



VOICES OF THE EXPERTS IN OUR MIDST

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Foreword



Dr Navina Evans **Chief Workforce, Training &** **Education Officer at NHS England**

As of June 2023, almost 1 in 5 NHS staff in England (19%) are reporting a nationality other than British. For doctors this figure rises to 35%, and for nurses it is 27%.

Internationally recruited staff are, then, an amazing resource of knowledge and expertise for patients in England.

Together, they connect the UK to 214 health systems around the world. They are not just skilled clinicians, but health diplomats who move across diverse health systems.

As such, internationally recruited staff are a source of learning for the NHS, and a resource with which to advance the development of health services around the world.

These are the themes with which I am proud to be associated with, not least through a partnership with THET, who have consistently broken new ground in championing the role of internationally recruited staff and those who identify as diaspora. The focus for THET, is the contribution diaspora health workers can make to improving health globally, but the organisation shares my passion for the myriad ways in which this knowledge of other health systems can improve the delivery of health locally, across the NHS.

In 2019 I was part of an inquiry initiated by THET and chaired by Lord Crisp, the former Chief Executive of NHS England, which asked: How can the NHS Learn more from Africa and Asia?

Diaspora health workers connect the UK to 214 health systems around the world. They are not just skilled clinicians, but health diplomats who move across diverse health systems.

It was during this inquiry that we reflected on the very significant number of overseas nationals working in the NHS. To-date, efforts have primarily been focused on inducting such staff into the NHS 'ways of doing things'. However, our discussion led to the proposal that such staff could be a resource of ideas around how the NHS might innovate, drawing on their knowledge of other health systems.

In 2021, I provided a foreword for THET's report, [Experts in Our Midst: Recognising the contribution NHS diaspora staff make to global health](#). This report highlighted the value diaspora staff bring both to the NHS and to the health systems in their countries of heritage. The report also revealed the challenges this group of staff face, including a range of biases and systemic racism which means their knowledge is underutilised both in the NHS, and in global health activity supported by the UK Government.

I am delighted to report that, since then, it is a challenge that we have begun to meet.

Through its partnership with NHS England, THET has also been able to award several Diaspora Volunteering Fellowships for Health Partnerships, which have been instrumental in capturing and promoting diaspora expertise and leadership, supporting the links staff working in the UK have with their countries of heritage. At NHS England, I have recently tasked a member of my team to champion this work.

In November, the Government recognised this work in its White Paper: [International development in a contested world: ending extreme poverty and tackling climate change](#): "We will harness the energy and expertise of NHS staff (where available) to promote knowledge and skills exchange for mutual learning between UK and partner health institutions in developing countries, building upon the extensive partnership experiences of organisations such as the Tropical Health and Education Trust, known as THET, and NHS England to help drive faster progress towards universal health coverage globally."

This report, entitled *The Voices of the Experts in Our Midst*, brings alive these themes in exciting ways. First, it is unprecedented in scale.

Almost 700 diaspora health workers have engaged in the development of this report, across the NHS in England and in Wales.

In the process, some valuable statistics have been unearthed, not least the fact that 35% of staff indicated that they have engaged in improving health in their countries of heritage. You will also hear the voices of individuals, such as that of Dr Rahman who comments: “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.”

I should declare an interest. I am originally from Malaysia, and for me coming to the NHS was a unique and sometimes difficult experience. However, an advantage this gave me was that it meant I was able to bring a global perspective to my roles – first as a child and adolescent psychiatrist and later as chief executive in East London NHS Foundation Trust (ELFT) and Health Education England (HEE) and now as the chief workforce, training and education officer at NHS England – a perspective which has aided me throughout my career and proven integral in shaping the way I support my colleagues, our workforce and the people we serve.

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

-Dr Mesbah Rahman

There are many staff working in the NHS who have familial and cultural heritage in other countries. Many of these ‘diaspora’ staff have also had their professional education abroad. They therefore bring unique knowledge and expertise into the NHS, not only in skills, but also in terms of culture and understanding of the diversity and needs of communities who access the NHS. However, this expertise is often under-utilised and overlooked, leading to diaspora staff being undervalued.

That is what this report is helping to change. And there is more to come. In 2024 NHS England is setting its sights on further improving the recognition of the expertise internationally recruited staff and those who identify as diaspora. We will do this in partnership with THET, and as part of a broader strategy led by FCDO and DHSC. Join us!

Foreword



Ben Simms **Chief Executive Officer, Tropical Health and Education Trust (THET)**

This report is, unashamedly, a celebration of the individuals who connect the NHS to over 200 health systems around the world. Those people who identify as belonging to a diaspora and/or have been recruited from overseas.

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.

It is our belief that the UK does not do enough to celebrate this knowledge. This report is a modest contribution designed to help change that. There is so much more to be done.

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

First, the members of the Advisory Committee chaired by Dr Navina Evans, who have guided THET in the development of this report. Their influence has been crucial. Its content is, however, entirely the responsibility of THET.

Secondly, the 700 or so NHS 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 in the UK - over 80 when we last counted. Their leadership is crucial.

Thirdly, I would like to thank our partners in government, in NHS England and NHS Wales in particular, and at the Bill and Melinda Gates Foundation who have given us the funding that has provided the space to think through these issues. It is six years since we published our ground-breaking report In Our Mutual Interest which elaborated on the themes championed by our Patron, Lord Crisp: health is global, we are in this together, equitable partnership is the way forward. It is so important that organisations like THET are allowed time to think and reflect, as well as to do.

There is one other important contribution we hope this report will make, and that is to encourage the UK to return to its commitment to spend 0.7% of its Gross National Income on Official Development Assistance.

Andrew Mitchell, Minister of State for Development and Africa at the FCDO, gave a speech to Chatham House earlier this year when he said: "I am determined that we shall drive-up support [for international aid]. To do this, we will need to get out of London, and not to visit capital cities around the world but to visit small towns and villages in our own United Kingdom, to explain what we do in simple and straightforward language that everyone can relate to."

The hospitals, GP surgeries and clinics where we find internationally recruited staff are in those small towns and villages that Andrew Mitchell refers to. Let us listen to their voice and celebrate their expertise and as we do so, let us acknowledge how much the UK gains from their presence in the UK and the responsibilities this places on us as a country, to support the work of building health systems in countries of heritage.

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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.

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**'

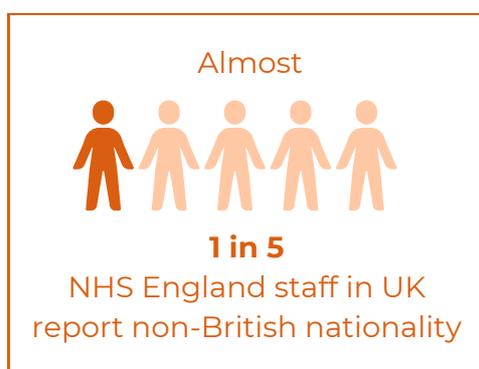
The network harnesses the knowledge diaspora staff have of other health systems to develop practical solutions that improve health service delivery in the UK and overseas.

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

Other important initiatives are unfolding. NHS England have appointed a ‘diaspora -focused’ role within the global health team, and for the past year, a nurse has worked on secondment to THET from NHS Wales to shape these activities.

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 funding.

Meanwhile the numbers of international staff as a proportion of the UK health workforce have continued to grow, now reaching 18.7%, almost 1 in 5 health workers.¹ 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.



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 diasporavoices. Storytelling is at the heart of this work, with a focus on platforming diverse perspectives.

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 UK health system, and diaspora engaging in global. 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 UK Health System



The experience that diaspora health workers face while working in the NHS and UK 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.

Within the NHS, much has been done over the last few years to recognise and mitigate some of these issues. The experiences of diaspora workforce tend to align closely with that of the Black, Asian and Minority Ethnic (BAME) workforce, so efforts to progress racial equality within the health workforce have a direct bearing. Many of the key issues emerging from diaspora health workers within our investigation align with issues that the Workforce Race Equality Standards data has raised.

For instance, it is noted in the latest report (2022)² that white applicants are 1.54 times more likely to be hired from shortlisting than BAME applicants. BAME staff are also more likely to experience harassment, bullying or abuse, in comparison to their white counterparts.

The Medical Workforce Race Equality Standards (MWRES) data from 2020 also disaggregates the experiences of International Medical Graduates (IMGs) from overall BAME medical staff, providing valuable data on the experiences of staff migrating to England and finding their feet within the NHS.³ Among those findings were that IMGs were more likely to face referrals, complaints, or investigations. They are less likely than their UK colleagues to pass speciality postgraduate exams.

Partially in response, the Welsh Government launched its Anti-Racist Wales Action Plan⁴ in July 2022, and in June 2023, NHS England launched

its Equality, Diversity, and Inclusion (EDI) Improvement Plan.⁵ Both strategies aim to improve the conditions that people with protected characteristics experience across the NHS. Crucially, accountability is factored into both plans, and it is notable that the EDI Improvement Plan targets include implementing comprehensive induction, on-boarding, and development for internationally recruited staff, recognising the importance of the experience of recently arrived internationally trained staff.

Other initiatives include guidance which has been produced on minimum requirements for the induction of International Medical Graduates.⁶ A focus on post-recruitment support, such as pastoral and professional support, has also been developed within nursing and midwifery within the NHS in England,⁷ as well as the launch in 2022 of the NHS Pastoral Care Quality Award for nurses and midwives recruited internationally.⁸

There is also currently an initiative underway to learn more about supporting internationally recruited staff so Trusts can learn from best practice and initiatives undertaken within England.

A workforce that is compassionate and inclusive for all has higher levels of engagement, motivation and wellbeing, which results in better care and reduced staff turnover

The 'Stay and Thrive' programme is being piloted in South-West and North-East England (see the case study of Nchima Mwaba later in this report).

Encouragingly, as these various initiatives show, there is greater emphasis now on ensuring the experience of migrating to the UK and working in the NHS is more positive, and measures designed to address this incorporate strong accountability measures. It is also being tied directly to the recruitment and importantly the retention of health workers in the NHS. As NHS England's EDI Improvement Plan specifically states: 'A workforce that is compassionate and inclusive for all has higher levels of engagement, motivation and wellbeing, which results in better care and reduced staff turnover.'⁹

Diaspora and Global Health



LMIC diaspora, and internationally trained staff, are present at all levels of the NHS and bring vast experience of the health system in their countries of origin. Thus, they have the potential to add value to the way in which the UK conducts its global health system strengthening (HSS) aims alongside the push for Universal Health Coverage (UHC).

Until recently, no specific plan existed to engage diaspora within the UK's development or global health strategies.¹⁰ While recognising the rich history of international health workers in the NHS, the UK's Global Health Framework (May 2023)¹¹ does not mention any specific efforts to engage diaspora in the delivery of its objectives. Encouragingly, it does seek to align international recruitment practices with these objectives, acknowledging the impact of international recruitment to the NHS on LMIC health systems, and with steps to address this. The FCDO's December 2021 Position Paper: Health System Strengthening for Global Health Security and

Universal Health Coverage also does not name diaspora health staff or representative organisations in its discussion on the UK's collective expertise.¹² This has changed, with the publication of the **FCDO's White Paper in November 2023, International Development in a Contested World.**¹³

Not only does this make explicit reference to the contribution NHS staff are making to building health overseas, as well as in the UK, it also acknowledges the contribution diaspora are making, through the exchange of knowledge and expertise and not just remittances.

Following the publication of THET's 2021 Experts in Our Midst report, Health Education England (now NHS England) began piloting a new NHS Diaspora Fellowship programme, supporting two Ugandan diaspora staff working in England to work closely with the Uganda Ministry of Health in identified areas of health system strengthening.¹⁴

This pilot is underway, with aims to ensure that the individuals on placement will feed back formally to their Trusts on return and bi-directional benefits of the work explored. There are plans to continue this initiative in 2024 expanding its coverage across England.¹⁵

With NHSE support, THET also undertook a programme of diaspora volunteering grants for Health Partnerships in 2022. 41 diaspora volunteers were engaged across 7 partnerships involving 6 NHS Trusts in England delivering a diverse range of projects with LMIC partners. These grants have enabled diaspora staff to engage in global activities and lead projects as diverse as *nursing leadership and development in surgery and maternity departments* in Kenya, to strengthening diabetes care and support in isolated and disadvantaged areas of the Visayas Islands in the Philippines.

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 awareness¹⁶, or within the structure of the global Health Partnerships affiliated with their 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 Nurses¹⁷).

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.

Diaspora Volunteering Bursaries for Health Partnerships

41 diaspora volunteers



7 partnerships



6 NHS Trusts



The Florence Nightingale Foundation, funded by NHS England, provides small grants to DHOs of around £10,000 for organisational development. Eighteen organisations received grants recently (August 2023)¹⁸ in the third and final grants round.

These grants are welcome support to these organisations who can find funding a major hurdle. They 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.

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, 25 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.

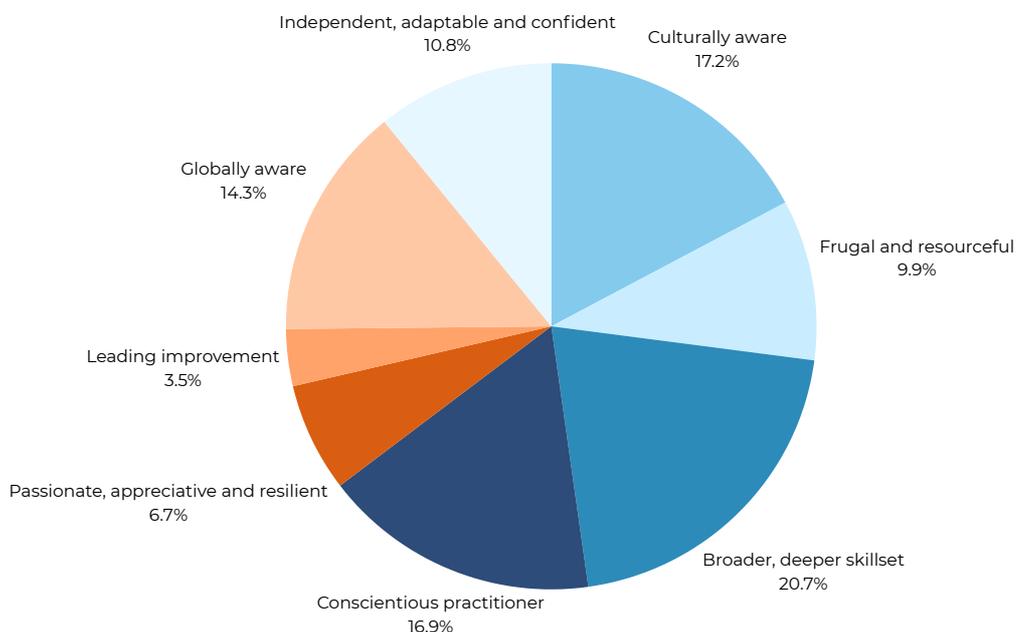
Limitations

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.

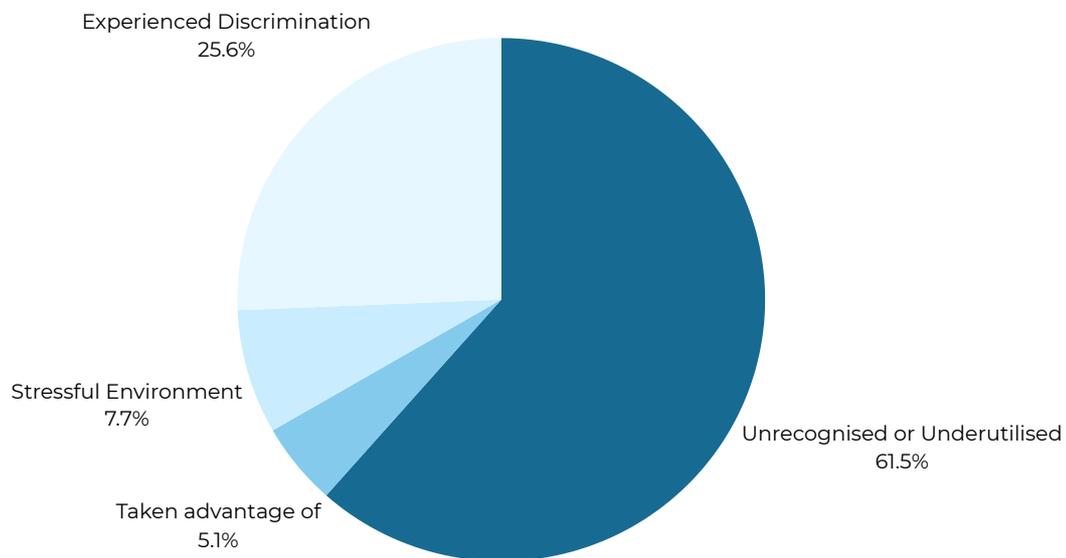
Overall, 74% of responses identified positive aspects of their practice within the NHS that they attributed to their overseas experience. These ranged from statements about resourcefulness gained from familiarity with more resource-constrained settings, to a greater appreciation for the NHS, to a greater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



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.

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.

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:

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.

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 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 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.



Cultural Competency

17% 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 in East London 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. A doctor operating from a community in the West Midlands remarked:



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 and UK health system 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.



CASE STUDY

Getting good nurses and helping them stay: A case study of Nchima Mwaba and the Stay and Thrive Project

Nchima Mwaba, a trained nurse with expertise in communicative practice, shared with us her story of transitioning from Zambia to the NHS in England. In Zambia, she enjoyed rapid career progression, but when she moved to the UK, she found that the NHS was more interested in clinical nurses. Consequently, she started at a much lower level than she was qualified for. This experience was shared by many of her colleagues who came from low- and middle-income countries (LMICs), who faced difficulties in navigating their career development, feeling unrecognised for their expertise, and struggling to adjust to the local culture and social life, as well as everyday living tasks, such as opening bank accounts and finding suitable accommodation.

Due to the challenges of managing work and a growing family,

Nchima shifted to a training position, which offered her more flexibility.

She observed that most of her peers from Africa faced the same struggles, including feeling undervalued and discriminated against in the workplace. As a result, out of the five nurses she started with, she is the only one who remains in the NHS. The NHS is currently facing significant challenges with high staff attrition rates, which includes diaspora health workers.

Nchima volunteers as Treasurer for the Association of Zambian Nurses UK (AZNUK), a UK based diaspora health organisation. The association provides diverse forms of support to Zambian nurses in the UK, ranging from restorative assistance to advice on religion, culture, the disciplinary process, and bereavement support.

This wrap around pastoral support can be attributed to NHSE-led research on ethical recruitment practices and the emphasis on comprehensive pastoral support, to facilitate the integration of international staff.

This evolution has been instrumental in creating a more inclusive and supportive environment for diaspora health workers within the NHS, ultimately enhancing their contributions and improving patient care.

Nchima was invited to join a national platform called the Stay and Thrive Project, and recently began her new role as Career and Pastoral Lead for Internationally Educated Nurses. The three-year project aims to support international recruitment and retention by learning from the past experiences of diaspora health workers. Piloted in the North-East and South-West of England, the project carried out several initiatives to enhance the experiences and retention of diaspora health workers.

These activities included creating a toolkit for NHS employers, which offers guidance on how to create a more inclusive and supportive workplace for diaspora health workers.

The toolkit covers recruitment, onboarding, training, and development. Additionally, the team conducted training sessions to help NHS staff understand the unique challenges faced by diaspora health workers and how they can provide support.

Finally, they established a network for diaspora health workers to connect with each other, share their experiences, and access support by being assigned to a mentor who provides help in navigating through the settling-in and the progression journey.

In the last 3 years, Nchima's employer, Mid Yorkshire Teaching NHS Trust, has successfully recruited 353 international nurses. Now, the next step is to welcome and support them by offering pastoral care, career development and integrating them into new communities



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 UK health system 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 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 within the UK health system 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 programmes. 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. In England, I've always run patient focus groups. 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.



Mentoring Doctors on WhatsApp in Pakistan – Dr Sidra Hasan

Dr Sidra Hasan, a GP in Walsall with Pakistani heritage, is improving Pakistani medical practices through a 200-member WhatsApp group. Her platform merges the cost-effective practices of the NHS with international insights, guiding Pakistani doctors on prudent medication use and patient monitoring. In Pakistan, patients must pay for healthcare, underscoring the importance of informed prescribing practices. Sidra's work emphasises the importance of patient education and the ongoing need for enhanced doctor training.

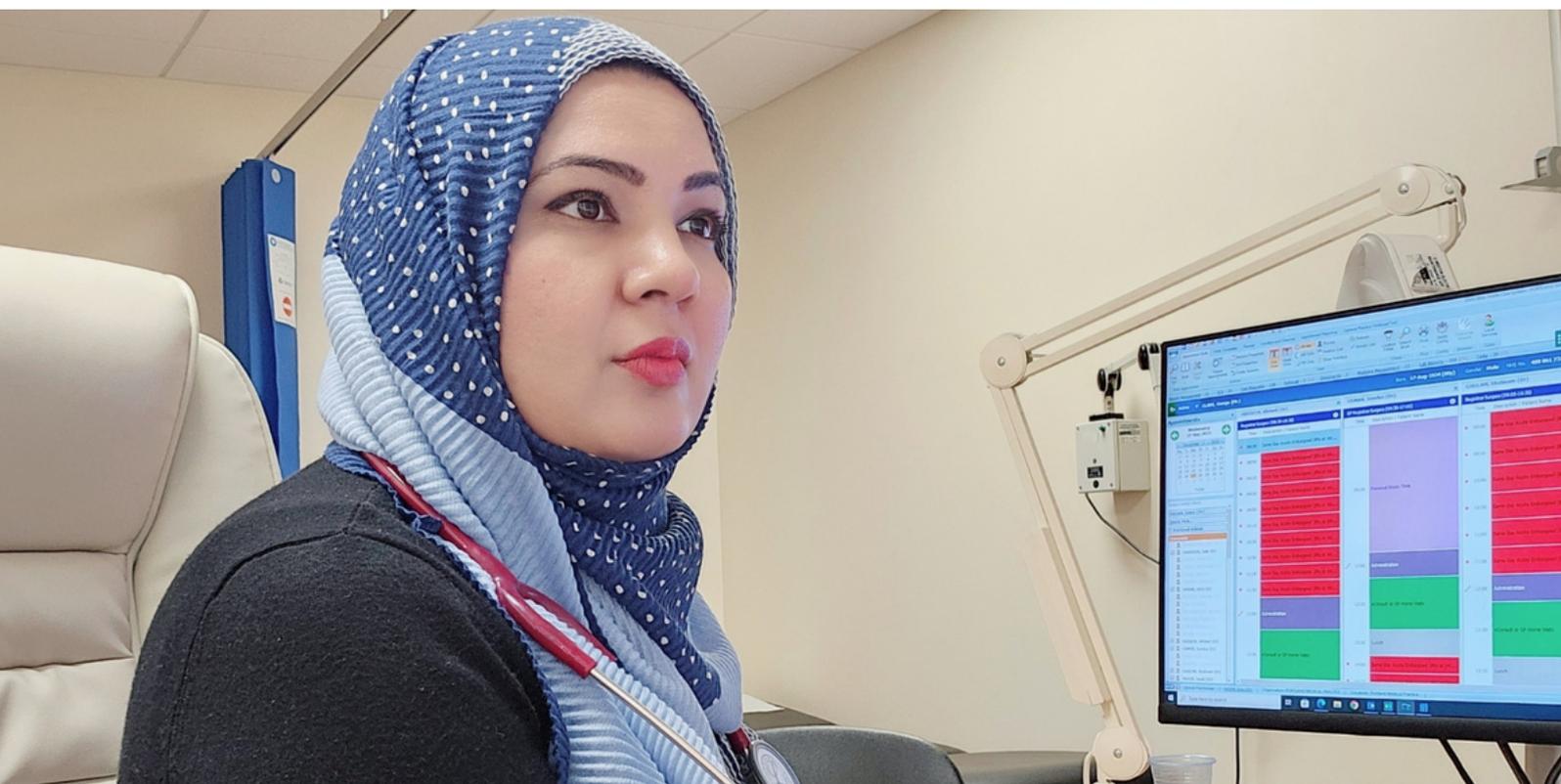
Group members exchange individual cases and stories and seek collective insights on approaching specific patient scenarios, and the platform has evolved into an expansive learning hub, benefitting not only group members but also their colleagues. Sidra, drawing from NHS guidelines, provides invaluable mentorship, with her guidance resonating strongly:

“They tend to value the advice that I provide on this platform because they know that this advice comes from here, and their feedback is that most of what I suggest makes sense even in their situations... It is very rewarding for me because I'm able to support my colleagues back home, who do not have the opportunity to be trained in a way that I have been trained, and I think they really value my opinion. So, it is helpful for them as well”.

The medical curriculum is a significant challenge in Pakistan. Sidra contends that the Pakistani training program leans too heavily on theory and textbooks, neglecting practical training. In contrast, UK medical students gain practical experience in GP practices much earlier in their education. Sharing her insights with her Pakistani colleagues, Sidra has advocated for a curriculum shift:

“So I have taken this message back home to the college that I was training in, and they are rotating more medical students earlier, as well as into the hospital and wards for them to see patients as well. So, there is this change, I would say, which I have brought”.

Dr Sidra's guidance is not just theoretical but is a testament to the impact of holding expertise in two healthcare systems. Her mentorship has become a cornerstone for Pakistani doctors striving to align with global medical standards, ensuring that patient care is both safe and scientifically sound. Sidra has been able to elevate clinical practices whilst also contribute to a broader shift towards a more sustainable and ethical approach to medicine in Pakistan.



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. One respondent spoke about being approached by her old place of work in Brazil to facilitate a programme of learning exchange in Paediatrics with Cambridge University Hospitals NHS Trust.

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



Opening Eyes in Uganda: A diaspora nurse's journey in transforming eye health in their home country – Primrose Magala

Primrose Magala, originally from Uganda, is a Senior Ophthalmology nurse at Moorfields Eye Hospital NHS Foundation Trust, a world-renowned centre of excellence for eye care. As a diaspora healthcare worker, Primrose was very aware of the disparity between the UK and Uganda.



“In my home country, people live with cataracts until they die, whereas here, a cataract is removed within 20 minutes, and within 2 hours, a patient is discharged and can leave with all the necessary medication and support.”

Primrose founded Eye Health Africa, and with the support of Professor Lyndon da Cruz, a renowned Bionic expert and consultant ophthalmic surgeon, she established the first exchange programme in 2017. Lubaga Hospital, one of Uganda's largest non-profit hospitals, agreed to host a team from Moorfields.



“On the first day, we saw over 2,000 people and had to turn away almost the same number. We learned so much from that experience. Not everyone needed to see a doctor, so we learned to prioritize and triage. We were able to identify those who needed to see a doctor, around 200-250 people, mainly for complex procedures that we could not perform. This taught us the importance of utilizing a multidisciplinary team effectively.”

Subsequent assessments by Primrose and her team revealed critical gaps in the management of eye conditions like glaucoma and retinoblastoma in Uganda, signalling an urgent need for specialised care. The programme has so far trained over 50 ophthalmologists in Uganda.

“Over time, thanks to additional resources, Lubaga has transformed its eye department from a small referral system to a centre of excellence. We support complex cases, and children travel up to 400 miles to receive our help. This project not only supports the local community but also teaches local and NHS healthcare workers. The exposure has allowed junior doctors to become educators and consultants. In fact, one consultant said that in four days in Uganda, he did things he had never done in seven years of working in the NHS. This is the impact we are making on the NHS.”

Primrose has been able to leverage her knowledge of the Ugandan healthcare landscape and the best practices from Moorfields to identify and act upon critical healthcare needs. Eye Health Africa is rooted in personal experience and expertise and allows Primrose to positively impact healthcare systems worldwide, affirming the value of supporting diaspora-driven contributions.

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 the 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 the UK 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 the UK 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 Gastroenterology 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.





Lucia Vambe: A diaspora health worker supporting mental health in Zimbabwe.

Lucia Vambe was born in Zimbabwe and came to the UK in the 90s where she trained as a mental health nurse. With over 20 years of experience in the NHS, Lucia has worked across various settings, including inpatient community, clinical governance and education teams. Lucia shared with us the need for increased resources to address pressing needs of mental health care in Zimbabwe.

There are some challenges in Zimbabwe's mental health system, which includes a reliance on paper-based patient records and a lack of

a wider community mental health services. Accessibility to adequate mental health treatment also remains a significant challenge.

Recognising this, Lucia established the Zimbabwe Life Project (ZLP) in 2018. This UK-based charity, founded by Lucia, comprises mental health nurses, doctors, and therapists who have come together with the aim of developing a skills exchange programme with mental health professionals in Zimbabwe. These professionals are volunteers, mostly using their own money and time to go to Zimbabwe and share their experiences.





"I remember our first visit to Africa with the group, some of them had never been there before, we witnessed first-hand how people manage difficult mental health situations with limited resources, yet still achieve positive outcomes. It was a humbling experience. In contrast, we have many resources here in the UK, yet we sometimes complain. This inspired me to share such examples during my clinical risk training sessions, which had a great impact and brought about positive mindset when facing difficult situations. So far, we have had over 30 clinicians, including some who had never been to Africa, come to Zimbabwe with me and share their experiences and learning with our counterparts there."

The tangible support extended further, with the facilitation of various donations of medical equipment and supplies that ZLP gathers in the UK and ship to hospitals in Zimbabwe yearly.

Collaboration with host hospitals is a cornerstone of ZLP's operations in Zimbabwe. Since 2018, the work of ZLP has been acknowledged by the Ministry of Health & Childcare in Zimbabwe and the charity have received support from The British Embassy in Harare. Support is also strong in the NHS Trusts where ZLP volunteers work, and Lucia shared that NHS East of England had given ZLP permission to wear the NHS logo on their T-shirts as 'NHS volunteers '

Challenges

Funding

Most diaspora who undertake global health initiatives do so as part of the small-scale work of diaspora organisations, within health partnerships undertaken by their Trust, 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. 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 actors 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, and to the way in which the UK 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 the UK and abroad, and the strengthening of the UK's global engagement.

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.**
- **HEE (now NHS England) to match diaspora staff with opportunities in countries of heritage through the Improving Global Health programme.**
- **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.**
- **The NHS extend their sponsorship of a network of International Nursing Associations to other health professions.**
- **FCDO and DHSC to develop a strategy for diaspora engagement in partnership with the NHS.**
- **Greater coordination of LMIC governments engaging with their own diaspora.**

Considerable progress has been made in implementing these recommendations over the past two years both by THET and by NHS England, with a range of funds being made available to DHWs.

Most recently, we saw explicit reference to the importance of DHWs in the Government's November 2023 White Paper: [International development in a contested world: ending extreme poverty and tackling climate change](#).¹⁹ Recommendation 6.71 reads: "We will harness the energy and expertise of NHS staff (where available) to promote knowledge and skills exchange for mutual learning between UK and partner health institutions in developing countries, building upon the extensive partnership experiences of organisations such as the Tropical Health and Education Trust, known as THET, and NHS England to help drive faster progress towards universal health coverage globally."

We now look to the Government to develop a strategy to accompany this commitment and set ourselves the challenge of engaging DHWs in far larger numbers than we have managed to-date.

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 the UK and in global health work, are related to the lack of recognition of their expertise in both arenas. The negative experiences within the NHS put forward in our research suggest more needs to be done to ensure that newly arrived health workers in the UK feel supported in starting their roles, and their life in the UK, and that their skills, experience and qualifications are acknowledged in an efficient manner, ensuring that they can contribute to the best of their abilities, and be appropriately recognized for that including elevation to appropriate pay bands, faster.

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 UK health service:



Harnessing the Benefits of Diaspora Recognition and Empowerment

In both the UK 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 the UK 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 the UK. This could be by their expertise not being recognised at the right level within the UK health sector, or lack of support for well-targeted, networked, and impactful diaspora-led global health initiatives. This is why the commitment expressed in the recent White Paper is so significant.

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 UK health sector and assisting members to prepare applications. The application of the NHS's Diversity, Equity and Inclusion targets also has a role to play here, working to ensure that a higher percentage of BAME staff (and by extension DHWs) find representation in higher bands and leadership positions within the NHS.

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

In 2021 we recommended that the UK's Foreign, Commonwealth and Development Office (FCDO) and the Department of Health and Social Care (DHSC) develop a strategy for diaspora engagement in partnership with NHS England and NHS Improvement.

Funding emerged frequently in our discussions as a key barrier to small-scale, solo, partnership-based and diaspora association-led global health initiatives. Although there has been some progress including NHS England's Diaspora Fellowship Pilot, much more needs to be done to provide opportunities to unlock the potential of diaspora-led international work.

Via FCDO and DHSC, official development assistance (ODA) funds could be unlocked to provide greater support and ensure greater sustainability of well-targeted and clearly beneficial and impactful initiatives. The re-commitment of the UK Government to ring-fencing 0.7% of Gross National Income (GNI) to ODA would greatly help in this regard, and within this health ODA continuing to be a significant priority.

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 to build their technical and programmatic capabilities. We also, through our Diaspora Volunteering Bursaries for Health Partnerships programme, delivered with the support of NHSE, specifically encouraged Health Partnerships to centre DHWs in their work, and facilitated the engagement of 49 DHW volunteers over the course of 2022 and 2023.

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, and encourage others to do so.

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 of the UK health system. As one interviewee said:

There's so many organizations 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 UK 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?

Benefits to UK's Profile

Increasing UK dependence on health worker recruitment from LMICs is causing very real effects on the health systems in those countries. It is imperative that the UK finds a way of substantially contributing to the strengthening of LMIC health systems that adequately 'pays back'. Beyond ensuring that we are investing enough in global health by recommitting to spending 0.7% of GNI to official development assistance, 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 rows alongside the desire to progress on diversity, equity, and inclusion within the UK health sector itself, in recognition of how institutional racism and unconscious bias effects the diaspora. The recognition, platforming and empowerment of diaspora and internationally trained staff lie at the heart of the solution to both problems.

Motivation, Wellbeing and Retention

In the case of ITHWs, it was pointed out that the UK 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.

The work being done within the NHS on developing retention guidelines, and in initiatives such as the Stay and Thrive project, show that the NHS is taking steps to address this problem. Yet more must be done to ensure diaspora, and in particular internationally trained staff feel supported and appropriately recognised.

We commend the DHWs and DHOs that are working to provide pastoral support and advocating for internationally trained health workers. Also positive is the NHS Trusts and other organisations that have recognised and supported such work, including those involved in the Stay and Thrive programme, and Nottingham Universities NHS Trust, profiled below. The Florence Nightingale Foundation has also provided needed support to diaspora organisations, drawing on funding from NHS England, to build their capacity to continue this needed work. It is imperative this continues, preferably as a combined package of support delivered by diaspora organizations and NHS Trusts themselves.

Similarly, we commend efforts by some NHS Trusts 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 Nottingham University Hospitals NHS Trust.²⁰ 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.²¹ 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 many 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 UK health service in general. Further, many 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,²² and a series of recommendations made about how to identify and create an enabling environment for the adoption of such innovations.

Employers in the UK health system, including NHS Trusts and 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. In doing so, inspiration can be drawn from the Charter for International Health Partnerships in Wales,²³ and its intent to encourage reciprocal partnership working; or NHS Scotland's Global Citizenship Programme, with its focus of reciprocity and highlighting the benefits to NHS Scotland and the Scottish people.²⁴



NHS
Nottingham University Hospitals
NHS Trust

Platforming Diaspora: Nottingham University Hospitals NHS Trust

Nottingham University Hospitals NHS Trust have maintained an institutional link with Jimma University Hospital in Western Ethiopia, focusing on skills and knowledge sharing, since 1993. The partnership is mutually beneficial, providing diverse staff at Nottingham (from clinical staff to engineers and IT staff) with opportunities to take on placements in Ethiopia, learning about a different health system, improving professional and leadership skills, and gaining exposure to conditions less common in Nottingham, such as tropical diseases, trauma, and non-communicable diseases.

The Trust made a decision 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. The Trust has adopted a model of supporting individuals who undertake such work by granting them equivalent time, tackling the barrier that diaspora often find in having to give entirely of their allocated annual leave. So, when an individual gives one week of their annual leave to support health-related work in their country of heritage, the Trust will gift them another paid week to undertake the work. In return, the individual ensures to report on their work on their return, so that the Trust can benefit from their experience.

Later in 2023, the Trust will inaugurate a 'Global Health Lounge'. The purpose of this will be threefold: Internationally trained staff will be encouraged to participate in the dissemination of information about global health trends and practices, they will be brought in to workshops and discussions on research and innovation and supported to contribute, and it will also serve as a hub for pastoral support for ITHWs, helping them to integrate into work in the Trust and life in the UK. This approach simultaneously recognizes the expertise of ITHWs, and the support they require to thrive in their roles.

Through the recent creation of a full-time Head of Global Health Partnerships, the Trust are backing this approach, which recognizes 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, and 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.

'Global Health Partnerships play a pivotal role in the growth and progress of Nottingham University hospitals, fostering an outward mindset and cultural intelligence. By collaborating with institutions around the world, we strive to develop equitable healthcare for all, irrespective of geographic or socioeconomic disparities. These partnerships not only enhance our understanding of diverse healthcare systems, but also provide valuable opportunities for knowledge exchange, innovation, and the sharing of best practices. By working together on a global scale, we can address the pressing challenges of our time and make a meaningful impact on global health outcomes.'

Richard Holder – NUH Head of Global Health Partnerships and BAME and LGBTQI Network Chair

'We recognise the positive impact our collaborations are having on the local populations of our partners. We very much see this as a two-way partnership, where upon we hope to learn from our partners on how to improve health and well-being with very limited resources.'

Gilbert George – Director of Corporate Governance, NUH NHS Trust

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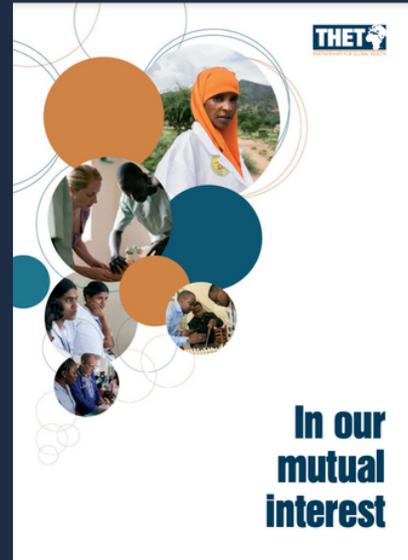
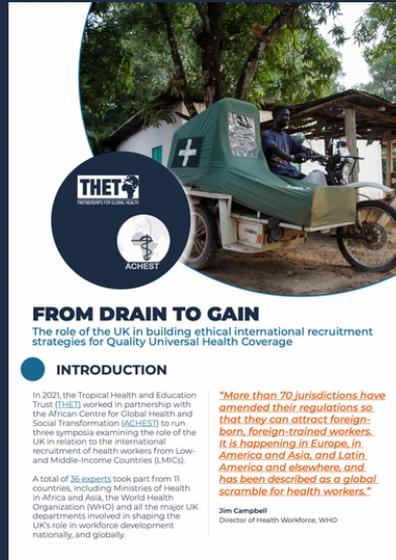
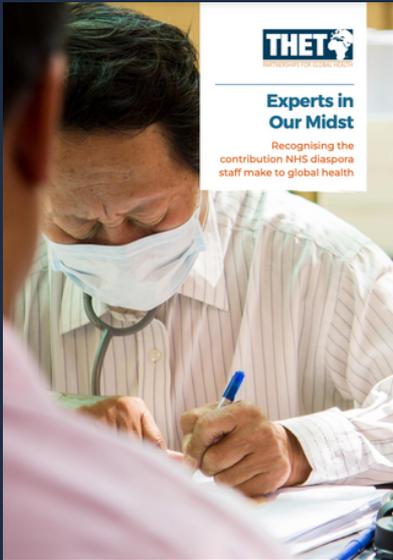
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About the Tropical Health and Education Trust (THET)

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

Find out more about our work at www.thet.org.

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