International Platform on Health Worker Mobility:
Evidence, Solutions and Instruments

Meeting Report

Geneva, Switzerland
13th- 14th September 2018

#Working4Health
#HWMigration
Summary

The meeting of the International Platform on Health Worker Mobility took place on the 13th and 14th of September 2018 at WHO Headquarters in Geneva, Switzerland. The meeting was jointly hosted by ILO, OECD, and WHO, as part of the Working for Health Programme. It built on the previously held High Level Dialogue on International Health Worker Migration (See meeting notes).

Seventy-nine participants gathered to discuss existing policy measures and to identify strategic actions to strengthen the management and governance of health worker mobility. The participants included thirty-seven representatives from national governments; eighteen representatives from civil society including representatives from trade unions, employers’ associations, national regulatory bodies and international credential verification organizations; and twenty-four representatives from international agencies.¹

Strategic actions identified by the meeting participants included strengthened information and knowledge exchange at the global level; capacity-related support for the development, implementation and monitoring of bilateral agreements; review of the criteria and list of countries with critical health workforce shortages; strengthened policy and multi-sectoral dialogue at the national level; and the development of knowledge repositories in relevant areas (e.g. texts of bilateral agreements, competency framework, mapping of qualifications across jurisdictions).

Detailed Notes

Senior leadership from WHO, OECD and ILO presented opening remarks and welcomed the participants to the meeting. The Director of WHO’s Health Workforce Department provided the context for the meeting and introduced its agenda (See Presentation). Mr. Campbell clarified the underlying logic of the meeting with sessions on health professional education, integration into host country health systems, and role of international cooperation to feed into the concluding discussions on the WHO Global Code of Practice and priority activities for the International Platform. Mr. Campbell additionally emphasized the value of the multi-sectoral and multi-stakeholder dialogue to address the escalating scale and complexity of health worker mobility. OECD’s Head of International Migration, in turn, helped place the objectives of the meeting within the broader discussions related to the global migration of skilled personnel. Mr. Dumont spoke in particular to the ambitious agenda of the Global Compact on Safe, Orderly and Regular Migration and introduced Michelle Klein Solomon, IOM’s Director for the Global Compact.

Ms. Solomon commended the timeliness of the discussions. She described the development of the Global Compact; its comprehensive content, covering twenty-three different aspects of migration; and reflected on the Compact’s procedural elements, with a strong monitoring and accountability framework complementing its non-binding nature. Ms. Solomon highlighted links in the text of the Global Compact to health worker mobility, including provisions towards improving ethical recruitment, recognition of qualifications, and supporting educational partnerships across countries while guarding against depletion of essential health workforce in countries of origin (See Final Text)

¹ List of Participants appended at the end of the document.
of the Global Compact, with HW mobility related provisions highlighted). Ms. Solomon concluded by emphasizing the importance of the December 2018 Marrakech Intergovernmental Conference on the Global Compact; the UN Secretary General’s decision to create a UN Migration Network coordinated by IOM; and encouraged meeting participants to put forward options for implementation and support in relation to the Global Compact.

Session I – Health Professional Education in a Global Context

Plenary
Six presentations provided the context for the session and ensuring discussion. Dr. Narayan, representing India’s Ministry of Health and Family Welfare, evidenced the significant expansion in health professional education in the country: with approx. 70,000 Under and Post-Graduate Medical seats and approx. 100,000 nursing seats available in India in 2018-2019. She also described ongoing health workforce reforms in India (See Presentation). Dr. Zapata, WHO’s SEARO HRH Regional Advisor, followed by presenting findings from a collaborative WHO and Department of Health, Kerala study on nurse production and migration in Kerala, India. Dr. Zapata’s presentation evidenced expanding production and trends towards oversupply of nurses in Kerala, with recommendation to strengthen collaboration with States in India and with other countries facing shortages (See Presentation). Dr. Mckinley, representing the Foundation for Advancement of International Medical Education and Research, in turn, spoke to the rapid internationalization of medical education. Her presentation identified that the majority of almost 60,000 medical students graduating between 2015 and 2019 who applied for the recognition of their foreign qualifications through the Education Commission of Foreign Medical Graduates (ECFMG) had received their education outside of their country of citizenship (See Presentation). Next, Ms. Jia, representing China’s National Health Development Research Center, in her presentation highlighted the scale of health professional education in China and associated cooperation. Notably, 4.2 million students were identified as enrolled in health education institutions or vocational schools in China in 2017, including a minimum of approx. 3,500 foreign students studying medicine in English-medium medical colleges in China. Ms. Jia also identified that through government to government agreements 1,000 medical doctors were stationed in 43 African countries in 2017 (See Presentation). Dr Luthria, Senior Economist at the Social Protection, Labor and Jobs Global Practice at the World Bank, evidenced the opportunity to collectively putting forward a more constructive narrative on the topic, with increased recognition of human capital and development as an outcome in itself. She additionally highlighted the opportunity to develop transparent bilateral agreements consistent with the WHO Global Code (See Presentation). Ms. Gencianos, representing Public Services International, spoke to the need to ensure that principles of tripartism and social dialogue, equity, sustainability and human rights including guidance from the WHO Global Code and ILO principles and ILO Principles and Guidelines for Fair Recruitment must serve as core elements of global skills partnerships to be considered (See Presentation). The presenter’s response to questions highlighted the need to address challenges with relation to recognition including differing terminology across jurisdictions; need to strengthen data; opportunity for global benefit from demographic dividend in some countries; and imperative to shift discussion on migration and mobility in the sector to shared prosperity and human capital development and away from the sole narrative of brain drain.
Working Group Discussion
The meeting participants broke into working groups to share their perspective on the issue and to identify opportunities for action. Key trends identified by the group included the increase in number of health professional education institutions; increasing size of classes; increased privatization of health professional education; emergence of innovative models for health professional education (e.g. distance learning); increased student mobility (including in part due to limited opportunity in home country); and international partnerships in relation to health professional education (e.g. overseas clinical placements and internships). Challenges in relation to the lack of harmonization and recognition of foreign qualifications, as well as transparency in policy and regulation, were identified as a key risk for mobile student (including students seeking to return to country of nationality). Examples from China, Cuba, South Africa and Jamaica served to illustrate this point. An important additional challenge identified included the mismatch between the skills, including soft skills (e.g. interaction with patients, collaboration in a team), in which health workers are trained and the intended practice in the destination country. Participants identified the opportunity to scale up health professional educational partnerships as a key element of international cooperation, with examples provided from Ireland-Pakistan/Sudan (International Medical Graduate Training Initiative) and Sri Lanka’s scheme for training abroad for specialized qualification. Participants also highlighted the potential to engage more strategically with diaspora groups to support educational partnerships (including as an explicit part of bilateral agreements), with diaspora groups identified as playing an important role in securing internships, clinical placements, and scholarships, as well as linguistic and cultural integration.

Session II – Integrating Migrant and Refugee Health Workers into Host Country Health Systems

Plenary
Four presentations set the stage for discussion on the opportunities, challenges and innovations in integrating migrant and refugee health workers into host country health systems. Mr. Erik Magnusson from Sweden’s National Board of Health and Welfare described Sweden’s effort to simultaneously respond to both the increased inflow of migrants and refugees into Sweden in recent years and the substantial unmet demand in the health sector. Sweden’s Fast Track initiative sped up the process of entry into Sweden’s labour market from 15 to 2 months, with an increase in number of licenses issued. Key to the success of the initiative was removing the requirement to hold residency permit in order to apply for a Swedish license; shift to knowledge tests for all 21 regulated professions rather than validation of qualifications-related documents; and explicit focus in the initiative to “work with – not against” those seeking a Swedish license (including information presented in English and Arabic) (See Presentation). Ms. Stacey Pillay, CEO of Africa Health Placements, next spoke to the important role of South Africa’s Foreign Health Professional Policy and civil society in supporting migrant and refugee health workers to take up vacant public positions in South Africa. Ms. Pillay described how the SA Foreign Health Professional Policy has streamlined and sped up the process for migrant health workers (e.g. single application as opposed to application to five different agencies; reduction in overall time from 18 to 5 months). She additionally pointed to large demand in Europe and North America to work in African countries and described the mechanism in SA to recognize accreditation by UK institutions (See Presentation). Ms. Kara Corrado described the work of the Educational Commission for Foreign Medical Graduates as a leading entity supporting 14 countries with assessment of the skills and verification of credentials for medical
doctors: ECFMG processes approximately 35,000 credentials annually. Ms. Corrado identified the time required to verify credentials and multiple verifications requested as two key challenges to mobile physicians, with postal delays, war and natural disaster as compounding factors. Ms. Corrado described ECFMG’s technological innovations to significantly reduce both the time required and redundancy in requests (e.g. portability of information) (See Presentation). Ms. Maggie Lennon followed by speaking to the role of the Bridges Program in supporting migrant and refugee health professionals to enter the Scottish labour market. Bridges helps health professionals navigate the continuum of processes, including qualifications assessment and verification, language support and assessment, clinical training in preparation for exams, support for clinical placements and observation, and assistance with registration and employment applications. Similar to previous speakers, Ms. Lennon emphasized the limited time beyond which clinical skills become unreliable and the need for targeted support to migrant health professionals to help navigate complex processes (See Presentation).

Working Group Discussion
As for the previous session, the meeting participants broke into working groups to further exchange perspectives on the integration of migrant health workers. Participants noted that improved integration processes and policies was relevant not only for high income countries but also increasingly for middle and low-income countries. Complexity in processes, diversity of stakeholders, and lack of transparency were identified as a central challenge across countries with respect to the integration process. Examples were shared pointing to just how cost intensive and time consuming the process of integration can be, both from the individual health worker’s perspective and that of government. As illustration, the representative from China pointed out that even when government to government agreements are in place, it can take up to three months following arrival for medical health workers to obtain a temporary license to practice (within the context of a service duration of 12 months). The negative public perception of migration and refugee, as well as broader discrimination towards migrants and refugees, was identified as another key challenge, with the opportunity to jointly advance a positive narrative focusing on the capabilities and contributions of migrant health workers. Employment-related discrimination, including wage gaps, limited professional development opportunities, and mandatory service in rural and remote areas, was identified as an area deserving focused attention. Participants cautioned against creating dual tracks for foreign-trained and domestically trained health workers within countries, including those arriving as part of international cooperation agreements. Participants also highlighted the prevalence of unscrupulous practices and the need to more closely engage with and better manage public and private recruitment agencies.

Government measures towards protecting overseas workers were identified as a positive practice, with experience shared by the Philippines representative. Participants recognized the important role of civil society in supporting different steps of the integration process, including support towards the verification of credentials, provision of language and cultural training, and support for the examination process. It was stressed that civil society could be further empowered to play this role with further clarity from government on the rules and processes for integration. The representative from Norway pointed to the establishment of a structured programme identifying the legal, technical and cultural requirements for entry into the labour market. Participants additionally highlighted the role of trade unions and the diaspora in ensuring equal opportunity and professional
development opportunities for migrant health workers. Recognizing that a significant proportion of migrant health workers work in rural areas, there was a call to ensure both their security and concerted action to reduce personal and professional isolation. Support from international organizations for a mapping of professional qualifications/competencies required across countries was also called for by the group. Participants also highlighted the opportunity to establish a coordinated integration mechanism across national stakeholders, including private sector actors. The discussion concluded with a question from one of the participants on who should pay for the costs related to integration (host country, source country, recruitment agency, or migrant health worker) and whether this might be considered at the global level.

Prof. Buchan summarized key points from the first day of the meeting (See Presentation).

Session III – International Cooperation to Maximize Benefits from Migration and Mobility

Plenary
Four presentations, in turn, described national, bilateral, regional and global arrangements and instruments that seek to maximize benefits from health worker migration and mobility. Dr. Gesmalla, Ministry of Health, Sudan, described the recent adoption of Sudan’s National Health Worker Migration Policy at cabinet level. The policy includes the following three pillars: promoting health worker retention, development of bilateral agreements (e.g. Sudan and Saudi Arabia; Sudan and Ireland); and mobilization of diaspora to support Sudan’s health system. Dr. Gesmalla pointed to the growing policy, professional and public concern related to decades of largely unmanaged health worker mobility as central to the development of the policy, with the WHO Global Code identified a useful policy level for both national policy development and development of bilateral agreements. Dr. Gesmalla highlighted the requirement for additional funding to strengthen implementation of the policy as well as support for improving coordination and development of bilateral agreements with destination countries (See Presentation). Ms. Alves Luciano, next, presenting on behalf of Germany’s Federal Employment Agency and GIZ, shared highlights of the Triple Win Project to recruit nurses into the German Labour Market. She described how the Triple Win project, including bilateral agreements with Bosnia-Herzegovina, Serbia, Philippines and Tunisia, seeks to advance the interests of Germany and its employers; the situation in the country of origin; and of the individual nurse. She highlighted the importance of monitoring bilateral agreements, with statistics but also annual meetings to discuss challenges and improvements. Ms. Alves Luciano identified the increasing demand in Germany for qualified nurses, with the Triple Win project looking for new partner countries (See Presentation). Dr. Okullo, Chairman of the Uganda Medical Council, followed by describing the ongoing process of regional harmonization of training, licensing and regulation in the East African Community. He pointed to significant progress, including the development of joint standards, harmonization of curricula, assessment criteria for medical schools and teaching hospitals, and joint inspection of training institutions across the five countries. The process has strengthened regulatory councils, improved training standards, and resulted in faster registration and licensing of doctors, with additional need to strengthen professional councils and monitoring across the region (See Presentation). Ms. Antonia Carzaniga and Dr. Joscelyn Magdeleine from the WTO next clarified the role that General Agreement on Trade in Services plays in relation to health worker mobility, including description of the I-TIP database which currently includes 100 regional trade agreements notified to WTO (See Presentation). Mr. Dhillon from WHO, next
presented findings from a review of health worker mobility related commitment in GATS and Regional Trade Agreements, as well as a draft working paper for comment (See Presentation). The discussion that followed included description by Dr. Gesmalla on the process to develop bilateral agreements with Saudi Arabia and Ireland, and the role of diaspora in supporting development of these agreements. A question was raised around eligibility to join the Triple Win Project, with Indonesia in particular concerned about the criteria for countries with critical health workforce shortages applying across occupations (e.g. shortage for medical doctors but not for nurses). Ms. Alves Luciano confirmed that federal decision not to recruit from countries on WHO’s critical workforce shortage list and the importance to revisit the list. Dr. Okullo further described how the EAC example has been shared across the African region. He identified the progress towards harmonization in 6 EAC countries as a substantial achievement that has been supported at the highest governmental level. With respect to the value of the GATS Framework, WTO colleagues pointed to two defining features offered in the trade arena: legal guarantee and potential for trade offs.

**Working Group session**
In the final working group session, participants continued the discussion on challenges, promising practices and support required to strengthen international cooperation in the area. The absence of fora for policy-related dialogue on health worker migration and mobility within and across countries was identified as an important challenge by participants. A number of participants pointed to the lack of expertise in developing bilateral agreements; others spoke to the imbalanced power between countries during negotiation. Participants emphasized the need to pay specific attention to gender-related challenges, investment in human capital in the source country, and engagement with the private sector in the development of bilateral agreements. NHS England’s agreement with India’s Apollo hospitals for the temporary recruitment of General Practitioners and Nurses was provided an example of collaboration with the private sector. The representative from Jamaica shared efforts towards advancing bilateral cooperation with Cuba. She emphasized the need to focus not simply on service delivery but also include mechanisms of knowledge transfer. Experience of Jamaica’s engagement with its diaspora communities was also shared, with the Jamaican diaspora actively engaged in both delivering surgery-related services and skills development activities.

The participants also specified support and partnership required to advance the cooperation agenda. The participants pointed to areas of potential support from the International Platform, including strengthening data and information, supporting the sharing of knowledge and experience in relevant areas (e.g. repositories of bilateral agreements, national competency frameworks, mapping of required qualifications across jurisdictions), and to facilitate the negotiation, monitoring and implementation of bilateral agreements. A specific call was also made to revisit the criteria and list of countries with critical health workforce shortages.

**Session IV – WHO Global Code of Practice (2018-2020)**
Mr. Dhillon and Mr. Xu, representatives from WHO, introduced the WHO Global Code of Practice, its legal and institutional arrangements, highlights from the 3rd Round of Code reporting, and key governance processes and dates. Article 5.1 recommending Member States to discourage active recruitment from countries with critical health worker shortages and Article 9.5 on the periodic review of the Code relevance and effectiveness and treatment of the Code as a dynamic text were
specifically highlighted (See Presentation). Mr. Campbell pointed to the opportunity for meeting participants to contribute to Member State dialogue and decision-making process with respect to Code governance. He emphasized the tight time frame to consolidate knowledge in order to inform the Code’s 2nd review of relevance and effectiveness. Dr. Jacob, the co-chair for the 1st review of Code relevance and effectiveness, provided select highlights from the report to the World Health Assembly. She also described the role of the WHO Global Code as fundamental to informing Ireland’s National Strategic Framework for National Health Workforce Planning. The United States, Norway, and Wemos were next invited to share their perspectives related to reporting during the 3rd round of the WHO Global Code. RADM Nessler explained that a multi-agency taskforce has been created on the Code (e.g. Health and Human Services, Homeland Security, USAID), with strong support from the US for the instrument. Mr. Sirnes from Norway explained that reporting had been made easier during the 3rd Round, while maintaining the content. He pointed in particularly to the value of the triannual report as an opportunity to take stock of the issue at national level. He suggested that future reporting instruments could attempt to differentiate between labour migrants and other types of migrants; and that while public hospitals were aware of the Code more is required to inform municipalities and private actors. Ms. Mans, spoke on behalf of Wemos, and their role in both reporting on the Code and advocating for its implementation and promoting a multi-sectoral approach, as well as supporting, other civil society organization to submit independent stakeholder reports on the Code. She pointed to the importance of sustainably investing in the health workforce regardless of the short-term economic situation. Discussants again raised the issue of the need to revise the criteria for countries with critical health workforce shortages. Mr. Campbell explained that the 2nd review of the Code relevance and effectiveness is an important opportunity to revisiting the Code, including options for addressing criteria. He also noted, as per the previous review, it is the Expert Group that will report to the World Health Assembly and not the secretariat. He additionally encouraged participants to put forward evidence, suggestions, recommended practice by May 2019 in order to best inform Code review.

Session V – Parallel Dialogue

Two parallel sessions were held. The Member State and International Agency Dialogue was co-chaired by Dr. Gesmalla, Ministry of Health, Sudan and Dr. Narayan, Ministry of Health and Family Welfare, India. The Civil Society dialogue was chaired by Ms. Mans from Wemos.

Member States and International Agency Dialogue
The co-chairs of the meeting introduced the session. Dr. Gesmalla began by sharing her perspective on suggested actions and next steps for the international platform. She pointed to the importance of regional and global support to strengthening implementation of Sudan’s National Health Worker Migration Policy. She requested support from WHO and IOM to facilitate dialogue with destination countries interested in engaging at the bilateral level. Dr. Gesmalla additionally emphasized the importance of exchanging monitoring and evaluation learning to ensure that policy development appropriately matches the challenges related to migration and mobility. Dr. Narayan, in turn, pointed to the significant expansion in health workforce in India over the last decade, opportunity to benefit from the demographic dividend, and the need to more flexible in defining what constitutes a shortage. Dr. Narayan pointed to the opportunity for the Platform to support dialogue on bilateral agreements, with WHO serving as a repository of bilateral agreements in the area. She additionally
emphasized the importance of together reframing and restricting the dialogue positively, highlighting the contribution of migrant and refugee health workers. Dr. Kadiro, the representative from Nigeria, followed by specifically requesting support towards finalizing Nigeria’s Draft National Health Worker Migration Policy, with inclusion of both internal and external migration. He additionally sought support for strengthening data and engagement with the private sector. Dr. Co, from the Ministry of Health, Philippines, emphasized her earlier point on the need to build country capacity in bilateral agreements, as well as to build system to monitor their status (including monitoring of mutual recognition agreements).

Ambassador Singye from Bhutan, referencing ongoing efforts to establish nursing schools for both domestic and international supply, specifically called for a review of the criteria and list of countries with critical health workforce shortages. Dr. Perera from Sri Lanka echoed Ambassador Singye’s request, recognizing in particular the changed context. She additionally highlighted that the Code could serve as a mechanism not simply to exchange information on recruitment and migration, but also training standards, competency frameworks, and best practices on bilateral agreements – envisioning a repository that could be drawn upon by Member States. She additionally highlighted the need to promote the Code with other sectoral agencies at the national level. Ms. Ormhaug similarly asked how this issue may be raised by Norway in other ongoing discussion, such as at ILO. Dr. Wihanasari from Indonesia followed by again emphasizing the importance of reviewing the list of countries with critical shortages, as well as active use of the Code to develop win-win bilateral agreements. She pointed to Indonesia’s regret in not being able to participate in the triple win programme. Dr. Noree from Thailand emphasized that the Platform should highlight positive practices and maintain the key principle of no negative effects on the source country health system. Rear Admiral Nessler from the United States cautioned that it was important to not only focus on health professionals, with home health and personal care aids the fastest grown health occupations in the US. In response to Dr. Perera’s idea for the Platform to serve as an observatory at the global level, Dr. Gesmalla highlighted the potential for national observatories to serve a channel for continual learning and further inform national and global dialogue. Ms. Ferguson from Australia’s permanent mission emphasized the value of a technical briefing to permanent missions over the coming months.

Mr. Van Der Laat, representing IOM, took the floor to respond to a number of Member State queries. He emphasized IOM interest in supporting collaboration with national government and relevant stakeholders. In addition to making links with the Global Compact, he expressed that IOM can support governments at local, regional and national levels. He pointed to the fact that IOM is currently involved in migration policy dialogues and improvement of migration policies in many countries and can help make the link to health worker migration and mobility. Mr. Campbell, representing WHO, reemphasized the value of taking forward an intersectoral agenda on this topic and the value for the Working for health partnership. He pointed to the opportunity to develop a staged action plan following the feedback by Member States. He additionally called on Member States, including permanent missions, to actively engage with the WHO Secretariat in taking forward the Platform’s work.
Civil Society Dialogue (as consolidated and shared by Wemos)

As for member states, civil society stakeholders discussed potential actions and next steps.

List of key issues: Focus on capabilities and credentials; more thinking/reflection on ethical recruitment; career paths and evolutions of competencies; need to focus on fair and ethical recruitment and decent work; stakeholder and social dialogue; strong link with Global Compact on Migration; professional development as an entry point; ethical practice vs changing demand, supply, needs in the global labour market; link health system development, sustainability, employment, absorption capacity for wages; economic conditionality, fiscal space, financing and coherence; need to elicit multiple dimensions of professional mobility; diversity of perspective important; common language (framing) e.g. mobility vs migration; narrative – what is the story we need to tell; mutuality of benefits – but clarify benefits; tension between temporary vs circular migration; also need support for retention and absorption in countries of origin; portability of benefits; circular cycle; life-story perspectives; representation in and legitimacy of the platform; technology and data sharing as to move forward; process round next steps.

Moving Forward / Priorities: 1. Coherence between policy on education, employment, health system development, financing (shared responsibilities not only mutuality of benefits); 2. Comprehensiveness in data and disaggregation; 3. Reflection of relevance and effectiveness, link with WHO Global Code process; 4. Platform to allow for dynamics and diversity; 5. Legitimacy and representation in platform require attention; 6. Dialogue, diversity, finding common language; 7. Clarify different values and worldviews represented in the platform; 8. Positive stories on migration of health workers but with focus on inclusiveness, sustainability and equity; 9. Patient and community practices need to be included; 10. Advocacy and best practices.

Closing Remarks

Prof. Buchan summarized the second day of the meeting, noting in particular its constructive nature and knowledge-element (See Presentation). Dr. Dumont expressed appreciation to the meeting participants on behalf of ILO, OECD and WHO for the number of concrete suggestions that can be taken forward individual and collectively. He emphasized the role of the Secretariat in continuing to strengthen evidence, knowledge of best practice, and targeted country support, with participants both contributing to and benefitting from this effort. Mr. Campbell closed the meeting by encouraging meeting participants to continue to engage with the Secretariat and others. He called on Member States to continue to share their perspective and needs, as well as to lead future actions, beginning with a technical briefing for Geneva-based permanent missions.
**Meeting Agenda**

**Day One**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 am to 9:15 am</td>
<td>Registration &amp; Coffee</td>
</tr>
</tbody>
</table>
| 9:15 am to 10:00 am | **Opening Session**  
Chair: James Campbell & Jean-Christophe Dumont                                 |
|                  | Welcome Remarks:  
Naoko Yamamoto, Assistant Director-General for UHC and Health Systems, WHO  
Stefano Scarpetta, Director for Employment, Labour and Social Affairs, OECD  
Allete van Leur, Director of Sectoral Policies Department (SECTOR), ILO |
|                  | • Introduction of the International Platform on Health Worker Mobility  
  o Objectives of the platform  
  o Expected outcomes of the meeting |
| 10:00 am to 10:15 am | **Global Compact for Safe, Orderly and Regular Migration & International Platform on Health Worker Mobility**  
Michele Klein-Solomon, Director, Global Compact for Migration, IOM |
| 10:15 am to 11:15 pm | **Health Professional Education in a Global Context – Plenary**  
Presentation (10 min for each speaker, 20 min discussion)  
Chair: Ibadat Dhillon  
A. Kavita Narayan, Ministry of Health and Family Welfare, India  
   Tomas Zapata, WHO SEARO  
   *Expansion of Health Professional Education/ EC Project Nursing Case Study*  
B. Danette Mckinley, FAIMER  
   *International Medical Schools & Physician Migration Patterns*  
C. Yao Yao Jia, National Health Development Research Center, China  
   *Medical Education for International Students in China*  
D. Manjula M. Luthria, World Bank Group  
   *Skills, Migration and Global Labour Markets*  
E. Genevieve Gencianos, Public Services International  
   *Perspective on Global Skills Partnership* |
| 11:15 am to 11:30 am | Coffee Break                                                          |
| 11:30 am to 12:30 pm | **Health Professional Education in a Global Context – Working Group Discussion**  
Experience, Participant Priorities and Platform Support (1 Hour)  
Chair: Ibadat Dhillon |
| 12:30 pm to 2:00 pm | Lunch                                                                 |
| 2:00 pm to 3:00 pm | **Integrating Migrant and Refugee Health Workers into Host Country Health Systems – Plenary**  
Presentation (10 min for each speaker, 20 min discussion)  
Chair: Oliver Liang  
A. Erik Magnusson, National Board for Health and Welfare, Sweden  
   *Fast Tracks into the Health Labour Market*  
B. Stacey Pillay, Africa Health Placements, South Africa  
   *Civil Society & South Africa’s Foreign Health Professionals Policy*  
C. Kara Corrado, Education Commission for Foreign Medical Graduates  
   *Innovations in verification and credentialing of health workers*  
D. Maggie Lennon, Bridges Programme, Scotland  
   *Integration of Refugee and Migrant Doctors and Dentists* |
<p>| 3:00 pm to 3:15 pm | Coffee Break                                                          |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
</table>
| 3:15 pm to 4:15 pm    | **Integrating Migrant and Refugee Health Workers into Host Country Health Systems – Working Group Discussion**  
Chair: Oliver Liang  
Experience, Participant Priorities and Platform Support (1 Hour) |
| 4:15 pm to 5:00 pm    | **Summary and synthesis of key emerging points**                                                  
Chair/ Facilitator: James Buchan |
| 5:00 pm to 7:00 pm    | **Group Photo & Reception**                                                                         |

**Day Two**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 am to 9:15 am</td>
<td><strong>Coffee</strong></td>
</tr>
</tbody>
</table>
| 9:15 am to 10:45 am   | **International Cooperation to Maximize Benefits from Migration and Mobility – Plenary**          
Presentation (10 min for each speaker, 20 min discussion)  
Chair: Jean-Christophe Dumont  
A. Amel Gesmalla, Ministry of Health, Sudan  
   *National Health Worker Migration Policy*  
B. Sonja Alves Luciano, German Agency for International Cooperation (GIZ), Germany  
   *“Triple-Win” project - Sustainable recruitment of nurses*  
C. Joel Okullo, Uganda Medical and Dental Council, Uganda  
   *Regional Harmonization of Training, Licensing and Regulation*  
D. Joselyn Magdeleine & Antonia Carzaniga, WTO  
   Ibadat Dhillon & Lihui Xu, WHO  
   *Trade in Services and Health Worker Mobility* |
| 10:45 am to 11:00 am   | **Coffee Break**                                                                                  |
| 11:00 am to 12:00 pm  | **International Cooperation to Maximize Benefits from Migration and Mobility – Working Group Discussion**  
Experience, Participant Priorities, Platform Support (1 hours) |
| 12:00 am to 1:30 pm   | **Lunch**                                                                                         |
| 1:30 pm to 2:30 pm    | **WHO Global Code of Practice (2018-2020)**                                                      
Chair: James Campbell  
A. Lihui Xu & Ibadat Dhillon, WHO  
   *Reporting and Governance Process*  
B. Country and Stakeholders experience |
| 2:30 pm to 2:45 am    | **Coffee Break**                                                                                  |
| 2:45 pm to 4:30 pm    | **Parallel Dialogue**                                                                             
Member States and International Agencies (Salle C)  
Co-Chairs: James Campbell & Gabrielle Jacob  
- Key priorities and discussion on next steps  
Civil Society (Salle B)  
Chair: Wemos Foundation  
- Key priorities and discussion on next steps |
| 4:30 pm to 5:30 pm    | **Closing Session: Agreement on the Next Steps**                                                  
Co-Chairs: James Campbell & Jean-Christophe Dumont  
- Summary and synthesis of key emerging points (James Buchan)  
- Conclusion with next steps  
- Closing remarks |
List of Participants

Governments

1. Paula Sujansky, Ministry of Health, Argentina
2. Sarah Ferguson, Permanent Mission, Australia
3. Madeleine Heyward, Permanent Mission, Australia
5. Rigtsal Dorji, Permanent Missions to the United Nations Office at Geneva, Bhutan
6. Yaoyao Jia, National Health Development Research Center, China
7. Valerie Maunoury, Ministry of Health and Solidarity, France
8. Sonja Alves Luciano, German Agency for International Cooperation (GIZ), Germany
11. Alireza Mirzasadeghi, Ministry of Health and Medical Education, Iran (*)
12. Margaret Fitzgerald, Health Service Executive, Ireland
13. Gail Hudson, Ministry of Health, Jamaica (*)
14. Murianki Anselmina Cirindi, Ministry of Health, Kenya
17. Parasram Gopaul, Permanent Missions to the United Nations Office at Geneva, Mauritius
18. Fee Young Li Pin Yuen, Permanent Missions to the United Nations Office at Geneva, Mauritius
20. Samira Fierro, Permanent Missions to the United Nations Office at Geneva, Mexico
24. Shakuri Ayinla Kadiri, Federal Ministry of Health, Nigeria
25. Erik Sirnes, Norwegian Directorate of Health, Norway
26. Christin Marsh Ormhaug, Norwegian Directorate of Health, Norway
27. Christine Joan Co, Department of Health, Philippines (*)
28. Mohammed H. Al-Doghether, Ministry of Health, Saudi Arabia (*)
29. Susie Perera, Ministry of Health, Sri Lanka (*)
30. Amel Gesmalla, Federal Ministry of Health, Sudan (*)
32. Erik Magnusson, National Board of Health and Welfare, Sweden
33. Martina Schwab, Federal Office of Public Health, Switzerland (*)
34. Thinakorn Noree, Ministry of Public Health, Thailand
35. Menekşė Onuk, Permanent Missions to the United Nations Office at Geneva, Turkey
36. Kerry Nessler, Health Resources and Services Administration, USA (*)
37. Michelle Washko, Health Resources and Services Administration, USA

*Designated National Authority (DNA) for the WHO Global Code of Practice
Civil Society

1. Stacey Pillay, *Africa Health Placement*
2. Maggie Lennon, *Bridges Programmes, Scotland*
3. Franklin Shaffer, *Commission on Graduates of Foreign Nursing Schools*
4. Peter Preziosi, *Commission on Graduates of Foreign Nursing Schools*
5. William Pinsky, *Educational Commission for Foreign Medical Graduates*
7. Herbert Beck, *European Federation of Public Service Unions*
8. Simone Mohrs, *European Hospital and Healthcare Employers’ Association*
9. Danette McKinley, *Foundation of Advancing International Medical Education and Research*
10. Nicholas Sciasci, *International Centre on Nurse Migration*
11. Isabelle Skinner, *International Council of Nurses*
12. Remco van de Pas, *Medicus Mundi International*
13. Baba Aye, *Public Services International*
14. Genevieve Gencianos, *Public Services International*
15. Joel Okullo, *Uganda Medical and Dental Practitioners Council*
16. Linda Mans, *Wemos Foundation*
17. James Buchan, *WHO Collaborating Centre, University of Technology, Australia*
18. Vanessa Candeias, *World Economic Forum*
19. Dessislava Dimitrova, *World Economic Forum*

International Agencies

1. Poonam Dhavan, *International Organization for Migration*
2. Carlos Van Der Laat, *International Organization for Migration*
3. Eliana Barragan, *International Organization for Migration*
4. Manjula Luthria, *World Bank Group*
5. Fethiye Gulin Gedik, *WHO-EMRO*
6. Cris Scotter, *WHO-EURO*
7. Gabrielle Jacob, *WHO-EURO*
8. Tomas Zapata, *WHO-SEARO*
10. Joselyn Magdeleine, *World Trade Organization*
11. Antonia Carzaniga, *World Trade Organization*