EVIDENCE BRIEF:

Improving diaspora engagement for health workforce and health systems strengthening in Kenya, Ghana, and the UK: preliminary findings

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Introduction

Diaspora health workers are uniquely positioned as individuals with relevant knowledge, experience, insights, relationships, and other connections who can contribute to at least two health systems—the health system of their country of heritage, and that of the country in which they are living and working as a member of the diaspora (henceforth referred to as "host country"). This bidirectional health systems strengthening by diaspora health workers remains under-explored. Our study is being carried out to better understand how to effectively engage with and support diaspora health workers to facilitate bidirectional health systems strengthening, with a specific focus on African diaspora health workers in the UK, especially those from Kenya and Ghana, and returnee diaspora health workers in Kenya.

Methods in Brief

We carried out a three-part study consisting of: an exploratory scoping review of literature on the role of diaspora health workers in bidirectional health systems strengthening; a mapping survey of organisations supporting diaspora health workers in the UK and in Kenya; and semi-structured interviews with diaspora health workers from different African countries in the UK and returnee diaspora health workers in Kenya, and key informant interviews with decision-makers in the UK and in Kenya who play a role in supporting diaspora health workers.

Preliminary Findings

Scoping review

We included 56 documents in our review. Overwhelmingly, documents described diaspora health worker contributions only in their countries of heritage or their host country, with five documents describing bidirectional health systems strengthening through the diaspora. Typically, bidirectional health systems strengthening was through diaspora health workers in a host country making additional contributions in their country of heritage through an established partnership, with reciprocal benefits, usually to the health worker's own capacities across both contexts.

In most cases, diaspora health workers contributed to host country health systems by filling critical gaps in service delivery—often requiring markedly reduced training investment by the host country—but also by: demonstrating cultural competencies; being adept at problem-solving and working with constrained resources; and leading community outreach/health promotion and supporting delivery of "migrant-sensitive" services within their catchment areas, especially where they hail from the same country of heritage. This outreach was pronounced during COVID-19. There was some mention of leveraging diaspora health worker insights to contribute to policy development, including to strengthen relationships between countries. Within countries of heritage, outside of providing remittances diaspora health workers: contributed medical and educational resources; set up or contributed to medical services; and supported capacity strengthening to local health workers, through formal or informal knowledge and skills transfer. Circular migration—when a diaspora health worker returns to their country of heritage—was cited as a goal across some documents, as these health workers would bring knowledge and other resources from their host country, whilst returning and thus filling the gap left through their initial departure. Formalised bilateral agreements may support reciprocal skills and labour transfer.

Mapping Study

We administered a survey or interviewed individuals from 14 diaspora organisations in the UK and seven in Kenya. These organisations did not always have an explicit focus on supporting the diaspora, which was particularly true in Kenya. Most work throughout all of the UK or all of Kenya. These organisations support from 80–6000 diaspora health workers.

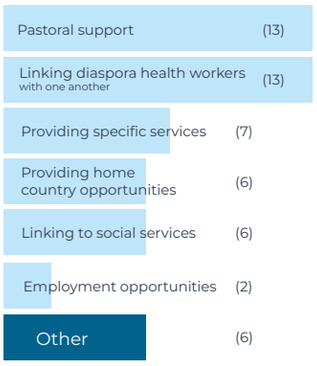

Figure 1. Primary functions of UK diaspora organisations

For the UK diaspora organisations (Figure 1), most organisations provide pastoral care and link diaspora health workers to one another. Some provide services themselves, drawing from expertise of members (e.g. mental health services) or link diaspora health workers to social services (especially for housing or

child benefits). Some provide opportunities to support initiatives in their country of heritage—this was particularly true where the organisation represented a specific country (e.g. The Ghana Nurses and Midwives Association, UK) rather than a much broader diaspora (e.g. Melanin Medics). "Other" functions of the organisation typically included support to professional development and mentorship, and targeted advocacy to see greater representation of Black allied healthcare professionals in positions of leadership. In addition to strengthening skills and competencies amongst members to enable them to fully contribute to health systems, in the UK, these organisations often had strong links—formal or informal—to diaspora communities and provided specific health outreach to these communities.

In countries of heritage, where they are active, diaspora organisations often operate in partnership with local clinical associations or governments to: run "missions", in which they provided clinical services; bring donated medical and educational resources; and lead capacity strengthening initiatives for health workers. These organisations are funded overwhelmingly through member contributions, and a lack of funding opportunities was highlighted as a persistent challenge.

Semi-structured Interviews

"But diaspora never or rarely get promotions. They've been here for 20 years and they are very sharp, but they are still band 5[...] Diaspora are discriminated against. There's almost a feeling of, "you're here to work", there's a feeling that you're not as good as everybody else. Even after years of experience, people still look down on you."

- Participant 2

"We get messages from the local community all the time, for example, about vaccination [...] We compensate for some failures in the NHS in understanding culture and attitudes towards health."

- Organisation 8

"I'm very active! It's as if I never left Kenya. I'm on the WhatsApp group with Kenyan obstetricians and gynaecologists. I also contribute to teaching. A lot of my research projects and the students I supervise are based in Kenya. [..] I've been involved in reviewing some national guidelines and offer an opinion."

- Participant 7

In interviews, it was clear that diaspora health workers are recognised as essential to the UK health system, reflecting the diversity of patient populations within the National Health Service (NHS) workforce itself and bringing cultural competence, different ways of communicating across diverse populations, and ways of working efficiently. However, diaspora health workers were seen by some participants as under-appreciated and were therefore not contributing as fully to the UK's NHS as they could be. A lack of representation of diaspora health workers—or Black and other minoritised populations—in NHS leadership was seen as constraining diaspora health worker advancement. This issue seemed to vary, however, Trust-by-Trust, with some interviewees reporting no perceived difference in opportunities for advancement between British-born and diaspora health workers.

> **Many diaspora health workers contribute to the health systems of their country of heritage in formalised or informal ways, often mediated through diaspora organisations or global health initiatives; those who do not, expressed a clear desire to do so in the future. However, a lack of funding and resources, limited time off, family responsibilities, and expired clinical registrations in countries of heritage limited their contributions.**

Key informants in the NHS felt that with the policy and operational focus within the NHS on clinical service delivery, consideration of longer-term health workforce policies and strategies that encompass diaspora health worker engagement was lacking. This gap is reflected in a near-total absence of mention of diaspora health workers/internationally educated professionals in NHS strategic documents (e.g. NHS Workforce Plan). Global health initiatives (e.g. partnerships between an NHS trust and a medical community in another country) were seen as a formalised way to support bidirectional health systems strengthening, drawing from diaspora health workers' proficiency in local languages and "insider" cultural competence to strengthen partnerships and participate in these initiatives in countries of heritage.

Recommendations

- Participants made suggestions to improve diaspora health worker engagement for bidirectional health systems strengthening. These included:
- Integrate considerations for diaspora health worker engagement from the policy level down, for example supporting their contributions, career progression and roles in countries of heritage
- Support diaspora health worker promotion and professional development pathways
- Improve systems to maintain clinical registration in countries of heritage
- Ensure earmarked time off within the NHS that is signposted for "missions" in countries of heritage
- Leverage NHS Trusts to mobilise resources, including drugs, equipment and educational resources
- Provide more funding and partnership opportunities to facilitate initiatives in countries of heritage, including to global health initiatives within the NHS
- Conduct and share research to better understand and quantify diaspora contributions to advocate for investment in diaspora health worker engagement
- Conduct and share research across initiatives in countries of heritage to make clear who is doing what and where to enable better cross-organisation or cross-NHS trust collaboration.

The final component of this study will be participatory workshops with participants from all aspects of the study to discuss and generate practical recommendations for improved diaspora health worker engagement.