DIASPORA ENGAGEMENT IN HEALTH IN THE EASTERN MEDITERRANEAN REGION

A desk review of experiences

IOM UN MIGRATION

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

Publisher: International Organization for Migration
17 route des Morillons
P.O. Box 17
1211 Geneva 19
Switzerland
Tel.: +41 22 717 9111
Fax: +41 22 798 6150
Email: hq@iom.int
Website: www.iom.int

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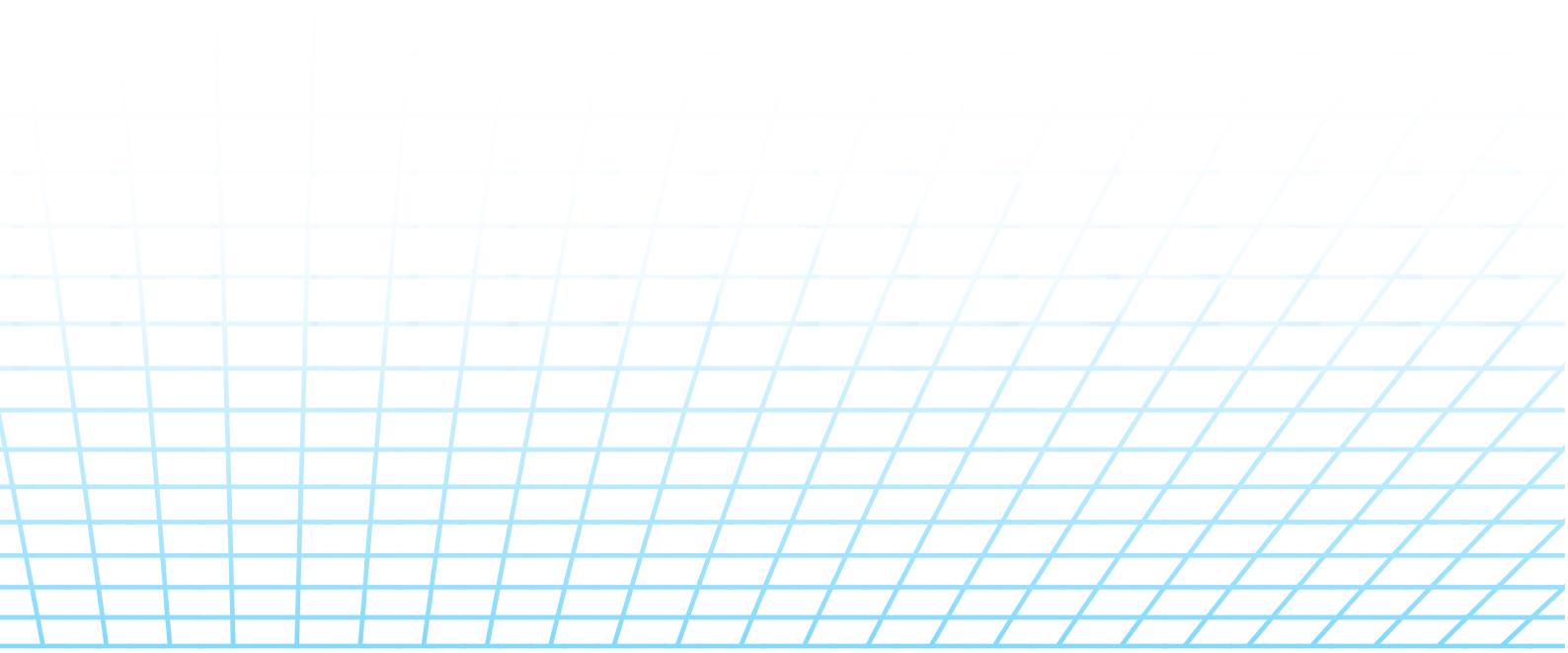


Foreword

We are at a crucial time for migration governance in the Eastern Mediterranean region. The COVID-19 pandemic has exacerbated health workforce shortages and capacity gaps. The situation has highlighted once more the potential role that diasporas and migrant communities can play in providing essential services, supporting national health systems at the forefront of our common struggle.

Objective 19 of the Global Compact for Migration commits countries to "create conditions for migrants and diasporas to fully contribute to sustainable development", highlighting the key role that can be played by migrants and diasporas when they are empowered to effectively contribute to efforts towards achieving the Sustainable Development Goals (SDGs) in countries of origin, transit and destination.

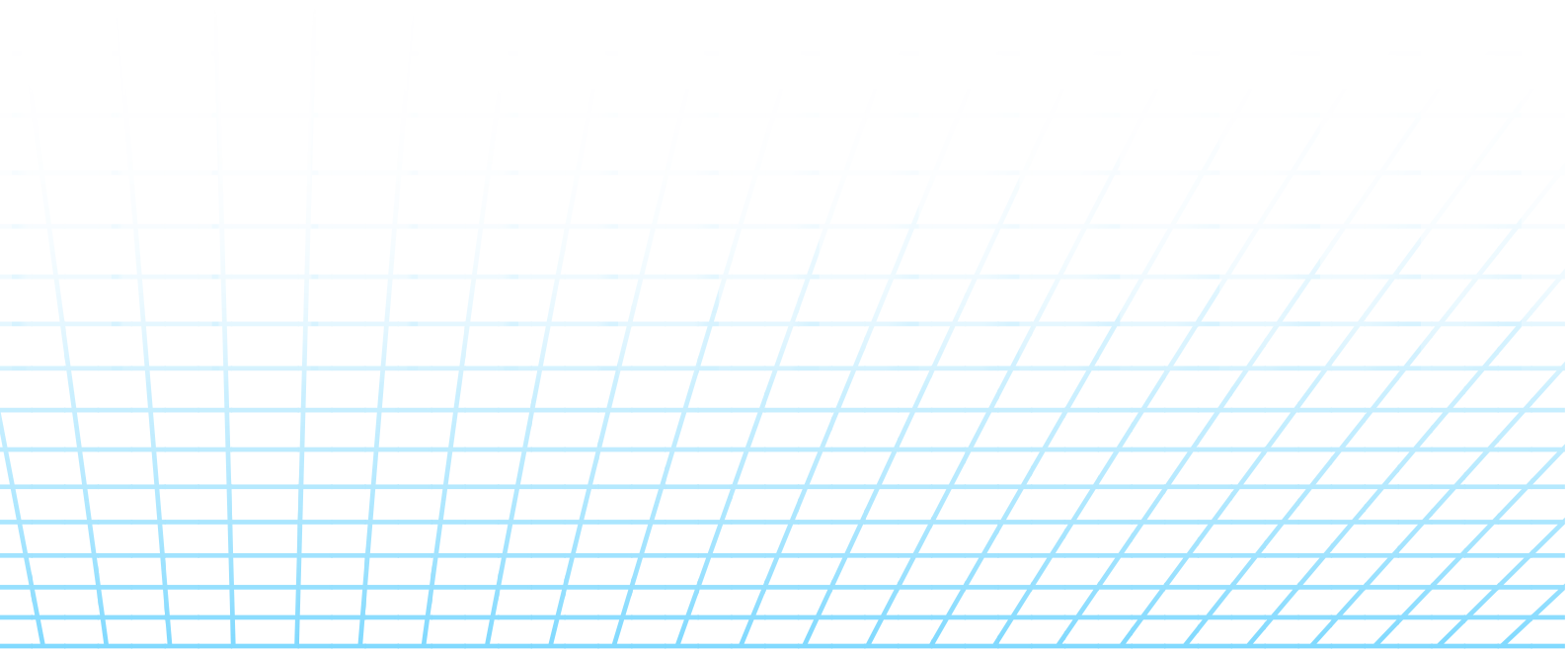
The COVID-19 pandemic has impacted migration and mobility – especially of skilled health personnel – at the global, regional and national levels. The crisis continues to have serious repercussions on national health systems in the Eastern Mediterranean region, which suffer from a depleted stock of health workers. Numerous drivers influence skilled workers' decisions to migrate to higher-income destination countries, with countries of origin often bearing the cost of their education and training – and in the end are unable to retain essential human capital and reap much-needed benefits. However, the skilled health workers of the Eastern Mediterranean region have demonstrated their willingness to contribute to health systems in both policy and service delivery in their countries of origin, and it is critical to tap into and benefit from this potential resource in responding to the pandemic and beyond.

WHO is undertaking close technical cooperation with Member States to strengthen their health workforce capacities, address shortages and mobilize surge capacities in response to COVID-19, recognizing the potential of the diaspora. With its strong operational role and capacity in the field, IOM has already facilitated successful diaspora engagement programmes, as well as promoting and facilitating diaspora engagement through the development of institutional policies that mainstream migration into national development plans. The Organization has also embraced the spirit of partnership and is engaging in a number of successful collaborations with other United Nations agencies.

Migration is a transnational, transboundary and multidimensional phenomenon that requires collective action. As the regional directors of our respective agencies, we recognize the benefits of collaboration as a unified United Nations family and have therefore agreed on a joint workplan. This publication is just one of many joint activities intended to support health system strengthening by providing knowledge and evidence transfer through facilitating diaspora engagement. By effectively engaging migrants, countries can strengthen the health workforce at this critical time.

Dr Ahmed Salim Al-Mandhari
Regional Director
World Health Organization
Regional Office for the Eastern Mediterranean

Carmela Godeau
Regional Director
International Organization for Migration
Regional Office for the Middle East and North Africa



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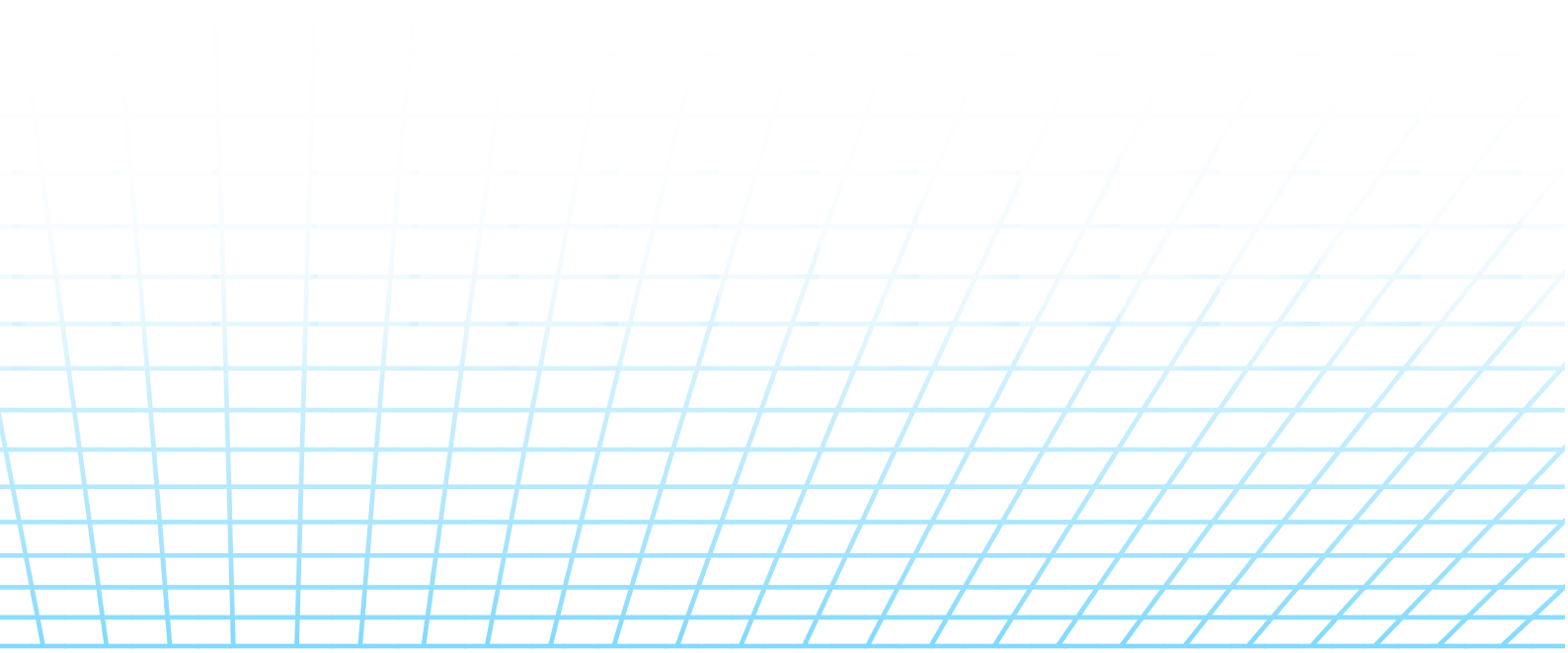

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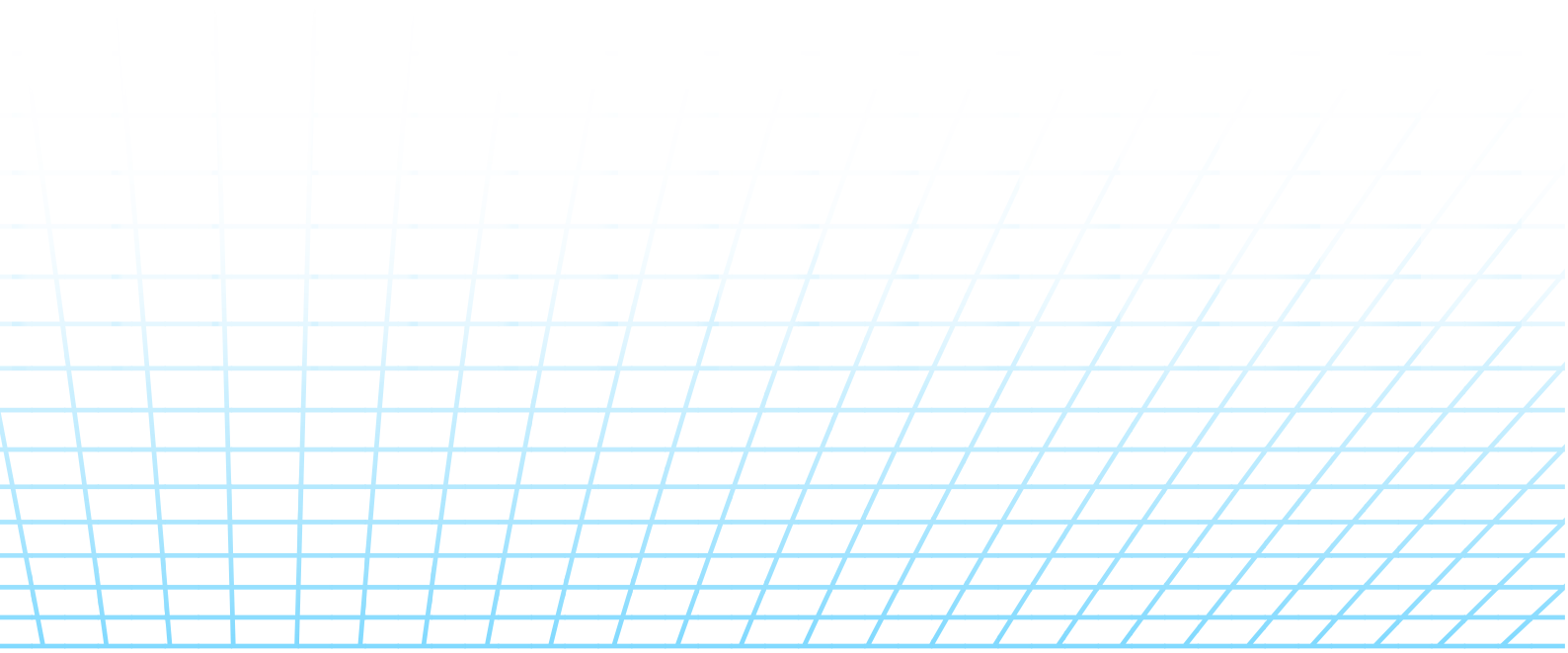
Abbrevations

COVID-19	novel coronavirus disease 2019
FHII	Moroccan Hassan II Foundation for Moroccans Residing Abroad
FINNSOM	Ministry of Foreign Affairs (Finland)
FMOH	Federal Ministry of Health (the Sudan)
GCC	Gulf Cooperation Council
GHO	Global Health Observatory
GMG	Global Migration Group
IDP(s)	internally displaced person(s)
IOM	International Organization for Migration
MIDA	Migration for Development in Africa
NGO	non-governmental organization
OCMRE	Observatory of the Moroccan Community Residing Abroad
OECD	Organisation for Economic Co-operation and Development
PPE	personal protective equipment
SAMS	Syrian American Medical Society
SMP	Skills Mobility Partnership
THET	Tropical Health Education and Trust
TOKTEN	Transfer of Knowledge through Expatriate Nationals
TRQN	Temporary Return of Qualified Nationals
UN DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
WHO	World Health Organization
WHO EMRO	World Health Organization Eastern Mediterranean Regional Office



Introduction

Definitions of *diaspora*

The use of the term *diaspora* is rooted in the paradigmatic case of the historical scattering of the Jews. From the beginning of the last century until the 1960s, the vast majority of published works on the theme of diaspora referred to the dispersion of Jews exiled from their countries (Brubaker, 2005). The use of the word spread over time to be applied to an increasing number of different ethnic populations, such as the Albanians, Japanese, Kurds and Palestinians. Around the 1990s, the term evolved to include, more generally, any emigrant group that continued to be involved in their homeland from overseas.

Three elements are commonly accepted to be constitutive of a diaspora (Brubaker, 2005). The first is the dispersion of people outside their home State or traditional "homeland". The second element is the orientation to this homeland as an authoritative source of value, identity and loyalty. The third core element is the notion of "boundary maintenance" and the preservation of a distinctive identity vis-à-vis a host society.

In the absence of a standard definition, IOM defines and uses the word *diaspora* to refer to "migrants and/or descendants of migrants whose identity and sense of belonging have been shaped by their migration experience and background" (Perruchoud and Redpath-Cross, 2019).

The IOM *International Migration and Development Training Modules* (Alvarez Tinajero, 2013) describe some common observations on diaspora communities, as follows:

(a) They connect multiple communities of a dispersed population (e.g. through shared imagination, memory or nostalgia).
(b) They maintain links based on the idea of a shared origin (real or imagined, and which could be a country, village, ethnic group and so on), whether directly (as in the case of first-generation immigrants) or indirectly (migrants' descendants).
(c) They maintain multiple shared attachments (which are as important as the idea of a shared origin) that make them a community – for example, a common history of dispossession, displacement and adaptation (Clifford, 1994).
(d) They maintain transnational circuits comprising flows of people, goods, money, ideas and information to and/or from a "homeland", which serves as a place of attachment.
(e) They produce a culture (through carefully chosen identifications) that represents them to both themselves and others, and that marks the difference and sets the boundaries between those who belong to their group and those who do not.
(f) They live "transnational lives" – that is, "living one's life across borders" – keeping relationships in dispersed social networks and nurturing feelings and families and maintaining cultures and citizenships between distinct sites (and, especially, different countries) and societies. In this sense, diasporic actors are transnational actors.

Research objectives and methods

Emigration is often seen as a failure of development, as if people "vote with their feet" to show their dissatisfaction with the prevailing conditions in the countries they are leaving behind (Hirschman, 1970). Nowadays, emigration and immigration are seen more positively in certain contexts, as reflected in major international cooperation and dialogue mechanisms, many of which take an approach to migration and development that emphasizes the resources and agency of migrants and diasporas. Today, diasporas are seen as agents of development and innovation, and as actual or potential bridges between countries and localities through their networks, multiple identifications and shared sense of belonging.

Many countries in the Eastern Mediterranean region[1] are experiencing significant emigration of health professionals. Although this is an important and growing phenomenon, there is a lack of data and very little research in this area. It is necessary to understand this phenomenon and its consequences to be able to develop solutions involving health diaspora engagement. This desk review is conducted to gain a better understanding of these matters and is guided by three main questions:

(a) What are the modalities of diaspora engagement?
(b) What are the experiences of diaspora engagement in the Eastern Mediterranean region?
(c) Building on these experiences, how can we enhance diaspora engagement?

Data collection starts with a literature search on two journal websites and a search engine. Specifically, a search on Google Scholar and the Human Resources for Health (HRH) and the *Eastern Mediterranean Health Journal* (EMHJ) websites is conducted using the following keywords: "diaspora", "brain drain", "LMIC/s" (low- and middle-income countries), "health workers" and "human resources for health". Each of the countries in the region is also used as a keyword in hopes of identifying relevant articles that present experiences from the region. Article titles are screened to filter out articles that are not specifically about the health diaspora but instead pertain to the health of migrants abroad (including internally displaced persons (IDPs) and refugees, among others). This method yields a very limited number of articles, highlighting the scarcity of information on this topic specific or pertinent to the region. Additional publications, including internal reports of the World Health Organization (WHO) and IOM (such as Mission reports), are identified through snowballing.

It should be highlighted that this joint WHO–IOM paper is merely a desk review of existing literature on health diaspora engagement that compiles and summarizes available data and information about existing health diaspora organizations[2] and institutions[3] and the challenges in relation to the emigration of health professionals. It does not entail any primary data collection or analysis of data, nor does it aim to produce research results based on primary data collection.

In spite of its limitations, this overview is an important and necessary first step towards a better understanding of the subject and the issues at stake. It aims to be a guide in carrying out meaningful and efficient projects in the future, including more in-depth and detailed research about health diaspora engagement in the countries of the Eastern Mediterranean region.

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1 In this paper, "Eastern Mediterranean region" refers to the World Health Organization grouping of the following 22 countries and territories: Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudia Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen and the Palestinian Territories.

2 "Diaspora organizations" refers to non-governmental bodies, including privately established groups, for example, a diaspora association established by migrants themselves and is not a governmental agency or office.

3 In the literature, "diaspora institution" is often used to refer to governmental and quasi-governmental bodies (see, e.g.: Gamlen, 2019; Gamlen et al., 2019).

The health diaspora

The health diaspora encompasses all kinds of health workers (nurses, physicians, dentists, pharmacists, etc.) who have migrated from their country of origin to practice their professions elsewhere. Migration of health professionals occurs due to any of a set of reasons, including relatively low wages and poor working conditions, a lack of professional development opportunities, and security concerns in origin or source countries, as well as a growing demand for health professionals in developed countries resulting from accelerating demographic changes, in combination with inadequate domestic health workforce planning and investment. This mass emigration of skilled health workers, especially the most skilled and qualified, is often labelled "brain drain" and has long been a major development concern. Such shortages significantly hamper the realization of health and development goals and are particularly felt in the medical education and specialized care sectors.

The critical shortage of human resources for health in many developing countries remains a barrier to attaining their health system goals. In relation to the World Health Report's (2006) call for global attention on human resources for health, the use of the health diaspora can be one way to meet this need.

Traditional approaches to skilled migration, so far, have tended to benefit labour markets and employers in destination countries; meanwhile, source countries, which bear the costs of education and training, are left with depleted numbers of skilled workers. To get the best of diaspora capacity for development and innovation, there is a need for a global approach to skilled migration. Indeed, skilled migration does not necessarily have to lead to "brain drain" in source countries.

Over the past few years, the contributions of migrants and diasporas to sustainable development in their respective origin and destination countries have been acknowledged in the 2030 Agenda for Sustainable Development, the New York Declaration for Refugees and Migrants, and at the annual summits of the Global Forum on Migration and Development (Frehywot et al., 2019). Policymakers have also increasingly turned to an all-party-benefiting alternative: the Skills Mobility Partnerships (SMPs). Rooted in Sustainable Development Goals (SDGs) 4, 8 and 10, and expressly called for in Objective 18 of the Global Compact for Safe, Orderly and Regular Migration, SMPs are an innovative tool centred around workers' skills formation and development that place special emphasis on multi-stakeholder collaboration.

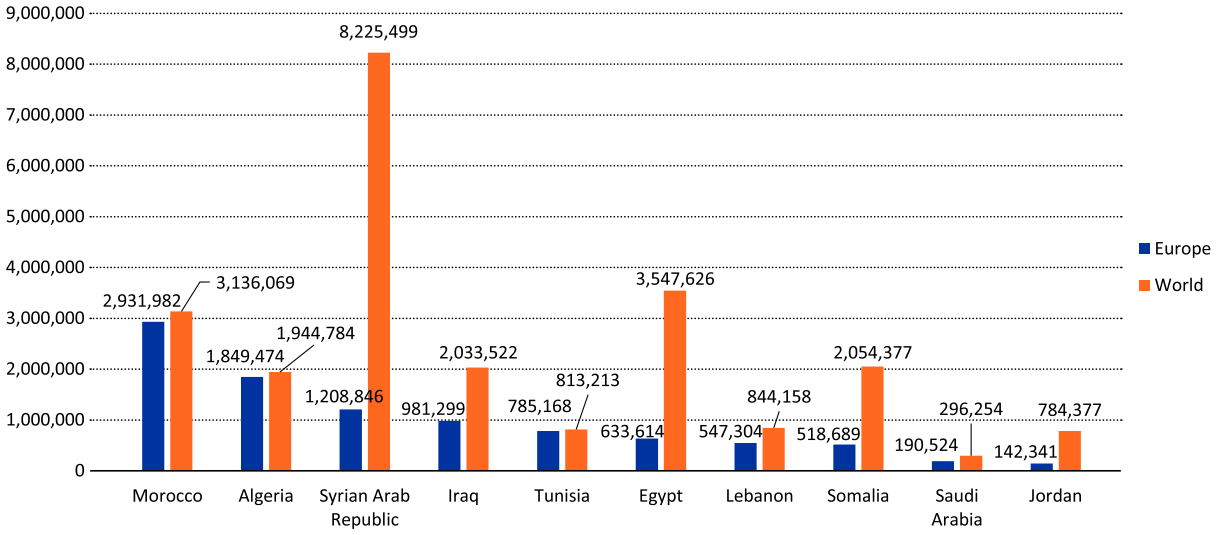
An SMP usually takes the form of a bilateral or multilateral agreement between States, under which training may be dispensed in either the source or destination country – or even a third country. In an SMP, trainees acquire skills recognized and valued by both parties (IOM, 2019a). Implemented effectively, an SMP can help the destination country address skills shortages and labour market needs, improve migrants' skills sets (and, thereby, their career prospects), and, not least of all, contribute to the source country's development through a better trained workforce, remittances, capacity-building and skills transfer. Diaspora involvement or engagement is not supposed to make up for a skills deficit in the source country, but is an element of the partnership around which source and destination countries cooperate to facilitate migration for development and fostering the engagement of skilled professionals in providing access to newly acquired skills and transfer of knowledge to professionals in the source country – a process now termed "brain circulation" or "brain bank" (Kapur, 2001).

In 2019, IOM published a paper, "Skills-based migration and partnership: Elements and essential prerequisites", which formulated a universal approach for SMPs. Aside from the elements that make up an SMP, the paper identified the advantages of having one in place and enumerated key stakeholders and prerequisites for – as well as challenges to – its successful implementation.

The situation in the countries of the Eastern Mediterranean region

Diaspora engagement is therefore crucially important, especially in the challenging context of the Eastern Mediterranean region, where large numbers of people emigrate from. In 2016, the top 10 source countries of migrants to high-income countries were, in descending order, Morocco, Algeria, the Syrian Arab Republic, Iraq, Tunisia, Egypt, Lebanon, Somalia, Jordan and Saudi Arabia (Figure 1). In 2019, a total of 10,465,190 migrants from the Middle East and North Africa region were residing in these most popular destinations among member countries of the Organisation for Economic Co-operation and Development (OECD): France, the United States of America, Germany, Spain, Italy, Canada, Sweden, the United Kingdom, the Netherlands and Australia (UN DESA, 2019b). These very same countries are facing health workforce shortages that migrant health workers are compensating for. In France, for example, the shortage of physicians has begun to be significant, with the number of general practitioners decreasing by 8 per cent since 2007; this shortage is expected to last at least until 2035 (Béguin, 2016). In the United Kingdom, the same phenomenon is observed: In 2019, the country lost more than 440 general practitioners and had more than 11,500 unfilled physician vacancies. The country is among those in Europe countries that are most reliant on foreign-trained doctors, with 28.7 per cent of British physicians having been trained abroad (Skopeliti, 2019). In Germany, health worker shortage is also an issue, with currently about 3 million Germans receiving care – a number expected to rise to 4.5 million people by 2060, when Germany will need an additional 3 million nurses (Sostmann, 2018).

Figure 1. Top ten Mediterranean sending countries to Europe and number of migrant departures to Europe and the world



Apart from emigration to OECD countries, there are also important flows of migrants within the region. Around 45 per cent (or 14.3 million) of all migrants and refugees from Arab countries remain in the region. A large proportion of migrants and refugees in the region tend to move to Gulf Cooperation Council (GCC) States, with Saudi Arabia hosting over 3.3 million migrants and refugees. The migrant and refugee population in GCC countries has grown substantially, from 8.2 million in 1990 to 30 million in 2019.

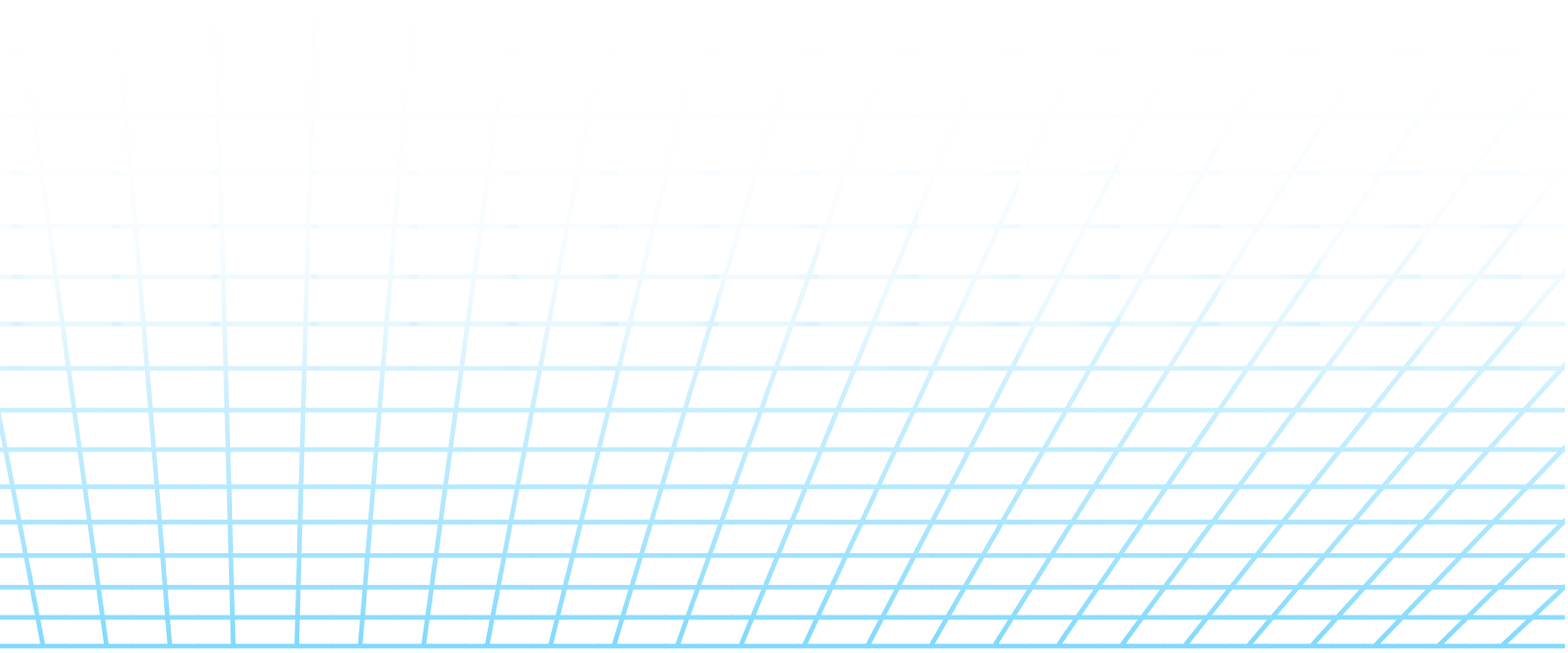
GCC countries are the most common destination for Sudanese (Abdalla, Badr and Omar, 2016), Egyptian, Yemeni and Jordanian migrant health professionals (OECD, 2015), most likely due to geographic proximity, attractive salaries and linguistic ties (Abdalla, Abuagla and Badr, 2016). Egypt is the main Arab source country, with almost 2.6 million migrants and refugees living in the subregion.

Considering the significant emigration of people, health labour markets in the region face particular challenges; although indirectly, this has implications on the economic crisis prevalent in the region and the stocks of health personnel serving national health systems. It is incumbent upon both countries of destination and countries of origin to strive to harness the development potential inherent in the health diaspora.

The shortages of health workers in some countries of the Eastern Mediterranean region are of great concern. In the Sudan, the number of physicians has fallen drastically – from 4.2 per 10,000 inhabitants in 2013 to 1.9 per 10,000 in 2017 (WHO EMRO, 2020d). In Jordan, the number of nurses and midwives has decreased considerably, from 48.6 per 10,000 inhabitants in 2013 to 18.9 per 10,000 in 2016 (WHO EMRO, 2020c). In Afghanistan and Djibouti, there were only 3.5 physicians and 5.2 nurses and midwives per 10,000 inhabitants in 2018. (WHO EMRO, 2020b). Somalia has the lowest rate in the region – 0.2 physician per 10,000 inhabitants in 2016 – a near-total absence (GHO, 2017).

It should be pointed out, however, that there is a wide disparity across Eastern Mediterranean countries in terms of available human resources for health, based upon national wealth. For example, GCC countries have over ten times more nurses and physicians per 10,000 population than Afghanistan, Djibouti, Somalia, the Sudan and Yemen (Aspen Institute, n.d.). In 2018, there were more than 26 physicians per 10,000 inhabitants in Saudi Arabia and Kuwait, and around 25 in Qatar and the United Arab Emirates (GHO, 2017). This disparity can also be explained by the fact that the vast majority of the health workforce in GCC countries are foreign-born and -trained; to be specific, 75 per cent of physicians and 79 per cent of nurses working in GCC countries are expatriates from both developed and developing nations (Aspen Institute, n.d.).

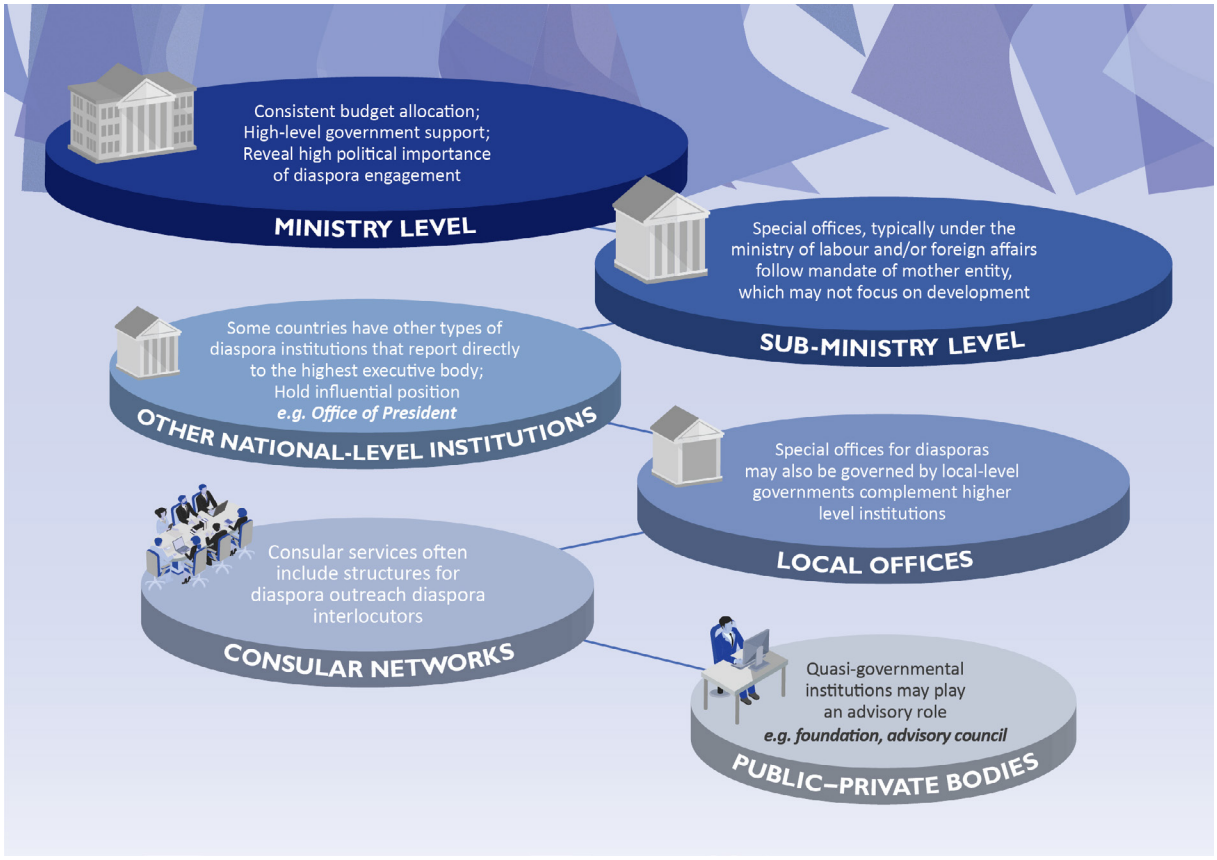
The policies of destination countries on diaspora contributions determine both the type and degree (including the amount or value) of contributions. Sudanese returnees from GCC States, particularly from Saudi Arabia, contribute primarily through monetary donations for public facilities (Abdalla, Badr and Omar, 2016); in comparison, returnees from OECD destination countries tend to focus on capacity-building.



Governmental and quasi-governmental institutions dealing with the diaspora

Diaspora institutions can create both enablers of and barriers to diaspora participation. IOM has identified six types of these institutions: (a) ministries (or equivalent ministry-level institutions), (b) sub-ministry institutions, (c) other national-level institutions, (d) local diaspora institutions/offices, (e) consular networks and (f) public–private bodies (Migration Data Portal, 2019). This classification is based on a government hierarchy and reflects a particular institution's level of influence and mandate, whether in or outside of the country, or both (Agunias and Newland, 2012). Which types of diaspora institutions exist in a source country is variable. Figure 2 gives brief descriptions of these institutions and their roles.

Figure 2. Types of diaspora institutions



Source: IOM, 2018a.

Diaspora engagement

In 2012, IOM, in cooperation with the Migration Policy Institute (MPI), developed a handbook for policymakers and practitioners: *Developing a Road Map for Engaging Diasporas in Development* (Agunias and Newland, 2012). The handbook, which is relevant to both home and destination countries, outlines four steps to effectively and sustainably engaging with the diaspora.

The first step for any government towards devising a strategy to facilitate stronger diaspora involvement in development is to identify its goals in undertaking this pursuit and define the internal tools and mechanisms (administrative, financial, etc.) required for the task. These goals of diaspora engagement cannot be set in a vacuum and should be seen as an integral part of development planning – not merely as a sideline or add-on. In addition, it must be remembered that while diasporas can bring important financial, intellectual and social capital to the development process, they cannot substitute for the cultivation of domestic resources – although they can most certainly contribute to or enhance it.

With reasonably clear goals articulated, the second crucial step for a government is to know the diaspora that it hopes to engage. This involves serious, comprehensive data collection, which includes mapping the location of the diaspora, compiling inventories of diaspora skills and experiences, and engaging a wide range of diaspora members in listening exercises to understand what the diaspora has to offer, what it is willing to offer, and what it expects from the government in return. There are new methods, such as those that rely on big data, that can be used to supplement traditional diaspora mapping tools, as they are able to locate diaspora members through website traffic information; these techniques are also really useful in learning more about diaspora members' occupations and skills, thanks to the onomastic analyses run on professional databases such as LinkedIn.

The long-term endeavour of building partnerships between governments and their diasporas is much more likely to succeed if it has a strong foundation of good communication and mutual trust. Because a partnership is a two-way street, all parties must feel that they are deriving value from the relationship. Building trust is therefore a necessary third element of the diaspora engagement strategy.

With trust established between a country's government and its diaspora, the characteristics of the diaspora well understood, and the objectives of diaspora engagement clearly articulated, a partnership for development involving the diaspora can be more successfully mobilized. This may require the creation of new government institutions and/or the revitalization of existing ones (Agunias and Newland, 2012). A detailed overview of government institutions in the Eastern Mediterranean region is listed in the following section.

Diaspora institutions in source countries in the Eastern Mediterranean region

There are a number of diaspora institutions through which the national governments of the following Eastern Mediterranean countries support their diasporas: Egypt, Iraq, Jordan, Lebanon, Morocco, Pakistan, Somalia, the Syrian Arab Republic and Tunisia. These diaspora institutions of the government are at the (a) ministry level, as seen in Iraq, Lebanon, Morocco, Pakistan, Somalia, the Syrian Arab Republic and Tunisia; (b) sub-ministry level, as in Egypt; (c) national level (other than ministries or sub-ministries), as in Egypt and Morocco; and (d) local level, as in Somalia; while some other institutions are (e) quasi-governmental, as in the case of Morocco (Agunias and Newland, 2012).

Overall, government *ministries or equivalent ministry-level institutions* work to systematically facilitate ties with migrants living outside the homeland. Their main activities include creating migration policies and developing strategies to harness the resources of diaspora groups to drive development (Frehywot et al., 2019). They have more consistent budgetary allocations, support from their respective governments and explicitly development-oriented mandates. Assigning diaspora engagement roles to ministries, which

are at the top of the hierarchy of diaspora institutions, signifies that governments consider diaspora engagement to be a politically important activity (Agunias and Newland, 2012). Table 1 lists countries of the region with ministry-level diaspora institutions, with their corresponding emigrant stocks and top destination countries.

Table 1. Eastern Mediterranean countries with ministry-level diaspora institutions

Source country	Ministry or ministry-level institution[a]	Emigrant stock, 2019[b]	Emigrant stock as a percentage of total population, 2019[c]	Top destination country, 2019[b]
Iraq	Ministry of Migration and Displaced	2 033 522	5.1	United States of America
Jordan	Ministry of Foreign Affairs and Expatriates	784 377	7.8	Saudi Arabia
Lebanon	Ministry of Foreign Affairs and Emigrants	844 158	12.3	Saudi Arabia
Morocco	Ministry in Charge of the Moroccan Community Residing Abroad	3 136 069	8.6	Spain
Pakistan	Ministry of Overseas Pakistanis and Human Resource Development	6 303 286	2.9	Saudi Arabia
Somalia	Ministry for Diaspora and Community Affairs	2 054 377	13.3	Ethiopia
Syrian Arab Republic	Ministry of Foreign Affairs and Expatriates	8 225 499	48	Turkey
Tunisia	Ministry of Social Affairs, Solidarity and Tunisians Abroad	813 213	6.9	France

Sources: [a] Agunias and Newland, 2012; [b] UN DESA, 2019b; [c] computed using data from UN DESA (2019a and 2019b).

Some countries in the region do not have dedicated government ministries for diaspora affairs, which are combined with other areas of concern, such as labour, tourism and foreign affairs under what are essentially hybrid ministries. Prominent examples of these are the Lebanese Ministry of Foreign Affairs and Emigrants, the Ministry of Social Affairs and Solidarity and Tunisians Abroad, and Somalia's Ministry for Diaspora and Community Affairs. Within these ministries are dedicated departments or agencies with mandates relating specifically to the diaspora (as in the case of Lebanon and Tunisia). Hybrid ministries are a cost-effective approach (Agunias and Newland, 2012), as they avoid the larger administrative and legislative expenses of establishing new institutions and allow for a more holistic approach to the creation of policies that address the interests of both the government and the diaspora in key areas such as trade and consumer affairs. This approach also helps to raise the country's diaspora portfolio and avoid friction between ministries that might deal with diasporas in different ways.

Sub-ministry institutions, typically under ministries of labour and foreign affairs, represent the second type (Table 2). While their main focus is typically migrant protection, their portfolios might also include initiatives that facilitate integration of diasporas into the societies of their respective destination countries, as well as participation in development activities back home. The specific programmes and activities of these institutions vary within and across countries, as not all parent ministries (or ministry-level institutions) are focused on development planning (Agunias and Newland, 2012).

Table 2. Eastern Mediterranean countries with sub-ministry-level diaspora institutions

Source country	Sub-ministry-level institution[a]	Emigrant stock, 2019[b]	Emigrant stock as a percentage of total population, 2019[c]	Top destination country, 2019[b]
Egypt	Emigration Section of the Ministry of Manpower and Emigration	3 547 626	3.5	Saudi Arabia

Sources: [a] Agunias and Newland, 2012; [b] UN DESA, 2019b; [c] computed using data from UN DESA (2019a and 2019b).

Other national-level diaspora institutions do not have full ministry standing (Table 3). As such, they report to higher executive government levels (Agunias and Newland, 2012) yet still enjoy considerable influence.

Table 3. Eastern Mediterranean countries with other types of national-level diaspora institutions

Source country	National-level institution[a]	Emigrant stock, 2019[b]	Emigrant stock as a percentage of total population, 2019[c]	Top destination country, 2019[b]
Egypt	Higher Committee on Migration	3 547 626	3.5	Saudi Arabia
Morocco	Interdepartmental committees	3 136 069	8.6	Spain

Sources: [a] Agunias and Newland, 2012; [b] UN DESA, 2019b; [c] computed using data from UN DESA (2019a and 2019b).

Local diaspora institutions/offices, while taking overall policy direction from higher government offices, function relatively independently. They are able to design programmes based on community needs while complementing the activities of higher-level institutions, with which they share the cost of diaspora engagement. Diaspora members can monitor their contributions and investments through government offices at the local level, improving accountability and facilitating the monitoring of successful programmes (Agunias and Newland, 2012).

Table 4. Eastern Mediterranean countries with local diaspora institutions/offices

Source country	Local institution/office[a]	Emigrant stock, 2019[b]	Emigrant stock as a percentage of total population, 2019[c]	Top destination country, 2019[b]
Somalia	Office for Development and Partnership with the Puntland Diaspora Community	2 054 377	13.3	Ethiopia

Sources: [a] Agunias and Newland, 2012; [b] UN DESA, 2019b; [c] computed using data from UN DESA (2019a and 2019b).

Quasi-governmental institutions lie somewhere on the spectrum between governmental and non-governmental bodies. Their functions vary: Some act as advisory councils, while others have more impact-based activities. Among the Eastern Mediterranean countries under study, only Morocco has been found to have such institutions (Table 5).

Table 5. Eastern Mediterranean countries with quasi-governmental diaspora institutions

Source country	Quasi-governmental institutions	Emigrant stock, 2019*	Emigrant stock as a percentage of total population, 2019*	Top destination country, 2019*
Morocco	• Hassan II Foundation for Moroccans Residing Abroad • Council of the Moroccan Community Living Abroad (CCME (French: Conseil de la Communauté Marocaine à l'Étranger)	3 136 069	8.6	Spain

Sources: [a] Agunias and Newland, 2012; [b] UN DESA, 2019b; [c] computed using data from UN DESA (2019a and 2019b).

The Hassan II Foundation for Moroccans Residing Abroad (FHII) was created in 1990 as a private institution, yet it maintains an especially close relationship with the Moroccan Government, which set its mandate. It is officially described as a "non-profit institution with a social vocation, endowed with a moral personality and financial autonomy" and as having "a stronger voice with host governments" than other non-governmental organizations (NGOs). Its ties to the Government are, specifically, with these persons-in-charge: The foundation is run by the Minister in Charge of the Moroccan Community Residing Abroad and HRH Princess Lalla Meryem of Morocco. FHII works in the areas of education, cultural exchange, sports and youth; legal assistance, social assistance, economic development, international cooperation and partnerships; and communications. In collaboration with IOM, the foundation created the Observatory of the Moroccan Community Residing Abroad (OCMRE) — a network of experts, researchers, academics and FHII partners. The main objective of OCMRE is to monitor and analyse the living conditions of Moroccans abroad through data collection and maintenance of an information system.

Health diaspora organizations in source countries

The involvement or engagement of diasporas with their respective source countries are categorized into several levels. The highest level of diaspora participation is self-mobilization, followed by collaboration, consultation, passive information-gathering and receiving of information (Migration Data Portal, 2019). These levels of participation essentially underpin the level of responsibility that diaspora members undertake for the development of the source country. To expound on these different levels: Self-mobilization is the retention of full ownership and responsibility for development initiatives. Collaboration is the sharing of responsibilities, either by delegating tasks to other actors or jointly implementing development interventions. Consultation entails discourse between development actors and the diaspora to inform policy or practice. Passive information-gathering is when diaspora members provide information to interested parties, including their governments. Lastly, diaspora members receiving information on development and related issues is also considered as a type of participation (Migration Data Portal, 2019). A number of diaspora organizations have been created by migrants themselves in their destination countries, illustrating self-mobilization. These health diaspora organizations focus on three objectives:

(a) Providing health-care services, training and humanitarian aid in the source country (IOM, 2019b);
(b) Creating a social or professional network of migrant health professionals in destination countries (Agunias and Newland, 2012);
(c) Supplying improved and culturally sensitive health care to the migrant population in the country of destination (Alvarez Tinajero, 2013).

Table 6 lists some health diaspora organizations for migrants from eight Eastern Mediterranean countries formed in destination countries, predominantly the United States and the United Kingdom.

Table 6. List of health diaspora organizations relevant to the Eastern Mediterranean region, 2019

Health diaspora organization	Year established	Website
Afghan Medical Association of America	1992	www.afghanmed.org
Afghan Medical Professionals Association of America	1989	www.ampaa.org
American Board-Certified Doctors for Egypt	2011	www.doctorsforegypt.com
American–Lebanese Medical Association	1994	www.almamater.org
Association of Afghan Healthcare Professionals UK	2011	http://aahpuk.org
Association of Pakistani Physicians and Surgeons of the UK	2004	http://appsuk.org
Association of Physicians of Pakistani Descent of North America	1976	http://appna.org
British Egyptian Medical Association	n.d.	www.facebook.com/BritishEgyptianMedicalAssociation https://britishegyptianmedicalassociation.co.uk
British Islamic Medical Association (for Sudanese descent)	n.d.	www.britishima.org
British–Iranian Medical Association	2009	www.facebook.com/BIMAUK
Egyptian–American Medical Association	2012	www.e-ama.org
Egyptian–American Medical Society	1988	www.egyptianamericanms.com
Iranian–American Medical Association	1993	www.iama.org
Iranian Medical Society	1986	www.iranianmedicalsociety.org/Index.cfm
Iranian Medical Society UK	1960	www.iranianmedicalsociety.org.uk
Iranian–American Medical Society of Greater Washington (Iranian Medical and Dental Society of the Greater Baltimore–Washington Metro Area)	1990	www.iamsgw.org
Iraqi Medical Association UK	1991	www.imauk.com
Iraqi Medical Sciences Association USA	1998	www.imsausa.org
Pakistan Medical Association UK	1948	www.facebook.com/pages/category/Medical-Company/PakistanMedical-Association-UK-346946281999626
Sudanese Junior Doctors Association UK	2016	www.sjda.uk
Sudanese Medical Association UK and Ireland	2010	www.facebook.com/groups/sma.ukandire/?ref=group_header
Sudanese–American Medical Association	2008	www.sama-sd.org
Syrian Expatriate Medical Association	2011	www.sema-sy.org/
Syrian–American Medical Society Foundation	1998	www.sams-usa.net
Syrian–British Medical Society	2007	http://sb-ms.org
Syrian Expatriate Medical Association	2011	www.sema-sy.org/

Source: Frehywot et al., 2019.

In some destination countries, there are multiple institutions for diaspora members from the same source country. In larger countries, this is often due to the geographic spread of diaspora members; for instance, the Afghan Medical Association of America is based in California and the Afghan Medical Professionals Association of America in Washington, with both organizations involved in similar activities.

In other instances, the organizations differ in their activity focus, as exemplified by the Iranian diaspora organizations in the United Kingdom. Iranian–British Society UK is involved in overseas aid, whereas British–Iranian Association is focused on addressing the needs of an increasing population of British–Iranian health-care professionals and the creation of a local community where members can help each other. Both organizations are based in London. In addition, some organizations differ in the frequency and scale of the activities that they carry out. It is difficult to comment on the frequency and scale of their activities based only on a web search, as some websites may not be regularly updated.

As explained above, the work of health diaspora institutions generally focuses on three areas: (a) providing services, training and humanitarian aid to source countries; (b) creating networks of migrant health professionals; and (c) providing culturally sensitive health care to migrant populations in destination countries. The first of these is very significant and is illustrated by the Association of Afghan Healthcare Professionals UK, the Egyptian–American Medical Society, the Association of Pakistani Physicians and Surgeons of the UK, the Iranian Medical Society UK, the Iraqi Medical Sciences Association USA and the Syrian–American Medical Society Foundation, which have all been involved in work related to humanitarian aid relief, assistance in clinical care provision, and provision of supplies and medical equipment in their respective countries. They raise funds, as well as sending qualified professionals back for providing training or direct clinical care. The outcomes of the missions have been documented on their respective websites and several news publications.

There are also contributions in medical education and capacity-building. An example of such work is that done by the Syrian–American Medical Society (SAMS), which sponsors a peer-reviewed online medical journal, the *Avicenna Journal of Medicine* (Frehywot et al., 2019). The journal website links members to other journals, such as the *British Medical Journal* and *The Lancet* (SAMS, 2020). Other capacity-building work of SAMS includes training campaigns for physicians in the Syrian Arab Republic and providing scholarships, mentorships and other educational programmes. Their online education projects aim to help Syrian medical students and physicians working in the country who have no access to continuing medical education (SAMS, 2020).

Another example in medical education is the work done by the Afghan Medical Professionals Association of America in promoting medical education and research and providing education assistance by means of teaching materials, training opportunities and collaboration with Afghan medical professionals.

A number of these organizations have double functions. As such, in addition to providing clinical care services or capacity-building in source countries, they also serve migrants in destination countries, ensuring solidarity between the established diaspora and newcomers. For example, the Egyptian Medical Society UK and the Pakistan Medical Association UK assist their fellow-national migrants in settling in the United Kingdom. The Iranian Medical Society in the US have activities for "enhancing Iranian culture" or which aim to "break linguistic barriers for elderly Iranian patients and introduce a Farsi-speaking physician to help and support their needs".

It is important to identify the facilitators, as well as barriers, to an engaged diaspora. One of the barriers to diaspora engagement described has been the lack of structured organization or focal point for the diaspora, resulting in reduced engagement from those who would otherwise be willing to help. Such lack may be simply be due to the fact that a diaspora organization or focal point has not yet been established, sometimes because there is not a large enough diaspora population in the destination country, but sometimes also because of political reasons.

According to the IOM database of global diaspora mappings, only Morocco (4 studies), Egypt (1 study) and Algeria (1 study) have undertaken such studies.

International organizations and diaspora engagement

A number of global NGOs have stepped into the field and developed projects to help minimize the effects of brain drain. Particularly, UNDP and IOM, as two United Nations agencies, have been promoting and facilitating diaspora engagement, aiming to address the operational challenges of migration, advance the understanding of migration issues, and encourage social and economic development through diaspora engagement in collaboration with partners and stakeholders.

IOM, in cooperation with the members of the Global Migration Group (GMG) and academia (i.e. MPI), has developed a number of key resources which can guide policymakers and diaspora organizations alike on how to engage the diaspora in an effective and sustainable manner.

The handbook for policymakers and practitioners in source and destination countries on, *Developing a Road Map for Engaging Diasporas in Development*, outlines four main steps of engaging with diaspora communities in a very practical and hands-on manner. In addition, there are the International Migration and Development training modules (which target government officials) on the nexus between migration and development more broadly, but which also show how collaboration between policymakers and diasporas can be strengthened by engaging both sides to enable development and empowering them through capacity-building and establishing mutual trust.

Finally, a handbook for policymakers and practitioners, Mainstreaming Migration into Development Planning, was developed with the GMG and which provides a step-by-step approach for governments on how to set up institutional structures and policy frameworks needed to effectively integrate migration into the development planning cycle.

Currently, IOM is working on a global methodology for a diaspora mapping exercise, building on the experience of some 150 diaspora mapping exercises undertaken by IOM missions worldwide, upon the request of governments. The methodology is being developed in cooperation with the University of Maastricht and will be available later in 2021 and includes the latest innovations in using big data for diaspora mapping.

Similarly, IOM has also developed a guide on how to write diaspora engagement strategies, again building on the experience of working with numerous governments on writing such documents, in an effort to assist others in this first crucial step of identifying their own goals in undertaking stronger diaspora involvement in development. Such strategy documents usually come with an associated action plan and a monitoring and evaluation framework.

All the aforementioned tools and methodologies are available to support governments in their efforts to better know their diaspora communities' needs and aspirations and to enter into a constructive dialogue with them and engage them in a sustainable, meaningful way in the development process back home. The tools can assist governments in Eastern Mediterranean countries to acquire the necessary know-how to engage with their diaspora, especially the health diaspora, and to make sure that these highly skilled professionals turn into a well-recognized and indispensable resource for health system policy formulation and programme implementation.

UNDP project: Transfer of Knowledge through Expatriate Nationals (TOKTEN)

The TOKTEN Programme is a UNDP-led initiative that aims to mobilize professionals living abroad for skills and knowledge transfer during short-term assignments back in the source country (Kleibo, 2001). The programme was piloted in the Syrian Arab Republic in the late 1980s, with more than 20 assignments to the country until 2001. It was taken to the Palestinian Territories in 1994, mobilizing over 350 Palestinians living abroad during its run. The last assignment was in 2004–2005 (UNDP, 2020), with

a duration of three weeks to three months per professional. TOKTEN was most recently instituted in Lebanon, where it does not provide a direct salary to participants but grants them roundtrip air tickets and daily subsistence allowances (TOKTEN Lebanon, 2020). The programmes iterations in all of these countries prioritized country objectives in the choices of projects they offer.

IOM projects on diaspora engagement

IOM is working intensively with countries of the Eastern Mediterranean region to encourage and channel the positive impacts of migration by mobilizing members of their diasporas residing in Europe and North America to contribute to their development. Within this framework, IOM has started a number of capacity-building initiatives to help countries benefit from the skills of their nationals in the diasporas. All of the projects presented thus far present diaspora engagement solutions in general, including health diaspora engagement activities, of which there are two types:

(a) IOM acts at the transnational level with various cross-country projects on diaspora engagement:
  (i) Temporary Return of Qualified Nationals (TRQN), notably in Iraq, the Sudan, Somalia and Afghanistan;
  (ii) Diaspora for Development Study Tour (DDST), notably in Yemen, Egypt, Jordan and Iraq;
  (iii) Strengthening African and Middle Eastern Diaspora Policy through South–South Exchange (AMEDIP), in Egypt, Tunisia, the Syrian Arab Republic, Morocco and Lebanon;
  (iv) Connecting Diaspora for Development (CD4D2) through knowledge transfer;
(b) IOM has also developed, at the national level, country-specific projects on diaspora engagement in Morocco, Somalia, Afghanistan and Iraq.

These programmes, carried out in collaboration with national governments and other stakeholders, promote effective management of health worker migration and health system capacity-building in source countries and skills/knowledge transfer from the diaspora.

IOM cross-country projects

1. Temporary Return of Qualified Nationals (TRQN), Phases I, II and III (2006–2015)
The Government of the Netherlands worked with IOM in April 2006 to start the Temporary Return of Qualified Nationals (TRQN) programme (IOM, 2020b). TRQN-III had the thematic focus, "Enhancing Government and Institutional Capacity by Linking Diaspora to Development". The objective of TRQN was to contribute to reconstruction and development initiatives in a number of former war- or conflict-affected countries. This was done by temporarily placing higher-educated diaspora persons in the Netherlands back in their home countries. TRQN-I and TRQN-II facilitated 479 assignments and had over 150 direct beneficiary institutions in both the public and private sectors. The third phase aimed to facilitate 405 skills transfer assignments across all countries involved (not just the Eastern Mediterranean region).

Eastern Mediterranean countries involved: Iraq, the Sudan, Somalia and Afghanistan.

2. Diaspora for Development Study Tour (2002–2003)
Beneficiary countries expressed interest in developing or enhancing strategies to better engage their diasporas in local development. The study tours undertaken by diaspora members back to their own countries allowed exposure to the destination country model and facilitated discussion of key issues among the participants, as well as share best practices and contribute to forward planning, all based on their own countries' experience in this area.

Eastern Mediterranean countries involved: Yemen, Egypt, Jordan and Iraq.

3. Strengthening African and Middle Eastern Diaspora Policy through South–South Exchange (AMEDIP)
The project aims to enhance the institutional capacities of national authorities charged with migration and development to better harness the contributions of diaspora communities.

Eastern Mediterranean countries involved: Egypt, Tunisia, the Syrian Arab Republic, Morocco and Lebanon.

4. Connecting Diaspora for Development (CD4D2) through Knowledge Transfer
The overall objective of CD4D2 is to promote an active role for the diaspora in developing the capacity of certain target sectors and institutions in focus countries (which have large diasporas) where specific expertise considered essential for the development of those sectors and institutions is sometimes disposed and becomes missing locally. This project particularly focuses on knowledge transfer in some priority sectors – health being one of them. The project aims to connect the diaspora to target institutions with identified expertise gaps as a successful formula for institutional capacity-building.

Eastern Mediterranean countries involved: Afghanistan, Iraq and Somalia.

IOM country-specific projects

1. Morocco

(a) Establishment of an Observatory of the Moroccan Community Living Abroad (EOMC), Phase II
The project consolidated and created institutional networks for better information-sharing and to undertake research for the benefit of the Hassan II Foundation for Moroccans Living Abroad (MLA).

(b) Programme of Development Project Co-Financing for Moroccan Migrants Resident in Cataluña (MIDA Cataluna/PDPC)
The project co-funded five projects in Morocco to the Moroccan diaspora in Catalonia.

(c) Migration and Return, Resources for Development (MigRessources)
The project contributed to economic and social development in Morocco through the improvement of the professional insertion of Moroccan migrants, identification of ways for the permanent or temporary return of qualified Moroccans residing in Italy, and enhancement of the impact of remittances.

2. Somalia

(a) Qualified Expatriate Somali Technical Support (QUESTS-MIDA), Phases I and II
So far, MIDA has placed 126 qualified Somalis returning to Somalia for six to nine months; the emphasis is on the fields of local governance and institutional development.

(b) Transition Initiative for Stabilization
The project, which aims to reduce conditions that allow extremism to thrive, has made 13 placements of qualified Somalis returning to Somalia.

(c) MIDA Health Northern Somalia, Phases I and II: "Institutionalizing health-care improvement through temporary returns of Somali health professionals residing in Finland" (MIDA HNS FINSSOM-I and MIDA HNS FINNSOM-II)
This project aims to contribute to consolidating sustainable development processes in Somalia by further engaging and enhancing the role of qualified Somali diaspora experts towards improving education and health outcomes. It promotes the transfer of skills and knowledge acquired abroad by qualified and highly qualified health professionals in the Finland-based Somali diaspora to contribute to the reconstruction and capacity-building of the human resource base of Northern Somalia's health sector.

(d) MIDA FINNSOM Health, Phase IV (Somaliland): "Institutionalizing health-care sector development through temporary returns of Somali diaspora health professionals" (MIDA FINNSOM-IV)
Based on the IOM Return of Qualified African Nationals (RQAN) programme, the MIDA FINNSOM Health initiative was launched in 2001. The project is working to improve the capacities of the health-care system and local health-care personnel in Somaliland and Puntland. A significant number of participating diaspora experts are from the Somali diaspora in Finland.

The project's priority focus is maternal and child health. Other activities include raising funds and shipping donated equipment from hospitals in Western countries (IOM, 2018b). To this date, a number of hospitals have established and operationalized neonatal units and maternity wards, and others have seen a dramatic decrease in maternal and neonatal mortality. The staff that work in these units have all been trained by the returning diaspora experts. Beyond working to transfer technical skills and knowledge in the medical field, the MIDA FINNSOM Health also builds the leadership, planning and supervision capacities of local health-care institutions and ministries.

3. Afghanistan

Return of Qualified Afghans (around 10 different projects 2002–2012)

Notable figures concerning the project include the following:

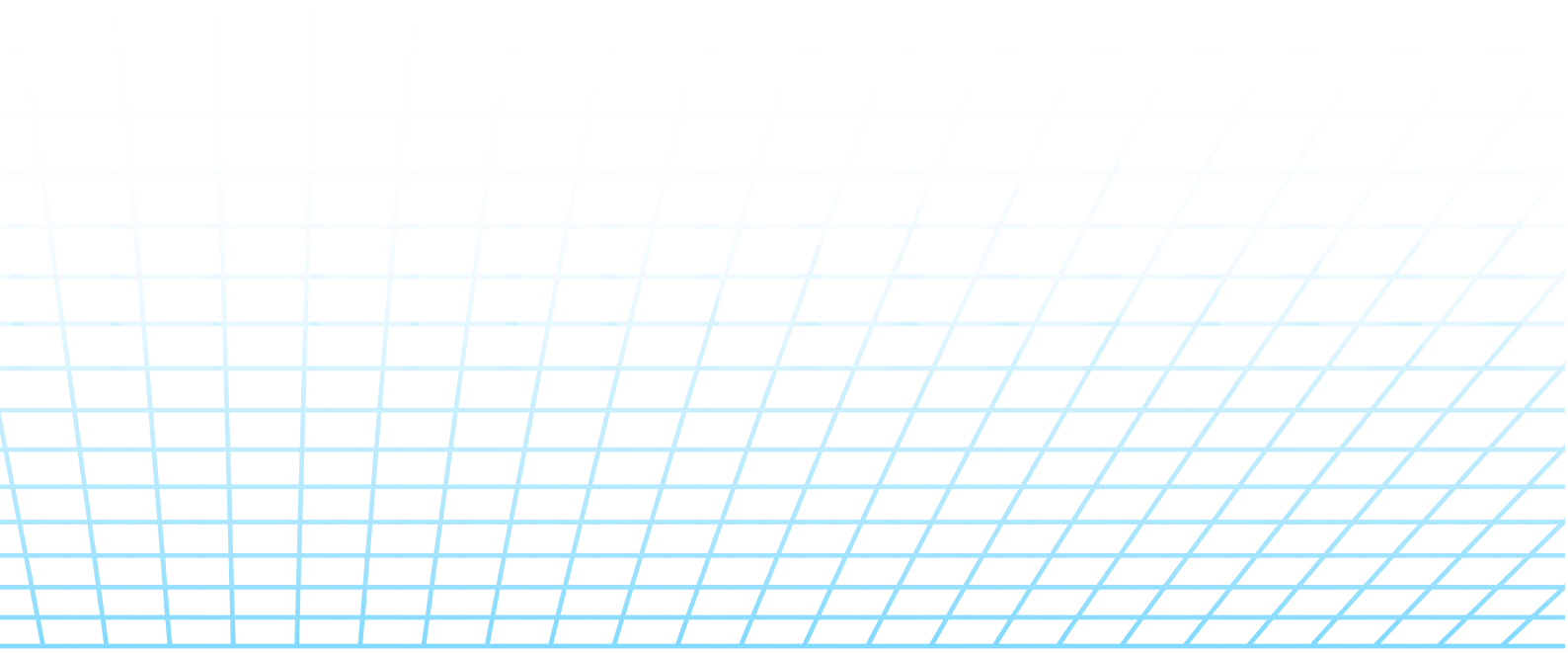
- 1,365 experts returned to Afghanistan through IOM
- 200 female experts returned
- 31 countries where experts returned from
- 24 Afghan ministries where experts have been placed
- 33 government institutions where experts have been placed
- 28 provinces where experts have been placed

4. Iraq

(a) Survey and Skills Bank on Qualified Iraqis Residing in Norway (2003–2004)
The survey was carried out among Iraqi nationals in Norway to assess their professional capacities and how they could contribute to post-conflict reconstruction in Iraq. The data was stored in a computer database is to be used to match human resources with job openings in Iraq.

(b) Capacity-building for the Ministry of Displacement and Migration in Management of Return Migration and Return of Qualified Iraqi Nationals (CBMM–Iraq) (2004–2006)
The project helped to build and strengthen the capacity of the Government to manage migration and assisted return of IDPs and Iraqi migrants, as facilitated recruitment and insertion of qualified professional Iraqi expatriates.

(c) Return of Qualified Iraqis (RQN-TOKTEN) (2004–2007)
The project aims to enhance the institutional capacity of the Iraqi Ministry of Displacement and Migration (MODM) and other Iraqi public administrations through the short- and long-term deployment of selected Iraqi experts.



Other examples for diaspora engagement from Eastern Mediterranean countries

Although the region suffers from high emigration, there are only a few documented examples of good diaspora engagement. The Sudan and Somalia are two of the most prominent and active countries in the region with regard to engaging their diasporas and documenting the process.

The Sudan

The brain drain phenomenon and emigration is one the biggest challenges of human resources for health development in the Sudan. Approximately 30 per cent of the 3,000 annual medical graduates migrate every year, and around 3,500 highly skilled Sudanese physicians with postgraduate qualifications in a range of disciplines are currently working and living abroad (Abdalla, Badr and Omar, 2016). Most of these migrant health professionals are general practitioners. These numbers keep growing, despite efforts that the Sudan has taken to prevent the emigration of health workers. The Sudanese Government has introduced a compulsory one-year period of national service for physicians after the completion of their internships, before they could obtain their university qualifications, as a strategy against their immediate migration after graduation. There is also a policy that requires physicians to obtain written approval from employers to travel abroad.

Although there is high emigration, Sudanese health professionals have a high level of willingness to contribute to their country (Abdalla, Badr and Omar, 2016). These contributions mainly take the form of personal initiatives and are voluntary, as there is no set mechanism in place to engage the diaspora. The majority of contributions are clinical services and academic work, such as teaching in Sudanese universities, attending scientific meetings and presenting at conferences. There is a small proportion of the diaspora, mostly based in GCC countries, that have made monetary donations, carry out management consultancies and run advocacies for health.

An early example is the visiting programme of Dr Kamal Abosin, a famous Sudanese nephritic surgeon. Since it started in January 2001 until 2004, Dr Abosin and his team, in collaboration with Sudanese staff, performed more than 40 operations (FMOH, 2012). It is not known if the programme is still ongoing. Other typical clinical service programmes include short-term visits to clinical facilities and are similar to Dr Abosin's work.

There are also contributions which aim to strengthen links between source and destination countries and build capacity in the source country. For example, activities such as the writing and signing of a Memorandum of Understanding between the Academy of Medical Royal Colleges in the United Kingdom and the Sudan Medical Specialization Board are a starting point for further collaboration. This was facilitated by the Sudan Doctors' Union in United Kingdom and the Republic of Ireland and the Irish–Sudanese Immigrant Physicians' Training Initiative (Abdalla, Badr and Omar, 2016). There is also a Diaspora Doctors' Initiative, of the Sudan Doctors' Union, which asks members to volunteer in clinical settings during holidays in the Sudan.

Likewise, a proposal for institutional twinning and collaboration between St James's Hospital in Dublin, Ireland, and different Sudanese tertiary hospitals and centres, was made by the Sudan Medical Association UK and Ireland (Abdalla, Badr and Omar, 2016).

The country's political and other contexts complicate the ease of effective contributions. Most stakeholders would consider the contributions of the Sudanese health diaspora to be of a small magnitude considering their number and expertise (Abdalla, Badr and Omar, 2016). Nevertheless, the contributions of Sudanese physicians in the diaspora are greater than those from permanent returns, which are becoming rare due to recent financial constraints and political instability (Abdalla, Badr and Omar, 2016).

The Government of the Sudan has developed a number of policies to ease and encourage return. These policies that permit academic professionals from the diaspora to have work part-time for multiple public and private universities – which had previously been reported to encourage return migration to seek employment in public academic institutions. Even though returnees still face social and professional difficulties on their return, the contacts they have maintained and their back-and-forth movements reduce these difficulties. Additionally, there are now dual/multiple citizenship and residency rights, issued by the Ministry of Interior in the Sudan, which are expected to enhance diaspora contributions by making travel and investment easier.

The literature suggests that barriers to diaspora engagement are institutional in nature. There is a lack of focal points and coordination between investors and receivers. This has sometimes led to duplication of efforts and wastage of resources, as multiple diaspora associations from abroad would approach the same local institution in the Sudan for investment.

Somalia

There are ten identified categories of supporters contributing to relief, development and political life in Somalia through diaspora involvement: individual households, local NGOs, clan-based or hometown associations, professional associations, transnational associations, mosques, private investors and shareholders in private businesses, members of boards of trustees, women's groups and youth groups (Hammond et al., 2011). These categories often overlap: for instance, a local NGO may also be a clan-based association or a youth or women's group. Focused group interviews and other research have revealed that given the nature of the projects being financed and the self-reported estimated numbers of beneficiaries – diaspora support for people living in Somalia is providing crucial assistance, often to areas where the international community does not have reliable access.

Aside from fiscal transfers, the diaspora is involved in sending in-kind assistance (books, medical supplies, machinery, etc.), as well as technical support provided in person. The recipients of these efforts are mainly local NGOs, social service providers and private investors.

Tropical Health Education and Trust

Tropical Health Education and Trust (THET) in London has been working to improve the capacity of Somalia's health workforce since 2000. The Trust opened a Country Office in Hargeisa in 2011. For the last 18 years, THET has led projects as part of the Health Consortium for the Somali People, funded by the former UK Department for International Development (DfID).

The activities are focused on capacity-building, such as training villagers in remote areas to become community health workers and support their communities with health-care services that would otherwise be unavailable. In addition, THET provided funding for staff of the Somaliland Nursing and Midwifery Association has been provided[4] and worked with the diaspora to facilitate other projects such as Prepared for Practice Project (PfP) (2017–2021). The project delivers an extensive, integrated educational programme including interactive, online student-teaching, blended faculty training to improve

[4] Refer to the THETpartnerships YouTube channel (www.youtube.com/user/THETpartnerships) for more information.

teaching skills, an online support network for postgraduates, and national policy improvement. By 2021, graduates from the three schools are expected to show increased clinical reasoning ability and clinical competency, with more confidence to enter clinical practice. The Trust is also working on the Formation of Plan for Nutrition Human Resource Development in Somalia (2017).

THET has also supported a number of vertical disease-based projects, such as suicide prevention, epilepsy, children's health, sexual health education, and other educational programmes focused on mental health training for nurses and training biomedical engineers.[5]

Pakistan

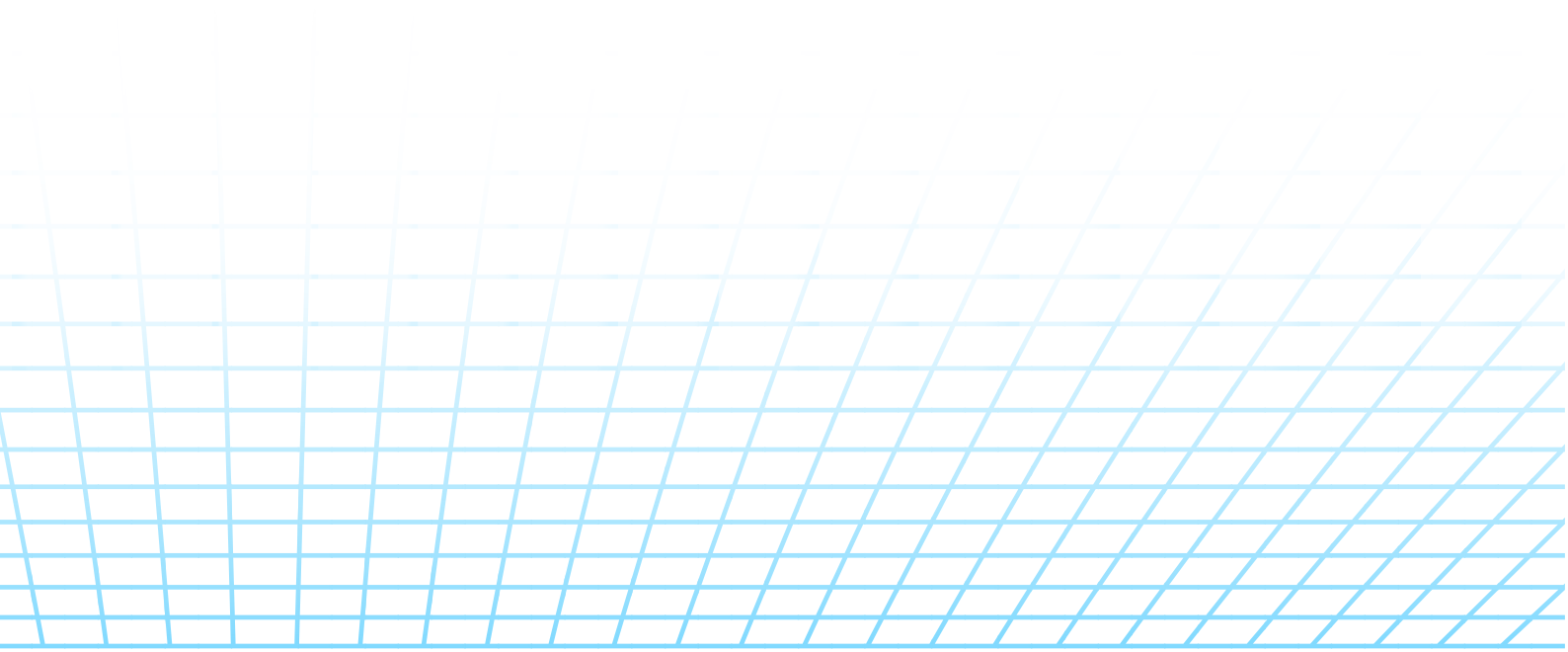
There are around 8.8 million Pakistanis overseas, making them the seventh largest diaspora community in the world. The diaspora is highly motivated to contribute to the development of the home country, exemplified in part through monetary contributions. A prominent example of the magnitude of their contributions is the fundraising for the construction of the Shaukat Khanum Memorial Cancer Hospital, which opened in December in 1994. The Government of Pakistan urged overseas Pakistanis to make donations and, as a result, raised over GBP 1.5 million in six weeks. A more recent fundraiser where the diaspora was a significant contributor was for the Diamer Bhasha Dam, which raised over USD 66 million by January 2019 (Pakistan Supreme Court, 2020).

Health professionals constitute a significant proportion of the Pakistani diaspora, with the latest estimates putting the number of trained Pakistani physicians living abroad at 30,000. While a majority of them reside in the United States, there are also sizeable overseas Pakistani communities of health professionals in the United Kingdom, the Middle East, continental Europe and East Asia.

Majority of engagement activities are primarily driven by individuals or through organizations in destination countries. A prominent organization is the Association of Physicians of Pakistani Descent of North America (APPNA), which has over 3,000 members of the total pool of 17,000 Pakistani health-care professionals in the United States and Canada. In the United Kingdom, the Association of Pakistani Physicians and Surgeons has a strong engagement presence and a big part of their activities involve development projects in Pakistan (e.g. mobile clinics and public health awareness projects; see Annex I). In addition, Association of Pakistani Physicians of Northern Europe (APPNE) has a membership of over 275 physicians.

Given the magnitude of health diaspora abroad, Pakistan is launching the Yaran E Watan Project in 2020. The Ministry of National Health Services Regulations and Coordination (MNHSRC) and the Ministry of Overseas Pakistanis and Human Resource Development (MOPHRD) have partnered with IOM, WHO and a number of other organizations, including the host country organizations mentioned above, to develop an online platform for the Pakistani diaspora to facilitate their sustained engagement for health sector development. Within their mandate, they aim to create mechanisms that reduce barriers for engagement and exchange, facilitate a diverse range of activities, and provide appropriate recognition and support to the Pakistani diaspora (Yaran E Watan, 2019).

[5] Refer to the THETpartnerships YouTube channel (www.youtube.com/user/THETpartnerships) for more information.



The COVID-19 pandemic and diaspora engagement

The rapid increase in the numbers of COVID-19 cases and their geographic spread has created enormous demand and stress on health systems and health workers worldwide. Health-care workers are the frontline responders to the pandemic, and, as such, there is tremendous pressure on them.

The increasing workload has resulted in shortages in the health workforce in general, but also particularly in certain specialties such as intensive care, infectious diseases, pulmonology and respiratory therapy, and more (WHO EMRO, 2020a). The acute onset of the epidemic has meant little time for adequate training and has resulted in a shortage of equipment (ventilators) and supplies to enable health staff to provide adequate care to patients.

Heavy workloads and highly stressful working environments have led to long working hours, psychological distress, fatigue, occupational burnout, and sometimes even physical and psychological violence. Health workers are also at risk of becoming infected, and even losing their lives, and may fear transmitting the infection to their families and loved ones. The current shortages of personal protective equipment (PPE) significantly increases the risk further. (WHO EMRO, 2020a)

These challenges not only affect the health-care workers on an individual basis, but from a systems perspective as well. The shortages of workers can result in an interruption of essential medical services. The health professional education system is also affected through the interruption of studies.

Diaspora engagement is one way to support countries' efforts in the COVID-19 response, and address the challenges faced by health-care workers and health-care systems. The health diaspora can contribute by sharing their expertise, giving their time and/or making monetary donations. Despite restricted travel due to COVID-19, several diaspora organizations have been actively supporting source countries through virtual engagements. For example, the Sudanese Doctors' Union in UK is supporting the Sudan's COVID-19 response by sharing technical expertise through online webinars (Sudan Doctors' Union UK, 2020a) and by raising funds via their website for the Oxygen Generation Plant Project of Al-Fashir Hospital, in collaboration with the Association of Sudanese Medical Engineers in UK. Similarly, the Armenian health professionals in the United States, shared their experiences in tackling COVID-19 in New York hospitals through an online knowledge-sharing session (IOM, 2020a).

The opportunities in diaspora engagement are multifaceted. Diaspora members can assist with the problem of interrupted health professional education by mentoring students or young graduates, providing online capacity-building sessions, and assisting in the maintenance of essential medical services through telemedicine.

Diaspora contributions to the health sector are not limited to the health diaspora, as several non-health diaspora organizations globally have sent funds and supplies to their source countries (IOM, 2020a). For example, the Bangladeshi diaspora raised funds to provide PPEs to health-care workers and physicians in Bangladesh (Ghosh, 2020), while the Lebanese diaspora community in Australia sent testing kits to Bsharri Government Hospital (Chehayeb, 2020). As final examples, the Rwandan diaspora in South Sudan (*Agence de Presse Africaine*, 2020) and the global Eritrean diaspora (*Africa News*, 2020) have both raised significant funds to support fellow citizens in their home countries.

The COVID-19 pandemic is a crisis that needs a multidimensional response, tailored to each country's context. With close links to source countries, the diaspora can mobilize quickly during a humanitarian crisis and be part of the essential response both on the ground and from afar. Their knowledge of local customs, and the trust given to them by the communities they come from, allows them to be key facilitators for the delivery of critical services and resources in areas that are difficult to access.

A global commitment

In May 2016, 43 diaspora organizations supported by the Diaspora Emergency Action and Coordination (DEMAC) initiative signed up to 17 diaspora commitments as part of the World Humanitarian Summit (WHS). The countries of the diaspora institutions include Somalia, the Syrian Arab Republic, Sierra Leone and Nigeria. The commitments included providing a voice and delivering actions towards resolving root causes of conflict and current conflict situations, aligning humanitarian response activities with humanitarian principles; ensuring social inclusion and working holistically and meaningfully with all humanitarian response stakeholders towards efficient, inclusive and people-centred humanitarian action to support vulnerable people and communities (Yaran E Watan, 2019).

The Global Compact for Migration, endorsed by 150 countries in December 2018 in Marrakesh and then adopted by the United Nations General Assembly through resolution 73/195 on 19 December of that year (United Nations, 2018), calls, in its Objective 19, for the creation of conditions for migrants and diasporas to fully contribute to sustainable development in all countries.

The Global Compact encourages governments to be committed to empower migrants and diasporas to catalyse their development contributions, and to harness the benefits of migration as a source of sustainable development, reaffirming that migration is a multidimensional reality of major relevance to the sustainable development of source countries, transit and destination.

From a number of actions, only the ones of particular relevance to the engagement of health professionals and as a confirmation to what was already discussed above, shall be listed:

(a) Ensure the full and effective implementation of the 2030 Agenda for Sustainable Development and the Addis Ababa Action Agenda by fostering and facilitating the positive effects of migration for the realization of all Sustainable Development Goals.

(b) Integrate migration into development planning and sectoral policies at the local, national, regional and global levels, taking into consideration relevant existing policy guidelines and recommendations, such as the Global Migration Group's Mainstreaming Migration into Development Planning: A Handbook for Policymakers and Practitioners, in order to strengthen policy coherence and effectiveness of development cooperation.

(c) Facilitate the contributions of migrants and diasporas to their source countries, including by establishing or strengthening government structures or mechanisms at all levels, such as dedicated diaspora offices or focal points, diaspora policy advisory boards for governments to account for the potential of migrants and diasporas in migration and development policymaking, and dedicated diaspora focal points in diplomatic or consular missions.

(d) Promote migration policies that optimize the benefits of diasporas for source countries, destination countries and their communities, by facilitating flexible modalities to travel, work and invest with minimal administrative burdens, including by reviewing and revising visa, residency and citizenship regulations, as appropriate.

(e) Cooperate with other States, the private sector and employers' organizations to enable migrants and diasporas, especially those in highly technical fields and in high demand, to carry out some of their professional activities and engage in knowledge transfer in their source countries, without necessarily losing employment, residence status or earned social benefits.

(f) Build partnerships between local authorities, local communities, the private sector, diasporas, hometown associations and migrant organizations to promote knowledge and skills transfer between their source countries and their destination countries, including by mapping the diasporas and their skills, as a means to maintain the link between diasporas and their source country.

The way forward

Countries of the Eastern Mediterranean region face health workforce shortages, even though they have relatively young and well-trained health workforce and adequate educational capacities for potential scale-up. However, the magnitude of out-migration from Eastern Mediterranean countries is high due to economic or security reasons, resulting with a significant well-trained and experienced diaspora.

The experience demonstrated that health professionals in the diasporas of Eastern Mediterranean countries are keen to support and contribute to development and the health sector in their home countries through development or humanitarian opportunities. This review summarized that diaspora can be organized in different ways and they can also be engaged in a variety of methods.

Eastern Mediterranean countries can benefit from tapping into these potential resources to help strengthen health workforce and health systems. The engagement itself can be multifaceted, ranging from skills- and experience-sharing, to raising funds and equipment for source countries. It is also paramount to ensure that engagement is done in a systematic and meaningful way.

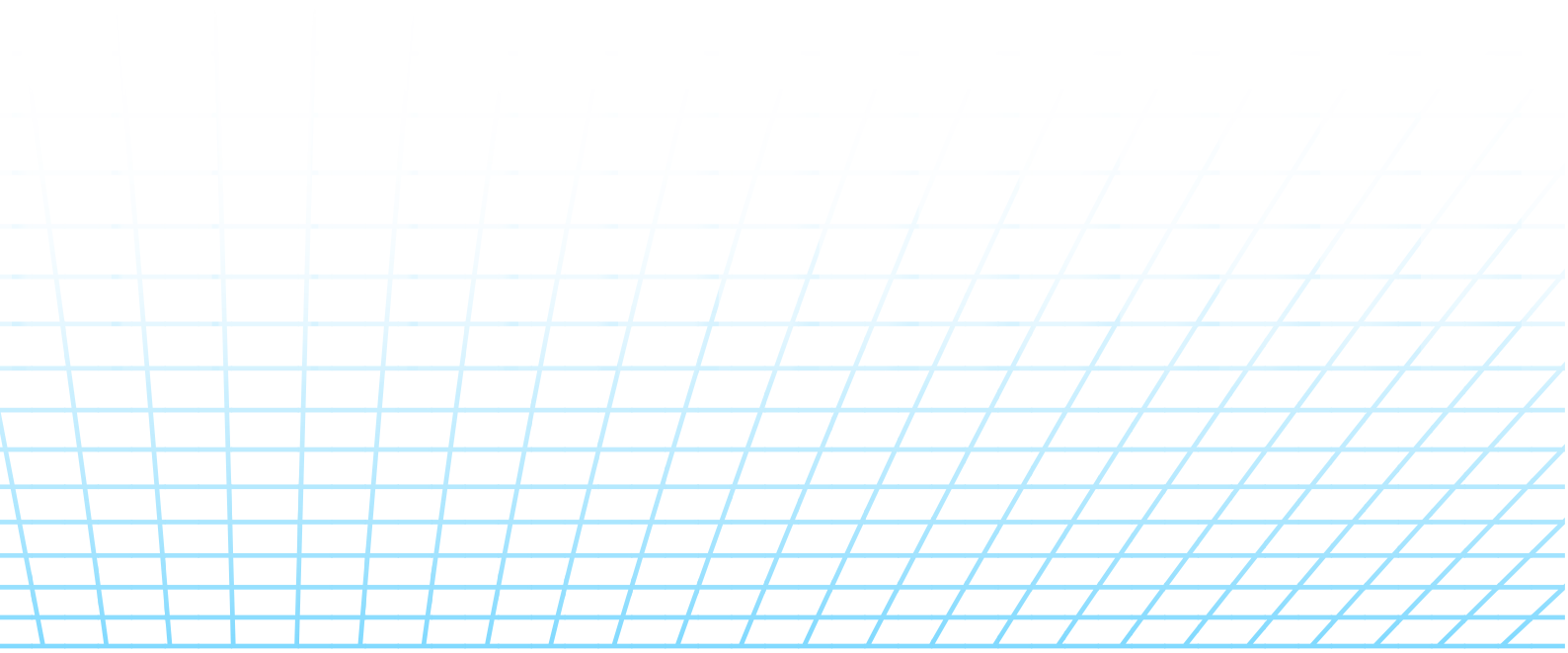
Data collection and analysis should be promoted to better understand the needs, shortages, available workforce and skills in demand in both source and destination countries.

One way to address skills shortages and labour market needs can be through Skills Mobility Partnerships. These partnerships can be utilized as an all-party-benefiting alternative to address destination countries challenges, while at the same time benefiting source countries' via capacity-building.

Diaspora engagement programmes need to be well-coordinated and supported by governments in order to yield a sustainable impact. There needs to be a clear and robust plan, resilient to unpredicted changes along the way. These programmes can extend into the preparedness, response and recovery phases in countries facing emergencies, including the COVID-19 pandemic.

There needs to be clear and strong commitment from both the diaspora and beneficiary institutions to ensure the successful and sustainable implementation of such projects. It is crucial for both source and destination countries to work together on the training and formation of health workers, and implement projects that allow and facilitate the engagement of the health professional diaspora abroad. OECD countries, in particular, should invest more to ensure that not only destination countries benefit, but also that there is more equity in terms of the availability and sustainability of a well-trained health workforce in source countries.

Engaging diaspora brings about opportunities, but does not come without its own challenges. Carefully thinking a programme through is at the core of its successful implementation.



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International Organization for Migration (IOM)
17 route des Morillons, P.O. Box 17, 1211 Geneva 19, Switzerland
Tel.: +41 22 717 9111 • Fax: +41 22 798 6150 • Email: hq@iom.int • Website: www.iom.int