THET
PARTNERSHIPS FOR GLOBAL HEALTH

LLEISIAU'R ARBENIGWYR YN EIN PLITH

VOICES OF THE EXPERTS IN OUR MIDST

Contents

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Definitions

The definition we use for diaspora reads: “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.” In practice, the vast majority of diaspora respondents quoted in this report are themselves migrants and are often Internationally Trained Health Workers (ITHWs). Second generation (or earlier) diaspora health workers have also been included, given links are often maintained with their countries of heritage. Due to the global health aspect of this report, we have drawn heavily (but not exclusively) from diaspora of Lower and Middle-Income Country (LMIC) heritage.

Foreword

This report is, unashamedly, a celebration of the individuals who connect the NHS to over 200 health systems around the world. A growing number of our NHS Wales staff report a non-British nationality. A smaller number than in NHS England, but certainly increasing. Still more staff identify as belong to a diaspora, with strong ties to countries of heritage.

THET is deeply excited by them as individuals, and by the ways in which they are using their knowledge of different health systems to improve health for patients in the UK and in their countries of heritage.

These individuals are the health diplomats who move with ease between health systems, learning as they go. What a resource of ideas they are for us, as we seek to improve health for everyone, everywhere – the centre piece of THET's mission as a UK charity working internationally.

The NHS has increasingly looked beyond the borders of the UK to recruit the best talent in healthcare, and it is imperative that we take steps to understand and appreciate the value that diaspora staff bring to the NHS

It is our belief that Wales does not do enough to celebrate this knowledge. This report is a modest contribution designed to help change that.

There are three groups of people we would like to thank.

First, Sue Tranka, the Chief Nursing Officer, and her team. They have supported and guided this work in Wales from the outset and, crucially, made possible the secondment to THET of Kokila Swamynathan from the Cwm Taf Morgannwg Health Board. In a recent blog published on the THET website, Sue reflected: "The NHS has increasingly looked beyond the borders of the UK to recruit the best talent in healthcare, and it is imperative that we take steps to understand and appreciate the value that diaspora staff bring to the NHS." Sue speaks with particular authority on this subject, given that she is the first Chief Nursing Officer in the history of Wales or of the UK, to have been trained internationally. The influence of Sue and her team has been crucial. Its content is, however, entirely the responsibility of THET. We hope we have met their expectations.

Secondly, we would like to thank the more than 450 NHS Wales staff who have engaged with us in the creation of this report; in the survey, in the focus groups, and by partnering with us on global health activities over many years. At the centre of this have been the growing number of diaspora-led health groups that are now operating across the UK - over 80 when we last counted. Their leadership is crucial.

Diaspora health workers connect the UK to 214 health systems around the world.

Third, we would like to thank the community of staff and individuals across the Welsh health community and its health institutions – and including the members of THET's sister organisation, the Wales and Africa Health Links Network. These are the pioneers who think and learn globally, to act locally, improving health outcomes for patients at home, and overseas. Wales has a distinguished track-record in promoting global engagement, notably through its Charter for International Health Partnerships for Wales. We hope this report serves as a modest contribution towards celebrating just how deep those connections are.

Ben Simms, Chief Executive Officer, THET
Dr Julia Terry, Chair, Wales and Africa Health Links Network
Kokila Swamynathan, Diaspora Engagement Advisor at THET, 2023

Section 1

Background to this Report

In 2021, the Tropical Health and Education Trust (THET) released a report entitled **'Experts in Our Midst: Recognising the contribution NHS diaspora staff make to global health.'** The report examined the contribution that diaspora and internationally trained staff make to healthcare delivery in the UK, as well as global health and Health Partnerships. It aimed to enable and empower diaspora NHS staff. It included recommendations targeted at THET, Health Partnerships, the National Health Service (NHS) Hospital Trusts and Boards, NHS England, and the Foreign, Commonwealth and Development Office (FCDO).

Since the first report, there has been an uplift in recognition of diaspora health workers. Within THET's Experts in Our Midst programme (EIOMP), THET has worked with NHS organisations across England and Wales to create a '**Diaspora Network for Global Health'.**

The network harnesses the knowledge diaspora staff have of other health systems to develop practical solutions that improve health service delivery in the UK and overseas.

The founding NHS organisations leading this network include Nottingham University Hospitals Trust, Cambridge University Hospitals Trust, East London NHS Foundation Trust, Northumbria Healthcare Foundation Trust, West Yorkshire Health and Care Partnership, and Cwm Taf Morgannwg University Health Board. Within the programme, THET has also organised a number of events in the UK aimed at exchanging ideas on promoting collaboration and inclusion of diaspora in the global health space. Further, THET has identified 44 diaspora ambassadors to act as advocates for global health through policy engagement.

For the past year, a registered nurse has worked on secondment to THET from NHS Wales, with support from CNO Wales, to shape these activities. Connecting with Black, Asian and Minority Ethnic (BAME) staff networks, events have been held in Aneurin Bevan and Swansea Bay University Health Boards to platform and celebrate diaspora staff, as well as discuss the way the Boards can build upon and benefit from the global connections they bring.

Much more needs to be done to scale up a globally engaged NHS, including using domestic funds for beneficial outcomes in LMICs, and increasing opportunities for diaspora health workers to access UK Aid and other global health funding.

Meanwhile the numbers of international staff as a proportion of the UK health workforce have continued to grow, in England they represent 18.7%, almost 1 in 5 health workers. In Wales, non-UK nationalities represent 6.4% of the workforce. Further, as the numbers of health workers from the EEA reduces post-Brexit, the amount from other parts of the world, particularly those who have trained in LMICs is increasing. In the year to March 2023, the initial registrations on the NMC register from outside the EU/EEA showed an 11.9% increase.

This second report seeks to build on the findings and recommendations of the first report, with a greater emphasis on people's own experiences, amplifying diaspora voices. Storytelling is at the heart of this work, with a focus on platforming diverse perspectives.

This report is written to speak specifically to the Welsh context, recognising the differences with other parts of the UK in terms of health system governance and global health support and opportunities. Although the survey data and interviews draw from survey respondents across England and Wales, Welsh specific information is included, and all case studies are drawn from Wales.

The aim is to promote a globally engaged NHS, committed to contributing to global health and learning and improving in its core function through global engagement. Part of this is understanding its diaspora workforce as a strong asset, which includes individuals with unique perspectives and experiences, as potential bridges for bi-directional learning between the UK and other health systems. Also, to recognise the diaspora workforce as experts in the UK health system due to their experience of different ways of working and often broader skills base.

The rest of this section will set out the context, both for diaspora within the Welsh health system, and diaspora engaging in global health. Section 2 will focus on the diaspora value to and experience within the UK's health system in their own words. Section 3 will share personal experiences within global health initiatives and offer a series of case studies highlighting key findings. Section 4 ends with a discussion of key points and learnings.

Diaspora in the Welsh Health System

The experience that diaspora health workers face while working in the Welsh health system is of paramount concern to the issue of retention and wellbeing. The insights gathered for this report provide many examples of negative experiences that diaspora health workers face, including a lack of career progression, challenges around language, culture, communication and induction, as well as discrimination and racism.

In July 2022, the Welsh Government launched its Anti-Racist Wales Action Plan[4] with a stated purpose of making a "measurable difference to the lives of Black, Asian and Minority Ethnic people." The health section of the Plan includes priority actions on leadership and workforce, including a leadership and progression pipeline for BAME staff, and commissioning an independent audit of workforce policies and procedures. The focus of the Plan is therefore of particular interest to diaspora communities and health workers, which align very strongly with BAME communities.

The Plan places a responsibility on public bodies, including NHS Health Boards, to develop anti-racism action plans and report demonstrable progress against them. For instance, Betsi Cadwaladr Health Board has published their 'Plan on a page' setting out their local approach to meeting anti-racism targets.[5] This is in addition to the four-year Strategic Equality Plan that public bodies must produce and report against under the Equality Act 2010.

The Anti-Racist Wales Action Plan commits to making a "measurable difference to the lives of Black, Asian and Minority Ethnic people." Public bodies, such as NHS Health Boards, are responsible for developing anti-racism action plans and to report demonstrable progress against them.

As part of the Anti-Racist Wales Action Plan, a scoping group was established to build on learning from NHS England's implementation of the Workforce Race Equality Standards (WRES),[6] and to develop recommendations for Wales. Currently the WRES is being populated, and it is expected that the publication of the first data report will take place in the first half of 2024.[7] This should greatly improve the data available to understand the situation faced by the minority ethnic and diaspora health workforce and assist organisations in taking steps to address issues.

Further encouraging initiatives include the priorities of the Chief Nursing Officer (CNO) for Wales,which row alongside the Anti-Racist Wales Action Plan and other initiatives. The CNO has specific aims to improve professional equity by promoting the mentorship, leadership, and networking of 'global majority' nurses and midwives, as well as supporting the development and implementation of the WRES data to inform areas in need of focus.[8]

These are very positive developments, and the availability of more and better-quality data on the status of the health workforce in Wales will be of great assistance to future planning and strategies. The voices and testimonies contained in this report highlight the importance of progress in this area.

Diaspora and Global Health

LMIC diaspora, and internationally trained staff, are present at all levels of the NHS in Wales and bring vast experience of the health system in their countries of origin. Thus, they have the potential to add value to Welsh global health objectives, expressed in several Government policies and strategies, alongside the push for Universal Health Coverage (UHC).

The Welsh Government's support for global health is directed through its Wales and Africa Programme. This programme supports people and organisations in Wales to act on poverty in Africa and focuses efforts on bilateral agreements with select countries (which currently include Lesotho, Namibia, Uganda and a partnership with Somaliland which is being explored). The programme includes the International Learning Opportunities (ILO) programme which support 8-week placements across four themes including health, and therefore open to health workers in Wales to apply. Health is also one of the four themes of the Wales and Africa grant scheme, which makes £240k available for small grants each year to Welsh organisations. The case studies in this report will highlight the importance of this scheme for small-scale global health initiatives, and it's significant that the funding of this scheme comes from the Welsh Government, and not from Official Development Assistance (ODA) funds NHS organisations in Wales, including the Health Boards, Trusts and Special Health Authorities, usually don't have specific policies around global health work, nor do they routinely provide support to diaspora or other health workers involved in them to undertake global health work. There are several institutional health partnerships that operate within NHS organisations, however, some of which have received direct funding support from the Welsh Government, such as the link between Betsi Cadwaladr Health Board and Kenya (profiled below).

In 2015, Wales became the first country in the world to establish the UN Sustainable Development Goals (SDGs) in national law by enacting the Wellbeing for Future Generations Act. [9] **Among the seven well-being goals of the Act was the commitment to ensure a 'Globally Responsible Wales'.**

Health Boards, alongside other Government bodies, are to report against their activity in relation to this goal.

The NHS Wales Charter for International Health Partnerships has been a key guiding document for global health vision of the NHS in Wales since its first publication in 2014.[10] It is notable that the charter specifically encourages Health Partnerships operating in Wales to reach out to diaspora organisations in recognition of their expertise and value to international health initiatives. It remains among the only Government documents within the UK to do so. It also contained certain enabling stipulations for global health work, such as the provision of special leave for health workers, and recognising international engagement as CPD. Most health organisations in Wales are signatories of the Charter.

The Wales and Africa Programme's current action plan (2020-2025) includes as a key action to 'Support the delivery of the commitments of the NHS Wales Charter for International Health Partnerships.'[11] In 2023, Public Health Wales updated their International Health Strategy which has been developed to align with the Charter and to contribute to its aims.[12]

It has been noted previously by THET that the Charter is often seen to be supported in theory, while at a practical level it does not enjoy prioritisation as 'core work' at the Board or Trust level, especially with the many competing demands on the NHS.[13] It has also been pointed out that the stipulations within the Charter, such as the granting of special leave, are not always adhered to by Boards, and that there is a lack of communication about the Charter amongst staff. It is hoped that renewed commitment by Public Health Wales and others will see re-engagement with the charter by employers across Wales.

Diaspora contribute to global health in various ways. These may be formalised, via diaspora organisations such as the Ghana Nurses Association UK in the field of raising diabetes awareness,[14] or within the structure of the global Health Partnerships affiliated with their Health Board or Trust. But contributions may also be informal. Many diaspora health workers contribute to the health system in their country of origin, or in other countries, through self-funded means or the giving of their time (often using annual leave) to advance the capacity development of health workers through training and mentorship, or even donation of medical equipment, consumables, or funds.

There are now over 85 Diaspora Health Organisations (DHOs) operating in the UK. These are organisations founded and run, typically, by diaspora health workers from a particular country of origin (though some operate on a multinational, regional, or identity group basis such as British Sikh Nurses).[15] Their key focus is usually the support of newly arrived and long-term health workers in the UK with practical and pastoral support, as well as advocacy on behalf of their members. Some of these organisations have also branched out into global health activity focused on the country of origin, funded either by membership fees, or in some cases grants. This usually takes the form of partnerships with organisations or health facilities in the country of origin. DHOs are typically operated by full-time health workers giving their free time, and without expertise in grant applications, or project management.

As this report shows, diaspora health worker contributions to global health are commonplace, while being thoughtful and impactful and are made more valuable by the presence of diaspora health workers themselves. Cultural competencies such as appropriate communication and expectation setting, knowledge of the workings of other health systems, or greater political awareness, are often cited as reasons that diaspora involvement leads to greater impact and sustainability in global health initiatives.

Section 2

Diaspora Health Workers in the UK - Contribution and Experience

Methodology

This report is the result of two phases of data collection. The first was an online Diaspora Health Worker Survey. The survey was designed to collect key information about respondents, including country of heritage, whether they have ongoing connections with their country of heritage and the nature of these connections.

THET partnered with several NHS Trusts in England, specifically engaging those with global health departments and existing Health Partnerships to disseminate the survey. THET also sent the survey to diaspora-led health organisations across England and undertook promotional activities. The programme expanded into Wales, with support from the Chief Nursing Office of Wales, backing Health Boards in Wales to champion this initiative. By October 2023, the survey had generated 685 responses, **41% of which were from health workers based in Wales.**

The second phase in data collection were focus group discussions and interviews with diaspora health workers (DHWs) in September and October 2023. The interviewees were selected from survey respondents drawing from sampled representation of key themes from the analysis of the survey data. The focus groups and interviews were conducted online in small groups, facilitated by a social research consultant. Key informant interviews were also undertaken by THET's Head of Research, Evidence and Learning. In total, 23 individuals were interviewed during September and October 2023. Quotes have been paraphrased slightly for readability. The data collection for this report is from England and Wales, the focus countries of the Experts in Our Midst Programme.

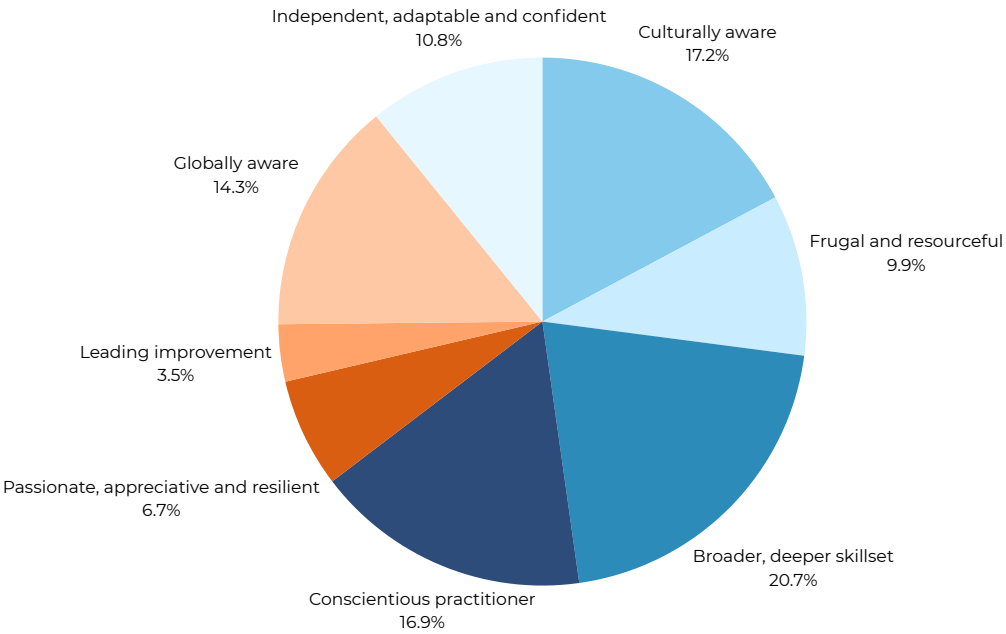
Limitations

A larger sample size for data collection would have been preferable. We had challenges in scheduling interviews with health workers, and in ensuring the survey was adequately engaged with across networks. Due to the nature of the networks used to promote the survey, the vast majority of respondents have been drawn from the NHS, rather than other components of the UK health system.

In September and October 2023, analysis was undertaken of responses to THET's Diaspora Health Worker Survey. Particular attention was paid to the following question: 'Please describe the effects (of your overseas training/experience) on your UK practice, with examples if necessary.' Of the 685 responses, 297 (43%) were able to be coded into distinct themes.

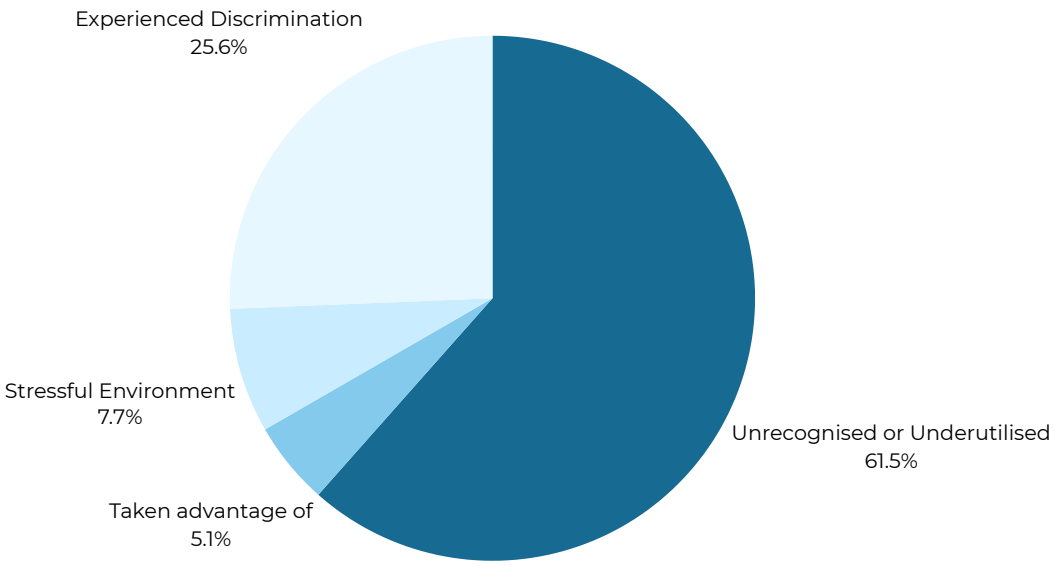
Overall, 74% of responses identified positive aspects of their practice within the NHS that they attributed to their overseas experience. These ranged from statements about resourcefulness gained from familiarity with more resource-constrained settings, to a greater appreciation for the NHS, to a greater awareness of the cultural needs of patients from minority communities.

The responses overwhelmingly highlighted the benefits of overseas training and practice. We found that we could divide the statements made into eight broad categories:



16.5% of respondents, however, felt that their overseas experience or training had disadvantaged them in some way in their work in the NHS. They focused mainly on aspects of practice in the NHS that the respondents were unfamiliar with on arrival, and which therefore hindered their ability to perform at full capacity until appropriate training or familiarisation had taken place. Interestingly, 23% of these respondents focused on unfamiliar cultural aspects of living in the UK, or of organisational culture, rather than clinical practice.

A further 9% of respondents used the question to share negative experiences of adjusting to working in the UK. A significant percentage given this was not the intent of the question. These responses fell into four broad themes:



When focusing only on respondents from Wales, which made up 41% of all respondents, the numbers were slightly different. Those focusing on positive attributes related to their overseas experience fell to 65%, those focusing on negative experience within the Welsh health service rose slightly to 10%, while those reporting unfamiliarity with aspects of work in Wales (and therefore were more negative on the value of their overseas experience) rose significantly to 25%. Of these, the vast majority were focused on unfamiliar clinical practices, which represented over 19% of the total respondents.

Below, the survey findings and identified themes are discussed alongside findings from the subsequent interviews and focus group discussions, and relevant quotes (paraphrased) are drawn from each to highlight themes and provide relevant detail. The percentages given take into account all respondents to the survey (from across England and Wales).

Map overview of survey respondents:

Europe

Bulgaria
Czech
Cyprus
Republic
Denmark
Finland
France
Germany
Greece
Hungary
Ireland
Italy
Malta
Norway
Poland
Portugal
Romania
Russia
Spain
Wales

Africa

Botswana
Cameroon
Egypt
Gambia
Ghana
Ivory Coast
Kenya
Libya
Malawi
Mauritius
Morocco
Mozambique
Namibia
Nigeria
Somalia
Somaliland
South Africa
Sudan
Tanzania
Uganda
Zambia
Zimbabwe

South America

Brazil
Colombia
Guyana

Oceania

Australia
New Zealand

Middle East

Palestine

North America

Barbados
Belize
Canada
Cuba
Jamaica
Trinidad and
Tobago
USA

Asia

Bangladesh
Hong Kong
India
Indonesia
Iran
Japan
Malaysia
Myanmar
Pakistan
Philippines
Qatar
Sri Lanka
Thailand
Tibet

Skills and Knowledge

21% of responses that discussed the benefits of international experience mentioned the possession of broader, deeper skillsets as an observed difference with UK trained colleagues.

This also emerged as a strong theme within the interviews. The combination of limited resources and 'generalist' curricula design for health training in LMICs leads to the development of multi-skilled and resourceful healthcare professionals.

Some comments focused on the experience of moving from one health system to another, and the effect it had on their clinical expertise, with one clinician referring to their experiences working in Philippines and the UK and learning from both, so they are more 'well-rounded' as a clinician.

Due to the scarcity of medical equipment and technology in LMICs, and facilities which are often understaffed or lacking specific capacities, expectations on health workers are broader in scope, and various forms of task-shifting are often required to fill gaps. For instance, one comment mentioned nursing training:

> *Nursing education in my country is really good as we cover all the sections of nursing, for example we (learn) medical, surgical nursing, pediatrics, psychiatric, community nursing, midwifery etc... and helps a lot to work confidently in any other country.*

More often, respondents focused on particular areas of clinical work, and commented on the way in which their training and experience elsewhere have given them greater insight and skill:

My exposure and experience acquired as regards to diagnosis and management of infectious diseases and (long-term care) were richer as I had the opportunity to see cases that I will never see in the UK.

Back in Nigeria, we had witnessed the menace of eclampsia so much that we were always very aggressive with (it's management). However, in my rotation through Obstetrics and Gynaecology in the UK, I discovered that many midwives and Obstetricians had actually managed very few women or none at all and so could hardly be as aggressive in the management when it was needed.

Experience of operating in low-resource environments enhances the resourcefulness of health workers, this is especially true of health workers whose origins lie in LMICs. 9.9% of positive responses (10.2% in Wales) mentioned the **frugal and resourceful** competencies of diaspora health workers (DHWs). Some answers to the survey question included better understanding and ability to work and cope in situations with shortages of medical workforce & essential investigative tools/equipment. Other respondents referred to better experience of working with limited resources and avoiding waste. As one respondent described it:

Being used to working hard, using limited resources and providing the best possible care. Also appreciating what we have here, and not being wasteful or taking anything for granted.

Attitude and Resilience

17% of responses portrayed DHWs as **conscientious practitioners**, bringing a more holistic and patient-focused mindset to their work, as well as high levels of professionalism, as a consequence of overseas training and experience.

Respondents referred to taking person-centred approaches accounting for people's needs, and being more organised and better able to undertake time management at the bedside, always making patient's safety the priority.

> *Work ethic is the most important for us as Filipino, we work with dedication and love towards our patient. We have studied all parts of nursing so we can work wherever area of specialty we are allocated and with proper training too.*

11% of responses (19% in Wales) mentioned that, as a result of their background, they were also more **independent and confident**, born of having operated independently and in situations that place greater emphasis on individual decision making. This included experiences of having to function in less-than-optimal circumstances, as well as having greater responsibilities, such as the following respondent:

> *I have worked in environments with more autonomy for the local teams to make treatment decisions and better communicate those decisions with the stakeholders.*

Resilience was a theme that was raised in many interviews. One example highlighted that DHWs, as well as other BAME workers often 'go the extra mile' in ways unique from their peers, despite incredibly challenging situations:

> *I remember working in forensic services, and people get, you know, assaulted and attacked and verbally racially abused, and they don't go home, or they don't go off sick. They will continue with their duties, despite the fact that, actually, they're well within their rights to do so. And I don't know what that is, whether that's a cultural thing. I'm not sure... but there's this need to just kind of stiff upper lip and put up. Shut up. Keep on going. And I feel like those are the things that keep the cogs of the NHS turning.*

(c) Dr Sidra Hasan

Cultural Competency

17% (12% in Wales) mentioned the value of **cultural awareness**. This involves understanding the needs of migrant/diaspora populations including cultural or ethnic differences in health seeking behaviour, and culturally acceptable treatment or service delivery to benefit health service delivery for better outcomes. The responses highlight how such insights can be useful for improving communication and dismantling barriers to accessing services and ensuring culturally appropriate treatment or delivery.

Many of the statements in the survey focused on the knowledge and insight gained on cultural differences, and how they can affect, for instance, health-seeking behaviour. As one respondent from the Middle East noted there may be differences in how some treatments are viewed, such as in relation to genetics, for people from his region. Another respondent from Pakistan highlighted the value of her understanding of socio-cultural differences, even contrasted to Pakistani doctors who have long been based in the UK.

During an interview, a crisis nurse demonstrated a shared view among the study's respondents that by identifying as BAME, a majority of DHWs were confident about being able to reach out to, understand and offer medical treatment even in cases where such would have been challenging:

> *Culturally, in lots of black and minority ethnic families, there's a stigma to mental health. There is also distrust for services... Being black, however, I think there is a way that my identity and personality work to help access and understand some of those barriers and some of that guardedness, where it comes from.*

Another respondent pointed out that there is no one size fits all approach and that all people are unique: ***"However, knowing how to deal with patients from different cultures effectively will definitely impact on their treatment positively."***

Many respondents highlighted engaging DHWs in health outreach is a practical and effective approach to reaching demographic groups that are often considered hard to access. Given persistent health inequalities and barriers to access this is an area where the NHS needs considerable support. Respondents from BAME backgrounds argued that these so-called "hard-to-reach" communities are their neighbours and community members whom they regularly interact with in places of worship, schools, or other social spaces:

> *I know people from my own community. I meet them in the mosque, I meet them in social gatherings, weddings and whatever other events that are happening locally. When they see me talking about something, they feel like they can trust it more compared to, you know, when it comes from someone they have only seen for ten minutes. My personal interest is women's health, contraception, and sexual health. I am trying to raise awareness of these issues here in the UK through patient education forums. Engaging through coffee mornings with women of my ethnic background and raising awareness about breast cancer and menopause has yielded some encouraging results. This is what I feel like doing for my own community here.*

Several respondents raised that their experience as diaspora helps them communicate with patients from different backgrounds.

> *I believe that having trained and worked elsewhere has made me aware of cultural healthcare differences and made me more understanding of patient's expectations. Some attitudes that helped to manage expectations are for example: to provide leaflets or written advice in the patient's primary language; to try to understand and explain the differences in the health system and how the patient will receive treatment here; to listen to patients and to provide extra time for them to answer in English; to repeat and make sure that the treatment plan is clear.*

Diaspora Experience in the UK

The survey and interview responses demonstrate that DHWs bring substantial value to the NHS through their experience and knowledge, but the data also has much to say about how DHWs view their experience of coming to the UK, and whether their experience of the NHS is positive or negative. The picture here is mixed, but key findings can be drawn, both in terms of challenges that DHWs have in adapting to the UK health system, barriers that they find in doing so, which can often be demotivating, and successes, or positive experiences which are motivating factors for DHWs and are often cited as reasons for appreciation for the NHS in particular.

Challenges and Barriers

Finding 1: DHWs can find adapting to clinical and organisational practice in the UK difficult

Several responses to the survey noted the differences between practice in the UK and their country of heritage, and often significant time needed until individuals feel they can contribute fully. One respondent raised the example of very different protocols between Ghana and UK and considerable efforts to switch.

A common theme was the inadequacy of induction programmes given on arrival, and how they can impact performance. One comment in the survey said:

> ***I find it harder to find the right channels to escalate things. Our induction at the hospital I worked at in my home country would include not just the divisional organisational chart, but other allied health staff. This is helpful in knowing how the whole system works and also helpful in getting in touch with the right people when highlighting concerns.***

Additionally, a few comments noted the strain that staff in general are under in the current environment within the NHS. Although these issues don't just affect DHWs, their experience of working in the NHS can be just as, if not more, affected than their UK colleagues. An example:

> ***Work in the UK is really exhausting. The place I worked before, you will not see people trying to run away from the work... There is something which is wrong in the system otherwise, why this many resignations and people leaving professions?***

Finding 2:

DHWs can struggle with the language and culture of the UK workplace in ways that constrain their full engagement and participation

Interview participants mentioned that despite having proficiency in English, they faced difficulties in being an active part of meetings and expressing their views in ways that were heard and acted on. Study participants reported having to repeat requests multiple times. Additionally, they lacked knowledge about how to present themselves effectively in writing, such as preparing CVs for job positions and articulating their experience during interview panels. Some respondents recall discovering how they were perceived as 'dangerous or threatening' by using hand gestures while speaking, using a loud voice, or avoiding eye contact, all of which were behaviours and norms in their home cultures. Others referred to needing to learn accents. One study participant's experience captures some of the cultural dilemmas as they relate to communication:

> ***A lot of the feedback that I got was 'it's the way in which you say something, it's the words that you use, it's your language.' I made an avid effort to learn to code-switch to be able to speak the language I felt would have me heard. But what I discovered is even with the right vocabulary, even with the right accent, there was still a barrier to my opinion being heard, and that had nothing to do with the words or the way in which I was saying the thing.***

The struggle to adapt culturally within the UK and alongside UK colleagues was occasionally mentioned in the responses to the survey. An example:

> ***I have (different) beliefs, culture and lifestyle compared to UK residents, I learned and practiced a lot to adjust and created better ambience to work in UK.***

Finding 3:

DHW experience and expertise is often unrecognised and/or underutilised, and many feel their suggestions are disregarded.

Linked to limited professional growth, DHWs often reported that they felt disregarded and undervalued, with their contributions to meetings and planning considered less relevant despite their extensive experience. For some respondents, there were narratives of 'experience swept under the rug' as staff failed to integrate and contribute or deliberately kept quiet to avoid 'trying to appear too smart.'

An interviewee mentioned:

> ***Although I have a Masters, (and) two degrees, and I can do something more, all that is disregarded. And I'm working with people with Ph.Ds. who are healthcare assistants... So, for me, that has been the biggest challenge in the twelve years in the NHS; being band seven when I am filling in for the doctor, and going back to band six as soon as I leave the room. And yet, if you look at the productivity, the outcome, the standards... and yet you're not really recognized. It is painful. It is very, very painful. So, I think the NHS should have a platform to empower us because if you look at what we have and then you ignore us, then it's your fault. Give us the resources to upgrade.***

Other study participants reported that they would avoid anything that would make them appear "to be smarter". This often had the result of stifling thinking or innovation which could result in service improvements.

Survey respondents commented quite often on being 'deskilled' as a result of a narrowing of their field of practice or being unable to utilise the range of skills they arrived with. As one respondent put it: ***"I lost most of my professional skills here in UK because back home when trained as a general nurse you do almost everything".***

Finding 4:

DHWs often feel they are less likely to progress within the NHS compared to their local counterparts in England and Wales

The interviews revealed mixed experiences with respect to support for the professional progression of DHWs. While in a majority of cases individuals felt trapped and dormant with no room for growth, some individuals, particularly those that had experienced some training in England and Wales, felt that they had supportive mentors. One of the most frustrating experiences for DHWs was reported as the inability to progress professionally within the NHS, especially after attaining Agenda for Change band seven. Thoughts on the reasons for this included disproportionately lower access to committed mentors for BAME staff, lower representation of BAME groups in the recruitment interview panels, insufficient information on the professional progression process, and deliberate exclusion from progression underpinned by racism.

DHWs reported lacking access to feedback on their performance in recruitment processes, including having difficulties in understanding the interview process, preparing for it, and impressing the panel. During the interviews, some DHWs expressed concerns about the panel's representativeness. Respondents also felt that to progress beyond the lower pay bands, they had to either switch to the private sector to gain senior-level experience and then return to the NHS as a band eight professional or move from the clinical field to other areas such as research or training.

> ***I look after a group of nurses from Africa, in particular, in my hospital. Crossing the divide from band 6 to 7 and 7 to 8, and then 8 to consultant nurse position, almost impossible... the only way they can get it is to move sideways either out of the organization they're in, even if they like it, to another organization do what they need to do for a while, and then come back into the post. But (that) is a lot of movement in order to try and get something, which naturally should come if you've got the right credentials.***

Finding 5:
DHWs can face racial discrimination and bullying in the NHS

Racial discrimination and bullying were themes that emerged from the survey, sometimes as explanations for challenges faced, and sometimes in terms of patients' treatment of staff. For instance, in relation to lack of progression, one respondent reported that they expected no chance of a promotion due to their skin colour. Another respondent spoke about experiencing bullying and insufficient support:

> ***I was bullied here in UK. I did not (receive) proper training. I (had to) learn on my own. (I am) planning to leave UK. Mental health is affected. Not all, but mostly they will tell they will help you and support you, but (it's) all only verbal. No actions at all. No equality. Sometimes we feel that we are slaves.***

Some interviewees reported instances of patients requesting to be treated by white staff members, while in other cases, patients' relatives preferred to speak to junior white staff members, such as healthcare assistants, rather than BAME doctors or senior nurses when discussing the condition of their loved ones. Others spoke about not receiving adequate protection from leadership when they felt they were harassed by patients or other staff, told their concerns were simply misunderstandings. It was noted that these types of misinterpretations are more likely to happen when healthcare workers lack confidence in their understanding of the local culture, which also hampers their ability to stand up for themselves.

One respondent reported victimisation by their manager: ***"If a patient missed their medication, she'd call me even if that wasn't my patient, on the assumption that I was the one who would have missed it. So, I got picked on quite a lot."*** The same respondent linked this with the fact that DHWs often have very strict immigration related employment options, meaning they often have to put up with difficult situations. Another respondent spoke of their experience in short-listing for a nursing role, reporting that their manager automatically excluded those with 'foreign names'.

Successes

The survey and the subsequent interviews also highlighted very positive experiences within the NHS, that respondents felt were key to successes in their journey.

Finding 1:
THE NHS provides opportunity for DHWs to grow professionally in numerous ways, and an often positive working environment

In contrast to some of those respondents who felt de-skilled or not adequately recognised, some survey respondents had a positive view on growth and the use of a broader skillset. For example, one reported that following policies and procedures as well as guidelines and evidence-based practice has enriched their nursing career, making them feel more competent in practice. A trained midwife spoke about their practice widening to include giving care in collaboration with medical practitioners looking after high-risk maternity cases, which wasn't the case in their home country. Another nurse reported that narrowing focus had brought challenges initially but then gains:

> ***(N)ursing fields of practice in the UK (are) very specific to adult, children, mental health and learning disability. It was a change that I had to gradually embrace as an adult registered nurse in this country because it limited my nursing practice to adults only. I further specialised in neurological disorders in adults, and it helped me understand each disorder deeper based on evidence-based practice. I was also surprised to find out that specialist nurses/ advanced nurse practitioners can do independent and supplementary prescribing which is an added skill that we don't have for nurses in the Philippines.***

Appreciation for the NHS as an organisation was also a strong theme within the survey, especially for those coming to the UK from countries without strong public health provision. Other reported that their trusts were employee friendly, or that people were helpful. Some respondents simply described their appreciation of the NHS:

> ***My experience of healthcare overseas has made me cherish the NHS, a service free to everyone regardless of socioeconomic background.***

Finding 2: The NHS provides great opportunities for world-class training

Having access to high-quality and world-recognised formal and in-service training was cited by most respondents as the main positive experience they have had in the NHS. Some respondents argued that locals are not fully aware and appreciative of the quality of the healthcare system in the UK, particularly when this is compared with their home countries. Notably, some DHWs are already sharing some of the systems, processes, and guidelines, where applicable, from the UK and promoting these in their countries of origin. Diaspora nurses, for example, appreciated the opportunity to train in the UK, something they would never have been able to afford. As one nurse put it:

> ***"I think for me the first positive experience is the ability or the opportunity to have training in whatever sector within the health (service). I think that's a positive, especially where learning or education is quite expensive for most of us who come from different countries of the world. I come from Uganda. So, the fact that I could train as a nurse in the UK, and not have to pay for it, that was positive. That's why I came to the university here, because at least I was able to pursue my career, at no cost to my parents. The other positive was to look at the different areas of nursing that you could take part in.***

Finding 3:
The experiences of DHWs are informing interventions aimed at improving onboarding and adaptation to the UK health sector for new diaspora entrants.

Diaspora health workers' reflections are being used to design interventions that aim to improve the well-being and retention of NHS staff. One of these interventions is the creation of associations organized by profession and country. Professional associations play a vital role in supporting their members by providing moral support, advocating on their behalf, and representing them in hearings and tribunals. This is particularly useful in situations where members feel that they might not receive a fair process. Nursing associations, for instance, have been seen to provide guidance and support to newly immigrated healthcare professionals. This support includes assisting them with tasks such as opening bank accounts, settling into their jobs, managing the work-family balance, and dealing with work-related problems. The nursing associations achieve this by providing advice, information, online training to support employability, and petty cash. Country health associations are registering formally, supporting other LMIC peers to set up their own, and building linkages to support their home countries of origin.

> ***We formed the Filipino Nurses Association, which is a diaspora group, and it's only when I joined the diaspora, and I'm a sitting officer that the contribution as a group had to me is so obvious... We are achieving more than we would individually. It's so hard, but together we encourage each other. Whenever one has an issue, we escalate the issue. Some of us even go now to the chief exec of the Trust and speak to them: do you know that there is a nurse who's being harassed or bullied in your trust? This is what's happening. Are you aware of that? So, we are raising awareness of racism or bullying, of harassment.***

Section 3

Diaspora Health Workers in Global Health: Value and Impact

Our interviews with Diaspora Health Workers (DHWs) shed light on individuals' experiences when participating in global health activities, as well as their views on the contribution they are making.

Our survey revealed DHW's experience made a significant impact on their worldview. This was expressed in many ways throughout the survey and ranged from appreciation for the NHS when compared with their country of heritage, to building motivation to contribute to the health system 'back home' or contribute to LMICs in general. 14% of respondents (9% in Wales) mentioned this in some way. This included appreciation of free at the point of care treatment, and sadness about a perceived lack of commitment to global health initiatives.

> *I have had more exposure to advanced ways of practice, I have acquired more knowledge and improved greatly on my skills as a healthcare professional. I have also come to realise how much opportunity I have to impact my colleagues back home with such knowledge through diaspora exchange programs and am passionate about investing the knowledge and skills back in my home country through the help of digital technology.*
>
> *(Overseas experience) enabled me to better understand the global health challenges and impacts on various global communities. It improved my practice and increased my awareness of various factors affecting health decisions and their impacts on different communities. It helped me adjust my teaching and coaching approaches to have higher impact on learner needs. It motivated me to advocate and lobby for change on challenges that affect the health and well-being outcomes of staff and communities. It improved my role modelling of inclusive, compassionate and equitable leadership skills.*

Many of these individuals, reflecting on their own experiences, form clear opinions about the disparity between health systems in different parts of the world, and clarity about where one health system can learn from another. In this sense, diaspora can be seen as the connection through which knowledge exchange between two systems can be filtered in a targeted and appropriate way.

They also show that personal experience in this regard can build strong personal motivation for contributing to, and even leading initiatives aimed at health systems strengthening. This sense of purpose and connection can lead to long-term sustainable and impactful interventions.

Finally, the survey highlighted the scale of activity that diaspora are already undertaking. Out of the total number of respondents, 35% indicated that this connection involved either detailed continued global health activity, or an indication that they had volunteered (or continued to volunteer) in their countries of heritage.

There are obvious caveats to any conclusions that can be drawn from this. Survey respondents are potentially skewed towards individuals motivated to report on their global health activity. However, it does show that within the diaspora population there is potentially a significant body of individuals who are motivated to involve themselves in international health system strengthening work.

The value that DHWs bring to global health activities, with their experience, knowledge, skills and motivation is considerable, and as discussed earlier in the report, apart from some initiatives in their early stages, there is little institutional recognition of this, or official engagement through Government or third sector actors. Our interviews with DHWs focused on the perceptions they had on the impact of work they have been involved in, and their value, as diaspora, within that work.

Local and International Knowledge

A key value of DHWs when it comes to global health or development work within LMICs, is their experience and knowledge of at least two health systems. This is especially true for those who were trained in LMICs, as they have first-hand knowledge of the challenges and opportunities faced. As a result, they can be valuable partners in developing and implementing effective health programs. Depending on their level of engagement with the country of heritage health system, a diaspora health professional may have clear knowledge of the needs of the health system and be able to draw from their experience in the UK health system (or vice versa).

> *Our ability to see beyond what's not working, into innovation, allows you to enter a sphere that says 'well, what are the possible solutions?' It puts your problem-solving hat on.*

Particularly, having experience of ways of working in the UK has informed approaches that are not common in their countries of heritage. According to one respondent, experience in the NHS has also been key to developing the confidence required to take on global health work and advocacy.

> *Sitting and talking to the patients and saying, "What do you want" is an unusual concept in Africa. I've always run patient focus groups (where I work). But I (started) patient focus groups in Ethiopia. I sat with the women outside and I said to them, "What do you need? What would make your life better?*
>
> *The entire experience in the NHS gives us, the diaspora, real confidence. An African woman for that matter, why would we be taken seriously? The confidence in manoeuvring that definitely comes from the NHS. As well as the activism, the right to defend and stand up for others, knowing that everyone has a right to health.*

A very common theme, however, was the way in which knowledge of both systems allows DHWs to effectively 'translate' expectations and assumptions between partners in global health initiatives, ensuring everyone involved is aligned. One respondent had, through her diaspora organisation, facilitated a UK partner charity to undertake Physiotherapy training in Zambia:

> *It's a struggle to navigate two health systems unless you have fully worked in both of them. You'll always need someone to help with that process... (DHWs) can understand how to translate the need a lot better and deliver services that are more impactful. It's a very important awareness to have.*
>
> *When we've had diaspora members go with (our partners), they don't have to start making those relationships and understanding systems from scratch. Our member could facilitate and arrange (the training sessions). The physios were very happy to have someone who has worked with them on this side, who was able to help interpret their training in a way that (helped) them to be most effective.*

CASE STUDY

Leveraging support for Zimbabwe's specialists – Dr Zedekiah Sibanda

Dr Zedekiah Sibanda is a Consultant Paediatrician based at the Royal Glamorgan Hospital (Cwm Taf Morgannwg University Health Board). Originally from Zimbabwe, Dr Sibanda undertook his medical training in Harare before pursuing post-graduate training in the UK. From 1996, he practiced as a consultant in Bulawayo for four years, but after returning to the UK in 2000, he has practiced in Wales for over 20 years.

> *As soon as I came back to the UK, I knew I wanted to continue to contribute in some way to Zimbabwe. Due to my work in Wales I can offer something that local specialists can't. I feel I add value.*

Dr Sibanda started travelling to Zimbabwe regularly, combining family visits with support to trainee Paediatricians in Harare and Bulawayo. Initially, these were supervision and mentorship visits, and over time he began teaching in sub-specialities such as Neurodisability. Dr Sibanda estimates that he would support 10 to 20 students every year.

Dr Sibanda cites wanting to 'give back,' as a key internal motivation for pursuing this work. Common to many diaspora is a sense of guilt for having joined the 'brain drain', while making rational personal decisions to emigrate. He estimates that of the professionals he helped to train over the years, a third of them have now left Zimbabwe, and Paediatrics is far from the worst affected profession.

At one time there were more Consultant Anaesthetists from Zimbabwe in Swansea than there were in Bulawayo, the second largest city in Zimbabwe.

Dr Sibanda joined a diaspora-led organisation called Zimbabwe Health Training Support (ZHTS), an umbrella organisation that supports numerous health system strengthening initiatives by providing an organisational framework. With this support, Dr Sibanda was successful in securing funding via the Wales and Africa grants scheme. In this way he has supported larger training sessions, for instance in the treatment of Epilepsy, supporting the input of Welsh colleagues, such as specialists in Paediatric Neurology and Physiotherapists.

The work I lead has greatly benefited from the funding, but it has never needed a lot of money. Leveraging volunteering is hugely valuable, as expertise is worth a lot more.

Facilitating Bi-Directional Opportunities

Most of the interviewees had facilitated bi-directional benefits through their global work, bringing benefit back to the UK via their Trusts or colleagues, as well to their countries of heritage.

Sometimes DHWs are in a good position to facilitate direct institutional linkages, of benefit to both sides. More commonly, projects that have been initiated by diaspora have been able to utilise other health workers from the UK, adding to their professional development:

> *(With international work) you get a broad and diverse experience within your skillset. When you're (working in a LMIC) you get challenged to think in different ways in order to have an impact. When you come back, I feel you're more capable of handling challenging situations.*
>
> *Experiencing a different environment has allowed you to grow in your profession. It helps both ways.*
>
> *We're currently working with the Ministry of Health (in Zambia) to facilitate an exchange programme so that we can offer that to learners from here and from there.*

Engaging Networks and Power Structures

Some of the interviews revealed instances of diaspora health workers engaging with key networks and governments at a strategic level to create a deep impact. This often involved influencing policies and decisions by key Government institutions. This was often the result of being able to tap into strong networks with professionals and organisations in their home countries, providing them with a vast network of support and resources. The case studies presented in this section all demonstrate this.

CASE STUDY

Building expertise and contributing globally - Amanda Daniel

Amanda Daniel has been the Lead Nurse Specialist for IPC Primary and Community Care at Public Health Wales since 2020. Her interest and expertise in IPC evolved over a career that has been enriched by international experience.

While initially training and working as a cardiac nurse, Amanda pursued an opportunity to take a 6-month placement in India in 2005 after completing a Diploma in Tropical Nursing, working for an organisation called Calcutta Rescue. There, she was able to bring her cardiac nursing background to bear on the rising tide of non-communicable diseases (NCDs).

While working as the Lead Clinical Nurse Specialist at the Hospital for Tropical Diseases in London, Amanda continued seeking opportunities to apply her expertise overseas, and to learn from overseas colleagues.

Through a travel scholarship she spent time in Bangladesh working with people with Leprosy and on other neglected tropical diseases (NTDs), and in Cambodia with Volunteer Service Overseas (VSO) working with the Ministry of Health on reducing hospital acquired and surgical site infections. She has also spent time in Ethiopia and Sierra Leone as an IPC advisor during the Ebola Virus Disease outbreak.

Amanda has also taken the opportunity afforded by the Wales and Africa Programme's International Learning Opportunities (ILO) scheme. Amanda worked closely with Teams4U, applying Anti-Microbial Stewardship (AMS) programming to health centres in East Uganda, co- developing a point prevalence survey, and researching antibiotic prescribing practices.

Amanda's journey started with the stories her parents told her about Kolkata. They had migrated to the UK in the 1960's before Amanda was born, but they ensured she had a good understanding of Bengalese culture. From their own experiences of health in India they would also talk about issues like tuberculosis and leprosy. Amanda grew up feeling a sense of responsibility towards India, and carried that into her career, sparking all the learning and professional development that her overseas work has given her. Amanda's story shows the value that even second-generation diaspora bring, with their often deep connections to their countries of heritage.

They had migrated to the UK in the 1960's before Amanda was born, but they ensured she had a good understanding of Bengalese culture. From their own experiences of health in India they would also talk about issues like tuberculosis and leprosy. Amanda grew up feeling a sense of responsibility towards India, and carried that into her career, sparking all the learning and professional development that her overseas work has given her. Amanda's story shows the value that even second-generation diaspora bring, with their often deep connections to their countries of heritage.

> *"Working in partnership with colleagues overseas has given me so much insight into outbreak management and the importance of strengthening capacity in IPC, embracing these opportunities have taken my career in interesting and unexpected directions. The benefits have been wide ranging; enhancing cultural intelligence, building mutual respect with co-workers, and developing my leadership capabilities. Sometimes these are called 'soft skills' but they're no less important than clinical knowledge, and they've allowed me to make impactful contributions, both overseas and in Wales."*

Motivation and Attitude

DHWs often have deep motivations for engaging in global health work. This is often the result of a clear understanding of global health inequalities, combined with personal experiences. One respondent talked about their personal experience of the HIV epidemic in Africa, and how moving to the UK led to:

> *Waking up to inequalities to healthcare. There are people dying in Sub-Saharan Africa while people are surviving in the West because they have access to drugs... Why is it so unequal, and what should my reaction be?*

One respondent spoke very clearly about the difference in motivation between DHWs and others who take on global health work, pointing out that there are often clear personal reasons for DHWs to undertake this kind of work, and that it can lead to a difference in attitude towards the work itself:

> *(DHWs are) Interested in improving care (in LMICs) because these are their relatives. (This is opposed to) someone who is going there on a project mission or research mission who does not have any link... Yes, I'm going to be inconvenienced. But I'll travel on that bus for ten hours and reach that unreachable hospital in order to deliver a project.*

Others spoke about gratitude for their countries of heritage, especially if they had trained there. The following case study highlights this point:

CASE STUDY

Supporting Medical Specialisation in Bangladesh – Dr Mesbah Rahman

Dr Mesbah Rahman is a Gastroenterologist practicing in Swansea. Born and trained in Bangladesh, Mesbah came to the UK in 1990 and has since worked in both England and Wales.

> *I have never forgotten what my birthplace did for me by giving me the opportunity to become a doctor. So, since 2012, I have been going to Bangladesh every year, with a mission to help my colleagues in the field of gastroenterology to run clinical hands-on courses for training in endoscopy. We have been lucky that the Bangladesh Gastroenterology Society has been on board. In addition, we have support from the British Society of Gastroenterology, Swansea Bay University Health Board, and Swansea University Medical School.*

Dr Mesbah Rahman has played a pivotal role in reshaping medical education and specialisation in Bangladesh. Through his annual missions, he has facilitated a dynamic exchange of knowledge, benefitting both the medical community in Bangladesh and the UK. Through the partnership, students from Bangladesh have had a chance to come to the UK and train in Swansea and Birmingham, and UK colleagues have been given the opportunity to contribute to strengthening education in Bangladesh

Mesbah and his team developed the first endoscopy nurse training course in 2013 and since then, have regularly conducted training sessions for nurses in addition to he training of endoscopist and specialist gastroenterology doctors. Beyond clinical training, they have also delivered education in research

methodologies and have undertaken studies focusing on healthcare staff well-being and burnout.

Mesbah's collaborative approach has led to the enhancement of the academic curriculum for postgraduate students in gastroenterology. The efforts have been particularly impactful in standardising training and education through the Bangladesh College of Physicians and Surgeons.

In addition to postgraduate advancements, Mesbah's contributions extend to modernising the training curriculum for future physicians in Bangladesh. The partnership between Dhaka Medical College and Swansea University Medical School culminated in a significant memorandum of understanding (MOU) signed by the Dean of Swansea University in 2019, solidifying the commitment to medical education, training, and research. During a visit in 2020 by Mesbah and his team, the MOU was signed by the British Society of Gastroenterologists and the Bangladesh Gastroenterology Society in the presence of the Health Minister of Bangladesh.

Recently, agreement has been reached to facilitate knowledge exchange between radiologists in Wales and their counterparts in Bangladesh. This initiative aims to impart advanced interventional training techniques with the overarching goal of enhancing the quality of radiological services in Bangladesh.

Mesbah astutely acknowledges that this collaborative endeavour transcends the interests of both Wales and Bangladesh, emphasising its bi-directional nature. "It is a two-way process" he notes, placing particular emphasis on the invaluable lessons gained in navigating resource-constrained environments; a critical asset benefitting UK colleagues during the Covid-19 pandemic.

In recognition of Mesbah's work he has been awarded the prestigious British Society of Gastroenterology President's Medal in 2020. In 2022, he also received the Welsh Association of Gastroenterology & Endoscopy (WAGE) President's Medal and has Honorary Visiting Professorship in Gastroenterology at both Dhaka Medical College and Sheikh Russell National Gastroliver Institute & Hospital.

Cultural Effectiveness

The cultural understanding that DHWs can bring to global health initiatives plays a big role in the effectiveness of such work. This can be as simple as understanding the importance of and best approach to communication, how cultural norms can influence outcomes when working with local partners, this can be as simple as correct forms of greetings, understanding processes.

> *Perhaps because I had come from there to here, and then went back, I knew how important the dialogue, the two-way street communication, was. So, part of the reason of the success of some of the work we did was because that's how we started. We went to the place and sat with them and said "Right, what do you want, and how can we achieve it?*

Beyond that, it was also expressed that listening to partners may not be sufficient, rather getting a more complete picture of setting and of needs. Understanding this is crucial to designing a good intervention.

> *It's all very well and good (for health sector leadership or partners) to say we think you should do this or that. But one of the things I always used to insist was to go on site (i.e. to the facility) and look at the environment where potentially a program was going to work. And when you walk into a ward which is full of rusted beds and an operating theatre where the operating table is propped up partially by a stone, you know you cannot start. So, the most important thing is (at that stage), you need infrastructure funding. The scene needs to improve before you can come in and say, I'm going to make this happen, and I think that was critical. Understand your setting.*

Finally, understanding and taking into account cultural or traditional institutions is another area where diaspora have an advantage. As one respondent pointed out:

> *You could have a £1m grant, but if you're not in tune with the chief, and structures on the ground, nothing will happen. (Diaspora possess) a closer lens on the ground. What is effective, what is needed? … You're able to get on with the work, you know what works. You're not throwing a thousand emails around, like we do in the West.*

[BSG team with Trainees following completion of Hands-on endoscopy course (c) Dr Mesbah Rahman]

CASE STUDY

Diaspora Led Success – The Betsi-Kenya Health Link

The Betsi Kenya Health Link, a working partnership between Betsi Cadwalladr University Health Board (BCUHB) and Busia County in Western Kenya, was established in 2018 by Janerose Buyiekha, a member of the Corporate Team at BCUHB.

> *"My inspiration to establish the link came from working with BCUHB's International Health Group, and seeing the potential of linking the Board with Busia County, where I originally come from. Within BCUHB I was able to find colleagues and other volunteers committed to sharing skills, expertise and experience. Our long-term goal is to establish a sustainable partnership to tackle health inequalities at home and abroad." – Janerose Buyiekha*

The Link has expanded to include Dr Fiona Rae (Wrexham Maelor Hospital) as clinical lead, Dr Michael Greenslade (Eirias High School), and Bernard Okeah (Lecturer at Bangor University, also originally from Busia County). Participation in THET's Health Partnership Capacity Development Programme (HPCD), which facilitates networking and provides support to new partnerships, has been useful in the Link's development.

In early 2019, the Link undertook a fact-finding visit to Busia County referral hospital, and a Health Needs Assessment for Busia County, partly undertaken remotely due to the COVID pandemic. Identifying low adherence to

protective behaviours after sustained community COVID transmission, and with funding from the Welsh Government's Wales and Africa Grant Scheme, the Link developed a 'Community Events-Based Surveillance' system, delivering training to 68 Community Health Volunteers (CHVs) to provide online alerts of high-risk events directly to the District Public Health team.

The Link's intervention has proved impactful. The CHVs, who have cascaded the training received from the Link, reached over 2,500 community members, and completed nearly 900 risk assessments. They provided data on key non-COVID public health threats and detected a possible case of polio. This drew the interest of a University in the USA who have scaled-up the project across Kenya with their own funding.

A strength of the Link has been Janerose and Bernard's local knowledge of Busia County: their understanding of local contexts and ability to communicate effectively with staff and patients. In a region where many different languages are spoken, this has been invaluable. The impact that has been achieved is a testament to the potential of linking health workers internationally to improve health systems, and the value of placing the expertise of diaspora at the heart of that effort.

> *We are very grateful to Betsi Cadwaladr University Health Board and the Welsh Government for their support and for funding the Covid-19 Community Event Based Surveillance Project. It is our desire that this partnership will grow and develop further as we continue to learn, share knowledge and skills, good practice and experience.* – Link Partners, Kenya.

Challenges

Funding

Most diaspora who undertake global health initiatives do so as part of the small-scale work of diaspora organisations, within Health Partnerships, or within solo or small-group independent projects. There was widespread agreement that funding is a key challenge for such initiatives, particularly in early stages. Most of the respondents were involved in projects that were either totally or in-part self-funded, using their own money to travel and meet local expenses. Generally, they found support from their Trust or Health Board, or the NHS lacking. A number of respondents in Wales had received funding through the Wales and Africa grant scheme, and some appreciation was expressed to organisation that have made grants available small scale and diaspora led initiatives, such as THET and the Florence Nightingale Foundation. Some expressed frustration at their ability to compete for funds against other actors in the global health space:

> *As diaspora, we are maybe not reaching out to tap in to (available) grants.... Whereas our counterparts are quick, they're tapping into these grants, and (therefore) heading the projects.*

This has direct implications on the ability of diaspora to take their initiatives to scale, which can lead to frustration on a personal and professional level:

> *I think one of the problems that I found was, I started off (as a small project with local impact) at the beginning. I worked predominantly with the Fistula Hospital in Ethiopia. I was always there every year working with them. The impact in a certain environment can be quite huge. So, you can come in and you can change the way things happen. But what I was looking for was a much more global reach, and I felt that it was my duty as a clinician that I had to extend the scope to (for instance) surgical development and safe surgery.*

Administrative Burden

Another challenge was the ability of small-scale organisations to take on the various administrative tasks that successful proposal design and grant management requires. One respondent reflected on the requirements that most grants demand, and the often-opaque language used in the global health field:

> *As a practitioner in a medical field, you're not as well trained in (Monitoring and Evaluation) for instance, or report writing. You know, you need to teach people how to do M&E.*

Another, speaking on the experience of running a diaspora organisation that both supports incoming health workers in the UK as well as undertakes global health work, reflected on what would be helpful:

> *(We would benefit from) technical support to diaspora groups. We don't have experts outside nursing, so we're teaching ourselves how to run the association itself, we're not HR trained. If the NHS (for instance) were to say: 'We'll give you one day a month to feed into your diaspora group', and offer a training package, it would help a lot. As we're exploring a reciprocal learning project, if there was an offer to get into an agreement for (hosting) students on learning placements, it would also be beneficial. Having capacity to be able to move (quickly enough) so that you can get registration, sponsors for your projects etc.*

Time

All respondents stated that one of the main things they lack is time. Full-time health workers rely on annual leave to undertake global health work, whether they are undertaking that work themselves, as part of an organisation, or as part of an institutional Health Partnership. This hugely limits capacity.

The people (diaspora) are willing, but everyone has a full-time job. And so, you use your own resource to get yourself over there... Members (of the diaspora organisation) will donate their annual leave to go and support the project. (Generally), they're internally motivated to do that so they will go the extra mile even if they have to put their personal time to do that.

Time is a critical thing. A lot of people have to do this work in their own time (i.e. when on holiday). You can take a bit of study of professional leave, but it's not much. So if they said, okay, if your project is good enough. It's well researched, and you have a (clear workplan), we will give you 3 months paid leave to go off and do this project, but we'd like to see the following outcomes: A, B, C, D.

Recognition in England and Wales

Linked to all the above challenges, is the fact that the global health work described is not usually recognised within the institutions that DHWs work, even if there are clear bi-directional benefits that could be extracted. As the quote above shows, there was a general feeling that this should be taken into account by employers due to the benefits it brings for those who are involved, but, as many pointed out, this isn't often the case. Some respondents mentioned that they were not mandated to facilitate learning back in the UK, by, for instance, feeding back the experience and impacts of the work to their Trusts, while others mentioned recognition of their global health work was absent from HR processes:

The work I do in Zimbabwe doesn't come into my NHS appraisal. I take two weeks' off and far as the NHS is concerned, I'm on leave. (They) don't say I'm doing some high-level networking that might actually benefit us, so where is that valued most?

Similarly for the work that diaspora organisations do both in the UK and externally:

> *They don't fully recognize the value of the work that diaspora organisations do, either internationally or for new staff in the UK. Trusts don't usually know that diaspora organisations exist.*

Section 4

Discussion and Recommendations

The quotes and case studies in this report highlight the sizeable contribution that DHWs are making to the UK's health system, including in Wales, and to the way in which Wales engages globally. The challenges and barriers that DHWs face in doing this are significant, but joined-up thinking across sectors, and with a focus on recognising the expertise and experience of DHWs, could bring many strong and positive effects. This includes on the wellbeing and retention of DHWs, health service delivery in Wales and abroad, and the strengthening of global engagement.

The negative experiences within the NHS put forward in our research suggest more needs to be done to ensure that newly arrived health workers feel supported in starting their roles, and their life in Wales. It also highlights the importance of their skills, experience and qualifications being acknowledged in an efficient manner, ensuring that they can contribute to the best of their abilities, and be appropriately recognised for that including elevation to appropriate pay bands, faster.

THET's 2021 report put forward a range of recommendations for the UK Government, the NHS, THET and others aimed at improving the enabling environment for diaspora within Health Partnerships and global health in general. These recommendations are still relevant. In brief:

- **THET to develop a diversity network drawing from Health Partnerships, NHS and other diversity champions engaging with NHS BAME Staff Networks.**
- **THET to encourage capacity development of Health Partnerships to support grant applications.**
- **Health Partnerships to develop plans that engage the UK diaspora in their work.**
- **Greater coordination of LMIC governments engaging with their own diaspora.**

Considerable progress has been made in implementing some of these recommendations over the past two years by THET and some recommendation that were targeted primarily at NHS England have been progressed, with a range of funds being made available to DHWs.

Similarly, in 2021 we published a paper on maximising the benefit of Welsh engagement in global health through Health Partnerships, which made a series of recommendations for improving the enabling environment in Wales for Health Partnerships.[16] Many of these recommendations are directly relevant to supporting and improving the environment for DHWs in Wales who undertake international work:

- **Review and reinvest in coordination of international health work. A more direct link could be made between international work and benefits to individuals and the Welsh health system with more coordination, and more supporting for NHS organisations to fully implement the Charter for International Health Partnerships.**
- **Embed international work into the core business of the NHS using the Well-being of Future Generations Act.**
- **Fully implement the Charter for International Health Partnerships. Clear leadership at the Board level to allow oversight of the implementation of the Charter' stipulations, including the utilisation of diaspora expertise, and clear communication with staff.**
- **Providing more overseas learning opportunities for staff, e.g. through developing the global engagement of Health Education and Improvement Wales (HEIW).**

The survey and interviews for this current report, have highlighted the importance of these previous recommendations, and for that reason, it's worth re-stating and building on these. So many of the challenges faced by diaspora, both in health service delivery in Wales and in global health work, are related to the lack of recognition of their expertise in both arenas. To improve recognition and empowerment of diaspora health workers, we focus on several key areas that we believe are mutually re-enforcing. Here, we present a vision for a more globally engaged and reflective health service for Wales:

Harnessing the Benefits of Diaspora Recognition and Empowerment

In both the Welsh health system and in global health, recognition of the expertise of diaspora health workers, and the harnessing of their skills and knowledge, should be improved with the ultimate aim of strengthening health systems in Wales and abroad. The benefits of doing so are significant and are discussed below alongside suggestions for improvement in current policy and practice.

Strengthened Health Systems

The challenges that DHWs face in contributing fully to the strengthening of health systems at home and abroad are self-defeating for Wales, and for the rest of the UK. This could be by their expertise not being recognised at the right level within the health sector, or lack of support for well-targeted, networked, and impactful diaspora-led global health initiatives.

Here again, DHOs need to be commended for advocating for their members and supporting them to realise their full professional potential by signposting opportunities within the health sector and assisting members to prepare applications. The Anti-Racist Wales Action Plan has a role to play here, especially if it succeeds in realising a higher percentage of BAME staff (and by extension DHWs) being represented in higher bands and leadership positions within the NHS, supported by the CNO's professional equity priorities and targets.

In global health, breaking down the barriers and challenges that DHWs face in both joining or initiating global health project work, or in taking that work to scale, will be crucial in ensuring that it benefits from their expertise. This means ensuring that existing initiatives are adequately supported while new opportunities for diaspora engagement are developed.

Increase Funding Opportunities

Funding emerged frequently in our discussions as a key barrier to small-scale, solo, partnership-based and DHO-led global health initiatives. On this point, the Welsh Government's role in increasing opportunities for small-scale initiatives through the Wales and Africa programme must be commended, especially for maintaining its support during a time in which the UK's aid budget has been drastically reduced. The case studies in this report demonstrate the importance of this funding for Africa-focused diaspora health initiatives.

Diaspora engagement and leadership could be further encouraged by creating diaspora-specific opportunities through the Wales and Africa grants, or ILO opportunities. The consideration of supporting initiatives in other countries through the ILO that align with larger diaspora populations in Wales (for instance the new Somaliland initiative), or where there is particular interest within the diaspora community could be explored.

THET has and will continue to call on the UK Government to re-commit to the ring-fencing of 0.7% of Gross National Income (GNI) for ODA, a move that would, alongside the development of a clear strategy for diaspora engagement through FCDO, allow the creation of many more opportunities to support the well targeted, sustainable and impactful international work of diaspora individuals and organisations.

Support Capacity of Existing Initiatives

In 2021, THET committed to encouraging the capacity development of Health Partnerships to support the development of successful grant applications. In response, we implemented the Health Partnership Capacity Development Programme with support from FCDO, which ran from 2021-2022, supporting 21 small scale health partnerships, including in Wales, to build their technical and programmatic capabilities.

Given the challenges that one-person led, small-scale and other types of diaspora global health activity face in applying for funding, and undertaking project management and monitoring and evaluation; it makes sense for more capacity development support to be available in this regard, and THET will continue to seek ways to improve this picture. The work of non-Government actors in this space such as Hub Cymru Africa,[17] and member organisations such as the Wales and Africa Health Links Network (WaAHLN)[18] and the Sub-Sahara Advisory Panel (SSAP)[19] are invaluable.

DHOs are also valuable sources of expertise and providers of long-term institutional support to global health initiatives, particularly as many have a large membership to draw from. Their global health expertise and potential should be recognised, not only their support to the health system in Wales. As one interviewee said:

> *There's so many organisations out there. Doctors or Nursing organisations that do stuff in their countries of origin that we know about. You've got BAPIO (British Association of Physicians of Indian Origin), you've got BIMA (British Islamic Medical Association), you've got MANSAG (Medical Association of Nigerians Across Great Britain). I could go on for every single country. If I know who they are, why would the NHS (or Government) not*

know who they are? So, you know who they are, and each and every one of those organisations is doing something back in their countries of origin. Just start having organic conversations. What is it that you're doing? How are you doing that? Is there any way that we could potentially help and support you?

Previously, we had recommended that larger grants be made available through the Wales and Africa programme to support the scale up of more impactful initiatives over a longer timescale. This may have the added benefit of providing DHOs or other initiatives with longer-term support to develop their capacity and capabilities both in programme management, and in seeking further funding opportunities.

Benefits to Wales's Profile

Increasing Wales's dependence on health worker recruitment from LMICs is causing very real effects on the health systems in those countries. It is imperative that Wales finds a way of substantially contributing to the strengthening of LMIC health systems that adequately 'pays back'. As part of this, it makes sense to ensure that we are providing opportunity to those individuals with the internal motivation, knowledge, and expertise to substantially make a difference. Acting on the unique position diaspora have in terms of forging links between health systems by increasing their involvement, will not only improve the substance of that work, but also how it is perceived. This will become only more important as the assumptions behind 'aid' are questioned, and calls grow to decolonise the sector.

This complements the aims of the Anti-Racist Wales Action Plan, as it represents a key aspect of an anti-racist approach to global health, free from the perceptions that knowledge or skills transfer from the global north to the global south can have. Instead, diaspora would be at the heart of connections between health systems, identifying the bi-directional benefits of those connections.

It also connects to the vision of the Wellbeing of Future Generations Act and presents a way forward for health organisations such as Health Boards to understand, progress, and distinguish themselves against the Globally Responsible Wales goal through forging sustainable connections with other health systems in advancing the Sustainable Development Goals (SDGs).

Motivation, Wellbeing and Retention

In the case of ITHWs, it was pointed out that the UK (including Wales) is seen as a good place to undertake training that was well recognised in other high-income countries (HICs), but that after training there wasn't significant incentive to stay within the NHS, given problems with high workloads, remuneration, and other challenges listed in this report. There was a sense that the UK risks becoming a transit post for DHWs seeking to move to more permanent positions in other HICs.

> *(The NHS might be) singing and dancing about (their) 100% fill rate of 4,000 trainees this year. I'm telling you now, 2,000 of those are going to disappear and go to Canada, Australia, New Zealand, or elsewhere. So you know, there's no point filling your bucket that's got a big hole at the bottom of it.*

A consistent theme within the survey and interviews was that of ITHWs feeling unsupported upon arrival and receiving inadequate induction. As the report has shown, this is related to unfamiliarity with clinical procedure, as well as the cultural and practical considerations of moving to and fitting in to a new country. In the NHS in England, the newly published Equality, Diversity and Inclusion Improvement plan has a specific aim to ensure improvement in this area, and it would be useful in Wales to have the same high-level directive. Health Boards themselves, while pursuing their own Anti-Racist Wales Action Plans or Strategic Equality Plans often make progress on this issue individually, for instance a very comprehensive 'International Colleagues Support Pack' has been produced by BCUHB which covers a large range of practical and cultural advice (not yet available online). This is especially important considering the responses to the survey, discussed above, which show a higher percentage of respondents in Wales reporting unfamiliarity with clinical and cultural aspects of work.

Similarly, we commend efforts by some NHS organisations to platform their diaspora staff, through recognized days/events for international or BAME staff. THET has been involved in some of these initiatives, working alongside BAME

networks to platform and celebrate the expertise of ITHWs in locations like Swansea Bay University Health Board, and Aneurin Bevan University Health Board. These help to build visibility and a sense of belonging. A national diaspora health workforce day would encourage more Trusts and organisations to do the same.

THET has previously highlighted the connection between global health engagement and health worker wellbeing through a public inquiry we ran in 2021, chaired by Sir David Nicholson.[20] This demonstrated a strong motivation to undertake global health work amongst DHWs. Opening pathways to allow a greater level of engagement in global health would therefore powerfully complement other efforts to promote the support and wellbeing, and ultimately greater retention of staff.

Employers in the UK health system have started taking a more supportive approach (as an example, see the profile on Nottingham University Hospitals NHS Trust below). In several examples, allocating dedicated budget to resource global engagement work. We encourage employers to consider the professional development and bi-directional benefits, and significant wellbeing and retention benefits of global health work and adopt flexible supportive policies for staff members undertaking such work. Linking global health work to professional development plans more explicitly is a potential way to approach this.

Bi-Directional Benefits

The case studies in this report highlight the extent of bi-directional benefits of diaspora-led global health initiatives. The opportunities that these initiatives have opened for the professional and personal development of the individuals involved, in terms of clinical skills and knowledge, leadership, and resilience and wellbeing, are also of enormous potential benefit to NHS organisations and the Welsh health service in general. Further, many Health Boards and Trusts have found additional benefits, such as research linkages, exchange programmes, and bi-directional practice-based and technological innovations.

The link between global health work, and even the expertise of DHWs, and innovations derived from LMIC health systems that could benefit the UK health system, was explored in 2019 with THET's Innovation Roundtable,[21] and a series of recommendations made about how to identify and create an enabling environment for the adoption of such innovations.

Employers in the Welsh health system, including NHS Health Boards, should be encouraged to assess the global health engagement of their diaspora and internationally trained staff, and explore opportunities for bi-directional benefits. The Charter for International Health Partnerships in Wales provided some direction on this, highlighting the importance of reciprocal working, and as part of that utilising the expertise of diaspora organisations to deepen insights and improve programme quality.

CASE STUDY

Supporting and Learning from Diaspora: Nottingham University Hospitals NHS Trust and Swansea Bay University Health Board

While maintaining a long and mutually beneficial partnership with Jimma University Hospital in Western Ethiopia, Nottingham University Hospitals NHS Trust in England decided in 2021 to expand their international project and partnership work, and to be led by diaspora staff as to the location and nature of that work. As a result of this process, new projects are being developed in Ghana and Barbados. Recognising the value they bring to such work, diaspora staff are actively encouraged to engage with international projects and partnerships, which are related to population health, and on targeting inequalities in healthcare; something that staff from within the Trust can both contribute to and learn from international partners.

Beyond that, the Trust are also actively supporting already existing, informal, diaspora led international work by granting people who undertake it leave equivalent to the annual leave that they invest in the project. In return, the individual ensures to report on their work on their return, so that the Trust can benefit from their experience. They are also starting a 'Global Health Lounge' initiative, providing internationally trained staff with a chance to disseminate knowledge and expertise about global health trends and practices, discuss research and innovation, and receive pastoral support, helping them to integrate into work in the Trust and life in the UK. This approach simultaneously recognises the expertise of ITHWs, and the support they require to thrive in their roles.

The Trust are backing these approaches through the creation of a full-time Head of Global Health Partnerships, who oversees and promotes a) the expertise that diaspora staff bring, and the value they add to the Trust's work and its global health activities; b) the connection between recognition of and opportunities for diaspora staff, their professional development, wellbeing,

and potentially, greater retention within the Trust; and c) the benefits to the Trust of strong bi-directional partnerships with overseas partners, and the opportunities through this for staff development, education and learning, and research and innovation.

In Wales, Health Boards are also keen to support diaspora led international work. There are differences such as the large size of the organisations, and dispersed workforce, compared to typical NHS Trusts in England. Even so, a lot of mutually beneficial partnership activity takes place within the NHS in Wales, and many Health Boards are travelling in a similar direction of connecting Diaspora expertise with the benefits of international partnerships.

At Swansea Bay University Health Board there is a building desire to platform and learn more from their diaspora workforce. In November 2023 the Board held a diaspora celebration event hosted by Gareth Howells, Executive Director of Nursing on behalf of the Chief Executive (Dr Richard Evans), hearing from individuals involved in a wide variety of initiatives including research and academic connections, and the value of diaspora perspectives initiatives like the mental health response for Ukrainian refugees in Wales.

The Board understands the importance of this recognition, and of ensuring people have the ability to utilise and demonstrate their expertise. They are especially cognisant of the effects this has on the wellbeing and retention of their diaspora workforce. While acknowledging that funding is a limiting factor, the Board is currently exploring a framework of support for this work, following up on the November event. This could take the form of a certain number of sabbaticals each year to allow staff to pursue international work, while ensuring it is visible and celebrated, and crucially, that support is offered on an equitable basis not just to medical staff, but also to nurses and allied health professionals.

> *"As part of our drive to become a High-Quality Organisation, we recognise that international staff have brought so much care and skills to our health board over many years, but they also bring a lot in terms of culture. They really complement the excellent staff we have here.*
>
> *Our recent event allowed us to have an open discussion about how the health board can strengthen and build on the connections our staff have".*
>
> – Richard Evans, Chief Executive, Swansea Bay University Health Board

References

[1] Baker, C, NHS Staff from overseas: statistics (Briefing Paper No CBP 7783, House of Commons Library, 20th November 2023) <https://researchbriefings.files.parliament.uk/documents/CBP-7783/CBP-7783.pdf>

[2] StatsWales (2023), Percent of NHS staff by organisations staff group and nationality, <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/staff-characteristics/percentofnhsstaff-by-organisation-staffgroup-nationality> Accessed 7th Dec 2023.

[3] Nursing and Midwifery Council (2023), The NMC Register Wales Annual Data Report, <NHS England (2021), Medical Workforce race equality standard 2020 data report, <https://www.england.nhs.uk/publication/medical-workforce-race-equality-standard-2020-data-report/>> pg 7.

[4] Llywodraeth Cymru Welsh Government (2022), Anti-racist Wales Action Plan: <https://www.gov.wales/anti-racist-wales-action-plan-contents> Accessed 7th Dec 2023.

[5] Betsi Cadwaladr University Health Board, Anti-Racist Action Plan, , https://bcuhb.nhs.wales/use-of-site/publication-scheme/class-five-our-policies-and-procedures/equality-and-human-rights/anti-racist-action-plan> Accessed 7th Dec 2023.

[6] NHS England (2023), NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts, <https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/> Accessed 7th Dec 2023.

[7] Interview – Ceri Harris, Head of Equality and Human Rights, Betsi Cadwaladr University Health Board, 23rd November 2023.

[8] Llywodraeth Cymru Welsh Government (2022), Chief Nursing Officer for Wales: priorities 2022 to 2024, <https://www.gov.wales/chief-nursing-officer-wales-priorities-2022-2024#94408> Accessed 7th Dec 2023.

[9] Future Generations Commissioner for Wales, Well-being of Future Generations (Wales) Act 2015, <https://www.futuregenerations.wales/about-us/future-generations-act/> Accessed 7th Dec 2023.

[10] International Health Coordination Centre (2020), A charter for international health partnerships in Wales, <https://phwwhocc.co.uk/wp-content/uploads/2020/07/IHCC-Charter-for-IHP-Interactive-E.pdf> Accessed 7th Dec 2023.

[11] Llywodraeth Cymru Welsh Government (2020), Wales and Africa: Action plan 2020 to 2025, <https://www.gov.wales/wales-and-africa-action-plan-2020-to-2025-html#:~:text=The%20Wales%20and%20Africa%20programme,groups%20with%20private%20sector%20engagement.> Accessed 8th Dec 2023.

[12] Public Health Wales (2023), Public Health Wales: Our international health strategy 2023-2035, <https://phwwhocc.co.uk/resources/public-health-wales-our-international-health-strategy-2023-2035/> Accessed 8th Dec 2023.

[13] THET (2021), Wales's Health Partnerships with Africa: Maximising potential for mutual benefit, <https://www.thet.org/wp-content/uploads/2021/10/Waless-Health-Partnerships-with-Africa-maximising-potential-for-mutual-benefit-FINAL-05.05.21.pdf> pg 23.

[14] Ghana Nurses Association UK, Raising Diabetes Awareness in UK and Ghana, <https://www.gna-uk.org/raising-diabetes-awareness-in-uk-and-ghana/> Accessed 7th Dec 2023.

[15] British Sikh Nurses, <https://www.sikhnurses.co.uk/> Accessed 7th Dec 2023.

[16] THET (2021), Wales's Health Partnerships with Africa: Maximising potential for mutual benefit, <https://www.thet.org/wp-content/uploads/2021/10/Waless-Health-Partnerships-with-Africa-maximising-potential-for-mutual-benefit-FINAL-05.05.21.pdf> Accessed 7th Dec 2023.

[17] Hub Cymru Africa, <British Sikh Nurses, <https://www.sikhnurses.co.uk/> > Accessed 12th December 2023

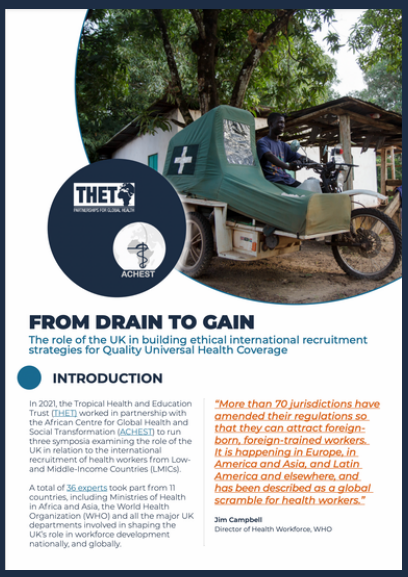
[18] Wales and Africa Health Links Network, <https://www.wfahln.org/> Accessed 12th December 2023

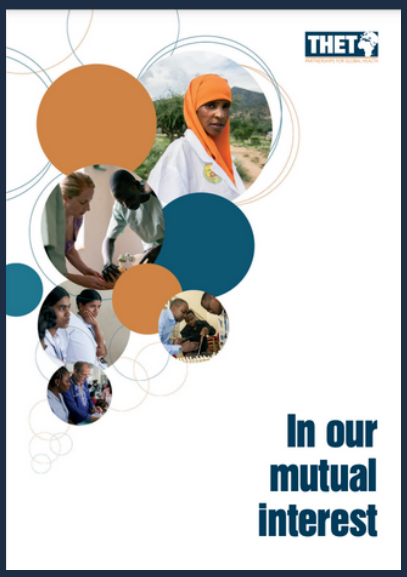
[19] Sub-Sahara Advisory Panel, <https://www.ssap.org.uk/> Accessed 12th December 2023

[20] THET (2022), Health worker wellbeing and global engagement, <https://www.thet.org/wp-content/uploads/2022/02/Health-worker-wellbeing-and-global-engagement.pdf>

[21] THET (2020), Innovation: How the NHS can learn more form Africa and Asia, <https://www.thet.org/wp-content/uploads/2020/03/Innovation-Round-Table_.pdf>

Previous reports:





About the Tropical Health and Education Trust (THET)

Today, one billion people will never see a qualified health worker in their lives. For over thirty years, THET has been working to change this, training health workers to build a world where everyone has access to affordable and quality healthcare. We do this by leveraging the expertise and energy of the UK health community and supporting health partnerships between hospitals, colleges, and clinics in the UK and those overseas.

From reducing maternal deaths in Uganda to improving the quality of hospital care for injured children in Myanmar, we work to strengthen local health systems and build a healthier future for all. In the past seven years alone, THET has reached over 84,000 health workers across 31 countries in Africa, the Middle East, and Asia in partnership with over 130 UK institutions

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