THET
PARTNERSHIPS FOR GLOBAL HEALTH

Experts in Our Midst

Recognising the contribution NHS diaspora staff make to global health

Contents

Introduction

True to its ethos of working in partnership to support health workers across the world, THET embarked on an inquiry centering on the very important and topical issue of NHS staff with heritage from low- and middle-income countries (LMICs), whom we respectfully refer to as diaspora NHS staff within this report.

The intention was to highlight an area that has not been systematically explored before - the contribution diaspora NHS staff make to the advancement of health in the UK and global health, and to Health Partnerships between the UK and LMICs in particular.

During my time as a Trustee, THET managed more than £30million of UK Government funds to support UK health professionals link with colleagues overseas through Health Partnerships - the heart of THET's work. More recently, THET has engaged in policy discourse which emphasises the interdependence of health systems. Themes explored have included the growing competition for health workers in an increasingly mobile world; opportunities to encourage bi-directional learning inherent when healthcare workers come together from very different perspectives; the scope for innovation that these encounters can spark, as well as the thornier issue of unconscious biases that we all grapple with. These topics inform and are informed by the contribution made by diaspora NHS staff, the central theme of this current report, and represent a growing body of thinking that THET is producing on how to optimise the Health Partnership model.

From a personal perspective, I was delighted to be invited, as an outgoing THET Trustee, to chair the steering group of eminent members who brought an enormous wealth of knowledge, lived experience and wisdom to bear on this inquiry. It was a double delight, not only because of my long links with THET, but also because I embody the experience of diaspora that this report seeks to capture. I am following in the footsteps of what the report terms 'the success of post-war recruitment campaigns in the UK encouraging Jamaican nurses to move to or train in the UK'.

Experts in Our Midst explores the broader current context and promotes the marginalised voices of diaspora NHS staff within the wider, often hostile,

environment. We know that diaspora NHS staff have always played a valuable role in Health Partnerships. What we did not know was the scale of their engagement, the challenges faced, nor how best to amplify their voices to demonstrate the impact diaspora can have on global health projects.

Within the report there is an acknowledgement of a worsening social and economic climate for members of diasporas, increased racism and scapegoating of diaspora and migrant communities, attacks in the media and of course the disproportionately harsh impact of Covid-19. It is important to acknowledge that although the report does not claim to have all the answers, it does at least begin to address head on these issues with practical approaches that may help us to better understand the value and impact such health workers can increasingly have, both in their workplaces in the UK but also through their interactions with countries of heritage.

The report attempts to do so in order to influence the behaviour of THET and our work within the wider Health Partnership community. But more widely, the report makes a contribution to the discussions around the value diaspora staff add to global health activity, and indeed to the NHS, through the sharing of expertise and learning born of their understanding of different health systems. The recommendations, therefore, are designed to help shift the dial, in a modest way, to combat the unconscious bias and racism that shapes attitudes to information exchange and bi-directional learning between the UK and LMICs.

I am firmly of the view that it is vital that THET's inquiries influence practice and are followed through, rather than being of passing interest. I therefore look forward to the reception and implementation of the recommendations contained within this vitally important report, a report that pushes the boundaries and challenges complacency.

Frances Day-Stirk
FORMER PRESIDENT
International Confederation of Midwives
and former THET Trustee (2014-2020)

Forewords
To do or not to do

The anecdotal understanding of diaspora contributions underwent a dramatic transformation following the publication of IMF and World Bank data on remittances in the early part of this century. AFFORD, through its own action research and policy agenda, further improved understanding on diaspora as development agents: especially the impact on investment and the SME sector from these remittances; and also, on skills sharing, working with VSO to test a DFID funded diaspora volunteering initiative through which the organisations involved were able to recruit 600 diaspora to support a range of activities, including specifically health related programmes.

The International Organisation for Migration (IOM) commissioned mapping studies followed, of Sierra Leone and Lesotho health care professionals, identifying the structures and resources that would enable them to contribute more both to the NHS and to their countries of origin. During the pandemic we have seen the critical dual role diaspora continue to play, here and in their countries of heritage.

This latest report by THET is strongly welcomed, reaffirming much of the testimony of the earlier studies on diaspora. AFFORD is however excited by the strong action focused conclusion and recommendations driven by the three E's of enable, engage, empower.

These recommendations reinforce our belief that we should be moving beyond data gathering mode to what AFFORD's former chair, Prof. Gibril Faal, defined as a 'practice-based mode'. He noted in relation to the Global Compact on Migration:

An agreement-Implementation matrix and practice-based approaches should emerge from the recommendations made here, where further detailed data can be generated through actual piloting or implementation of projects, through which we understand opportunities and challenges. This is particularly urgent given Covid-19 and the renewed focus on recruiting health professionals from Africa and the global south.

Onyekachi Wambu
EXECUTIVE DIRECTOR
The African Foundation for Development (AFFORD)

A Stronger, Fairer NHS

The last year has been uniquely challenging.

Globally, Covid-19 has tragically killed millions and left millions more trying to recover from their experiences. We have all been challenged, personally and professionally, especially those working in healthcare, caring tirelessly for patients in circumstances none of us could have imagined.

The Black Lives Matter protests of last summer birthed a social movement which continues to inspire communities to demand change. The pandemic amplified social injustice and inequality, but the pandemic didn't cause them, they were already there.

We can't allow this moment of shared suffering and collective challenge to pass without trying to mould our future, a collective approach to building a better and fairer world. Our membership of the global healthcare community makes us central to meeting that challenge.

Which is why this report is both timely and important.

Having sponsored a health partnership when I led the East London Foundation Trust, I've long believed in the transformative opportunity of global work for NHS people and the benefit it can bring to their organisations.

This report highlights excellent practice, including NHS England and NHS Improvement supporting diaspora networks, and Health Education England using overseas volunteering to develop NHS staff as part of our Improving Global Health through Leadership Development Programme.

Engaging and supporting colleagues from minority ethnic backgrounds and the diaspora has always been central to a stronger, fairer NHS. Moving forward, ensuring the NHS benefits from the strengths, experience, and perspectives these colleagues can bring to leadership roles is a challenge we must meet.

As recommended here, I pledge HEE will work with partners to ensure we better meet the needs of minority ethnic and diaspora staff and learners, because it is the right thing to do, and the NHS needs us all to do it better.

Dr Navina Evans
CEO
Health Education England

Engaging and supporting colleagues from minority ethnic backgrounds and the diaspora has always been central to a stronger, fairer NHS. Moving forward, ensuring the NHS benefits from the strengths, experience, and perspectives these colleagues can bring to leadership roles is a challenge we must meet.

[1] Faal, G - Overprincipled and Underperforming: Why We Need a Practice-based Global Compact on Migration - Gibril Faal | IOM Online Bookstore

Executive summary

This report is organised in to three sections. The opening section examines the contributions made by members of diaspora NHS staff to a globally engaged NHS, and to their countries of heritage. The starting point for the report is the recognition that the UK has one of the highest levels of reliance on internationally trained healthcare workers of any OECD country.

One in three doctors and one in eight nurses in the UK were trained in another country.

The numerical significance of diaspora NHS staff is a considerable benefit for the NHS and UK patients, but the report goes further. It seeks to understand the often-hidden contribution such staff make in shaping a globally engaged NHS, and in discussions around the improvement of healthcare delivery in the UK.

The first section of the report acknowledges the low percentage of Health Partnerships reporting on diaspora engagement, re-enforcing that sense that the contribution and expertise of diaspora NHS staff is not fully acknowledged. Nevertheless, some interesting insights have been found in relation to the contribution, challenges and constraints facing diaspora NHS staff, including in relation to racism within the NHS. This theme of unconscious bias and persistent racism and how this prevents us from fully utilising the expertise and knowledge of diaspora NHS staff, at home, or in countries of heritage through global health engagement, runs throughout the report.

Section 2 explores these themes with an eye to the structural issues that could be addressed in order to fully realise the benefits to the NHS.

It looks at operational issues and policy gaps before returning to issues associated with equality, diversity, inclusion and leadership, all of which have been exacerbated by the Covid-19 pandemic.

It explores how these can contribute not only to an improved NHS but may also lead to greater and more impactful global engagement of diaspora NHS staff with countries of heritage as part of the UK's wider contribution to improving health in LMICs. Funding, the need for increased capacity building and improved coordination are all key to this section, as is a focus on the role of governments, both our own in the UK and that of LMICs.

In the final section of this report, we set-out the approaches which may enable, engage and empower diaspora NHS staff in optimising engagement with countries of heritage whilst bringing benefits to the NHS, organising our thoughts around five clusters of recommendations. This forms the heart of the report which has lessons for THET, for the wider Health Partnership community and Governments.

Methodology

The research and evidence gathering process which informed the development of this report comprised four main approaches.

A **public inquiry** was held to explore the broader context of the engagement of UK health and social care professionals who identify as being members of a diaspora with their countries of heritage and the relationship of these activities to the UK. Evidence was heard from a range of witnesses from professional associations; academia; diaspora international non-governmental organisations (INGOs); diaspora health organisations; country health alliances; NHS arms-length bodies and healthcare professionals of diaspora heritage. The organisations and individuals participating provided country-specific and continent-wide perspectives from across Africa and Asia.

A **rapid literature review** of published and grey literature was conducted to gather a wide range of evidence to inform the key topics of this report. This comprised exploring the themes identified at the public inquiry. Themes studied in relation to diaspora were equality and inclusivity; the impact of Covid-19; leadership; networking and collaboration; coordination; and funding.

The University of Westminster also conducted a scoping review of evidence from published and grey literature sources to gain a better understanding of the scale and nature of the contribution healthcare professionals who identify as members of a diaspora are making to Health Partnerships, and to establish how healthcare professionals who identify as members of a diaspora of a low- and lower-middle income country benefit Health Partnerships.

Semi-structured interviews were conducted with 12 key informants from academia, the public sector and civil society.

As part of our inquiry, we **surveyed** 227 Health Partnerships funded now or in the past by THET to find out whether they were diaspora led or diaspora inclusive. We received 14 responses in total, 12 Health Partnerships stated that they were diaspora led or diaspora inclusive.

We acknowledge that this represents a very small proportion of Health Partnerships funded currently or in the past by THET.

To expand our inquiry, we followed up these initial questions with a further survey to 135 Health Partnerships not funded by THET in addition to the 12 THET funded Health Partnerships who responded positively to the earlier question about whether they were diaspora led or inclusive.

We did so to help deepen our understanding of the scale and nature of this form of engagement and the barriers faced. Nine responses were received from the following types of Heath Partnerships – health alliances, THET funded Health Partnerships, NGOs, unions, charitable organisations and a community interest company.

Again, we do not claim that this fully reflects the perspectives of the many diaspora NHS staff within Health Partnerships.

In order to guide the development of this report, a Steering Group of leading figures in diaspora engagement was also convened. Steering Group members included representatives from academia, Health Education England, NHS Confederation and INGOs.

Limitations

We acknowledge the limitations of this report. We focus on the NHS predominantly in England but cite examples from Wales and Scotland to provide comparisons and help illuminate good practice.

Across the UK, health is a devolved matter. Devolved governments do not, however, have control over development cooperation or immigration. Our recommendations are, in the main, directed at UK government departments. However, as many of the themes explored are shared by all, we hope that aspects of each recommendation may also be of interest to devolved governments.

We do not explore the private sector's relationship with the NHS or its role in engaging members of diasporas.We also appreciate the vital role care homes and care systems play in the delivery of services and the gendered nature of many of its healthcare worker's journeys from LMICs to the UK. We do not dwell on this or indeed how such institutions and in particular ethnic minority staff working within them have been particularly affected by the Covid-19 pandemic.

Our research has uncovered a very small part of the many layered tapestry of interconnecting stories that make up diaspora NHS staff's experiences of working in the UK and their engagement with their countries of heritage.

We acknowledge that geography and historical context are crucial and that each and every one of us has our own story to tell irrespective of ethnicity or country of origin.

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Diaspora and health

In this report we focus on NHS staff who identify as being a member of a diaspora. Our focus is mainly, but not exclusively, first generation members of diasporas. Since this report is written by THET, we bring a particular focus on diaspora engagement in Health Partnerships and what this means for their countries of origin or heritage, as well as the NHS.

Definition:
Diaspora

There is no widely accepted definition of diaspora and the term is used to signify many different phenomena. For the purpose of this report, we use the following definition of diaspora:

"Modern diasporas are ethnic minority groups of migrant origins residing and acting in host countries but maintaining strong sentimental and material links with their countries of origin."[i]

SECTION 1 **Diasporas - the facts**

Introduction

In this opening section we will examine the contributions made by members of diaspora NHS staff, both to the NHS and to countries of heritage and will examine the impact of the Covid-19 pandemic.

1.1 The contribution members of diasporas make to countries of heritage

The dense web of connections between diaspora communities and countries of heritage is most commonly the creation of individuals and groups acting on their own initiative, rather than a product of government intervention.[ii] Indeed, there is a growing recognition that diaspora communities facilitate increased trade, investment and cultural linkages between the different countries that they are connected to, and that they are important development actors.[iii] The resources of these communities that flow across borders vary considerably and range from skills, knowledge and ideas to cultural capital, finance and trade links.

Beyond the individual and family level, diaspora organisations include associations of migrants originating from the same locality, ethnic affinity groups, alumni associations, religious organisations, professional associations, charitable organisations, development NGOs, investment groups, affiliates of political parties, humanitarian relief organisations, schools and clubs for the preservation of culture, virtual networks, and federations of associations.[iv]

Economic

Remittances[2v] are usually understood as financial or in-kind transfers made by migrants to relatives and friends in their countries of heritage. Remittances reached a record $554Bn in 2019 overtaking foreign direct investment and accounting for more than 5% of GDP in at least 60 LMICs.[vii]

Of this global figure, African diaspora remittances in 2018 were US$86Bn of the total.[viii] To illustrate how critical these figures are at individual country level, in Nigeria, the amount officially remitted through financial systems in 2018 ($25.08 billion) slightly exceeded the entire federal budget for that year ($25.06 billion).[ix]

In terms of the UK, remittances to all countries amount to £23.6Bn[x] per year as of 2019 placing it as the fourth largest remittance sender in the world with India and Nigeria as the main destinations of remittances from the UK.[xi]

Based on the annual remittances data,[xii] in 2018 outflows were equivalent to 0.4% of the UK's GDP. And while UK remittances overall comprise a small share of its GDP, they are nonetheless considerable when compared to Official Development Assistance – currently 0.5% of GNI.

As noted during our public inquiry, the economic impact that members of diaspora communities have is doubly noteworthy for they are both UK taxpayers who contribute to Overseas Development Assistance (ODA) and senders of remittances.

It is also worth noting that the UK both sends and receives remittances. In 2018, the UK received roughly £4.1Bn in remittances,[xiii] equivalent to 0.2% of its GDP, with Australia and the United States being the largest remittance senders to the UK.

However, economic capital is not only represented by remittances and savings, which constitute only a fraction of total private capital flow, it also includes direct investments made by diaspora members in business activities.

Data on remittances

Measuring of remittances - which are commonly understood here as the money migrants send back to family and relatives in origin countries - does often not include small money transfers. Computations are based on 'compensation of employees' and 'personal transfers.'
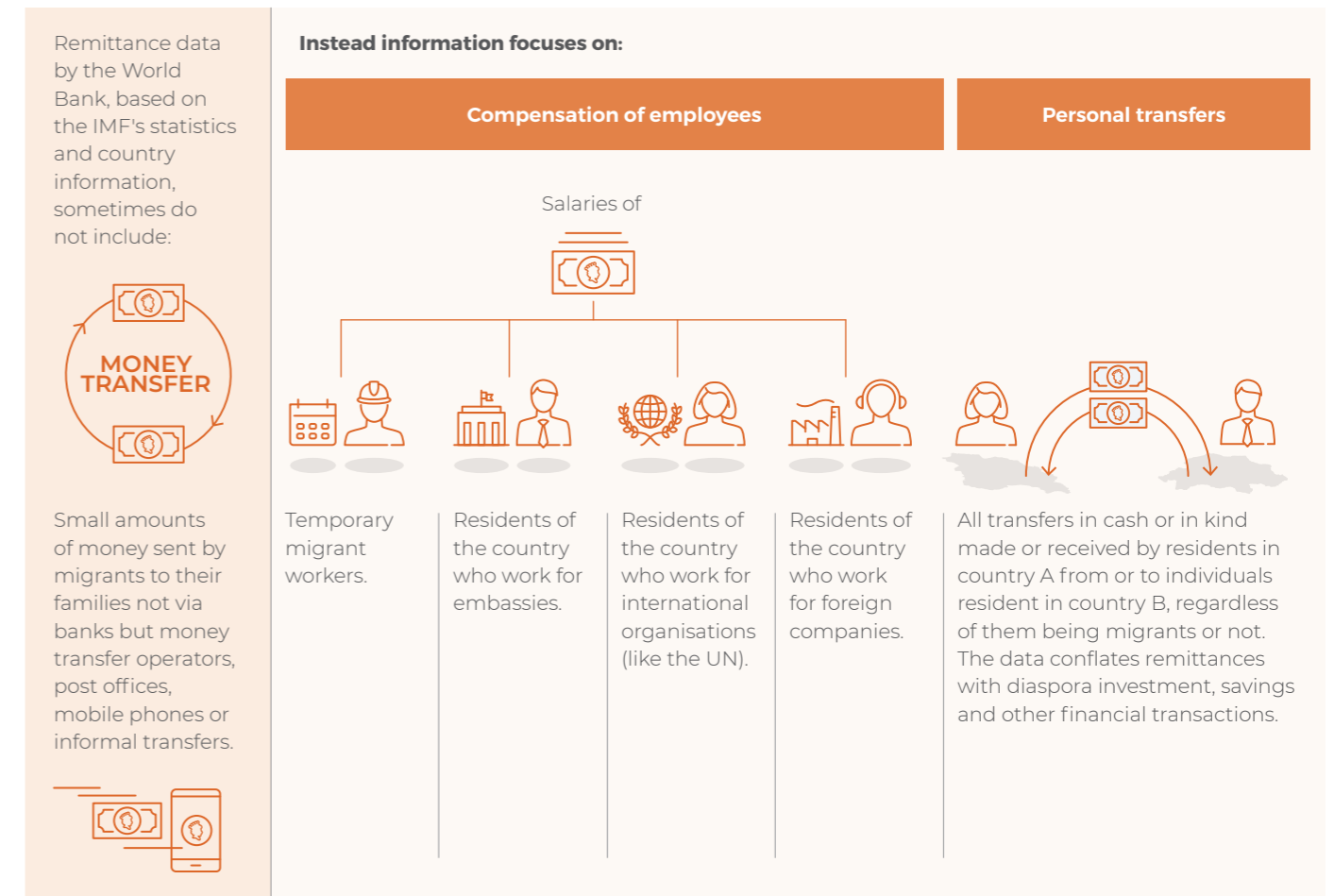

Figure 1: Data on remittances (IOM 2017)

For many countries, the diaspora is a major source of foreign direct investment (FDI), market development (including outsourcing of production), technology transfer, philanthropy, tourism, political contributions, and more intangible flows of knowledge, new attitudes, and cultural influence.[xiv]

It is also the case that members of diaspora communities will often be in a prime position to take advantage of new economic opportunities in the countries where they both reside and originate from, and they are more willing to invest as a result of their personal ties.[xv]

Philanthropy

Some diaspora organisations and individuals seek no personal return on investment, but rather pursue charitable enterprises. Such enterprises range from very small-scale, one-off efforts of community groups to more organised and durable efforts; from the donations of single individuals to powerful networks of like-minded donors.[xvi]

Our public inquiry also highlighted the need to bring African philanthropy into the contribution conversation. For example, data collected through the African Philanthropy Forum estimates that US$7bn in contributions are made every year by Africa's (or African diaspora's) high net worth individuals, but only $1bn can be readily traced. Much is hidden due to the poor tax policy environment for giving in countries in Africa.[xvii]

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2 The International Monetary Fund, the main provider of international remittances statistics based on Central Bank data, defines remittances as the sum of two main components in their Balance of Payments Statistics. "Compensation of employees": This refers to income earned by temporary migrant workers in the host country, and the income of workers who are employed by embassies, international organisations and foreign companies (or "the income of border, seasonal, and other short-term workers who are employed in an economy where they are not resident and of residents employed by non-resident entities" "Personal transfers": These are all current transfers in cash or in kind made or received by residents (be it migrants or non-migrants) from or to individuals in other countries ("all current transfers between resident and non-resident individuals."

3 In 2019, in current USD, the top five remittance recipient countries were India (83.1 billion), China (68.4 billion), Mexico (38.5 billion), the Philippines (35.2 billion), and the Arab Republic of Egypt (26.8 billion).

Human and social capital

Human and social capital, the focus of this report, may be described as the human resources that diaspora members constitute through their skills and knowledge, and the extended networks that they maintain. Skills accumulated by diaspora members are invaluable to the development of a variety of sectors such as health, education and technology. The transnational networks that they maintain are crucial to facilitating a more open flow of trade, investment, skills and knowledge, and are based on relationships with families, friends, colleagues and associations.[xviii]

These social and cultural activities may have an even more profound, if indirect, effect on development of countries of heritage than the economic activities we describe above. Sometimes referred to as "social remittances", the ideas, behaviours, identities and social capital that flow from receiving country to sending country communities can be profound.[xix]

1.2 The contribution members of diasporas make to the NHS

Clinical contribution

The UK has always struggled to train and retain sufficient numbers of healthcare workers to serve the needs of the population. Since the NHS came into being in 1948, the UK has depended on its ability to recruit overseas-trained staff. To some extent, therefore, the NHS has relied on overseas-trained healthcare workers since its inception.[xvi] Recruitment campaigns for nurses in Malaysia, Mauritius and the Caribbean were common in post-war Britain and by 1971, 12% of British nurses were Irish nationals.[xx]

In recent years there has been a significant increase in the number of nurses and midwives on the permanent register in England who trained outside the EEA. The Philippines was the most popular non-EEA country followed by India.[xxi]

In fact, England has one of the highest levels of reliance on internationally trained healthcare workers of any OECD country. One in three doctors and one in eight nurses in England were trained in another country.[xviii] Taken together, some 13% of the NHS workforce in England were trained overseas, rising to 28% amongst doctors.[xxiii] And so, the benefits accrued to the NHS from the contribution of diaspora staff have been and continue to be enormous.

Cultural competency

It is widely understood that improved healthcare outcomes can be influenced by NHS staff being more aware of the issues around culture and health. In addition to their clinical expertise and knowledge, diaspora NHS staff bring what we may term 'cultural competencies' to bare not only on colleagues but also to patients served.[xxiv]

Cultural Competence e-learning packages[xxv] designed to support all NHS staff in developing cultural competency are to be welcomed. As are initiatives from, for example, Diverse Cymru who have produced a cultural competency certification scheme funded by the Welsh Government.[xxvi] It is perhaps worth highlighting the ambition of this Welsh initiative which began in 2018 and has become yet more urgent since the onset of the Covid-19 pandemic and the rise of the Black Lives Matter movement. The scheme aims to:

- Proactively address any cultural or unconscious bias issues to make a practical, positive and ongoing difference in the workplace environment and to the services provided.

- Use an evidence-based approach that focuses on supporting participants to effectively meet and respond to the needs of their culturally diverse workforce/service users in a resource efficient and cost-effective manner.

- Provide participants with relevant techniques and interventions to incrementally work towards providing an effective, practical and culturally appropriate work environment and, as a consequence, culturally competent services.

Our inquiry made clear the need to address issues of access to services during the Covid-19 pandemic. 'Texts and letters' following up diagnoses or initial treatment are not enough; 'we need to build a face-to-face rapport with BAME patients that look like me'. Trust between clinicians and patients is of vital importance. While this may sound self-evident, the growing data on tragic inequalities in patient outcomes dependent on background means it cannot be taken as a given.[xxvii][xxviii] Improving the cultural competency of all NHS staff is therefore critically important. It is clear that diaspora NHS staff have particular competencies to offer and that fully harnessing their power will be vital if we are to build a future NHS that values all of its staff and serves all of its patients equally.

Case study

East London Butabika Health Partnership - encouraging two-way learning and peer to peer support with peers from same or similar heritage

East London NHS Foundation Trust has been working in partnership with Butabika Mental Health Hospital in Kampala, Uganda to strengthen mental health services for over 15 years. Through this Health Partnership, NHS volunteers spend time in Uganda training their colleagues and identify practices that can improve services in the UK.

The Ugandan partner initially asked for support in setting up their in-patient mental health services. East London worked with Butabika Hospital and service users to develop a Peer Support Worker training programme. They initially trained 12 Peer Support Workers to work alongside statutory mental health services in Uganda to provide community care at a level that hadn't been available before now.

There can be an anxiety about working with people who have lived experience, training them and working alongside them. However, the project very quickly exemplified the benefits of this approach, not only for the patients or peers who receive peer support in the community, but also for service delivery.

Following the success of the programme in Uganda, a sister programme was set-up in England. So far 115 Peer Support Workers have been trained at the East London Foundation Trust, providing support to over 1,000 patients.

Raolat Adenike Agunbiade-Erin, a first-generation diaspora health worker of Nigerian heritage, is a service user and one of the trained Peer Support Workers. Raolat explains her role as being about, "meeting with others in informal, public spaces to discuss one another's mental health and talk through emotions and feelings". Since Raolat qualified in July 2020, she has supported and has been supported by a number of peers from people of the same heritage as well as from further afield, in countries across East Africa and the Caribbean.

For Navina Evans, the former CEO at East London, the Health Partnership has not only benefited their Ugandan partners and service, but has also benefited East London staff as well as service users and families across East London.

This approach not only demonstrates the two-way nature of learning in such Health Partnerships, but also the power of engaging people with lived experience to work as Peer Support Workers with peers of similar heritage.

Case study

Anaesthesia is global – Cooperation between health systems can nurture future leaders

Naomi Shamambo is a Trustee of the Global Anaesthesia Development Partnership. The partnership has been working in Zambia since 2012, expanded to Ethiopia in 2018 with further plans to work in Kenya and Rwanda in the future. The partnership engages partners and volunteers from around the world to train and mobilise a specialist anaesthetic workforce to support the provision of safe anaesthesia worldwide.

Naomi gained her MMed Anaesthesia training programme in 2016 from University Teaching Hospital, Lusaka in Zambia before starting her training as a Consultant. During her training in 2018, Naomi came to the UK for four weeks on an Overseas Healthcare Leadership training programme at Worthing Hospital, Western Sussex Hospitals NHS Foundation Trust. During the placement, Naomi received clinical as well as operational leadership training alongside training in advocacy and how to influence policy makers.

Since then, Naomi has returned to Worthing on the Medical Training Initiative (MTI) scheme and is part of a vibrant faculty engaged in global health. Teaching remotely, Naomi works closely with the Brighton-Lusaka link alongside many other nationalities through the MTI programme.

Naomi explains that, "the support I have personally received has been invaluable not only in terms of my personal development also in the way it has helped to shape me as a leader to tackle the challenges faced by the health system back in Zambia."

Naomi has clearly benefited from exchanges to the UK but Naomi has also taken the opportunity to reflect on what she has learned in Zambia as well as in the UK and how each can learn from one another. Naomi is clear that she plans to return to Zambia to continue to shape and lead the field of anaesthesia enriched by her experiences both in Worthing as well as Lusaka.

Engagement with countries of heritage

NHS staff may benefit in a number of ways by engaging with LMICs. These benefits are common across all NHS staff regardless of background.[xxix] However, it is also worth considering that diaspora NHS staff who engage with countries of heritage may have greater contributions to make in certain domains than NHS staff from non-diaspora backgrounds.

For example, diaspora NHS staff may enhance or build a broader range of clinical skills through engagement with their country of heritage. However, in some instances, their knowledge of tropical diseases and awareness of cultural aspects of health may already be well established but further developed through engagement with their countries of heritage. Not only does this improve health services for patients in the UK as a whole, but it has clear advantages for patients in the UK with the same or a similar heritage.

Communication, teamwork, patient experience and dignity

Our inquiry underlined the fact that diaspora NHS staff understand their own potential to empower people for they know that words and behaviours can be interpreted differently. Furthermore, their appreciation and respect for other cultures is profound. This, for example, can translate into a significant impact in the health seeking behaviours of ethnic minority patients here in the UK.[xxx]

Management skills, policy development and academic skills

Diaspora NHS staff have a marked ability to work within a system with unfamiliar power dynamics and cultivate a deep appreciation for the value of new ideas through a profound understanding of other health systems. However, our inquiry findings suggest that much more can be realised in these latter domains and we will explore this in the subsequent sections of this report.

Table 1: How individuals can benefit from engaging with LMICs[xxxi]

Clinical skills	• Ability to use a broader range of clinical skills • Increased awareness/knowledge of tropical diseases • Increased awareness/knowledge of cultural aspects of health
Management skills	• Ability to be adaptable in leading • Ability to work within a system with unfamiliar power dynamics • Ability to manage projects
Communication and teamwork	• Understanding that words and behaviours can have different meanings • Ability to co-operate • Ability to work as part of a team
Patient experience and dignity	• Understanding own potential to empower people • Increased respect for other cultures • Appreciation of free universal health
Policy development	• Appreciation of excellent human resources in NHS • Understanding of other health systems • Appreciation of value of new ideas
Academic skills	• Training delivery and research skills, understanding how to target training
Personal satisfaction and interest	• Lifelong interest in global health and development • Can-do attitude

Case study

King's Global Health Partnerships – engaging diaspora to work in their country of heritage

King's Global Health Partnerships has been supporting partners in Somaliland to strengthen the health system for over 20 years. Over the last five years the partnership has been collaborating with a range of partners on Prepared for Practice, a project which improves the education of doctors, nurses and midwives.

The project has engaged students, universities, and the Ministries of Education and Science and of Health Development in Somaliland on a range of projects to improve the quality of teaching and enhance the governance, management and oversight of higher education for health. Through this approach the partnership has been transforming education for the Somaliland health workforce of the future.

UK health workers and other professions who volunteer to work on projects come from diverse backgrounds including those from Somali heritage.

Fatima Addan is a research manager who leads on a distance learning module as part of the project's work to strengthen the quality of teaching, learning and assessment. Fatima is highly motivated to engage: 'being of Somali heritage, volunteering with the project has given me a great deal of satisfaction knowing that I was contributing to the professional/academic development of students from the same heritage.' Fatima's responsibilities have grown from being a volunteer tutor to leading on developing online teaching materials which she then helped to deliver. This has helped Fatima 'to practice my leadership skills as well as giving an invaluable academic teaching experience. Fatima continues, 'In my current professional role, I would probably have not had the opportunity to gain the academic teaching experience.'

Another participant in the project of Somali heritage is Marwa Jama, a general surgery trainee who leads on another of the project's distance learning modules. Marwa has developed by engaging in the project: 'It has made me a better teacher and I have taken on formal and informal roles within teaching and organisation of teaching.' In addition, 'it has been useful in opening my eyes to global surgery and has empowered me to do more.'

The project's practical approach in equipping healthcare workers with skills they might need instead of simply replicating their academic learning has been invaluable. The significant level of inclusion of health workers and other professions from Somali heritage is a notable feature of this partnership. But, if anything, both Marwa and Fatima believe that yet more engagement of the Somali diaspora from as many disciplines as possible is required for they are uniquely well placed 'to better understand and appreciate the local context in the design of programs and the development of learning module content.'

1.3 Diaspora engagement in global health – a hidden contribution?

Our public inquiry confirmed that diaspora NHS staff make significant contributions to their countries of heritage and to the NHS, both individually and through organisations. However, many of these contributions remain unconnected and not well documented. There is, therefore, a need to better understand these contributions.

Health Partnerships

There exists no single definition of a Health Partnership but for the purposes of this report we define them as:

Partnerships connecting members of the UK health community with counterparts in LMICs with the aim of improving health and health services based on ideas of co-development between actors and institutions. They might be exclusively diaspora focused, may engage members of a particular diaspora in their work or may not.

Our approach

As part of our inquiry, we initially asked 227 Health Partnerships previously or currently funded by THET whether they were diaspora led or diaspora inclusive. We received 14 responses in total. 12 Health Partnerships stated that they were diaspora led or diaspora inclusive.

Countries ranged from Cameroon, Ethiopia, Somaliland, Uganda, Zambia and Zimbabwe in Africa and India, Myanmar and the Philippines in Asia. Health themes ranged from Orthopaedics, Quality Improvement, Antimicrobial resistance, Nursing, Surgery, and Breast cancer investigation, diagnosis and specialist care.

This represents a very small proportion of Health Partnerships funded currently or in the past by THET. While we cannot conclude that this reflects the total number of diaspora led or inclusive Health Partnerships, it does suggest that there likely exists an underrepresentation of diaspora NHS staff within Health Partnerships and that Health Partnerships are not thinking as consciously about this matter as they might.

To expand our inquiry, we followed up on our initial questions with a further survey to 135 Health Partnerships not funded by THET, in addition to the 12 THET funded Health Partnerships who responded positively to the earlier question about whether they were diaspora led or inclusive.

We did so to help deepen our understanding of the scale and nature of this form of engagement and the barriers faced. 9 responses were received from the following types of Heath Partnerships – health alliances, THET funded Health Partnerships, NGOs, unions, charitable organisations and a community interest company.

The number of healthcare workers engaging in each organisation's activity ranged from under 50 to more than 1,500. This includes Doctors, Junior Doctors, Oncologists, Ophthalmologists, Radiologists, Pathologists, Surgeons, Nurses, Mental Health Nurses and Midwives, as well as a number of Allied Healthcare Professionals including Optometrists, Occupational Therapists, Pharmacists, Psychologists and Social Workers. Healthcare managers, administrators and IT specialists are also involved, alongside academics such as Tutors, Lecturers and Researchers.

The Health Partnerships who responded most commonly focus on the following health themes:

1. **Maternal health**

2. **Health workforce**

3. **Mental health**

4. **NCDs**

5. **Universal Health Coverage**

Contribution

When asked what skills healthcare workers bring to the projects each Health Partnership is delivering, the most popular responses were as follows:

1. **Clinical skills**
   - (ability to use a broader range of clinical skills).
   - (increased awareness/knowledge of cultural aspects of health).

2. **Management skills**
   (ability to manage projects).

3. **Patient experience and dignity**
   (understanding own potential to empower people).

Challenges and constraints

Health Partnerships were asked a sequence of questions exploring how they engage in policy influencing, issues associated with racism, collaboration with others and what constraints diaspora NHS staff face in engaging with Health Partnerships. The aim of this was to deepen our understanding of the challenges faced by these bodies and by the diaspora NHS staff who run them.

Policy work

We asked Health Partnerships whether they had worked with policy makers in the UK to address constraints which may prevent the scale-up of activities in LMICs. One respondent shared their experience of working with policy makers to ensure oxygen delivery as part of the Covid-19 response. A number also talked of workforce issues. For example, working with organisations such as the NHS Confederation and Nursing and Midwifery Council on the recruitment and development of diaspora healthcare workers within the UK, and on their engagement with countries of heritage. Other examples shared involved working with Professional Associations on the development of ethical placements in the UK for colleagues from LMICs.

Health Partnership are also working on a range of activities with policy makers in the UK to improve the health systems of LMICs they work with. One respondent told us that they are 'developing more Nurse Practitioner pathways in [the] UK and Africa, and also encouraging more Allied Healthcare Professionals to participate in research. Many are marginalised due to the education gaps.'

Other respondents are working with the WHO on the roll-out of Mental Health Gap Action Programmes, as well as with policy makers on emergency Covid-19 response training.

Racism

Health Partnerships were asked to describe activities which challenge negative perceptions of diaspora communities and that tackle racism. They were also asked to outline activities they engage in which highlight positive good practice and inclusion of diaspora communities.

Highlighted activities ranged from research projects and strategic engagement to the utilization of communications channels.

'One example of strategic engagement shared by respondent cited that 'members of our organisation are on health boards where they actively challenge discriminatory policies and influence change. The organisation also hold educational conferences on topical issues to raise awareness of workforce problems to influence health employers and empower members of the organisation. We also provide mentorship and support as most of our members are senior retired healthcare professionals.'

Another Health Partnership responded as follows: 'we are tackling the challenges faced by Black, Asian and minority ethnic (BAME) communities in the UK, focusing on the negative perceptions of diaspora communities, the root cause is discrimination and racism, including NHS institutional racism. We are currently engaging with NHS International Recruitment and NHS Improvement teams to see how we can support them in tackling the mentioned challenges. We are also engaging with NHS Trust BAME leads to raise awareness and engage colleagues to be more involved in bringing about positive change. An example is the acknowledgement of Black History Month with a Certificate of Recognition for BAME staff who have made a positive impact in health education and practice development. Also, as a result of the awareness initiatives, an NHS Trust is making Black History Month a yearly event for the first time since its existence.'

In addition, 'conferences, traditional media, social media' and 'radio broadcasts in UK, conference presentations in UK and internationally, local fund-raising and engagement events' were all cited as means of addressing negative perceptions and highlighting positive good practice and inclusion of diaspora communities.

An example of one such engagement event focused on 'health promotional and awareness activities on health topics that predominantly affect people of the African and Caribbean diaspora.'

This Health Partnership also, 'recognises the importance of social engagement in uniting communities and promoting mental wellbeing. To address this, we have an Annual Caribbean Concert that attracts hundreds. The items explore the Jamaican culture in music, dance and drama and is both engaging for the elderly in reminding them of their homeland and an educational opportunity for the younger ones to stimulate their interest in sustaining their rich cultural heritage.'

Collaboration

When asked whether Health Partnerships collaborate or coordinate with other diaspora led organisations, the following responses were received:

- Never _____ 11.1%
- Rarely _____ 11.1%
- Occasionally _____ 22.2%
- Often _____ 55.6%

*Figure 3: Health Partnerships on collaboration (THET 2021).*
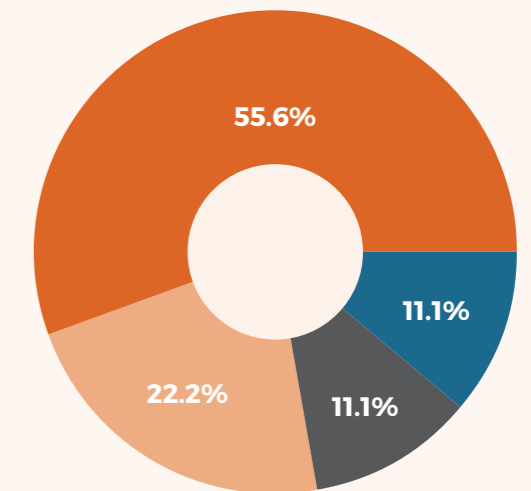
A clear majority of respondents stated that they did collaborate with other Health Partnership to promote knowledge sharing and to share ideas on how to further engage stakeholders.

Funding

We asked whether Health Partnerships actively fundraise for diaspora-related work and what their main sources of funding were. All respondents actively fundraise, and cited the following as sources of funding:

- Corporate _____ 0%
- Government _____ 11.1%
- Trusts and foundations _____ 11.1%
- Currently all work is done out of pocket, from my wages _____ 11.1%
- We organise fund raising events such as concerts, dinner and dances _____ 11.1%
- We have fund raising events to raise for projects _____ 11.1%
- Individual donations _____ 44.4%

Figure 4: Health Partnerships on funding (THET 2021).
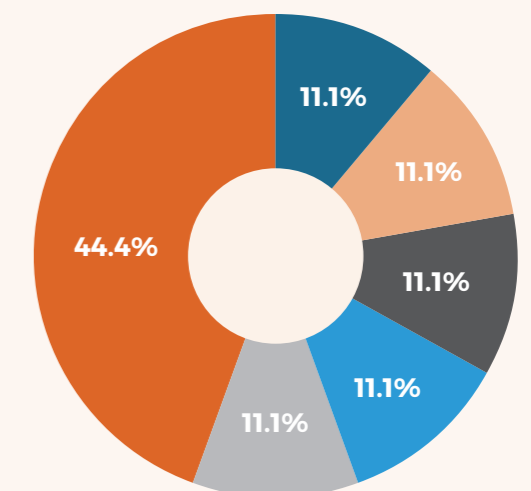
We also asked whether they experience any challenges with fundraising for their partnership.

A wide range of challenges were identified, including:

'Grant applications can be costly in terms of time and expertise and with variable outcomes.'

'A lack of understanding, by funders, of specific context.'

'Difficulties in fitting into funder's criteria.'

'A large number of charities are competing for funds; bigger organisations have a stronger voice.'

Constraints

Health Partnerships were also asked to identify any factors that they felt constrained healthcare workers in their contribution to the Health Partnership. Responses were as follows:

- Government constraints: 'sanction on Sudan'; 'government harassment of healthcare professionals'.

- Capacity constraints: 'a number are retired and therefore limited in what they can undertake'; age and risk factors.

- Funding constraints and lack of available space for community activities.

- Lack of administration staff available.

- Covid-19 constraints: 'Our Trust has been exceptional in supporting volunteers for GHP work, but the C-19 pandemic has constrained time even for work-from-home contributions (as well as travel) due to local NHS demands and family care and commitments'.

Support mechanisms

And finally, we asked in what ways could healthcare workers who engage in Health Partnerships be better supported in their contribution. Responses were as follows:

- Better understanding of the problems being addressed 'Understanding the humanitarian crisis in Venezuela, funding specific projects (malnutrition, junior doctors, etc)'.

- Funding, grant writing, administrative training: 'They need training in IT and social media. Help in developing bids for funding projects to make a difference in addressing health inequalities.'

- Psychological support: 'as they are reluctant to seek support from their respective workplace due to fear that it may be used against them in the future to blight their career prospects.'

- Recognition and individual support: 'They are usually well supported but recognition of the value of global health contributions to the workforce and local communities here in the UK needs constant work and can be especially difficult to communicate in the current political and economic climate (C-19 notwithstanding)'.

Health Profession Alliances engaging diasporas

Although limited, there exists some data on the scale and nature of Health Profession Alliance activities. In the UK, for example, there are twenty-four medical diaspora organisations focusing on providing healthcare services, training, and where necessary, humanitarian aid to their home country.[4] These organisations also nurture a social or professional network of migrant physicians as well as supply improved and culturally sensitive healthcare to the migrant population within their host country.[xxxii]

18 nursing and midwifery diaspora organisations have been identified in the UK.[5] 17 of these organisations have a country focus and one, the Commonwealth Nurses and Midwives Federation, has a pan-national focus. The Nurses Association of Jamaica is the longest-running organisation, perhaps reflecting the success of post-war recruitment campaigns in the UK encouraging Jamaican nurses to move to the UK.

Most of these organisations were set-up prior to the Covid-19 pandemic. However, members of the two largest diasporas - Indian and Filipino – set-up organisations amidst and in response to the pandemic, these being the British Indian Nurses Association and the Filipino Nurses Association United Kingdom. The Covid-19 pandemic has also strengthened some wider diaspora networks. For example, a new group of diaspora doctors has come together in Wales, supported by the Sub-Sahara Advisory Panel (SSAP) as a result of individual efforts to assist countries of heritage during the pandemic.[xxxiii]

Tanzanian health workers through Tanzania UK Healthcare Diaspora Association (TUHEDA) were also heavily involved in addressing the pandemic within the UK-diaspora and in Tanzania.

Nursing and Midwifery Diaspora Organisations in the UK

NNAUK
Nepalese Nursing Association UK

NNCAUK
Nigerian Nurses Charitable Association UK

NAJ UK
Nurses Association of Jamaica UK

AGNAP
Association of Guyanese Nurses and Allied Professionals

ASANUK
Association of South African Nurses in the UK

BINA
British Indian Nurses Association

B.O.N.A
Barbados Overseas Nurses Association

CAN UK
Cameroon Nurses Association UK

GHM UK
Gambia Healthcare Matters UK

GNA UK
Ghana Nurses Association UK

TOSHPA
The Organisation of Sierra Leonean Healthcare Professionals Abroad

UNMA-UK
Uganda Nurses Midwives Association

ZHTS
Zimbabwe Health Training Support

CNMF
Commonwealth Nurses and Midwives Federation

PNAUK
Philippine Nurses Association of United Kingdom

FNA
Filipino Nurses Association United Kingdom

MNA
Malawian Nurses Association UK

APNA
All Pakistani Nurses Association

[5] NNAUK (Nepalese Nursing Association UK)   ; NNCAUK (Nigerian Nurses Charitable Association UK); NAJ UK (Nurses Association of Jamaica UK); AGNAP (Association of Guyanese Nurses and Allied Professionals); ASANUK (Association of South African Nurses in the UK); BINA (British Indian Nurses Association); B.O.N.A (Barbados Overseas Nurses Association); CAN UK (Cameroon Nurses Association UK); GHM UK (Gambia Healthcare Matters UK); GNA UK (Ghana Nurses Association UK); TOSHPA (The Organisation of Sierra Leonean Healthcare Professionals Abroad); UNMA-UK (Uganda Nurses Midwives Association); ZHTS (Zimbabwe Health Training Support); CNMF (Commonwealth Nurses and Midwives Federation); PNAUK (Philippine Nurses Association of United Kingdom); FNA (Filipino Nurses Association United Kingdom); Malawian Nurses Association UK; APNA (All Pakistani Nurses Association)

African nationals in the diaspora have long been applying their qualifications and skills in developed countries

Development programmes engaging diasporas

In addition to the contributions made by individuals and Health Partnerships, a range of initiatives exists which aim to engage diaspora in more structured programmes to support development in countries of heritage.

For example, in 2008 the UK's then Department for International Development (DFID) initiated a £3 million ($4.7 million) programme, The Diaspora Volunteering Programme, with VSO, a UK-based international development charity. The programme supported more than 20 diaspora organisations, providing funding to help skilled professionals from UK diaspora communities to volunteer in their countries or continents of heritage. Despite demonstrable impact, the programme was allocated no further funding by the new Conservative government when it concluded in 2011.

Building on the momentum of The Diaspora Volunteering Programme[xxxiv] in 2011, VSO worked in partnership with the Diaspora Volunteering Alliance (DVA) to identify strategic stakeholders at the international, regional, national, UK regional and local level to support diaspora organisations to influence their programmes, policies, and resource allocations for the benefit of diaspora volunteering and international development.

The resulting report[xxxv] made a number of recommendations on how diaspora organisations can work more effectively with INGOs, and African counterparts, to access resources and funding, increase engagement in policy dialogue and affect change. However, there is little evidence to suggest that momentum was maintained.

Migration for Development in Africa (MIDA) was a capacity-building programme which began in 2001 to help to mobilise competencies acquired by African nationals abroad for the benefit of Africa's development. Based on its long experience in the Return of Qualified African Nationals (RQAN), IOM launched this programme to strengthen its capacity building efforts in assisting African countries to benefit from the investment they have made in their nationals. Many African nationals in the diaspora have long been applying their qualifications and skills in developed countries in Europe and North America. Such qualifications and skills should be brought back into the mainstream of development of the African continent. Through its mobility-based approach, MIDA aimed at helping African nationals to directly contribute to the development of their countries of heritage.[xxxvi]

Co-funded by DFID in 2008, Comic Relief's Common Ground Initiative[xxxvii] supported and built the capacity of small diaspora organisations to work in development projects. In June 2015, Comic Relief was awarded a further grant of £12 million from DFID for a second phase of its work, which focused specifically on development in Africa. During this phase, which concluded in July 2019, Comic Relief provided funding to diaspora-led organisations through the UK Small NGO Fund. The programme also provided non-grant support to diaspora communities working in Africa on rights and inclusion and diaspora finance and investment. Once again, on completion of a successful second phase, no further funding was forthcoming.

SECTION 2 **Diasporas - discussion**

Introduction

In the opening section of this report, we surveyed the contributions made by diaspora NHS staff both to the NHS and to countries of heritage, with a particular focus on Health Partnerships. In this section we will discuss the structural issues that could be addressed to fully realise the benefits to the NHS. We will also explore operational issues and policy gaps that exist which may hinder the engagement of NHS staff with countries of heritage.

2.1.1 Equality, diversity and inclusion

"Inclusion is core to the NHS Constitution and the NHS Long Term Plan, and yet it is still one of the biggest challenges that health systems face globally, nationally and locally." [xxxvii]

The NHS is the fifth largest employer in the world, and 21% of its workforce is from an ethnic minority background, compared to 13% of the UK's general population. [xxxix]

Nurses and midwives form the largest collective professional group within the NHS. One in every five are from an ethnic minority background, rising to much higher levels (up to 40 per cent) in some parts of the country, such as London. [xi]

The NHS is founded on a core set of principles and values that bind together the diverse communities and people it serves. Working towards race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution.

In Scotland, the 2020 Workforce Vision [xli] sets out a commitment to valuing the workforce and treating people well.[6] NHS Wales abide by a set of core principles.[7]

The Welsh Government goes further and is currently developing a Race and Equality Action Plan with the aim of making cultural changes which support an anti-racist stance.

And yet the NHS is still beset with difficulties in realising its vision for inclusion as expressed in its constitution. This message emerged loud and clear at our public inquiry with comments such as:

'The NHS is diverse but not inclusive, which means that there is no voice on issues facing the diaspora.'

'The diaspora story is also a story of power and hierarchy and class and race and how these factors transcend our lives.'

'Racism is still prominent, and this is not being measured because the questions are not being asked. The NHS frontline is largely made-up of immigrants and this is not recognised.'

'Racism in perceptions of the NHS was clear in the video thanking the NHS at the start of Covid-19 pandemic which was mostly white.'

'Unconscious bias is still prominent against African women.'

Why is it important for this inquiry?

NHS Boards recognise the fact that returns on investment in race equality are cumulative and measurable in terms of greater staff engagement and satisfaction and that this can lead to better patient outcomes and more efficient use of resources. However, unconscious bias and persistent racism still prevent us from fully utilising the expertise and knowledge of diaspora NHS staff, at home, or in countries of heritage through global health engagement.

Discussion

The NHS Workforce Race Equality Standard (WRES) [xlii] was introduced in 2015 to ensure employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The Standard led, for example, to a recent evaluation of the medical workforce which created an evidence base to expose racism and discrimination.

Over recent years, the NHS has become increasingly proactive on issues of staff and staff development with work being conducted on the development of ethnic minority networks, as well as aspirations for recruitment with specific interventions aimed at ethnic minority communities.

The NHS is therefore beginning to change and is doing so by translating evidence of discrimination into meaningful action.

But, as Figure 5 shows, while ethnic minority representation may be increasing in the NHS, there is still a clear drop in representation in the higher pay bands.
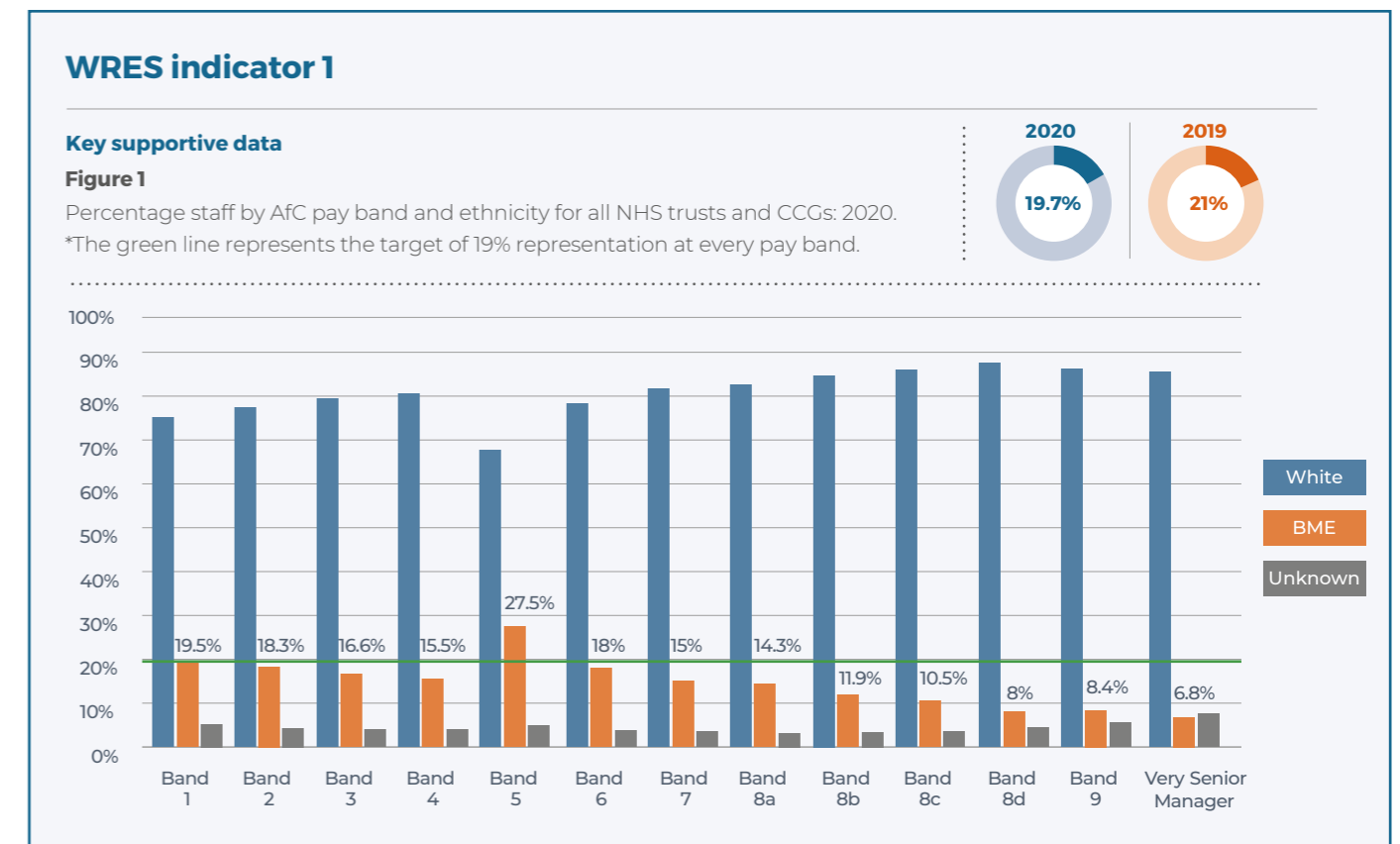

WRES indicator 1

Key supportive data

Figure 1

Percentage staff by AfC pay band and ethnicity for all NHS trusts and CCGs: 2020.
*The green line represents the target of 19% representation at every pay band.

2020 19.7% **2019** 21%

Figure 5: BAME pay bands in NHSE (NHS 2015)

Ethnic minority nurses, midwives and health visitors are under-represented in senior Agenda for Change (AfC) pay bands across the NHS. The number of ethnic minority nurses, midwives and health visitors at senior AfC pay bands is increasing, but this is not happening at a pace that will ensure equality in representation across the workforce.[xliii]

Further evidence shows that ethnic minority staff are still less likely to be treated favourably than their white colleagues regarding training and development and have poorer experience and progression opportunities.[xliv] If this is the case for ethnic minority staff within an NHS context, then what affect is this having on their ability to engage in countries of heritage through Health Partnerships affiliated to their NHS employers?

There are, however, encouraging developments. More and more BAME Staff Networks are being set-up across the NHS which aim to empower ethnic minority staff to achieve their potential through strengthening diversity. One network, for example, is working towards the following objectives:

1 Ensure the network has a recognised voice within senior management groups such as board level and senior management committees.

2 Embed professional development equity for BAME staff.

3 Help the Trust board to improve, promote and embed an inclusive leadership culture.

4 Foster good partnerships and collaboration with local, regional and national systems.

5 Influence the delivery of Quality Services to BAME citizens in our communities.

In academia, there is less engagement on race equality than in the public sector. Some progress has been made, with a race equality public action group being recently established at the National Institute for Health Research (NIHR). Imperial College London has also recently established an Ethnicity and Health Unit to study racism in research and scholarship and its impact on the research workforce and outputs.

Impact of Covid-19

Although Covid-19 has seen diaspora NHS staff from ethnic minority backgrounds reach out to help both in the UK and in countries of heritage, it has also had many ill effects.

The immediate concern is that diaspora NHS staff from ethnic minority backgrounds have been disproportionately affected by the Covid-19 pandemic. A report from Public Health England pointed to racism and discrimination as a root cause affecting health and the risk of both exposure to the virus and becoming seriously ill. Other possible factors include risks linked to occupation and inequalities in conditions such as diabetes which may increase disease severity.[xlv]

This was underlined in An Avoidable Crisis[xlvi], a review commissioned by the Labour Party and led by Baroness Doreen Lawrence:

"Covid-19 is having a disproportionate and devastating impact on ethnic minority communities. Not only are Black, Asian and minority ethnic people dying at a disproportionate rate, they are also overexposed to the virus and more likely to suffer the economic consequences. Despite repeated warnings, the Government has failed to take sufficient action.

Covid-19 has thrived on inequalities that have long scarred British society. Black, Asian and minority ethnic people are more likely to work in frontline or shutdown sectors which have been overexposed to Covid-19, more likely to have co-morbidities which increase the risk of serious illness and more likely to face barriers to accessing healthcare. Black, Asian and minority ethnic people have also been subject to disgraceful racism as some have sought to blame different communities for the spread of the virus."

We learned earlier of the importance of remittances to LMICs. However, remittance flows in 2020 to LMICs are likely to fall by 7.2 per cent to US$508Bn, followed by a further decline of 7.5 per cent to USD$470Bbn in 2021 largely due to the economic crisis caused by the Covid-19 pandemic.[xlvii]

And while it is unclear what impact the pandemic will have on the ability of diaspora NHS staff from ethnic minority backgrounds to engage in global health, it is apparent that a great deal is at stake as we emerge from the Covid-19 global pandemic. A pandemic that has disproportionally affected diaspora NHS staff from ethnic minority backgrounds.

In Wales, the Welsh Government worked with health workers from ethnic communities to develop the all-Wales COVID-19 Workforce Risk Assessment Tool. This was the first major piece of work from the advisory group, which was set up to look at the reasons why people from ethnic minority communities are disproportionately impacted by coronavirus. The task force was set up by Mark Drakeford, the First Minister of Wales and it was co-chaired by Judge Ray Singh and Dr Heather Payne. Two subgroups were created – one focusing on the risk assessment by Professor Keshav Singhal – and a second looking at the socio-economic factors which may influence poorer coronavirus outcomes.

Through leadership, the challenges of inclusion must now be met

2.1.2 Leadership

"Through leadership, the challenges of inclusion must now be met. This is particularly relevant in the face of a growing body of evidence that demonstrates the critical role that inclusive leadership plays in ensuring that Health and Care systems operate effectively. The time has come to focus efforts on the development of compassionate and inclusive cultures that truly value the diverse health and care workforce, enabling them to deliver the best quality services to our increasingly diverse communities."[xlviii]

The issue of leadership is intrinsically linked to inclusion. If we are to fully utilise the expertise and knowledge of diaspora NHS staff, at home, or in countries of heritage through global health engagement, the lack of representation of diaspora NHS staff in leadership positions should be addressed. This issue emerged strongly at our public inquiry with comments such as 'leadership must be representative of the population worked with and for' and 'leadership requires humility to listen and change.'

Why is it important for this inquiry?

As the NHS struggles to emerge from the Covid-19 pandemic, post-Brexit, the need to value every member of staff is more vital than ever before. This requirement is important not only for those already working in the NHS, but also for those yet to arrive. And whilst further international recruitment is a given, being able to successfully retain staff will be essential in the years ahead if the UK is to maintain its global reputation as an attractive and fair employment destination.

Central to realising this vision is a need to make the shift from viewing inclusion as a problem to be addressed towards viewing it as fundamental to leadership and change in the NHS of the future. Inclusion can in fact be viewed as a central pillar of innovation, collaboration, and service improvement.[xlix]

Discussion

Recent work with international nursing associations conducted by NHS England and NHS Improvement through their International Nursing Associations Diaspora (INAD) Engagement Programme[8] has emphasized the need to enhance the leadership skills of nursing leaders within the associations to strengthen the collective voice of nurse leaders on issues that relate to international recruitment, representation and rights of diaspora NHS nurses.[l]

NHS England and NHS Improvement are also working with the Florence Nightingale Foundation to deliver leadership training for diaspora group nurse leaders. This initiative aims to support group leaders to provide on-going, culturally sensitive leadership support to their colleagues.

The work of professional associations is also of note. For example, the Royal College of General Practitioners (RCGP) are developing a BAME action plan and have a strong track record of tackling inequality through their Equality, Diversity and Inclusion Steering Group.[li]

When considering other existing programmes, two NHS Leadership Academy programmes are of particular interest. Firstly, Improving Global Health through Leadership Development (IGH), which aims to support the delivery of sustainable improvements in health and healthcare, in partnership with communities in LMICs. The programme offers a personal and leadership development experience for NHS participants who are recruited as volunteers. The goal is to create a cadre of leaders with system-strengthening skills who are able to make a real difference to the NHS on their return to the UK.

A recent study[lii] of the IGH programme highlights 2019 Workforce Race Equality Standard (WRES) data showing that only 8.4% of board members in NHS trusts and 7.7% of very senior managers are from ethnic minority background. This is much lower than the ethnic minority representation in the overall NHS (19.7%) and indeed in the IGH programme (20%). A higher percentage of junior doctors are from ethnic minority background than senior. More work is therefore required to address the structural barriers which deter ethnic minority groups from taking up senior NHS roles. Programmes such as IGH are ever more relevant within this context.

The NHS Leadership Academy's Building Leadership for Inclusion (BLFI) programme[liii] is also of interest[9]. Following a recent review of the BLFI programme,[liv] a number of recommendations were developed to further support the sustainability of its work. The recommendations resonate strongly with THET's values and those of the Health Partnership community.

For example, the recommendation that participants on the BLFI programme create genuine opportunities to engage with and share lived experience is notable as it goes on to encourage facilitated spaces for challenging, honest conversations around race, gender, disability, LGBT+ and other protected characteristics. This is an area of particular interest to Health Partnerships as they learn from others in LMICs. As discussed in the previous section, diaspora NHS staff can lead on addressing unconscious bias in the workplace. Health Partnerships also take a gender equality and social inclusion (GESI) approach to their work in order to consider and address unequal power relations and inequalities experienced by individuals as a result of their social identities.

Another recommendation, namely that participants on the BLFI programme should focus on culture and relationships, is also worth highlighting. The problem being addressed here is that individualistic approaches to leadership and inclusion pay insufficient attention to the quality of conversations, patterns of relationships, social capital and development of shared value.

The recommendation goes on to suggest that although the majority of those who work in public service, and particularly the NHS, do so because they care about what they do and the services they provide, crucially this untapped energy and motivation is currently being squandered. This energy and motivation runs strongly through all Health Partnerships.

Finally, we may also consider the recommendation that participants on the BLFI programme take a practice-based approach to trial and experimentation. The recommendation suggests taking an action research approach, which incorporates opportunities for feedback, reflection and learning. It also highlights collaborative inquiry, co-production and appreciative inquiry as key elements in building the engagement and tapping into the knowledge, expertise and lived experience of those involved. This chimes strongly with the approach that successful Health Partnerships take, with particular attention to principles of partnership such as Respect and Reciprocity and Commitment to Joint Learning.[lv]

The values that underpin Health Partnerships are particularly pertinent in helping to realise the vision of an NHS where every member of staff is valued. Nurturing diaspora NHS staff as future leaders can strengthen the NHS and can support engagement with countries of heritage.

Conclusion

Addressing issues associated with equality, diversity, inclusion and leadership – all of which have been exacerbated by the Covid-19 pandemic – can contribute not only to an improved NHS but may also lead to greater and more impactful global engagement of diaspora NHS staff with countries of heritage. Further, global engagement of diaspora NHS staff in an age of human resources for health (HR) crises in all health systems is critical if we are to address the enormous inequalities that continue to grow between LMICs and high-income countries (HICs).

...successful Health Partnerships take, with particular attention to principles of partnership such as Respect and Reciprocity and Commitment to Joint Learning.

[8] The INAD programme was initiated to identify and engage with International Nursing Associations providing support to overseas nurses and midwives within the NHS. The aim is to form a collaborative with these organisations to promote pastoral care and other services to internationally recruited nursing staff. The programme also aims to enhance the representation of international nurses and midwives from ethnic minority communities and encourages their collective voice on issues that matter to them.

[9] The Building Leadership for Inclusion (BLFI) programme seeks to raise the level of ambition, quicken the pace of change, and ensure that NHS leadership is equipped to achieve and leave a sustainable legacy in relation to equality, diversity and inclusion (NHS Leadership Academy, 2018).

2.2 Funding, capacity building and coordination

In this section, we will examine issues of funding, capacity building and coordination that if addressed may catalyse the engagement of NHS diaspora staff with countries of heritage.

Why is it important for this inquiry?

We have noted the important part that addressing issues relating to equality, diversity, inclusion and leadership plays not only in improving the global engagement of diaspora NHS staff with countries of heritage, but also in developing an NHS that is stronger and more representative.

In addition, three further areas stand out as key to unlocking the full global engagement potential of diaspora NHS staff: funding, capacity and coordination.

Discussion

Funding

As noted in the opening section of this report, there have been a small number of government-funded diaspora related initiatives in the recent past but there are no current programmes.

What emerges is a picture of pilots and initiatives initially funded by the government and INGOs then discontinued. As noted earlier, we asked 227 Health Partnerships whether they were diaspora led or diaspora inclusive. We received fourteen responses with twelve Health Partnerships stating that they were diaspora led or diaspora inclusive.

"Funding criteria setting often excludes some of the people who are doing the most important work"

Diaspora Organisation representative

Nursing diaspora organisations have reported that diaspora initiatives see financial constraints and their lack of capacity to fundraise as an important barrier to sustained engagement.[lvi] The lack of capacity can be viewed as a vicious cycle whereby opportunities are missed due not necessarily to the potential strength of a project, but to weak applications stemming from limited capacity. Therefore, it is to be welcomed that NHS England and NHS Improvement have launched a new small grants scheme which provides diaspora groups with funding to strengthen their pastoral support offer for international nurses arriving in the UK, and further promote their organisations to their community.

And indeed, some go further, suggesting that funding criteria from government and INGOs excludes those diaspora organisations that are already doing the work, that processes are convoluted, and that there exist structural impediments to accessing funding. These impediments result in a missed opportunity to reap the efficiency and sustainability gains inherent in strategically supporting diaspora engagement in development and global health.

A similar narrative can be heard within academic research where 'funding for global health is diverted through non-diaspora organisations, perhaps because of lack of presence in academia.'

Capacity building

Another area key to unlocking the full global engagement potential of diaspora NHS staff with countries of heritage is that of capacity.

AFFORD[lvii] is perhaps the best example of a Diaspora Organisation which aims specifically to build the capacity of their members and diaspora communities through policy, advocacy and lobbying, as well as project delivery. AFFORD have been markedly successful in a number of fields, in particular entrepreneurship, with small grants and business support provided to a number of UK based diaspora organisations.

An increasing number of Health Partnerships are being formed to mobilise the expertise of UK NHS staff for the benefit of partners in LMICs. Often aligned with NHS Trusts and sometimes diaspora inclusive, they can struggle to secure funding to support their work despite the considerable and distinctive expertise they bring to international development.

The lack of resources – in terms of human capital and know-how – in small Health Partnerships can prohibit them from scaling up their activities and having greater impact. If we want to see these Health Partnerships flourish and achieve their potential ambitious, tailored support is necessary to develop their capacity, organisationally and holistically, so that they can implement international development projects effectively and receive adequate funding to do so.

Unconscious bias

When NHS staff engage with LMICs, we have seen that barriers and unconscious biases exist which inhibit learning.[lviii]

Diaspora NHS staff will have their own perceptions of their countries of heritage which may or may not be accurate or up to date.[lix] They are unlikely, however, to have unconscious biases deterring them from learning from their experiences in their countries of heritage.

Diaspora NHS staff can not only learn from their experiences in LMICs, but may bring this learning back to the NHS. There are, however, structural impediments deterring this transmission of learning back into the NHS.

In addition, although Covid-19 has seen diaspora NHS staff reach out to help both in the UK and in countries of heritage, it has also had many ill effects. These effects must be recognised, and diaspora voices must be listened to in order to overcome them.

Coordination

At our public inquiry we heard that there has been very little formal collaboration between diaspora organisations and the NHS. Encouragingly, NHS England and NHS Improvement have developed a network of International Nursing Associations with the express aim of scoping and developing collaborative relationships between associations, facilitating the formation of collective voice for issues that concern them. An important element of this initiative is the creation of an online platform to allow diaspora organisations to network and share best practice.

One further example is that of large networks of Health Partnerships between the UK and LMICs called Health Alliances. For example, the Myanmar UK Health Alliance[lx] encourages mobilisation of members of the Myanmar diaspora. The Alliance provides connections for diaspora to heritage country counterparts and assistance in receiving approval from the NHS for overseas work. Where the heritage country government lacks a plan for mobilising the diaspora, Health Alliances can fill the gap and encourage government support for diaspora help. However, it is worth also pointing out that many Myanmar healthcare professionals do not actively work with the Alliance.

The example of the Myanmar UK Health Alliance, the recent military coup notwithstanding, is encouraging, however, a great deal more work is required. This is important firstly because greater coordination will encourage improved impact where it is needed the most. Secondly, because a more joined up approach will enable greater returns to flow back into the NHS.

Diaspora NHS staff can not only learn from their experiences in LMICs, but may bring this learning back to the NHS

Case study

Uganda UK Health Workforce Alliance

Rates of non-communicable diseases (NCDs) such as diabetes, cardiovascular disease, cancer, chronic respiratory diseases, and mental illness are rapidly increasing worldwide, especially in LMICs like Uganda. Much can and must be done to delay or prevent the rise of these diseases, before the cost of treating them threatens to overwhelm health services.

Through dialogue with Ugandan policy makers and in partnership with UK based organisations, including East London NHS Foundation Trust and Time to Change, a programme led by the charities Mind and Rethink Mental Illness, the Uganda UK Health Workforce Alliance is working to influence policy and practice in Uganda.

Through this, the Alliance and partners are making a valuable contribution to halting the rapid rise of NCDs in both Uganda and the UK. For example, the Alliance coordinated an educational awareness initiative—in collaboration with C3 (Collaborating for Health), Uganda Non-Communicable Disease Alliance, Heartsounds Uganda, Butabika Hospital, Uganda Nurses and Midwives Union, and the Ugandan Ministry of Health— aiming to help prevent NCDs among people with mental health problems in Uganda. As part of this initiative, a workshop was held with participants including nurses, mental health service users (peer support workers), and student nurses.

The Alliance, which members of the Ugandan diaspora are at the centre of, has provided a real opportunity to raise awareness among healthcare workers and the wider population of the challenge and preventable nature of NCDs, in relation to both physical and mental health. It has also provided healthcare workers with the knowledge and skills necessary to influence, inform, educate, and support their local communities and client groups.

Members of the diaspora play a key role in sharing knowledge and learning with their countries of heritage. By adapting their skills and knowledge, building on existing good practice, using established and effective networks and relationships where possible, and ensuring longer term sustainability and impact, members of the diaspora can help to creatively overcome poverty gaps.

The role of the diaspora in bringing together organisations and empowering their country of heritage, while also bringing learning back to the UK, was crucial to the success of this NCD prevention initiative in Uganda.

A strategic review[lxi] of Health Alliances between Sierra Leone, Uganda, Zambia and the UK also noted four areas where further progress could be made:

Coordination of contribution to focal countries health objectives and systems.

The Alliances have made significant progress in raising awareness of Ministries of Health priorities and policies and why alignment is important. Alliances require more time and a more flexible approach to programming and resourcing if they are to demonstrate whether they can also deliver a more strategic, demand-led contribution to focal countries strategic objectives.

Support and development of efficient partnership working in focal countries.

The Alliances have been able to deliver some very real value in supporting efficient partnership working in their focal countries. However, strategically it is important to weigh the opportunity cost of providing these types of services.

Support and development of effective and ethical partnership working.

The Alliances have provided valuable platforms for members to share their experiences. Information provision on funding opportunities is particularly valued. The value of Alliances in providing effectiveness information and learning opportunities is contested.

Facilitation of collaboration between members of Alliances.

There is an appetite for information to enable members to self-organise and avoid duplication. However, brokering new partnerships/ opportunities or actively facilitating discussions between members may be more effective in producing collaboration.

Conclusion

Constraints around capacity and financing are inhibiting the full global engagement potential of diaspora NHS staff with countries of heritage. More needs to be done to develop an accessible funding and capacity building environment that actively encourages and consistently develops diaspora engagement in global health. This, in turn, must connect with a service improvement culture in the NHS.

2.3 Policy and practice

Why is it important for this inquiry?

With improved policy and practice relating to engagement, governments of countries that host diaspora as well as countries of heritage can realise the value that diaspora populations may bring to development efforts in countries of heritage.

Discussion

Although the UK government has no published strategy on how it engages diaspora, its last international development strategy, UK Aid: tackling global challenges in the national interest, states that: "The government will also continue to drive development in regions where the UK has close ties, including strong historical, cultural and diaspora links, such as the Caribbean, Africa and South Asia. It will continue to honour its obligations to the Overseas Territories."[lxii] As noted earlier in this report, despite no apparent strategy, the UK government does have some track record of supporting diaspora-focused programs and institutions.

For example, the country offices of the UK's Foreign, Commonwealth and Development Office (FCDO) are encouraged to consult diaspora groups in formulating FCDO country assistance plans. Furthermore, the United Kingdom supports a Senior Executive Service drawn from diaspora members to fill senior positions in governments of post-conflict countries.[lxiii] In addition, the UK Government has previously used ODA to support platforms to facilitate diaspora involvement in development through *Connections for Development*. Such institutions encourage the systematic sharing of ideas and information while also serving as vehicles for capacity building.

While many governments acknowledge the importance of diaspora engagement in development, many still lack the capacity to design effective policies and implement them on a meaningful scale. This explains the gap between schemes that look good on paper and truly effective policies and programmes that actually make a difference. Indeed, effective engagement almost always requires a concerted effort toward capacity building.

The approaches of LMIC governments to members of their respective diaspora are equally important to that of host countries, such as the UK, if we are to successfully enable, engage and empower diaspora NHS staff.

Over recent years, an increasing number of countries have established institutions to facilitate ties with members of their diaspora more systematically. A survey of states participating in the Global Forum on Migration and Development identifies more than 400 institutions in 56 countries that are directly engaging diasporas through various programmes and policies. Of these institutions, 77 were created specifically to engage diasporas on a formal basis.[lxiv] Such diaspora institutions operate at different levels – from ministry, sub-ministry, national, or local level to consular network – or are quasi-governmental institutions. For example, the Somaliland Government has a Ministry for Diaspora and Community Affairs; Ethiopia has a Diaspora Affairs Directorate General within their Ministry of Foreign Affairs and Sierra Leone has an Office of the Diaspora within the Office of the President.

These efforts by both host and origin country governments are to be welcomed but most of what has been achieved by the UK in terms of engaging, enabling and empowering diaspora has not been maintained. There also exists little evidence of policy and practice focusing on global health engagement.

Conclusion

Government partnerships between HICs and LMICs can make a difference by sharing the burden as well as opportunity of engagement. As noted earlier in this report, high-income countries such as the UK government have in the past initiated programmes supporting the development activities of diasporas in their countries of heritage.

LMIC governments are arguably more engaged with members of their diaspora than HICs who host diaspora. This is perhaps due to the huge financial benefits that accrue from encouraging direct investment, as well as from attempting to ensure remittances are used for the common good.

In the final section of this report, we set-out the approaches which may enable and empower diaspora NHS staff to optimise engagement with countries of heritage whilst bringing benefits to the NHS.

The approaches of LMIC governments to members of their respective diaspora are equally important to that of host countries such as the UK

SECTION 3 Diasporas – recommendations: enable, engage and empower

Introduction

Based on the opportunities and challenges laid out in this report, we will now examine how best to enable, engage and empower diaspora NHS staff in support of efforts to optimise engagement with countries of heritage whilst bringing benefits to the NHS.

Inclusion

We have noted that the NHS is diverse but not necessarily inclusive and that there exists an underrepresentation of diaspora NHS staff from ethnic minority backgrounds in leadership positions. We have further noted that Health Partnerships experience a number of constraints when engaging the NHS, and that Health Partnerships although open to the idea of being diaspora inclusive are not necessarily so in practice.

The following recommendation addresses issues of equality, diversity and inclusion and proposes steps that can be taken to better channel the expertise of diaspora NHS staff from ethnic minority backgrounds to address inequality more widely.

Recommendation 1

1.1 We recommend that THET creates a diversity network drawing from a multidisciplinary membership of Health Partnerships and leaders from NHS organisations, NHS equality and diversity champions as well as student groups.

The proposed aims of this network would be as follows:

- To identify and document existing diaspora-led relationships with countries of heritage and support these to develop into Health Partnerships.

- To address the under representation of diaspora NHS staff from ethnic minority backgrounds in senior positions within Health Partnerships and appropriate representation of the population served.

- To support greater engagement between diaspora inclusive Health Partnerships and the NHS to help capture and promote innovation – whilst working in the NHS and in countries of heritage.

- To document the added value derived from engagement of diaspora NHS staff in countries of heritage to the individual and to the NHS institution.

- To raise awareness of funding and capacity building opportunities for such bodies.

We recommend that the network consider the following priorities:

Education

Educate one another to learn about the pervasive impact of discrimination and unconscious bias and understand what must be done to deliver equality in every aspect of the work and for communities served.

Measurement

Measure progress so that tangible results can be delivered against equality, diversity and inclusion objectives and that progress can be made where improvement is still required.

Safe spaces

Create safe spaces so that members are comfortable speaking up, asking questions and sharing experiences.

Champion causes

Publicly champion causes so that the influence of networks can be harnessed to support equality, diversity and inclusion and convey publicly an absolute commitment to these principles.

1.2 We recommend that NHS Trusts' BAME Staff Networks engage with THET's diversity network to support the engagement of diaspora NHS staff with countries of heritage.

We have noted the encouraging development of more and more BAME Staff Networks emerging across the NHS. Such networks are spearheading improvements in equity of continuous professional development opportunities and of representation at NHS Trust senior management level. This approach can empower ethnic minority staff to achieve their potential and can influence the delivery of quality services to ethnic minority patients in communities served within the UK.

We have also seen how diaspora NHS staff have particular skills to offer countries of heritage and that such engagement can benefit NHS Trusts and patients served. This approach could help to further realise the benefits to patients served in LMICs as well as in the UK.

We therefore recommend that NHS Trusts' BAME Staff Networks also engage with THET's diversity network to help support the engagement of diaspora NHS staff with countries of heritage.

Leadership

We have highlighted the need for the NHS to value every member of staff and to make the shift from viewing inclusion as a problem to be addressed towards viewing it as fundamental to leadership and change in the NHS of the future. But to achieve this vision, more needs to be done to support diaspora NHS staff to develop as leaders.

Empower ethnic minority staff to achieve their potential

Recommendation 2

2.1 Improving Global Health through Leadership Development (IGH) has already proven successful in attracting ethnic minority participants.

We recommend that Health Education England consults with diaspora NHS staff to gauge the desirability of matching diaspora NHS staff to placements in countries of heritage through the IGH programme.

This expansion of IGH could allow diaspora NHS staff to volunteer in their countries of heritage through a structured leadership programme. This approach could support health systems in countries of heritage, support NHS line managers to better understand the value of such engagement and further expand the skills of future diaspora NHS staff leaders.

Funding and capacity building

We have discussed the need to address issues around the capacity and financial constraints faced by Health Partnerships. The following recommendations aim to encourage an accessible funding and capacity building environment that actively encourages and consistently develops diaspora engagement in global health which connects with a service improvement culture in the NHS.

Support the aspirations of nurses to give back to their countries of heritage

Utilising the diasporas expertise in assessing need

Recommendation 3

3.1 We commend the work NHS England and NHS Improvement are doing in this regard, namely:

- A small grants scheme programme for international nursing associations to advance their pastoral support of established and newly arrived international nurses in the UK to help address financial challenges;

- A travel scholarship programme which will help to support the aspirations of nurses to give back to their countries of heritage.

We recommend that NHS England and NHS Improvement develop a similar approach for other healthcare professions represented by other Health Profession Associations in addition to nursing.

3.2 We recommend that THET conducts outreach work to encourage capacity building of Health Partnerships to support the development of successful grant applications. This includes setting a target of ten diaspora led or inclusive Health Partnerships engaging in the Health Partnership Capacity Development programme.[10] Support provided could include training and mentoring on the following:

- Strategic planning to define needs and harmonise with the needs of countries of heritage.

- Delivery and accountability of projects in countries of heritage.

- Impact and sustainability of engagement in countries of heritage.

- Strengthening of organisational buy-in from affiliated NHS health institutions.

This type of capacity building programme can support diaspora led or inclusive Health Partnerships affiliated with NHS institutions to successfully apply for funding to deliver projects in countries of heritage.

3.3 NHS England and NHS Improvement's work with the Florence Nightingale Foundation to deliver leadership training for diaspora group nurse leaders is to be welcomed.

We recommend that NHS England and NHS Improvement explore the synergies between their leadership training programme and THET's Health Partnership Capacity Development programme to further support diaspora NHS staff to develop as leaders.

Coordination

An environment supportive of greater coordination between the NHS, governments and Health Partnerships will encourage diaspora engagement with countries of heritage where it is needed the most. In addition, a more joined up approach will enable greater returns to flow back into the NHS.

Recommendation 4

4.1 Health Partnerships

We recommend that Health Partnerships develop plans that engage the UK diaspora of the LMIC they are partnering with where synergy exists. Priorities may include:

- Encouraging diaspora NHS staff and especially the younger generation to join and actively participate to strengthen the Health Partnership.

- Utilising the diasporas expertise in assessing need.

- Effectively and rapidly responding to emergencies such as flood relief, earthquakes, Covid-19 relief by PPE and vaccines.

- Developing and sharing information with NHS institutions that will attract the UK government, governments of countries of heritage and the membership of the diaspora to continue working to benefit the UK and the country of heritage.

4.2 Country health alliances

Health Alliances between the UK and LMICs such as Uganda and Myanmar can provide vitally needed system leadership to better coordinate and support partnerships between the UK's health sector and those of LMICs. However, we have noted that specific areas require further work if Health Alliances are to fully realise their potential.

We recommend that Alliances focus on the following areas to support greater linkages between the NHS and diaspora countries of heritage:

- Coordination of contribution to health objectives and systems of focal countries.

- Support and development of efficient partnership working in focal countries.

- Support and development of effective and ethical partnerships.

- Facilitation of collaboration between members of Alliances.

4.3 Health profession alliances

We commend NHS England and NHS Improvement's sponsorship of a network of International Nursing Associations. This is fostering collaboration and sharing of learning which in turn is leading to an opportunity for a number of small organisations to develop a collective voice on matters of most importance to them.

We recommend that NHS England and NHS Improvement take this model as an exemplar for other health professions and nurture the development of similar networks for doctors and allied healthcare professionals.

Policy options for UK and LMIC governments and agencies

If we are to enable, engage and empower diaspora NHS staff then a policy context which encourages strategic coordination of diaspora engagement in global health between the UK and LMIC governments and which connects with a transformative inclusion agenda in the NHS is necessary.

[10] The Health Partnership Capacity Development Programme aims to strengthen small civil society organisations (CSOs) working through Health Partnerships.

Develop a strategy for diaspora engagement

Recommendation 5

5.1 We recommend that the UK's Foreign, Commonwealth and Development Office and the Department of Health and Social Care develop a strategy for diaspora engagement in partnership with NHS England and NHS Improvement. This could form part of the UK Government's global health strategy if the UK government decides to refresh Health is Global.

The needs and skills of each diaspora is quite different based on a number of factors. This includes historical context and, perhaps most importantly, each generation's (and individual's) realities within their countries of residence and heritage. However, the IOM sets out of the following key steps in a road map for effective and sustainable engagement of diasporas:

1 Identify goals and capacities

2 Know your diaspora

3 Build trust

4 Mobilise the diaspora for development

5.2 While LMICs have made some efforts to engage members of their diaspora, greater coordination is required if LMIC governments are to maximise the impact of diaspora NHS staff and healthcare workers from other HICs.

Health is an investment that both underpins economic growth and is a major part of our national economies – an investment which also contributes to the economic empowerment of women and young people.

We recommend that LMIC governments strengthen existing structures to ensure the efficient engagement of their diaspora healthcare workers.

We also call on Ministries to:

- Systematically engage with health profession alliances and country alliances in the countries of greatest diaspora concentration.

- Collaborate with host country governments who may be able to support these efforts.

- Address barriers to engagement of diaspora and create incentives by promoting a triangular flow of talent and skills. This involves encouraging some healthcare workers to return to their country of heritage for short or longer-term periods.

- Invest in strengthening national institutions for tracking internal and international migratory flows and enable evidence-informed planning and policymaking.

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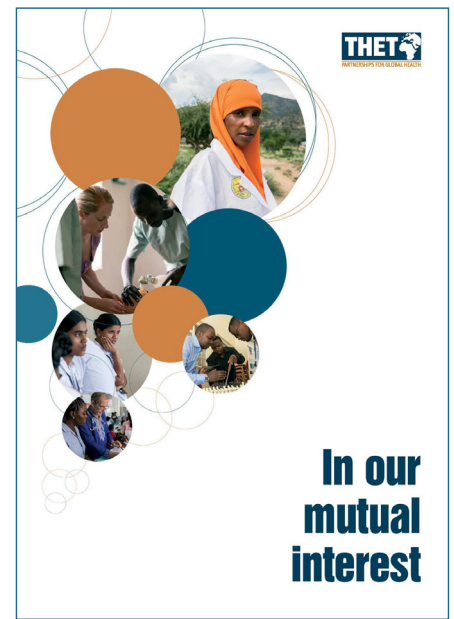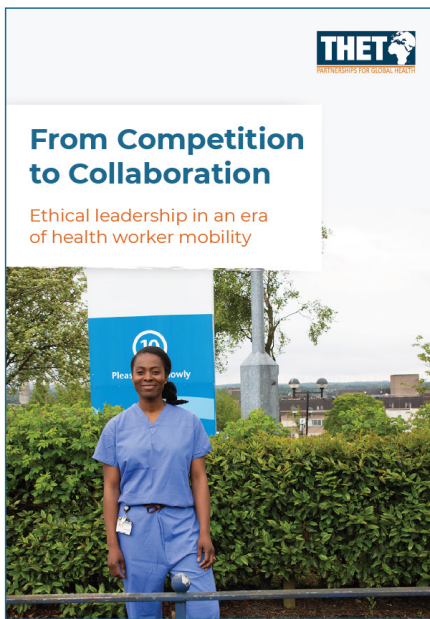
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One billion people in the world do not have access to a qualified health worker. THET has a vision of a world where everyone has access to quality health care. We achieve this by training and educating health workers in Africa and Asia, working in partnership with organisations and volunteers from across the UK. Founded in 1988 by Professor Sir Eldryd Parry, we are the only UK charity with this focus.

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