, 2024.

International Labour Organization. *General Principles and Operational Guidelines for Fair Recruitment and Definition of Recruitment Fees and Related Costs*. Geneva: International Labour Office, 2019.

Further discussion of vulnerabilities of migrant workers is provided in Section 3.2.

Debt linked to hiring and recruitment through staffing agencies can also serve to bind other medical professionals to their jobs, regardless of migrant status, although implications are usually greatest for workers who have traveled internationally for work. For example, staffing and recruitment agencies frequently utilize Training Repayment Agreement Provisions (TRAPs), which require employees to repay the costs of specialized training if they leave their position before a specified period, typically two to three years. Proponents argue that these allow employers to secure their return on the upfront costs associated with placing medical professionals, particularly those recruited from abroad. However, they can effectively function as a form of employer-driven debt that restricts job mobility.[35] Although the Federal Trade Commission (FTC) issued a final rule in April 2024 to ban most non-compete clauses and "functional non-competes" like TRAPs, this nationwide ban was struck down by a Texas federal court in August 2024 and officially removed from federal regulations in early 2026, leaving such agreements legal and prevalent under a case-by-case enforcement model.[36]

### *3.1.1 Illustrative Cases*

An investigation published in 2023 found that in the United States, foreign healthcare workers, especially those from the Philippines, reported paying recruitment fees, and upon arrival, were told that they faced penalties of up to USD 100,000 for early termination of a multi-year contract, in combination with wages that were lower than what was promised.[37] Recruiters in both the United States and the

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[35] National Nurses United. "Comment on CFPB employer-driven debt RFI." [Comment on docket CFPB-2022-0038-0001]. Consumer Financial Protection Bureau, 23 Sept 2022.

[36] Federal Trade Commission. "Non-Compete Clause Rule." *Federal Register* 89, no. 89 (May 7, 2024): 38342–38506.

"FTC Officially Removes Noncompete Rule from Federal Regulations." *ACA International News*, February 18, 2026.

Gartenberg, Gavi, and Julia G. Brinton. "Texas Federal Court Strikes Down FTC's Final Non-Compete Rule." *The National Law Review* XIV, no. 233 (August 21, 2024).

*Ryan LLC v. Federal Trade Commission*. No. 3:24-cv-00986-E. U.S. District Court for the Northern District of Texas. August 20, 2024.

[37] Almendral, Aurora. "Hidden System of Exploitation Underpins U.S. Hospitals' Employment of Foreign Nurses." Pulitzer Center, 2 Oct 2023.

Pettypiece, Shannon. "Trapped at work: Immigrant health care workers can face harsh working conditions and $100,000 lawsuits for quitting." NBC News, 4 Jun 2023.

Philippines reportedly use these tactics.38 Further, some of these nurses reported being threatened by the recruitment agency that if they left in spite of the fee, they would be reported to immigration authorities.[39] These workers also reported abusive practices, such as forced and unpaid overtime, that also created unsafe conditions for patients.[40] One Filipino nurse was promised free housing as part of his contract, and on arrival, discovered that the housing was actually a tiny room inside the nursing facility where he was working.[41]

In the United Kingdom, care workers recruited through third-party agencies have reported paying illegal recruitment fees of up to £20,000, before finding themselves in positions with fewer hours or lower pay than promised.[42] A study of nurses from East Africa in the United Arab Emirates found that nurses reported being confined to their accommodation and threatened with termination to compel work outside what was agreed, withheld wages, as well as gender-based violence and harassment.[43]

### *3.2 Migrant Workers and Immigrants with Precarious Residency Status*

Healthcare systems in many countries, particularly wealthier ones, rely heavily on migrant workers who often receive lower wages than native-born colleagues across a wide range of occupations.[44] In some settings, this reliance is especially pronounced in lower-paid, less desirable, or high-demand roles, but migrant workers are also well represented in higher-status professions such as physicians and dentists. The central concern, however, is the vulnerability created by certain recruitment and employment

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[38] Almendral, Aurora. "Hidden System of Exploitation Underpins U.S. Hospitals' Employment of Foreign Nurses." Pulitzer Center, 2 Oct 2023.

Pettypiece, Shannon. "Trapped at work: Immigrant health care workers can face harsh working conditions and $100,000 lawsuits for quitting." NBC News, 4 Jun 2023.

[39] "USA: Investigation Reveals Forced Labour, Exploitative Employment Contracts for Filipino Nurses". Business and Human Rights Centre.

"Immigrant Nurses – Be Wary of Staffing Agencies that Violate Federal Law." Center for Medicare Advocacy, 7 Dec 2023.

[40] Pettypiece, Shannon. "Trapped at work: Immigrant health care workers can face harsh working conditions and $100,000 lawsuits for quitting." NBC News, 4 Jun 2023.

[41] Pettypiece, Shannon. "Trapped at work: Immigrant health care workers can face harsh working conditions and $100,000 lawsuits for quitting." NBC News, 4 Jun 2023.

[42] Stacey, Kiran. "Sixfold Rise in Foreign Care Workers in UK Complaining of Exploitation." The Guardian, 19 Aug 2024.

[43] Equidem. *Shattered Dreams, Hidden Trauma.* Equidem, 2025.

[44] Lisiecki, Matthew and Vicky Virgin. "Essential But Ignored: Low-Earning Immigrant Healthcare Workers and their Role in the Health of New York City." *Center for Migration Studies*, 31 Jan 2025.

arrangements.

As noted above, hospitals, long-term care facilities, and home health systems in many countries depend on internationally recruited nurses, aides, and other health workers to address persistent labor shortages. While these migration pathways can fill critical gaps, some recruitment and contracting arrangements create significant risk. Migrant healthcare workers may face restrictive visa terms tied to a single employer, complex licensing requirements, recruitment fees, and contractual obligations that limit their ability to change jobs. These conditions can increase dependence on employers and labor intermediaries for immigration status, housing, transportation, and other basic needs. Workers may also be navigating unfamiliar legal systems, workplace norms, and languages while remaining geographically and socially distant from family and established support networks. Together, these factors can heighten vulnerability to exploitation, debt, and other forms of coercion.

The United States healthcare system depends on foreign staff, with immigrants comprising approximately 18.2 percent of the 16 million people employed in the sector. Approximately 26 percent of physicians and surgeons, 22 percent of dentists, 41 percent of home health aides, 28 percent of personal care aides, 15 percent of pharmacy technicians, and 22 percent of nursing assistants were born in countries other than the United States.[45] There is some association between country of origin and profession. For example, many nurses in the United States are from South and East Asia, particularly the Philippines. Many health aide and personal care assistants are from the Caribbean and Central American.[46] In other destination countries, reliance on migrant healthcare workers is concentrated in the United Kingdom, Australia, and the Gulf Region. In the United Arab Emirates, for example, approximately 96 percent of nurses are from other countries.[47] In addition to nurses from more traditional origin countries such as the Philippines, a growing number of nurses and care workers in the Gulf states are from eastern African countries, including Kenya and Uganda.[48]

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[45] Zavodny, Madeline. "The Contributions of Foreign-Born Workers to U.S. Health Care." *National Foundation for American Policy,* Nov 2025.

[46] Hulver, Scott et al. "What Role Do Immigrants Play in the Hospital Workforce?" KFF, 17 Jun 2025.

[47] Wehbe-Alamah, Hiba et al. "Nursing Research in Arab Countries: Current Status, Trends, Challenges, and Opportunities." *SAGE Open Nursing* vol. 10 23779608241246871., 15 Apr 2024.

[48] Equidem. *Shattered Dreams, Hidden Trauma.* Equidem, 2025.

*3.2.1 Illustrative Case*

Healthcare workers migrating from East Africa to the Gulf Region enter a framework that creates total dependency, where their legal residency, housing, and mobility are tied to a single sponsoring employer. This arrangement creates a significant power imbalance, as any attempt to express a grievance or leave an abusive workplace can result in the worker being classified as "absconding," leading to immediate arrest and deportation. Because their right to remain in the host country is contingent upon the approval of their sponsor, they are less able to report abuse or raise grievances.[49] Geographically separated from their support networks and often confined to employer-provided accommodations, these healthcare professionals have limited access to independent legal or social services.[50] They also typically owe debt to recruiters, as described in Section 3.1 above, pressuring them to maintain their employment, regardless of conditions.[51]

### *3.3 Workers Experiencing Poverty, Marginalization, and Absence of Alternative Income Options*

Poverty, marginalization, and a lack of social capital among workers in the healthcare sector exacerbate the risk indicators described above. People living in poverty often lack social networks and relationships that would otherwise support their access to economic, employment, and educational opportunities. Jobs that are dangerous, low-paying, unstable, or otherwise undesirable are often avoided by workers with access to better alternatives. This type of work is thus routinely done by individuals in extreme poverty, socially marginalized groups, immigrants who may not have local language fluency or transferable skills, and other minorities. With limited options, these workers may be more likely to accept coercive or deceptive terms and to remain in abusive or unsafe jobs. They may also take significant risks to secure employment, including illegally crossing borders to pursue false promises of work.

Healthcare workers in roles like personal care, home health care, and some nursing jobs tend to be

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[49] Human Rights Watch. *United Arab Emirates: Events of 2024.* Human Rights Watch.

Equidem. *Shattered Dreams, Hidden Trauma.* Equidem, 2025.

[50] Human Rights Watch. *United Arab Emirates: Events of 2024.* Human Rights Watch.

Equidem. *Shattered Dreams, Hidden Trauma.* Equidem, 2025.

[51] Zhang, Sheldon et al. *Forced Labor Among Kenyan Migrant Workers in the Gulf Cooperation Council (GCC) Countries: A Prevalence Estimation Report.* NORC at the University of Chicago, Dec 2021.

marginalized on multiple fronts. These jobs are low paid and workers are often migrants, more likely to be experiencing poverty or some type of social or economic marginalization (e.g., not fluent in the local language, from a community that is discriminated against, limited access to educational or training opportunities due to geographic or financial barriers), and/or who do not have access to alternative income options. Studies have found that approximately 36 percent of direct care and support workers in the healthcare sector in the United States live at or near the poverty line, with more than one-third reporting a lack of affordable housing and nearly half relying on public assistance such as Medicaid or Supplemental Nutrition Assistance Program (SNAP) benefits.[52]

Demographic patterns intersect with these economic outcomes. Direct care jobs are overwhelmingly held by women, who in 2024 and 2025 accounted for 91 percent of nursing assistants in nursing homes, 85 percent of home care workers, and 84 percent of residential care aides. People of color are also heavily concentrated in these occupations; although they represent a smaller portion of the overall United States labor force, they make up over 60 percent of the direct care workforce[53] and the majority of workers in care assistant roles in hospitals. Marginalization within healthcare extends beyond caregiving roles to include environmental services, cleaning, and food preparation positions. Women represent about 77 percent of hospital cleaning staff, and over 40 percent of cleaning workers identified as people of color in recent demographic snapshots.[54]

International data reflects comparable trends. In the United Kingdom, research indicates that nearly one in five residential care workers lives in poverty, making residential care one of the occupations with the highest rates of poverty among employed workers.[55] In Canada, a 2025 report from the Canadian Centre for Policy Alternatives notes that workers of color, particularly women, are nearly twice as likely as their white counterparts to occupy low-wage "care economy" roles, such as nursing assistants and residential

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[52] PH International. *Direct Care Workers in the United States: Key Facts 2025.* PHI, 15 Sept 2025.

[53] Duffy M. "Why Improving Low-Wage Health Care Jobs is Critical for Health Equity." *AMA Journal of Ethics* 24, no. 9 (Sept 2022):E871-875.

PH International. *Direct Care Workers in the United States: Key Facts 2025.* PHI, 15 Sept 2025.

[54] Zippia. *Hospital Cleaner Demographics and Statistics in the US.*

[55] The Health Foundation. "UK Care Workforce Twice as Likely to Live in Poverty as Average Worker." *The Health Foundation*, 17 Jul 2025.

aides.[56] Testimonials from care aides in Australia – who are predominantly female - describe the extreme financial stress of "survival" wages, where unpredictable schedules and underemployment prevent workers from securing loans or meeting basic cost-of-living requirements.[57]

### *3.3.1 Illustrative Case*

A 2022 report from the Business & Human Rights Resource Centre documented the case of 24 Bangladeshi women who were held in physical captivity by a recruitment agency in Riyadh after arriving for promised domestic care jobs. Rather than being placed with employers, the women were reportedly confined by the agency and deprived of adequate food, water, and medical care. The case illustrates risks that can arise before workers even reach their assigned workplaces. More broadly, migrant domestic workers in Gulf states are often made vulnerable by tied visa systems, in which legal residency is linked to a single sponsor or employer. In these settings, workers who perform essential but largely invisible labor in private homes may face indicators of forced labor, including passport confiscation, non-payment of wages, restricted movement, and threats of "absconding" charges if they try to leave abusive situations. [58]

### *3.3.2 Hazardous and Undesirable Work*

Workers who are subject to the forms of coercion described above are least able to protect their well-being, including exposure to health and safety risks. Healthcare workers operate in an environment that can present risks of exposure to infectious diseases, workplace violence, and physical injury. Workers who are already vulnerable because of migration status, poverty, debt, limited legal protections, language barriers, or dependence on an employer for housing or immigration status often have less ability to refuse dangerous assignments, request safer conditions and protective equipment, report potential risks, or leave a job. These constraints make them more exposed to risks that other workers might be able to avoid. At the same time, the existence of hazardous working conditions tends to make

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[56] Scott, Katherine. *Still Struggling: Racialized Workers in the Post-Pandemic Labour Market*. Ottawa: Canadian Centre for Policy Alternatives, Jun 2025.

[57] Martain, Sandra. "Workers' Health and Safety Rights in the Marketised Aged Care System in Australia." *Labour & Industry* 35, no. 1 (5 Jun 2025): 59–79.

[58] Business & Human Rights Resource Centre. "Saudi Arabia: 24 Bangladeshi Domestic Workers Allegedly Deprived of Nutrition & Healthcare After Being Held Captive Following Illegal Recruitment." *Business & Human Rights Resource Centre,* 7 Nov 2022.

these jobs less attractive to workers with more options, which can increase employers' reliance on workers who are under greater economic or legal pressure to accept them. In this way, preexisting worker vulnerability and hazardous job conditions can reinforce one another.

According to the WHO, occupational hazards in the healthcare sector include exposure to diseases such as tuberculosis, hepatitis B and C, HIV/AIDS, and emerging respiratory pathogens, as well as routine contact with disinfectants, sterilizing agents, and certain medications that may pose chemical risks.[59] Workers may also encounter physical dangers associated with radiation, noise, electrical equipment, and fire or explosion hazards.[60] In the United States, the Bureau of Labor Statistics reported that the healthcare and social assistance sector continues to lead all private industries in total workplace injuries, with approximately 308,000 cases recorded in the most recent annual data. The injury rate remains high at 3.6 per 100 full-time workers.[61] Long-term care facilities, acute care hospitals, and ambulatory treatment settings are regularly identified as workplaces with particularly elevated injury rates.[62] Workplace injuries in personal care and home care support roles – frequently held by migrant and immigrant workers – occur in private home settings where support, oversight, and security are often limited.[63] Housekeepers and maintenance workers in healthcare facilities face daily exposure to needle-stick injuries and infectious diseases. Data shows that injury rates for hospital housekeepers and maintenance workers remain among the highest in the service sector.[64]

Data from other countries reveals similar dynamics. In the United Kingdom, 2024-2025 statistics from the Health and Safety Executive (HSE) reveal that an estimated 680,000 workers sustained non-fatal injuries across all sectors, with the health and social work sector reporting a significantly higher rate of work-related ill health (5,360 per 100,000 workers) compared to the national average.[65] In Canada, 46.6 percent of healthcare workers are frequently exposed to biological and chemical risks, compared to the

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[59] World Health Organization. *Occupational Hazards in Healthcare*.

[60] World Health Organization. *Occupational Hazards in Healthcare*.

[61] U.S Bureau of Labor Statistics. *Injuries, Illnesses, and Fatalities.*

[62] OSHA Education School. *Top 10 Industries with Highest OSHA-Reported Injury Rates.* 22 Sept 2025.

[63] Obariase, Efosa MS et al. "Assessing Workplace Violence and Policy Impact: A Cross-Sectional Study of Home Healthcare Workers." *Home healthcare now*, *43*(3), 150–156, May/Jun 2025.

[64] U.S Bureau of Labor Statistics. *Injuries, Illnesses, and Fatalities.*

[65] Health and Safety Executive. *Health and Safety at Work: Summary Statistics for Great Britain 2025*. Bootle: HSE, 2025.

national average of 17.8 percent.[66] Recent data from the Association of Workers' Compensation Boards (AWCBC) confirms that the healthcare and social assistance sector remains a primary driver of lost-time claims in Canada. The lost-time injury rate can be as high as 2.6 per 100 workers, significantly higher than the average for most manufacturing sectors.[67]

Many healthcare workers report exposure to violence in the workplace, with estimates suggesting that a majority experience some form of aggression during their careers. Verbal hostility, intimidation, and threats are most frequently reported and a number experience sexual harassment.[68]

#### *3.3.3 Illustrative Case*

In a survey of 187 Filipino home care workers in Israel, more than half revealed they had experienced some form of work-related abuse, including sexual, physical, emotional, or exploitative abuse. Fewer than half of those who experienced abuse reported it at the time, and when they did, they usually told family or friends rather than formal authorities. None reported the abuse to the police. The primary reason given for not expressing grievances was a concern that it would worsen their situation overall. The findings of this study suggest that migrant home care workers face the risk of abuse but may have limited ability to seek formal help.[69]

### ***3.4 State-Imposed Forced Labor Programs***

The Cuban government deploys tens of thousands of health professionals to countries around the world, estimated to generate between USD 6 billion and 8 billion annually. The 2025 U.S. Department of State entry on Cuba's labor export program notes that medical professionals make up roughly three-quarters of Cuba's exported workforce and identifies the program as a major source of state revenue.[70] Evidence suggests that the state frequently garnishes 70-90 percent of the salaries paid by host countries, while

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[66] Government of Canada. Canadian Survey on Working Conditions. 2026.

[67] Association of Workers' Compensation Boards of Canada. *2025 Report on Work Fatality and Injury Rates in Canada*. Ottawa: AWCBC, 2025.

[68] World Health Organization. Occupational Hazards in Healthcare.

[69] Green, Ohad, and Liat Ayalon. "Whom Do Migrant Home Care Workers Contact in the Case of Work-Related Abuse? An Exploratory Study of Help-Seeking Behaviors." *Journal of Interpersonal Violence* 31, no. 19 (2016): 3236-3256.

[70] U.S. Embassy in Cuba. "Human Trafficking in Cuba's Labor Export Program 2024." *U.S. Embassy in Cuba*.

participants experience restricted freedom of movement and confiscation of their passports and professional credentials upon arrival at their destination.[71] The State Department further reports allegations that workers may be subjected to surveillance, threats of retaliation, family separation, penalties for refusing assignments, and restrictions on their ability to travel independently or leave the program. Some workers also reported that they did not freely volunteer for overseas assignments and feared that leaving the program could result in punishment, loss of professional status, or other consequences for themselves or their families.[72]

### *3.4.1 Illustrative Case*

In 2022, the regional government of Calabria, Italy, entered into a formal agreement with a Cuban state-owned entity to deploy approximately 500 medical professionals to address a chronic healthcare staff shortage in southern Italy. Under the terms of the initial decree, the regional government agreed to pay a gross monthly salary of approximately EUR 4,700 for each medical professional. However, investigative reports and human rights petitions revealed that the Cuban government retained up to 72 percent of these wages, while the remainder was transferred directly to the Cuban state-run medical services company.[73] The conditions of the Calabria mission were further criticized in petitions to the European Parliament, which highlighted that the medical professionals were deployed through a state-owned intermediary known for coercive practices. The Cuban government restricted workers from terminating their contracts or returning to Cuba and imposed severe professional and personal retaliation on those who did, including potential imprisonment or designation as “deserters” under Cuban immigration law.[74]

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[71] Rodriguez, Vaitiari. *The Dark Side of the Missions: Human Trafficking in Cuba’s Medical Missions*. New York: Human Rights Foundation, Aug 2022.

Comisión Interamericana de Derechos Humanos. “Derechos laborales y libertades sindicales en Cuba.” (Madrid: OCDH, 2024), 5–8.

Cubalex. “Informe Mensual: Situación de los Derechos Humanos en Cuba.” Sept 2025 (Havana: OCLEP, 2025), 2.

[72] U.S. Department of State, “Trafficking in Persons and Cuba’s Labor Export Program.” 20 Jan 2025.

[73] Peretti, Alessia. “Southern Italy scrambles for doctors after US pressure on Cuban programme.” *Euractiv*, 9 Mar 2026.

[74] European Parliament, Committee on Petitions. “Notice to Members : Petition No 0038/2023. 2024.“ *European Parliament*, 18 Dec 2023.

## 4. Forced Labor Risk in Production of Medical and Pharmaceutical Goods

Forced labor risk is also found in the upstream manufacturing and production of medical and pharmaceutical goods. Global supply chains for medical products often span multiple countries and tiers of production, with manufacturing processes for items such as protective equipment, pharmaceutical ingredients, and surgical instruments relying on networks of suppliers, subcontractors, and labor intermediaries. Production pressures, cost competition, and the reliance on migrant labor or informal subcontracting arrangements are known to create conditions in which workers face heightened vulnerability to coercion or exploitative practices In pharmaceutical supply chains, the final drug product may pass through several stages before reaching hospitals, pharmacies, or patients, including the production of raw materials, chemical precursors, intermediates, active pharmaceutical ingredients, excipients, formulation, packaging, and distribution, making supply chains highly opaque. Chinese manufacturers play a particularly important role in the earlier and less visible stages of production, including raw materials, solvents, and reagents for active pharmaceutical ingredients.[75] This presents risks given China's documented use of state-sponsored forced labor issues, as discussed below.

### *4.1 Illustrative Cases*

In Malaysia, migrant workers from Bangladesh and Nepal working in the production of rubber gloves reportedly experienced indicators of forced labor, including excessive recruitment fees resulting in a burden of debt, forced overtime, and degrading living conditions. The import of rubber gloves from Malaysia has been subject to regulatory action by U.S. Customs and Border Protection (CBP) because of these risks.[76] In late 2025, a rubber glove manufacturer faced allegations that Bangladeshi migrant workers who protested unpaid wages were forcibly deported. [77] Following CBP enforcement action, Top

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[75] Wosińska, Marta E., and Yihan Shi. "US Drug Supply Chain Exposure to China: Myths, Omissions, and Related Insights." Brookings Institution, 28 Jul 2025.

[76] Ellis-Petersen, Hannah. "US Bars Rubber Gloves from Malaysian Firm due to 'Evidence of Forced Labour.'" *The Guardian*, 15 Jul 2020.

Business & Human Rights Resource Centre. "Malaysia: Buyers Suspend Relationships with Glove Co. Mediceram after Alleged Continued Human Rights Abuse Impacting Bangladeshi Workers; Incl. Cos. Responses & Non-Response." 14 Jan 2026.

[77] Modern Slavery and Human Rights Policy and Evidence Centre. *Forced Labour in the Malaysian Medical Gloves Supply Chain*. Modern Slavery PEC, 29 Jun 2021.

Business & Human Rights Resource Centre. "Malaysia: Buyers Suspend Relationships with Glove Co. Mediceram after Alleged Continued Human Rights Abuse Impacting Bangladeshi Workers; Incl. Cos. Responses & Non-Response." 14 Jan 2026.

Glove and Brightway took specific remediation steps before import restrictions were modified. These included reimbursing migrant workers for recruitment fees, adopting a zero-cost recruitment model, improving worker housing and living conditions, strengthening grievance mechanisms, changing labor management practices, and using independent third-party audits to verify corrective action. In Top Glove's case, the U.S. Department of Labor reported that the company repaid more than USD 30 million in recruitment fees to over 10,000 migrant workers.[78]

Forced labor risks associated with the manufacture of active pharmaceutical ingredients (APIs) and medical equipment, including protective medical garments, in Xinjiang, China have also been reported.[79] The practice of "labor transfers" was associated with facilities that produce essential precursors for global drug manufacturing. State-sponsored "labor transfers" in Xinjiang function as a pervasively coercive system where Uyghur and other ethnic minorities are forcibly relocated from their homes to industrial facilities. The use of these practices in pharmaceutical ingredient factories creates a high probability that international pharmaceutical companies are inadvertently sourcing ingredients linked to state-imposed forced labor.[80] Recent reporting has sharpened this concern on the pharmaceutical side specifically, noting that the global pharmaceutical industry continues to rely on APIs and related products manufactured in Xinjiang. One recent report from C4ADS identified 76 pharmaceutical products exported from China that were produced only in Xinjiang, including some conventional drug products. The report also found that Xinjiang-linked pharmaceutical companies remained connected to international regulatory and procurement systems, including FDA registration pathways.[81]

A 2025 report prepared for the U.S. Senate Special Committee on Aging similarly warned that API subcomponents made by China-based entities with alleged ties to Uyghur forced labor may be entering U.S. medications. The report identified Sinopharm, Zhejiang Shindai Chemical Group, and Zhejiang

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[78] U.S. Customs and Border Protection. "CBP Modifies Forced Labor Finding on Top Glove Corporation Bhd." 9 Sept 2021.

U.S. Customs and Border Protection. "CBP modifies Withhold Release Order on Brightway Group in Malaysia." 11 Oct 2024.

U.S. Department of Labor, Bureau of International Labor Affairs. "Example in Action: Top Glove WRO and Subsequent Modification."

[79] Kharon Staff. *Pharmaceutical and Biotech Industry Faces Possible Exposure to Xinjiang Forced Labor*. Kharon, 13 May 2024.

Gerin, Roseanne. "Drugmakers Rely on Supplies Using Uyghur Forced Labor: Report." Radio Free Asia, 13 Jun 2024.

[80] Gerin, Roseanne. "Drugmakers Rely on Supplies Using Uyghur Forced Labor: Report." Radio Free Asia, 13 Jun 2024.

[81] C4ADS. "Side Effects: The Human Rights Implications of Global Pharmaceutical Supply Chain Linkages to XUAR." 8 Oct 2024.

Chemicals Import & Export Corp. as examples of China-based entities that may supply pharmaceutical ingredients or intermediates into downstream drug production, including through middlemen in India or other countries.[82]

The risk is not limited to a single country of final manufacture. Brookings cautions that discussions of pharmaceutical dependence on China often overstate or oversimplify finished API exposure, but also emphasizes that Chinese firms play a significant role in upstream inputs, including auxiliary chemicals, solvents, reagents, and other materials needed for API synthesis. This means that shifting final manufacturing or finished-dose production to another country may not eliminate forced labor risk if upstream chemical inputs remain opaque.[83]

## 5. Recommendations: Due Diligence Steps to Address Risks

### *5.1 Conclusions*

This report examined the forced labor risks in the operations and supply chains of companies supplying services, materials, and products across the healthcare sector.

The risks of exploitation of workers trace, in most cases, back to the inadequate due diligence processes of third-party services providers, labor agencies, and suppliers; and deceptive and exploitative recruitment processes that result in worker debt and compound other migrant worker vulnerabilities.

Companies should view the contents of this report as a starting point and seek to further develop their understanding of the specific weaknesses and risks in their supply chains at all tiers, in order to implement dynamic and ongoing risk assessments and mitigation strategies.

The findings largely point to potential gaps in companies' due diligence systems or approaches to managing risk. The following recommendations for addressing these potential process gaps offer healthcare entities practical guidance for implementing comprehensive measures to control forced labor

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[82] Exiger. "A Bitter Pill: Medicaid's Dangerous Dependence on China-Made Pharmaceuticals and Forced Labor." March 2025. Report prepared for the U.S. Senate Special Committee on Aging, 2025.

[83] Wosińska, Marta E., and Yihan Shi. "US Drug Supply Chain Exposure to China: Myths, Omissions, and Related Insights." Brookings Institution, 28 Jul 2025.

risks and protect their operations and individuals who may be vulnerable to exploitation within their supply chains. Effective due diligence requires a systematic approach that integrates risk assessment, prevention and mitigation, capacity building, and monitoring. This involves developing comprehensive frameworks that can identify and address potential forced labor indicators across diverse operational contexts. The goal is not merely to achieve compliance but to create sustainable systems that prevent forced labor and protect vulnerable populations while maintaining operational efficiency and competitive advantage.

The ResonsibleSourcingTool.org site overall and the Due Diligence Toolset specifically provide technical tools to support the implementation of the following recommendations. The recommendations that follow and the toolset referenced align with the UN Guiding Principles on Business and Human Rights and the OECD Due Diligence for Responsible Business Conduct. Tool 1 of the Base Due Diligence Toolset provides a model effective practice due diligence program for identifying potential risks in a supply chain, evaluating and prioritizing identified risks, implementing solutions, and monitoring and improving supplier performance over time.

### *5.2 Recommendations*

#### 5.2.1 Policy and Embedding Forced Labor Prevention Standards and Practices in Business Functions

5.2.1.1 Companies should include a clear prohibition against forced labor in their Codes of Conduct and supplier performance standards. (See Base Tool 2.) This should include the "employer pays" principle, which requires that all fees and expenses relating to the recruitment and placement of a worker are paid by the employer.

5.2.1.2 The policy should be clearly communicated to all business entities, including third-party service providers and labor agents, and included in business contracts. (See Base Tool 5.) The contracts should also require that the policy be cascaded to the suppliers' suppliers.

5.2.1.3 Procurement staff should be formally assigned, trained, and supported to screen prospective suppliers, including third-party service providers and labor agents, for their commitment and capacity to meet the policy standards on avoiding forced labor.

(See Base Tools 3, 7 and 8.) There should be clear consequences established for supplier performance on achieving the standards.

5.2.1.4 Review of a supplier's management of forced labor risks should be incorporated in regular supplier engagements, such as quarterly business reviews, quality audits, and other existing supplier management processes.

5.2.2 Risk Assessment and Prioritization

5.2.3.1 Conduct a combined supply chain mapping and forced labor risk assessment as a key first step in creating a targeted strategy for segmenting and prioritizing risks to address. (See Base Tool 6.) High level risk factors to consider include characteristics of country of operation, product or production processes involved, and workforce demographics (e.g., prevalence of migrant workers). Other factors to consider include a company's ability to influence suppliers based on volume/spend and the degree of harm to people that practices may cause.

5.2.3 Needs Assessment and Capacity Building

5.2.3.2 Based on the results of a risk assessment, companies should conduct deep dives (e.g., targeted research, risk assessments, rapid appraisals, supplier assessments) to develop and implement action plans to address the underlying causes of identified risk or issues. The activities, which should be informed by clear objectives and measurable success indicators, may range widely from supplier training to engagement in multistakeholder initiatives where companies individually lack the leverage to drive positive changes in an operating environment (e.g., where economic or political factors are immovable in the immediate term).

5.2.4 Monitoring

5.2.4.1 Companies need to routinely evaluate whether they are implementing their due diligence processes as planned (e.g., new suppliers screened for forced labor risks, review of corrective action plans during regular supplier business reviews).

5.2.4.2 The effectiveness of due diligence activities should be tracked to ensure the desired impacts are on target and sustainable (e.g., worker-paid recruitment fees are avoided, foreign migrant workers are in full control of their identification documents, and workers have access to remedy).