

2014

# Mapping of Sierra Leonean Health Professionals

in the United Kingdom, Germany, United States of America and Canada



International Organization for Migration (IOM)

A consolidation of three studies conducted for the International Organization for Migration (IOM)

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# EXECUTIVE SUMMARY

This series of mapping surveys was commissioned by the International Organization for Migration (IOM) in response to an initiative by the Government of Sierra Leone to address the shortage of health-care workers in Sierra Leone. The Government is seeking to harness the skills of its health-care diaspora to support the country's health sector through the transfer of knowledge, skills and sharing of professional experience. As part of its MIDA Health initiative,<sup>1</sup> the IOM is responding to a request from the Office of Diaspora Affairs in Sierra Leone to develop a national strategy to facilitate short term placements of Sierra Leonean diaspora health professionals in selected health facilities in Sierra Leone.

Between September 2012 and October 2013, the IOM commissioned three separate mapping studies of Sierra Leonean diaspora health professionals in United Kingdom, the United States and Canada, and Germany, respectively. The United Kingdom and the United States are the two most prominent destination choices for Sub-Saharan African health professionals, and moreover share the largest pools of Sierra Leonean health-care professionals in diaspora. In Canada and Germany there was a considerably smaller pool to draw from.

The latest census or survey results were obtained, figures for 2011 in each case. The pool of Sierra Leoneans officially living in the United Kingdom identified by country of birth was approximately 23,500. In the United States the number of Sierra Leoneans was approximately 34,000; and in Canada, approximately 2,500 were identified by country of birth. Germany had a pool of just under 2,500. Of the largest Sierra Leonean population hubs, the UK clusters were located in London and the South East regions; US clusters were in Maryland, Virginia and New York; in Canada, the hubs were in Toronto and Edmonton; and in Germany, in North Rhine Westphalia; Bavaria and Berlin.

In the United States and Canada the outreach first took place from September to October 2012. The second outreach effort took place from September to October 2013. The United Kingdom outreach was conducted over 11 weeks, from March to May 2013, and the German study was conducted over a period of 8 weeks and concluded by Augusts 2013.

The survey results highlighted key sociodemographic characteristics of Sierra Leonean diaspora health-care professionals in the relevant countries, identifying their specializations, educational and training histories. They captured health professionals' migratory trends, for example, length of stay in their country of residence and identified their main geographical locations within those countries. The surveys showed how diaspora health professionals currently engage with their country of origin, and assessed their willingness to contribute to Sierra Leone's health-care system. Lastly they provided insights into health professionals' perceived challenges surrounding their medical interventions in their home country and identified some of the issues which disincentive health professionals from returning, whether on a temporarily or permanent basis.

Sierra Leonean diaspora health-care professionals are well aware of the poor state of the health system in their home country. In many cases, the health professionals' interventions in Sierra Leone's health sector occurred after witnessing the precarious state of health facilities during their trips to the country. Sierra Leone is often singled out for its poor health performance. A recent UNICEF study ranked it the worst country in the world for child survival, with the under-five mortality rate standing at 185 per 1,000 live births.<sup>2</sup> Moreover the civil war between 1991 and 2002 exacerbated the shortage of health workers in-country, a legacy that has continued with one health

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<sup>1</sup> MIDA (Migration for Development in Africa) is IOM's capacity-building programme to help mobilize diaspora skills for the benefit of Africa's development.

<sup>2</sup> UNICEF 2012, *Committing to Child Survival: A Promise Renewed*. Progress Report, New York; United Nations Children's Fund.

worker (doctor, nurse or midwife) for every 5,263 patients reported in 2012, compared for instance, to the United Kingdom which has one health worker for every 77 patients for the same year.<sup>3</sup>

Diaspora health-care professionals were genuinely willing to improve the well-being of Sierra Leoneans, especially those directly affected by the civil war, and develop the infrastructure of the health facilities. There was also a strong desire to educate the population about basic health measures to prevent diseases, and to provide training for health professionals in Sierra Leone.

Many diaspora health-care professionals are already individually or collectively involved in contributing to the development of Sierra Leone's health sector. They associate themselves in groups and organize fundraising events to develop health missions to Sierra Leone, some travelling to Sierra Leone at least once a year. In the German study, approximately 60 per cent of respondents had contributed skills in various ways, for example through short-term clinical assistance in hospitals and donations of medication, clothes and medical equipment to facilities in their homeland.

Interest in a permanent or temporary return to Sierra Leone appeared to be affected by the respondent's age and his or her perceived well-being in the country of residence. Permanent return was perceived as more of an option among older health professionals. Findings from the German study indicated that three out of four retired respondents were willing to engage in knowledge and skills transfer schemes such as teaching at medical institutions in Sierra Leone. Younger respondents were more constrained by work obligations and family responsibilities, and indicated a preference for short-term volunteer placements.

To date most diaspora interventions have been piecemeal, occurring unilaterally, lacking any central coordination, and operating in the absence of any overarching strategic framework. These initiatives may have brought about some small benefits, but a more focused intervention by forming a strategic alliance between diaspora organizations, development partners and the Government of Sierra Leone is required.

To realize greater impact and sustainability, support for umbrella bodies such as The Organization of Sierra Leonean Health Professionals Abroad (TOSHPA) in the United Kingdom, and similar bodies in other countries, needs to be strengthened. Such organizations can serve as conduits for channelling individual efforts into a more effective joint intervention. This would also facilitate more strategic interventions and reduce unnecessary duplication or overlap.

Challenges faced by diaspora health workers during their interventions in the home country included inadequate support from the Government, strained relations with local professionals, and widespread dissatisfaction with the working conditions and ethics in Sierra Leone. These are more fully elaborated in the 'drivers, challenges, and recommendations' section of Chapter 3.2.

Several of the recommendations and suggestions echoed the same broad themes. Some recommendations included promoting better performance amongst and improving local conditions for, in-country health professionals; improving health-care governance and curbing corruption. However the recommendations with the potential for bringing the most immediate improvements are:

**For development partners:**

- a. Structure a comprehensive volunteering package: Include financial, logistical and preparatory support, on a par with international volunteer packages, inclusive of flight, accommodation and travel in Sierra Leone as well as daily stipend in the field. Particular features to incorporate:

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<sup>3</sup> *Medicine Versus Myth in Sierra Leone*, The Guardian, Monday 26 November 2012.

- i. Secure endorsement from IOM or international organizations of similar standing for the promotion of diaspora engagement programmes; this would help health-care workers obtain leave of absence from employers.
- ii. Cater for short-term as well as longer term engagements (1– 3 months).
- iii. Include induction/preliminary training for prospective volunteers. Prospective volunteers need to undertake some training techniques, not all good specialists are necessarily good trainers, and as a prerequisite to their deployment for fieldwork.

**For Sierra Leone authorities:**

- b. Develop a framework and strategy to incorporate diaspora input and ensure that Sierra Leonean professionals and institutions recognize and support diaspora initiatives.
  - i. Promote diaspora participation in-country with key health stakeholders and institutions; forge formal links with hospitals and institutions. Embark on civic education programmes to help local health professionals appreciate the role diaspora professionals can play. Organize briefings and information sessions at different medical institutions in the country.
  - ii. Build bridges with and for diaspora by reducing some of the bureaucracy they face, including facilitating fast-tracking of recognition of diaspora professionals' qualifications to enable them to practice in their home country.
  - iii. Strengthen the relationship between diaspora and home government by leveraging the role of the Office of Diaspora Affairs. Promote direct communication with the representatives of the Diaspora Office in Freetown or relevant officials involved in diaspora affairs. Having a designated Health Liaison Officer within the Office of Diaspora Affairs would enable that unit to monitor in-country diaspora activity, communicate requests for skills where shortages arise, and match diaspora health-care personnel to existing needs.

**For diaspora health-care professionals:**

- c. Adopt a consortium approach and develop an over-arching strategy to coordinate efforts, enhance collaboration and share learning. There are numerous initiatives but efforts tend to be fragmented, and individualized. Working together would minimize unnecessary duplication and enhance sustainability and impact. Strengthen and support umbrella organizations such as The Organisation for Sierra Leonean Health Professionals Abroad (a UK example).
- d. Build bridges with local professionals. Government authorities can promote relations and collaboration between health professionals abroad and their in-country counterparts. Diaspora members in turn can approach with an attitude of humility, and work alongside in-country colleagues to reduce the mutual sense of suspicion and rivalry.

The diaspora health professionals participating in these studies expressed a strong desire to contribute to the development of the health-care delivery system in Sierra Leone. They consider that to guarantee a successful diaspora engagement programme, the Government needs to act as a key facilitator to ensure that Sierra Leonean professionals and institutions recognize and support diaspora initiatives. These studies suggest that there is a window of opportunity to harness the efforts and skills of the diaspora community. The Government has made some inroads into addressing Sierra Leone's health problems. Hopefully a more focused intervention through forming a strategic alliance between diaspora organizations, development partners and the Government of Sierra Leone will provide a bridging framework to make placements in Sierra Leone for diaspora health professionals a reality in the near future.

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**United Kingdom** Moses Okech (Lead Researcher) and Denise Awoonor-Renner (Outreach Consultant/Support Investigator), reported in June 2013 under the direction of Onyekachi Wambu, Director of Engagement and Advocacy of AFFORD (African Foundation for Development).

Denise Awoonor-Renner also consolidated the three studies into this report.

**United States and Canada** Oscar Castellanos del Collado, Diaspora Mapping and Outreach Consultant, reported in October 2013

**Germany** Dr Ewane Fidelis Etah, Diaspora Mapping and Outreach Consultant, reported in August 2013

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## Confidentiality

Respondents were requested to provide personal details, particularly for future communication purposes. However, such personal data is excluded from this report and is protected by standard data protection principles.

## Disclaimer

This report does not purport to be exhaustive. The mapping teams that conducted this exercise and wrote the reports on behalf of IOM have taken every effort to ensure accuracy in their reporting. IOM is not responsible for any omissions or inaccuracies.

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# Acronyms

Destatis	Federal Statistical Office (Germany)
DFID	United Kingdom Department for International Development
FGDs	Focus Group Discussions
GoSL	Government of Sierra Leone
IOM	International Organization for Migration
KSLP	King's Sierra Leone Partnership
MIDA	Migration for Development in Africa
MoHS	Ministry of Health and Sanitation
NHSSP	National Health Sector Strategic Plan
NHS	National Health Service
OECD	Organization for Economic Cooperation and Development
ONS	Office of National Statistics for England and Wales
SSA	Sub-Saharan Africa
TOSHPA	The Organisation of Sierra Leone Healthcare Professionals Abroad
UNDP	United Nations Development Programme
UNPO	United Peoples Organization of Sierra Leone
WHO	World Health Organization
WIAD	Medical Association of German Doctors

# 1. INTRODUCTION

## 1.1 OBJECTIVES

This report consolidates three mapping surveys undertaken by the International Organization for Migration (IOM) in the United Kingdom, United States and Canada, and Germany between September 2012 and October 2013. The surveys aimed to identify available human resources in the Sierra Leonean health-care diaspora to support Sierra Leone's health sector, whether in training or other health institutions, by way of temporary return to Sierra Leone.

Under its Migration for Development in Africa (MIDA) programme,<sup>4</sup> which helps to mobilize African diaspora skills for the benefit of Africa's development, and in particular its MIDA Health initiative, the IOM seeks to address the challenges produced by the migration of health-care workers through the transfer of diaspora knowledge and skills to the benefit of their home countries' health sector.<sup>5</sup>

IOM intends to develop a national strategy to facilitate short term placements of Sierra Leonean health professionals in the diaspora in selected health facilities in Sierra Leone. This strategy will support the implementation of the National Health Sector Strategic Plan (NHSSP 2010–2015), Sierra Leone's national response to improving its health sector. Among the several issues identified in the NHSSP 2010–2015, the shortage of skilled staff and mal-distribution of existing staff remains a challenge to the appropriate delivery of Sierra Leone's basic package of essential health services.

IOM Sierra Leone is the leading implementing agency for this initiative. At the request of the Office of Diaspora Affairs, IOM is supporting the Ministry of Health and Sanitation (MoHS) by conducting a comprehensive situational assessment of migration health-related challenges and service gaps in order to develop interventions for better access to health care.

## 1.2 STRUCTURE OF THE REPORT

This report is divided into four chapters. Chapter one provides the background to this report. Chapter two explains the methodology used for these studies, which was a combination of literature review, focus group discussions, key informant interviews and questionnaires. It also discusses research limitations and challenges encountered.

Chapter three consists of two parts. The first part presents the findings from participants in the questionnaire surveys, and builds a profile of Sierra Leone health-care workers in the United Kingdom, United States and Canada and Germany respectively. The second part presents findings from the primary data (survey results, focus group discussions and key informant interviews), together with desk research, and includes a snapshot of census statistics of the Sierra Leonean population, identified by country of birth, in the relevant countries. Further, it outlines some of the issues that must be addressed in order to facilitate diaspora health professionals' contribution to the health sector in Sierra Leone.

Chapter four draws together the conclusions from the research and synthesizes the key recommendations from the feedback from healthcare diaspora members in the various countries surveyed. It highlights the main issues which, if tackled, have the most potential for harnessing diaspora skills and know-how.

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<sup>4</sup> MIDA is IOM's capacity-building programme to help mobilize diaspora skills for the benefit of Africa's development.

<sup>5</sup> International Organization for Migration, *Migration for Development in Africa, mobilizing the African diasporas for the development of Africa*, (Geneva, 2007. p. 14)

## 1.3 OVERVIEW OF SIERRA LEONE'S HEALTH SECTOR

### Health conditions, burden of disease and skills shortage

The health status of the people of Sierra Leone is among the most precarious in the world (WHO-AFRO), as demonstrated by some of the key health indicators. For example, life expectancy at birth for both sexes is 47 years old, almost 10 years less than the regional average (WHO, 2011).

Maternal and child health is still poor and the prevalence of major communicable diseases is high (WHO-AFRO). From 2008 to 2011, there was an increase in the maternal mortality ratio from 857 to 890 deaths per 100,000 live births (WHO, 2011). Moreover, 185 children per 1,000 live births die before reaching age five (WHO, 2011). The greatest burden of disease is on rural populations, and on females within those rural populations. Malaria is the most common cause of illness and death in the country (MoHS, 2009).

The country's devastating civil war between 1991 and 2002 saw up to 70,000 casualties and displaced 2.6 million people, about one third of the population (Kaldor and Vincent 2010; Tavakoli 2012). The war contributed to the chronic shortage of trained medical staff in the country, a legacy that has continued with only one health worker (doctor, nurse or midwife) for every 5,263 patients reported in 2012 compared to the United Kingdom which had one health worker for every 77 patients for the same year (The Guardian, November 2012).

Amongst the factors advanced to explain the shortfall of trained health professionals worldwide are insufficient training opportunities; lack of good training facilities, forcing some health workers to seek specialist training abroad; poor remuneration and poor planning by governments (WHO, 2008). These factors sit alongside pull factors in more developed countries which include better professional prospects, improved living and working conditions, combined with increased labour shortages in the health and social sectors of these countries. The changing demographics resulting in ageing populations in some developed countries have led to spiraling demand for health professionals from abroad (Gunvor, 2009).

Health professionals from Sierra Leone have been noted for their preference to migrate to mainly English speaking countries like the United Kingdom, the United States, Canada, Australia and New Zealand (Naicker et al., 2009).

### Government interventions

The Government of Sierra Leone, in collaboration with multiple stakeholders, has been undertaking high-impact interventions to improve the country's health-care situation (WHO-AFRO). The introduction of a free healthcare programme for under-fives, pregnant women and breastfeeding mothers in 2010 was one such initiative. Key donors including UNICEF, the World Bank, UNFPA, the African Development Bank, the European Union, Irish Aid, WHO and USAID provide support for the public management capacity for human resources for health and multi-tiered technical assistance and training to improve health service delivery (MacKinnon, 2012. p. 33).

One of the biggest challenges facing Sierra Leone's health sector is its workforce shortage. The Sierra Leone health system's incapacity to respond to the heavy disease burden is worsened by its inadequate human resources to ensure an appropriate delivery service (MoHS, 2009). Attraction and retention of health workers has been particularly difficult due to the Sierra Leone health system's structural deficiencies, some of which are outlined in the NHSSP and include: low staff remuneration; lack of incentives and poor career development (MoHS, 2009). The lack of qualified personnel and the poor quality training facilities perpetuate a vicious cycle that limits human resources growth (MacKinnon, 2012. p.13).

## 2. RESEARCH DESIGN AND METHODOLOGY

### 2.1 CORE METHODOLOGY

Each mapping study adopted a common research methodology incorporating a variety of qualitative and quantitative techniques in order to capture the Sierra Leonean diaspora in each target country with a focus on health professionals. The methodologies used were: Literature review, questionnaires, focus group discussions (FDGs) and key informant interviews. Literature reviews were excluded from this consolidated report because of space constraints. Key documents referred to in the report are featured in the bibliography.

Data collected was drawn from a structured questionnaire supplemented by focus group discussions and key informant interviews as well as desk research. Slight modifications were made from country to country to adapt to local circumstances or constraints, for example the number of FDGs and key informant interviews held. A broad definition of health professionals, based on WHO categories, was adopted (see example in Annex I).

#### Questionnaires

The questionnaires were structured to obtain information about the health professionals' demographic profiles; their interest in contributing to Sierra Leone's health sector; and information about diaspora networks and associations in their country of residence (see example in Annex II).

In each case, questionnaires were predominantly distributed via e-mail using SurveyMonkey software, targeted at health professionals of Sierra Leonean origin currently employed or with experience of working in the health sector of the relevant country.

The outreach effort primarily adopted a snowball sampling strategy, whereby respondents suggested other interested health professionals to be contacted.<sup>6</sup> Several Sierra Leonean community organizations and individuals played a key role assisting with dissemination of the questionnaire.

#### Focus groups/key informant interviews

The focus group discussions (FDGs) and the key informant interviews offered detailed insight into health professionals' experiences and initiatives in Sierra Leone and perceived barriers to them contributing to Sierra Leone's health sector. The researchers sought to obtain a diverse composition of focus group participants in terms of education, occupation and gender. An example of the focus group discussion and key informant guides appear in Annexes III and IV respectively.

#### *United Kingdom*

The United Kingdom survey took place over 11 weeks, between March and May 2013. Data was collected from 101 respondents mainly through the on-line questionnaire. Three focus group discussions were held around London, with an average of 6 respondents in each. FDG participant profiles are included in Annex V. Two key informants with in-depth knowledge and/or experience in working with Sierra Leonean diaspora health workers were interviewed.

#### *United States and Canada*

In the United States and Canada two outreach efforts were held, the first between September and October 2012. For the second outreach, September to October 2013, the questionnaire was expanded, capturing information on educational background and organizational membership.

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<sup>6</sup> A snowball sample is one in which the researcher collects data on the few members of the target population he can locate, then asks those individuals to provide information needed to locate other members of that population whom they know.

A total of 118 entries were registered. However, only 83 respondents fully completed the questionnaire, 11 partially, as they did not updated specific information on time. The partially completed questionnaires still provided insight and were included in the country report where possible. Overall, a total of 94 questionnaires were considered effective.

Focus groups were conducted via four group phone calls (three for US-based and one for Canadian-based Sierra Leoneans). A Twitter account was opened to circulate visual materials to engage Sierra Leonean social networks and to keep respondents updated on future developments.

In Canada the absence of large organizations was a challenge. Also it was difficult to contact community organizations as many did not have a formal website. However, some other small Sierra Leonean organizations in Canada were instrumental in facilitating the outreach to health professionals.

### **Germany**

The online survey was sent to identified health professionals and Sierra Leonean diaspora organizations in Germany. A total of 22 respondents participated in the online survey over the outreach period of eight weeks. The consultant held 32 interviews with members of the Sierra Leonean diaspora in Germany and 10 interviews with stakeholders of diaspora associations. Four FGDs were also held with diaspora groups in Berlin, Munich, Frankfurt and Hannover on their respective premises. The average participation rate was 10 people; including 5 female participants.

Respondents were mainly identified through social media such as Facebook, LinkedIn and Google searches tailored to the target demographic. The Sierra Leonean diplomatic mission in Berlin helped to pinpoint medical professionals and Sierra Leonean diaspora associations.

## **2.2 CHALLENGES AND LIMITATIONS**

Challenges and limitations encountered in common during the three surveys included:

- (a) Lack of control over questionnaire distribution. The snowball methodology made it impossible to track the total number of recipients or monitor the categories of health-care professionals reached. As the samples obtained were not representative the results cannot be generalized. Also, some medical disciplines may be overrepresented.
- (b) Data protection limitations. Data protection provisions precluded the researchers from reaching Sierra Leonean diaspora health professionals directly, because the law restricts the way organizations use information from their database of health professionals. Nonetheless, some institutions and networks did agree to forward the questionnaires to the target group.
- (c) Timing and budgetary constraints. The study period was relatively short with respect to the time consuming processes of identifying and enrolling target respondents, and issuing periodic reminders. Outreach to health associations and public health departments to obtain data on Sierra Leonean health professionals was equally time consuming. In Germany, cost considerations precluded the holding of FGDs in the more distant locations such as the north and travel to parts of former East Germany.

In Germany the Sierra Leonean diaspora constitutes a relatively small pool which is largely dispersed and it was difficult to penetrate smaller communities. Moreover, there was a lack of valid data on the migration of Sierra Leonean health professionals in Germany and its impact on the health system.<sup>7</sup>

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<sup>7</sup> In Germany research has focused on countries with a greater volume of migrants and health professionals. The Federal Statistical Office for example is more likely to analyze diasporas with a minimum population of 5,000. The Sierra Leonean diaspora in Germany is just half that number (Destatis, 2013).

### 3. RESEARCH FINDINGS - PROFILES OF SIERRA LEONEAN HEALTH PROFESSIONALS

#### 3.1 PRELIMINARY FINDINGS

Section 3.1 presents findings from the survey questionnaires, supplemented with some interview insights in the case of the German outreach. The surveys sought to highlight key sociodemographic characteristics of Sierra Leonean diaspora health-care professionals in the United Kingdom, United States and Canada and Germany, identifying their specializations, educational and training histories. The surveys captured migratory trends, for example, health professionals’ length of stay in their country of residence and their geographical locations within those countries. They showed how diaspora health professionals currently engage with their country of origin, and assessed their willingness to contribute to Sierra Leone’s health-care system, as well as their areas of interest (for example, clinical work, teaching, health planning).

This section is sub-divided into three country specific segments, which are in turn structured according to:

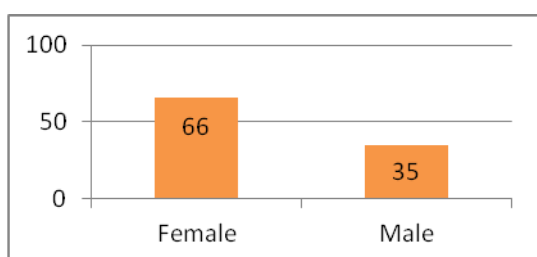
1. Key sociodemographic characteristics
2. Professional background and experience
3. Level of engagement with Sierra Leone
4. Interest in contributing to Sierra Leone’s health sector

##### 3.1.1 United Kingdom

The graphs in this section are generated from the questionnaire survey and based on the results from the 101 respondents who participated in the United Kingdom mapping exercise, unless otherwise specified.

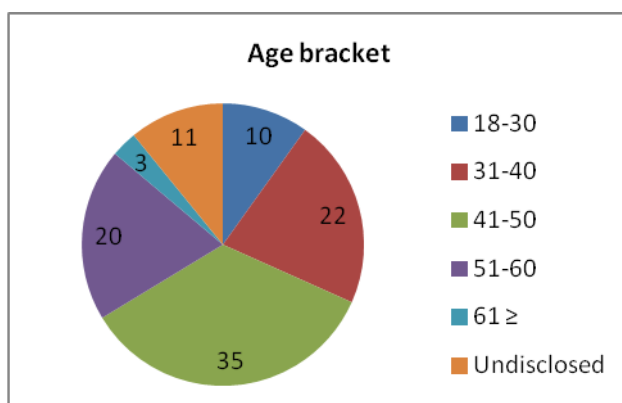
###### 3.1.1.1 Key sociodemographic characteristics

###### Gender breakdown



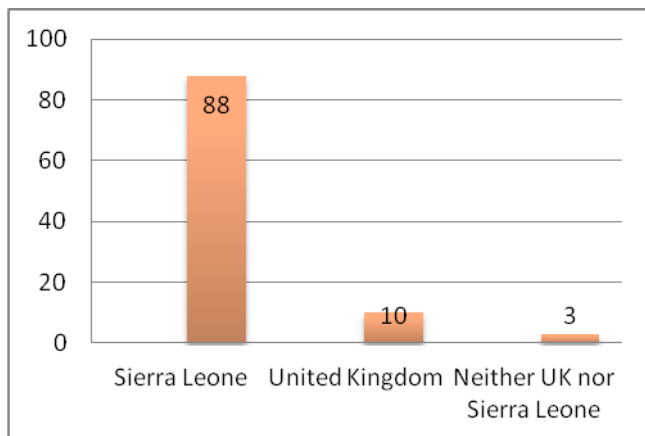
Out of 101 complete responses; 66 participants (65%) were female while 35 respondents (35%) were male health workers.

###### Age profile



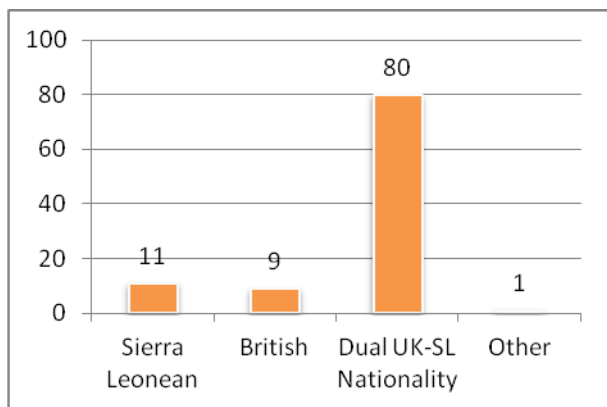
Based on the sample of 101 respondents, the majority of Sierra Leonean health workers in the UK health sector fall within the age groups of 41–50 years (35%) followed by those between 31–40 years (22%). This could be explained by the time taken to complete relevant training as well as to gain stability in the job market. Between the ages of 18 and 30, most would be health professionals are still finalizing their studies and training.

**Place of birth**



Of the respondents surveyed, 88, (87%) indicated that they were born in Sierra Leone; 10 (10%) were born in the UK while 3 were born outside either jurisdiction (3%). The interpretation from this is that for a sizeable number of Sierra Leoneans in the diaspora, Sierra Leone is their place of birth. This could be a very good platform for designing programmes aimed at engaging members of the diaspora, whether on a short or long term basis.

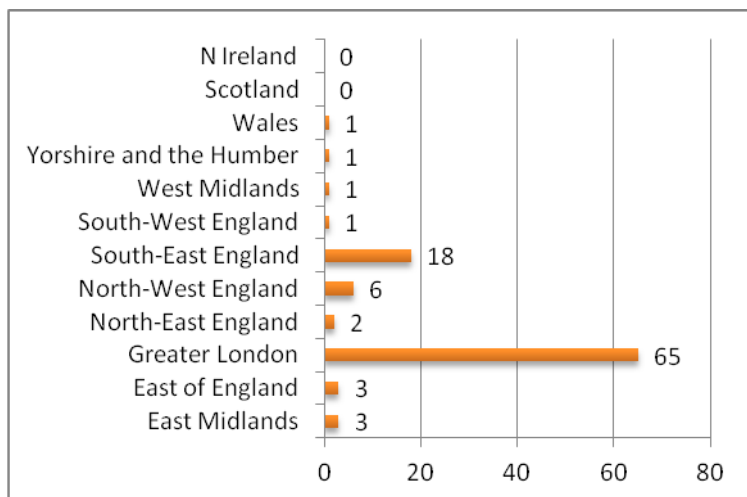
**Nationality**



Of those born in Sierra Leone, 80 respondents held dual British-Sierra Leonean citizenship as compared to 9 respondents who identified themselves as British nationals. 11 respondents indicated they were Sierra Leonean citizens. One individual, though of Sierra Leonean heritage, held a third country passport, that is to say, neither British nor Sierra Leonean.

**Place of residence in the UK (by region)**

The graph below shows regional clusters of the sample of Sierra Leonean diaspora health workers surveyed:

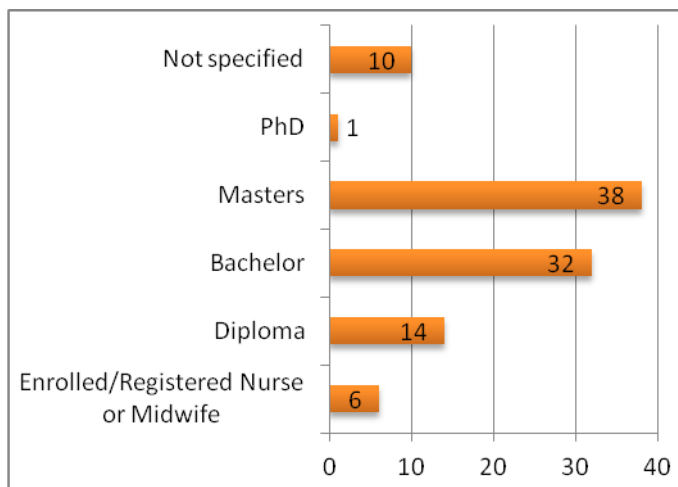


The vast majority of survey participants resided in the Greater London area (65%) followed by the cluster of residents in the South East of England, (18%).

The outreach exercise sought to include individuals residing in England, Scotland, Wales and Northern Ireland. However, the results ultimately reflected the higher concentration of England-based health professionals of Sierra Leonean origin.

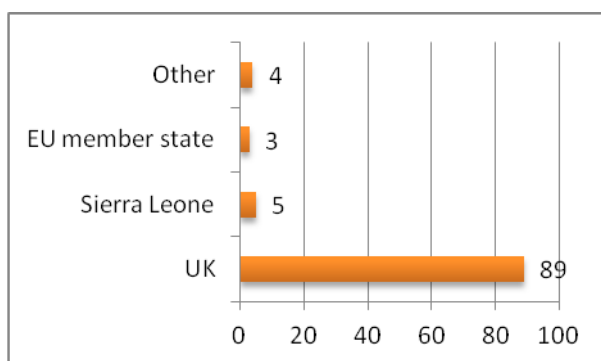
### 3.1.1.2 Professional background and experience

#### Highest educational qualification attained



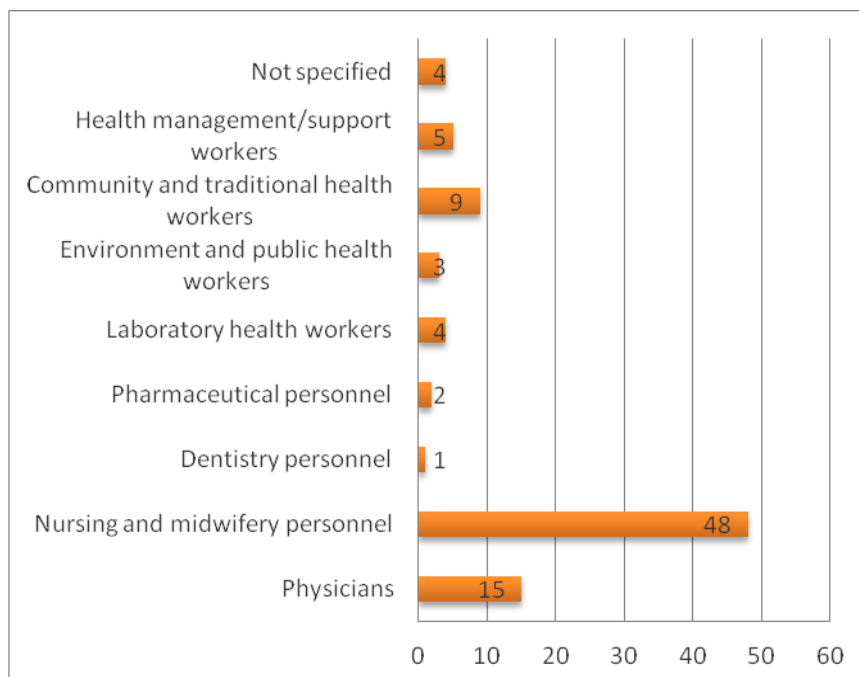
The majority of respondents were highly qualified with 38 (42%) of those specifying their highest qualification having Masters degrees, 32 (35%) with Bachelor's degrees, 14 (14%) with Diploma, 6 (7%) with enrolled nurse/midwife qualifications. One respondent had a PhD qualification. This implies that most Sierra Leonean health professionals resident in the UK have relevant qualifications which could be useful in future engagements involving training and mentorship.

#### Place attained highest qualification



Most respondents attained their education in the United Kingdom with only a minimum number having gained their highest qualification in Sierra Leone. This indicates that education may have been a reason for moving for most members of the diaspora or, those specific qualifications were a requirement for joining the UK health sector.

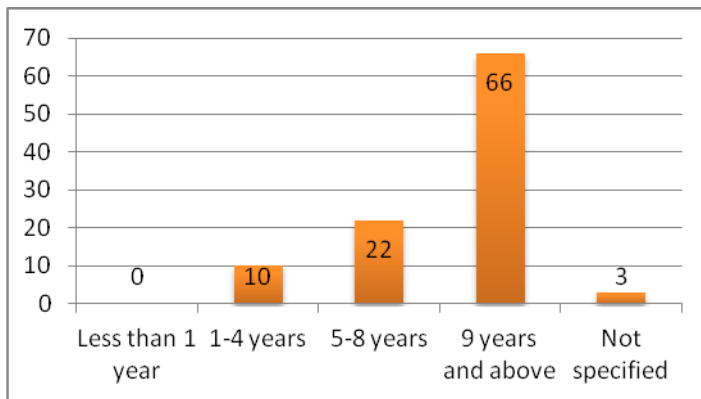
#### Professional field



Of the 87 respondents who answered this question, 48 were either nurses or midwives (55%). The next highest category represented were medical doctors, numbering 15 (17%).

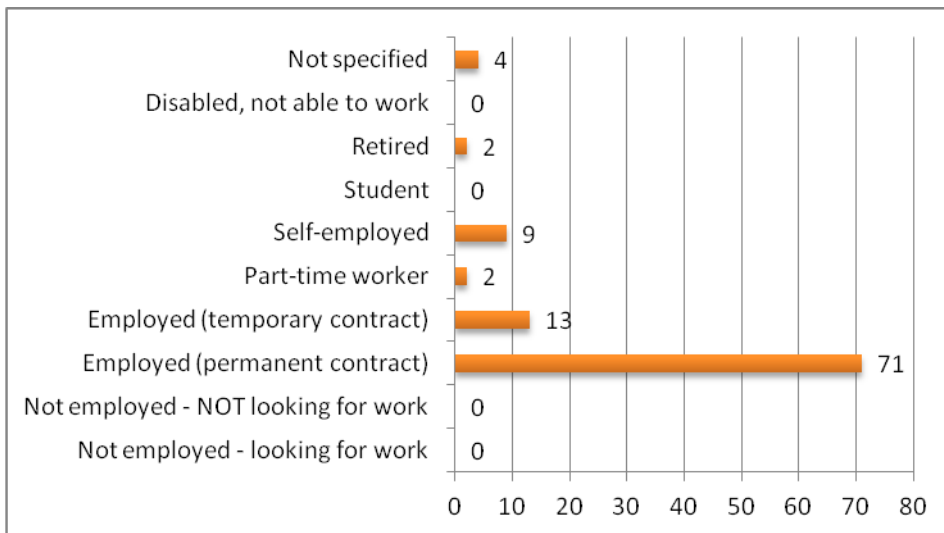


**Years of work experience**



Of the survey respondents indicating their years of experience, most (67%) indicated having worked for over nine years and only a small percentage (10%) had only worked for between one and four years.

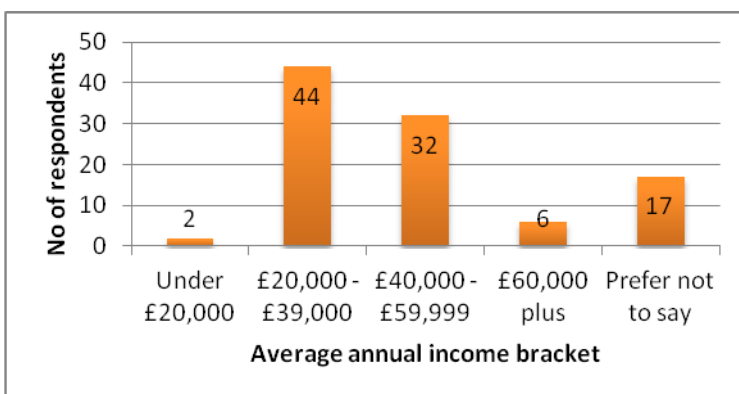
**Employment status**



The vast majority of respondents were employed on a permanent basis, followed by those on temporary contracts.

Any planned engagement strategy should take into account this kind of spread.

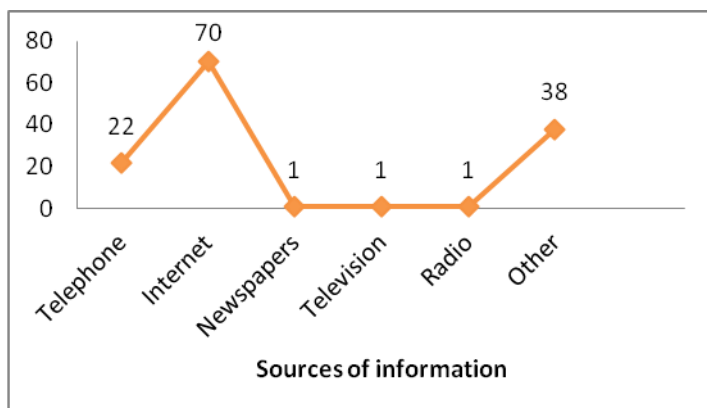
**Level of income**



This question on average annual income bracket (pre-tax) was included to help formulate benchmarks for remuneration levels or incentives to support individuals willing to offer their skills in Sierra Leone, beyond their regular earnings. Forty-four per cent of respondents indicated a salary range of £20,000 to £39,000 per year; 17 per cent opted not to disclose their income bracket.

### 3.1.1.3 Level of engagement with Sierra Leone

#### Communication channels

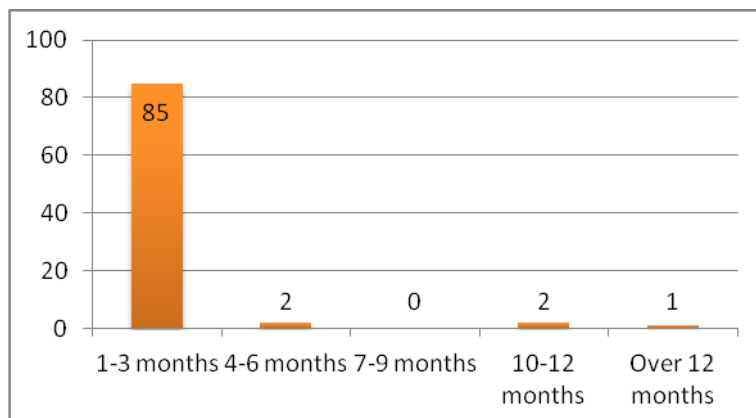


Respondents received information from and about Sierra Leone mostly using the internet to access online papers, Facebook and other web-based sources. The telephone was the next most used medium. Many respondents cited multiple sources of communication including visits to Sierra Leone, word of mouth via networks, e-mail, family and friends or diaspora groups.

#### Experience of working in Sierra Leone

Some 66 (65% of respondents) already had some experience of working in Sierra Leone. This could prove useful should they return to give their skills to the country. An understanding of the country's work culture and other context specific dynamics might help them settle down faster and get easily accepted by their peers.

#### Average stay in Sierra Leone

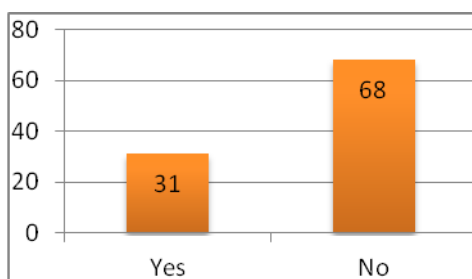


Ninety-six per cent (96%) of respondents had returned to Sierra Leone since leaving.

Aware of its relative importance in determining length of potential diaspora engagement programmes, respondents were asked how long they usually spend on their visits to Sierra Leone.

Up to 94 per cent of those answering this question indicated they usually stay for between 1 and 3 months during annual holiday breaks. A small number indicated longer stays of up to one year; which can be taken as professional breaks, during a negotiated period of unpaid leave. Eleven respondents did not specify.

#### Membership of diaspora associations, organizations or networks



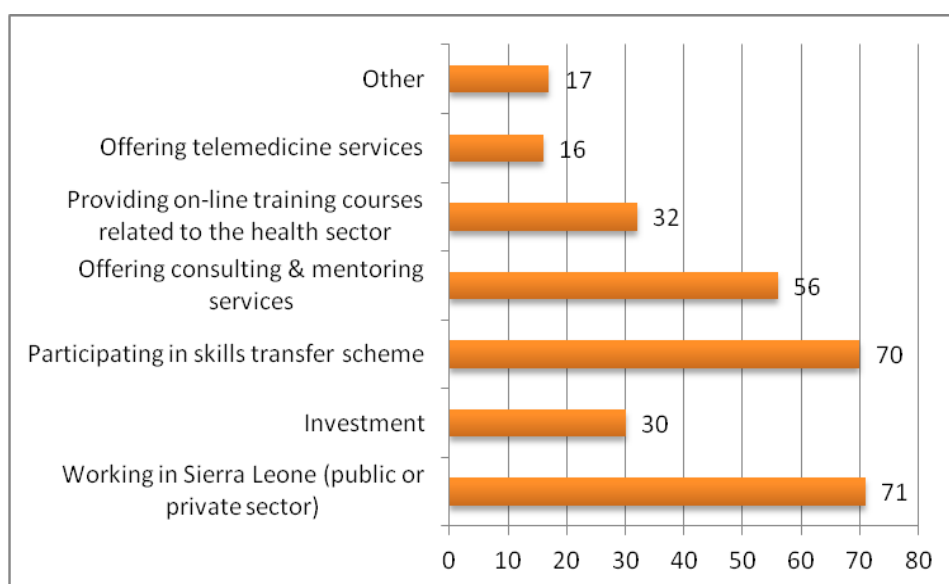
Efforts were made to identify which organizations diaspora health workers of Sierra Leonean origin belong to. This was deemed important in case of future mobilization and outreach for particular activities. Sixty-nine per cent of respondents were not part of any such organizations while 31 per cent were.

### 3.1.1.4 Interest in contributing to Sierra Leone’s health sector

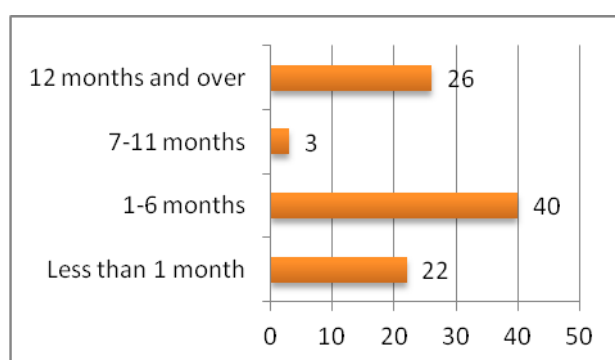
All survey respondents indicated their willingness to contribute to the development of Sierra Leone’s health sector. This was a very strong indication of support for any initiatives that required diaspora professionals’ effort. However, it is unlikely that this reflected the overall opinion of those who did not participate in the survey.

#### Possible areas for diaspora engagement

Respondents indicated their preference to contribute through working in Sierra Leone’s public and private sector, participating in skills transfer schemes and by mentoring and offering consultancy services as top priorities.



#### Length of potential placements



Most respondents indicated their willingness to go to Sierra Leone on work placements although a significant number also demonstrated interest in long-term programmes lasting for up to 12 months.

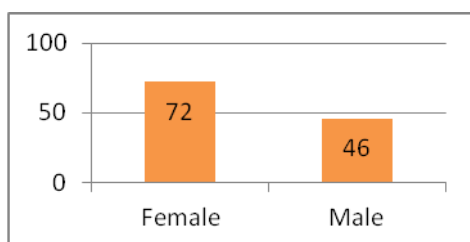
### 3.1.2 United States of America and Canada

The graphs in this section are generated from the questionnaire survey and based on the results from the 94 questionnaires considered effective from the mapping exercise in the United States and Canada, unless otherwise specified.

Of the 118 entries registered, only 83 were fully completed; 11 were partially completed owing to time constraints. The partially completed questionnaires still provided insight and were included where possible in the country report.

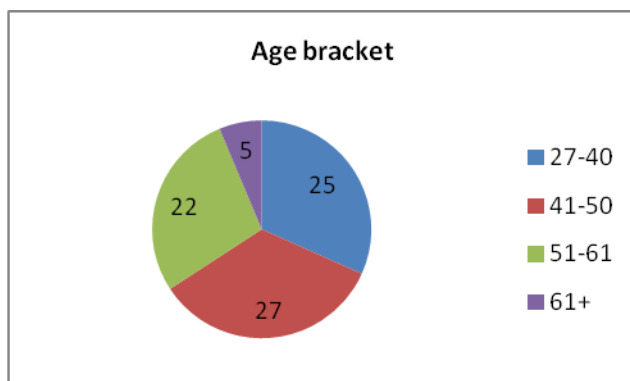
#### 3.1.2.1 Key sociodemographic characteristics

##### Gender breakdown



A larger number of women than men completed the questionnaire. Out of the total 118 entries, 72 respondents were women (61%) and 46 were men (38%).

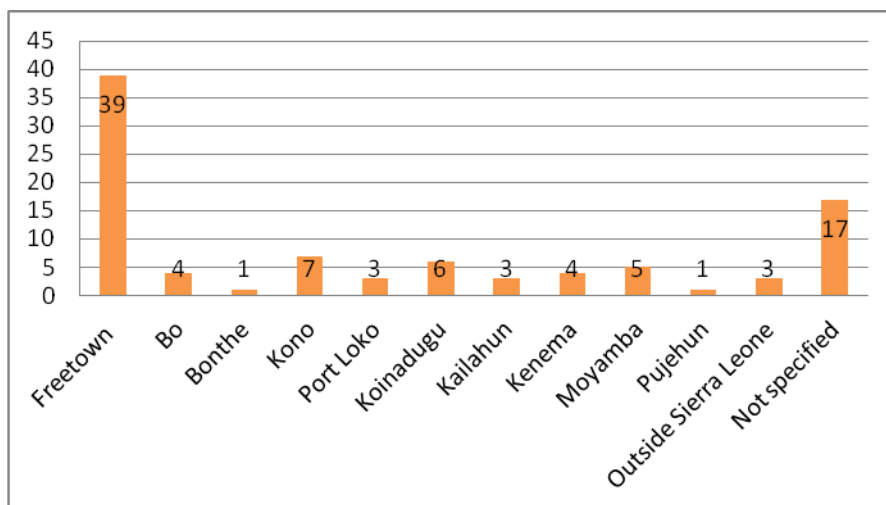
##### Age profile



The majority of the respondents were aged between 30 and 50. Twenty seven respondents were aged 41–50. Twenty five respondents fell within the 27–40 bracket, and 22 within the 51–61 range. Few respondents were older than 61.

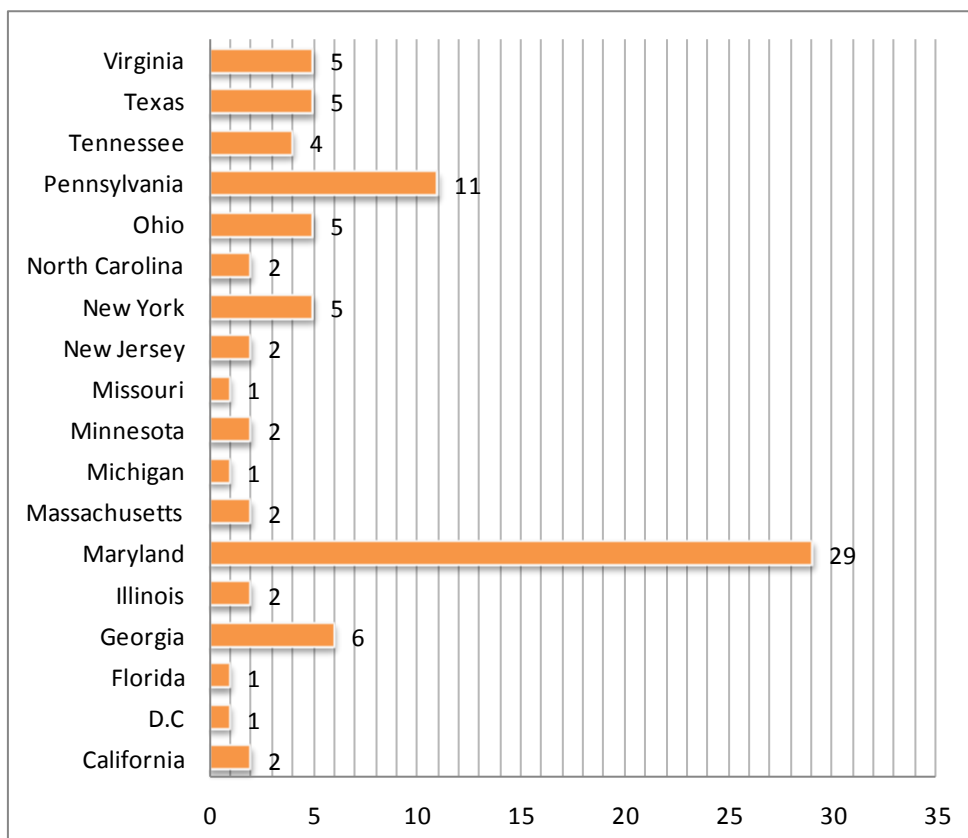
Some respondents opted not to disclose their age.

##### Place of birth



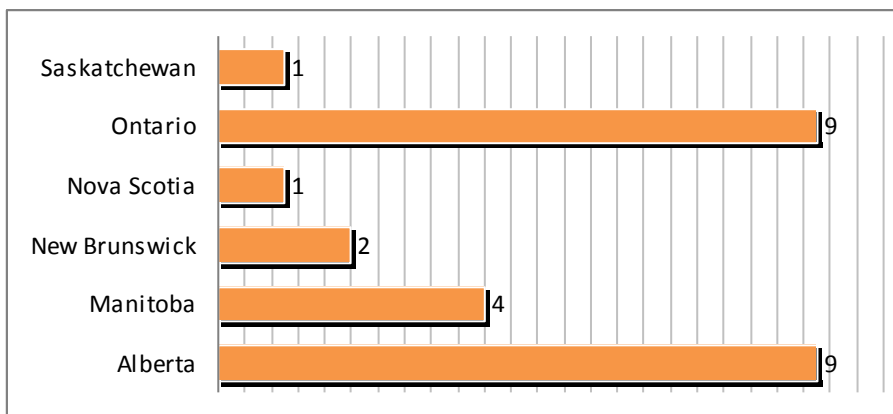
The large majority of respondents were born in Freetown. However, some other districts like Kono, Koinadugu, Bo and Moyamba appeared frequently.

**Place of residence (State – United States)**



Maryland was the most common place of residence of the health professionals who responded to the questionnaire. Pennsylvania and Georgia were home to a smaller group.

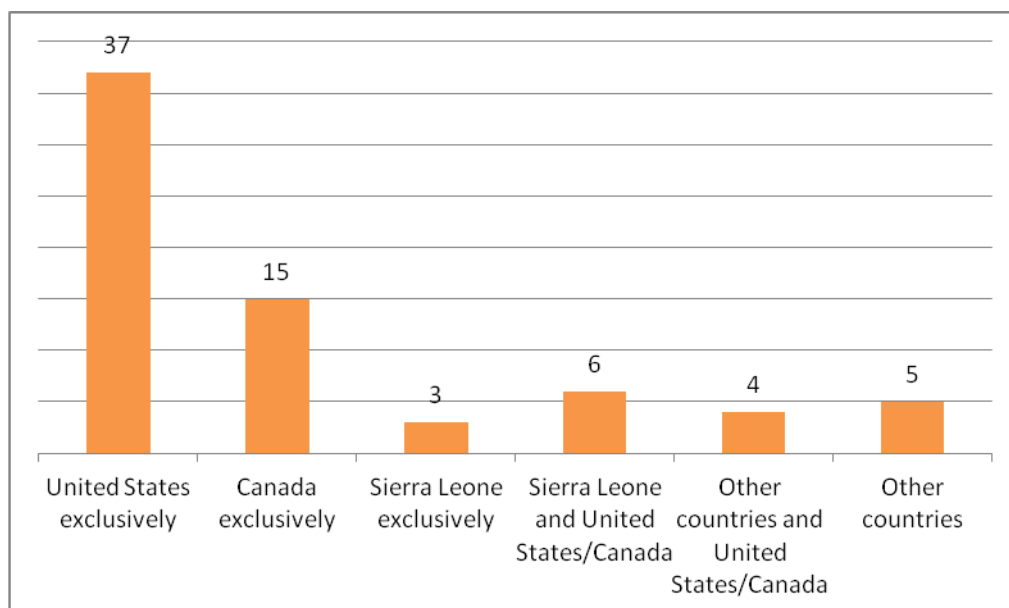
**Place of residence (Province – Canada)**



The majority of the health professionals living in Canada who responded to the questionnaire resided in Ontario and Alberta.

### 3.1.2.2 Professional background and experience

#### Place of educational attainment

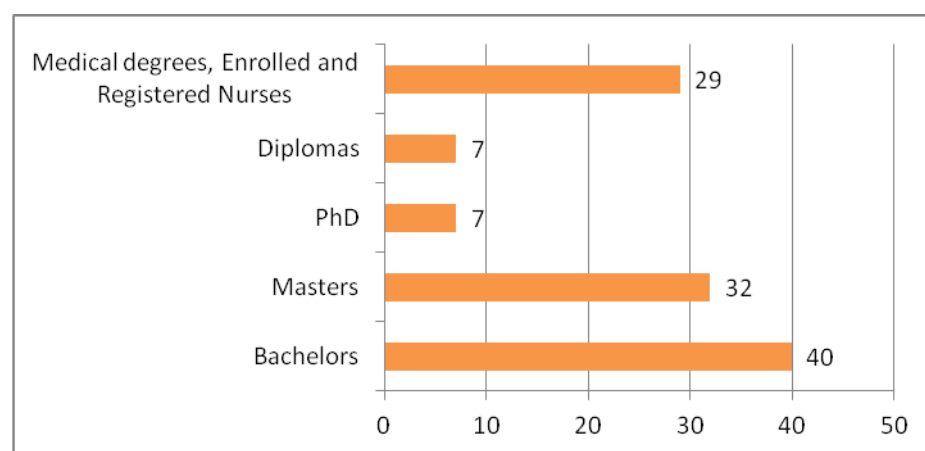


Most respondents obtained their degree in the host country. Normally, respondents who arrived with a degree from Sierra Leone continued their studies in a US- or Canadian institution.

Few remained with only a Sierra Leonean degree.

*Note:* Respondents were not asked to indicate their highest degree obtained. They could also have omitted degrees or certificates obtained prior to their arrival to the United States or Canada.

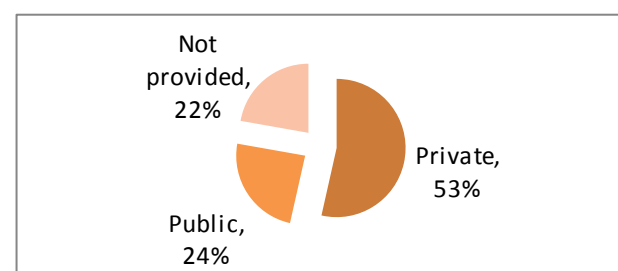
#### Type of degree obtained



The answers suggest that Sierra Leonean health professionals in the diaspora are highly educated. A large number of respondents have a Bachelors and Masters degree.

*Note:* Only medical related degrees were considered.

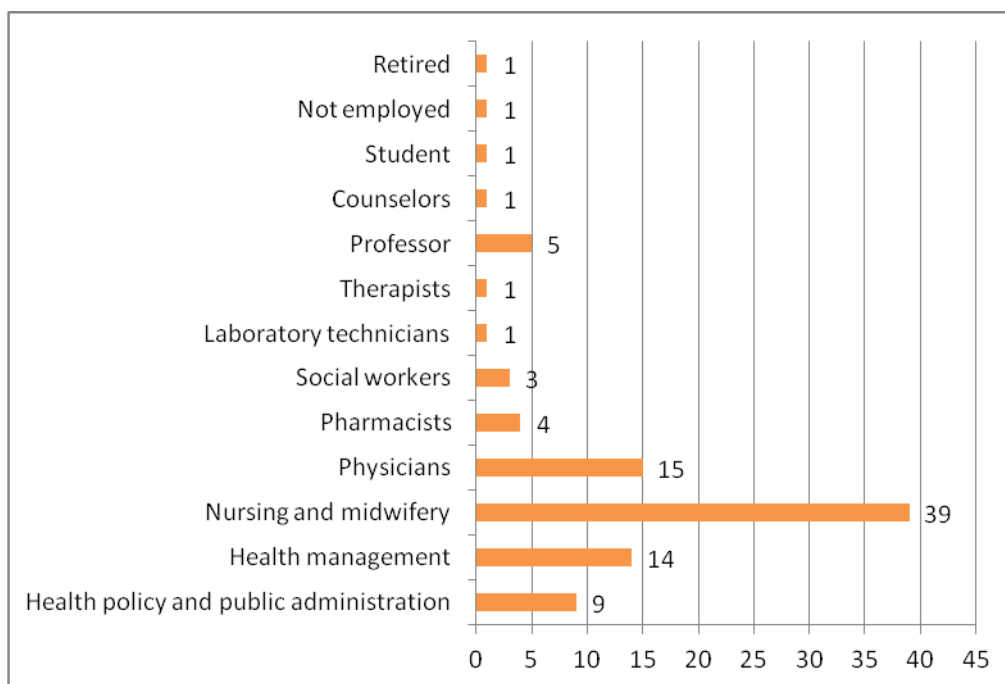
#### Public or private sector employment



Although many respondents did not specify their workplace, it is possible to say that most of them work in the private sector. Twenty four per cent of the health professionals are employed in the public sector such as: health departments and provincial or county hospitals.

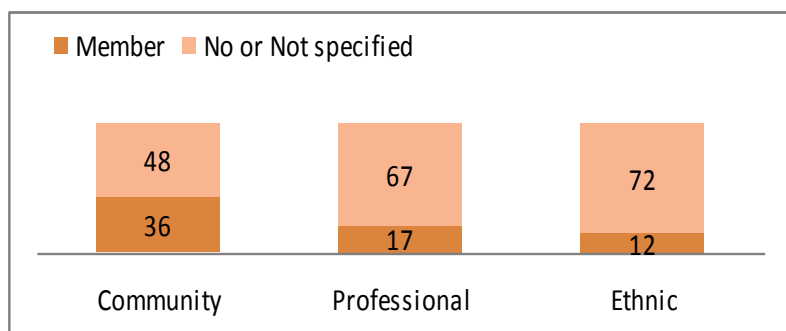
### Professional field

The majority of the respondents work in the nursing–midwifery occupations. Significant proportions of the respondents were physicians and worked in the health management field. Individuals involved in the field of health policy and public administration responded to a lesser extent.



### 3.1.2.3 Level of engagement with Sierra Leone

#### Membership of organizations



The high proportion of negative and unspecified answers shows that health professionals' involvement in community organizations is limited. This makes it difficult to accurately assess whether health professionals tend to be members of community organizations.

Most health professionals are affiliated to a community organization; few are members of a professional organization.

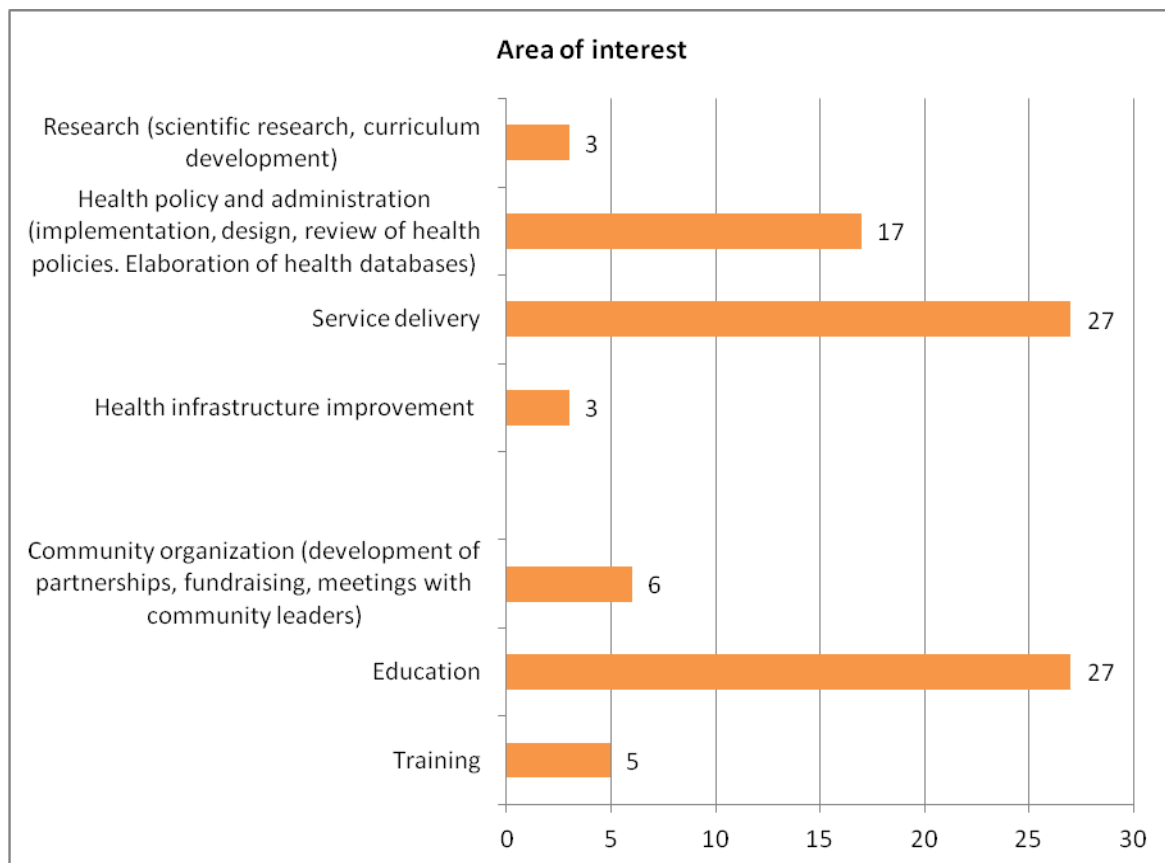
Regardless of their size, community organizations include all organizations dedicated to the assistance of the home country population.

Professional organizations include associations that work for the development of a particular sector (e.g. education or health). These are also organizations in which a majority of the members are professionals. Alumni associations are included in this category.

Ethnic organizations include organizations that assist people of a particular Sierra Leonean district or ethnicity.

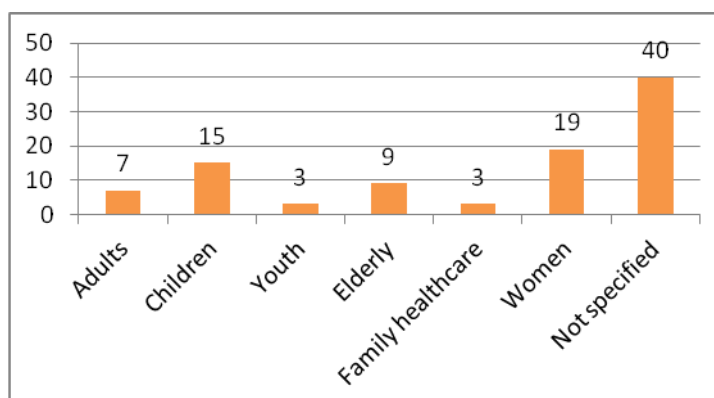
### 3.1.2.4 Interest in contributing to Sierra Leone’s health sector

Most health professionals expressed interest in contributing to the development of Sierra Leone’s health sector by performing health education related activities. Likewise, given their concern about the precarious conditions faced by the population, health professionals are interested in alleviating health difficulties.



### Target Beneficiaries

Health professionals most commonly targeted women and children to benefit from their interventions. Health professionals are well aware of Sierra Leone’s high rates of maternity and child mortality; consequently, their most common interventions are directed to improving women’s and children’s health.





### **Common drivers and incentives**



The word cloud illustrates the most common health professionals' incentives for engaging in medical missions/assignments in Sierra Leone.

Health professionals look to:

- (a) Provide basic care to patients and educate Sierra Leonean nurses on current nursing practice standards.
- (b) Work in acute care settings, and at community clinics, engaging in massive health education about sanitation and preventive health.
- (c) Perform community nursing activities, health promotion and teaching to patients, pregnant and post-partum women.

*Note:* Data for the word cloud was generated by answers to the following open question: "What are your interests in contributing to Sierra Leone's health sector?"

### 3.1.3 Germany

The Sierra Leonean diaspora in Germany is relatively small and largely dispersed, and as previously mentioned in Section 2.2, it was difficult to reach out to some of these professionals especially those located in smaller communities.

Data obtained from the Federal Statistical Office indicated that there were some health professionals (but no contact details) in the new federal states of Germany (former East Germany). The Sierra Leonean Embassy in Berlin equally confirmed the existence of such individuals but their contact details were not available. Consequently, this group could not be included in the outreach.

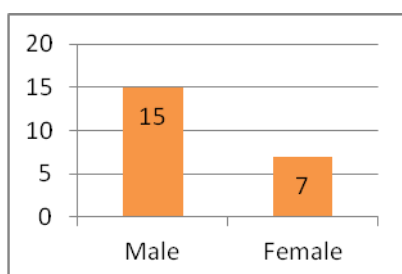
Time and budget limitations also made it impracticable for the consultant to travel to parts of East and North Germany to try to locate a single health professional. Moreover, the researcher was working from a private e-mail address, which contributed to the low response rate. Also, some professionals were unwilling to divulge extensive private information.

A smaller sample of 22 respondents, by comparison with the other countries, participated in the online survey over the outreach period of eight weeks. Consequently the consultant held 32 interviews with members of the Sierra Leonean diaspora in Germany and 10 interviews with stakeholders of diaspora associations, as well as four focus group discussions with diaspora groups in Berlin, Munich, Frankfurt and Hannover.

Most of the results from these in-depth findings are reported in Section 3.2. However, some of the interview findings that help build up a profile of German health workers are included in this subsection.

#### 3.1.3.1 Key sociodemographic characteristics

##### **Gender breakdown**



Of the 22 respondents, 15 were male (68%) and 7 female (32%).

##### **Age profile**

The average age of participants to the study was 42 years. Nurses and social care workers were aged 36 years on average, whereas about 50 per cent of medical doctors were aged over 55. Close to 13 per cent of the medical doctors were on a pension. As discussed further in Section 3.2, this is this category that possesses the technical know-how that can help transform health service delivery in Sierra Leone.

##### **Marital status**

About 58 out 76 (76%) of the health professionals in Germany were married while 14 (about 18%) were single. Another 6% (4 doctors) considered the questions too personal.

#### 3.1.3.2 Professional background and experience

Most of the findings relating to professional background, experience, disciplines and specializations were generated from secondary data, and as such, are dealt with in Section 3.2.

Almost all the medical doctors interviewed for this project completed their professional training outside Sierra Leone. Over 90 per cent (21 medical doctors) attended universities or professional schools in Germany while the remaining 10 per cent trained in other European Union countries.

### ***3.1.3.3 Level of engagement with Sierra Leone***

#### ***Connectedness***

Over 99 per cent of the respondents are in regular contact with families and friends in Sierra Leone using the telephone and internet as the major means of communication. About 30 per cent read newspapers from Sierra Leone on a regular basis.

Sierra Leonean health professionals in Germany maintain very strong ties with the homeland at the individual level, notwithstanding their current nationalities. An important contribution has been the flow of direct remittances to family members and friends in Sierra Leone using the rapid money transfer agencies such as Western Union, Moneygram and Ria. Respondents all reported sending money back on a regular basis. Over 65 per cent of health professionals in Germany had made private investments, businesses and had built houses for their families back home.

Approximately 80 per cent of the respondents visit Sierra Leone at least once every year and spend a minimum of four weeks in the country. Such visits are often to visit relatives at home and to cater for private investments.

About 50 per cent of respondents use the Sierra Leonean Embassy in Berlin to get information and connect with home. The diplomatic mission in Berlin has been proactive in hosting regular exchanges with individuals and groups of medical experts especially with the Bintumani association. These exchanges are possible channels for communicating health and development plans to the health professional diaspora and for exchanging ideas and information on how they might contribute back home.

#### ***3.1.3.4 Interest in contributing to Sierra Leone's health sector***

Some Sierra Leonean health professionals in Germany were willing to relocate either on a permanent or non-permanent basis back home but scared of the enormous sacrifices involved. Three out of four retired respondents were willing to engage in knowledge and skills transfer schemes such as teaching at medical institutions in Sierra Leone.

Fewer than eight per cent of medical doctors had extensive professional experience in Sierra Leone. About 30 per cent (seven doctors) had experience in teaching and training and were willing to assume such functions in Sierra Leone albeit on a short-term basis.

## 3.2 DETAILED FINDINGS

Section 3.2 presents findings from all three data collection methods, questionnaires, focus groups and key informant interviews, and is sub-divided into three country specific sections. It includes the in-depth findings from the group discussions and key informant interviews which served to validate some of the questionnaire findings, and gave a deeper understanding of diaspora health professionals' views and experiences. It also includes some census data and official statistics obtained from public records.

This section is sub-divided into three country specific segments, which are in turn structured according to:

1. Overview of the Sierra Leonean diaspora in the host country, including migratory trends and census statistics
2. Health professionals' initiatives, organizations and networks
3. Diaspora engagement – drivers, challenges and recommendations
4. Additional pertinent information from the original country report

### 3.2.1 United Kingdom

#### 3.2.1.1 Overview of the Sierra Leonean diaspora in the United Kingdom

##### **a) Migratory trends**

Interviewees commonly noted that there was a heavy influx of Sierra Leoneans into the United Kingdom even before the civil war of 1991–2002. There were several causes of this migration, but most were economic migrants. When they arrived, they found a high demand for health workers, offering access to residency, and most of them even changed their professions by taking further training so as to join the health sector.

During the civil war, more Sierra Leonean health professionals arrived in the United Kingdom, and others began undertaking further training. Respondents observed that then, it was relatively easy to find jobs within the National Health Service and many new migrants began training as nurses and midwives.

Since the war there has not been a significant inflow of health professionals from Sierra Leone and a few have actually gone back to settle in their home country.

With regard to areas of residence, respondents commented that most Sierra Leonean health workers reside in London areas such as Lambeth, Camberwell, Hackney, Shoreditch and Southwark. Outside London, respondents were also aware of some clusters around Birmingham, Bristol, Cardiff, Liverpool and Manchester, Reading and Sheffield.

##### **b) Census statistics**

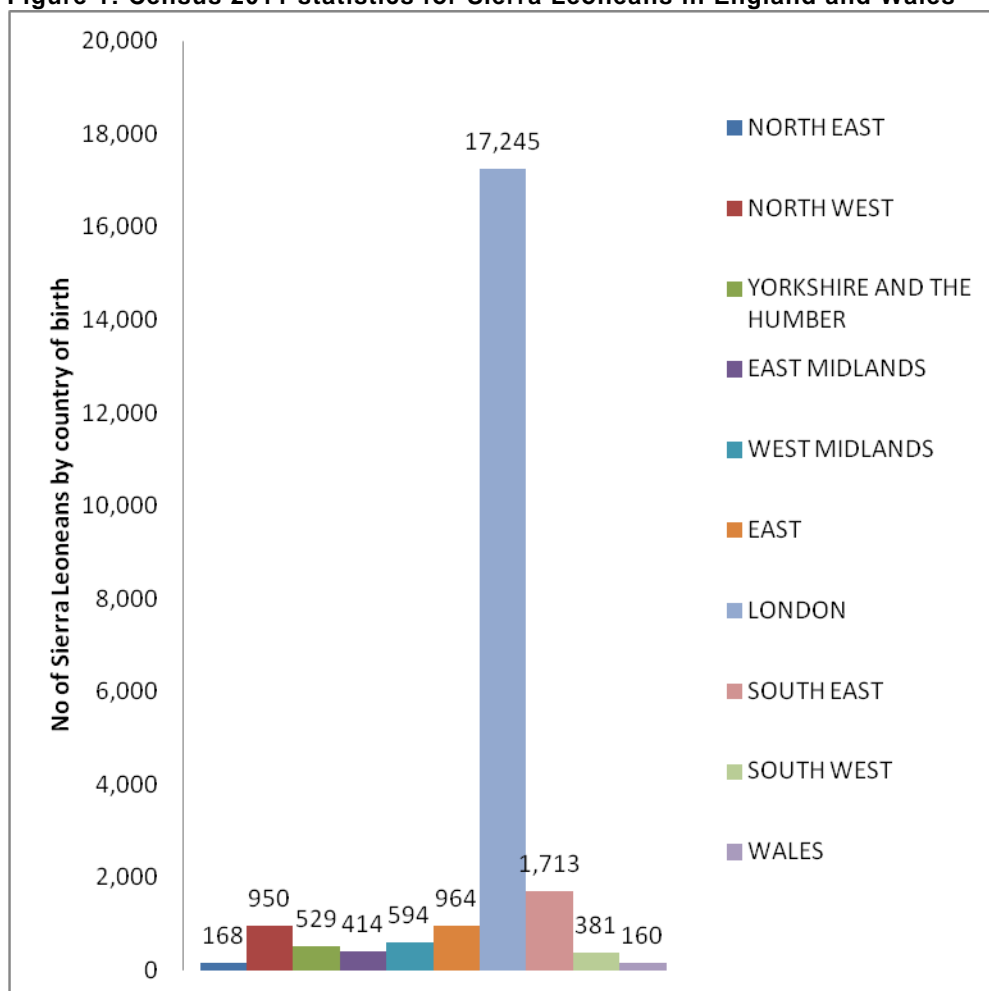
The last United Kingdom census was conducted on 27 March 2011, by three census offices: For England and Wales by the Office of National Statistics (ONS), for Northern Ireland by the Northern Ireland Statistics and Research Agency (NISRA) and for Scotland by the National Records of Scotland (NRS). This study references the latest available census figures for Sierra Leoneans identified by country of birth in all the major UK regions:

East Midlands, East of England, Greater London, North-East England, North-West England, South-East England, South-West England, West Midlands, Yorkshire and the Humber, Wales, Scotland and Northern Ireland.

## England and Wales

According to the UK Office of National Statistics there were 23,118 Sierra Leoneans identified by country of birth living in England and Wales by 2011. The relevant data table enumerated Sierra Leoneans according to the government region in which they resided. Of these, 22,958 were living in England with 160 in Wales. Details appear in Figure 1 below:

**Figure 1: Census 2011 statistics for Sierra Leoneans in England and Wales**



Source: ONS 2011 census data; Table QS213EW: Country of birth (expanded).

From the above statistics, the majority of Sierra Leoneans in the United Kingdom live in the London area (17,245) representing 75 per cent of the Sierra Leonean population in England and Wales. The second biggest cluster is to be found in the South East of England (1,713) representing 7.4 per cent of Sierra Leoneans in the country.<sup>8</sup> Overall, with a total population of 23,118, Sierra Leonean diaspora accounted for about 0.04% of the United Kingdom's overall population of 56,075,912 in 2011.

The census data further reveal that even in regions popular with the Sierra Leonean diaspora, there were areas of residence preferred by most of them. In London, most Sierra Leoneans live in Southwark, Newham, Lewisham, Lambeth and Hackney. Outside London, clusters were also found in Sheffield, Leeds and Liverpool.

<sup>8</sup> Counties within the South East include Berkshire, Buckinghamshire, East Sussex, Hampshire, the Isle of Wight, Kent, Oxfordshire, Surrey and West Sussex.

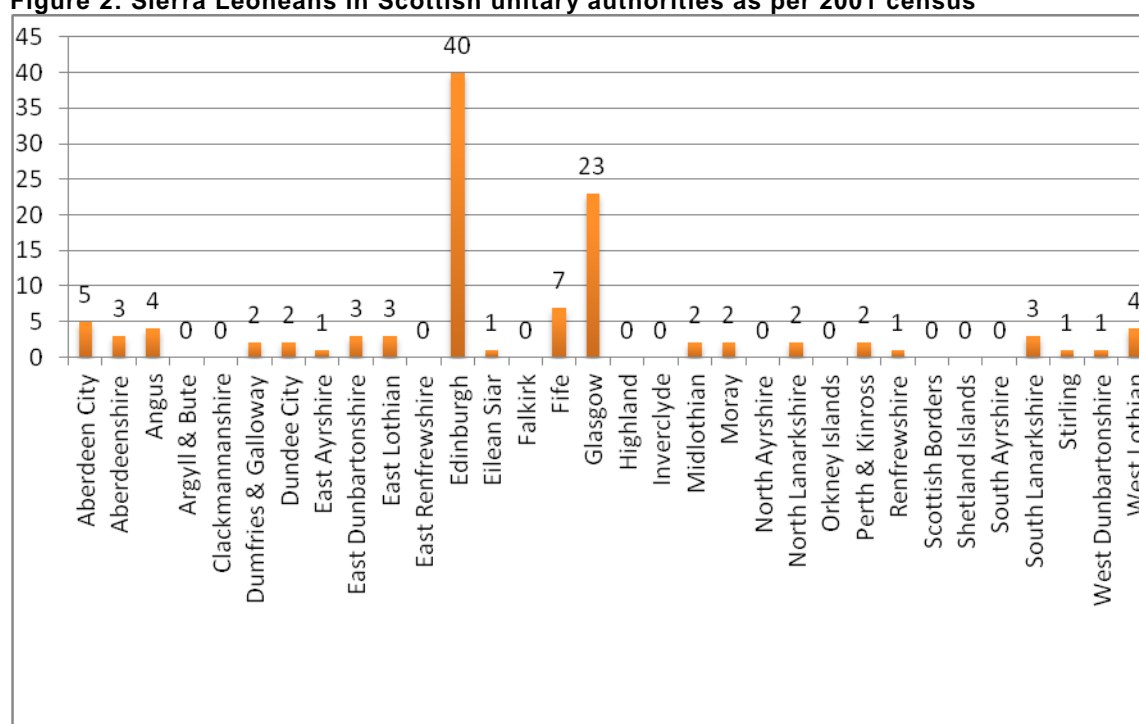
## Scotland

The operational model for collecting data differed in Scotland from that in England and Wales and Northern Ireland as each office employed the models that proved most effective from past experience.

Consequently the release table differed and data on national identity for Scotland from the 2011 census was not yet available at the time the UK report was submitted. Subsequent enquiries have shown that 377 Sierra Leoneans by reference to country of birth were resident in Scotland at the time of the 2011 Census, up from 112 in 2001.<sup>9</sup>

Figure 2 below was extrapolated from the Scotland Census 2001 and shows Country of Birth (Africa) for people living in Scotland at that time.<sup>10</sup> The original table has been adapted to show the geographical spread of Sierra Leoneans across the 32 Scottish unitary authorities. The highest populations appear in Edinburgh (40) and Glasgow (23) out of a total recorded Sierra Leonean population of 112.

**Figure 2: Sierra Leoneans in Scottish unitary authorities as per 2001 census**



Source: Scottish Census 2001.

## Northern Ireland

The 2011 Census for Northern Ireland revealed 25 people identified as Sierra Leonean by country of birth. There was no breakdown available as to how these are spread across administrative regions.<sup>11</sup>

### 3.2.1.2 Health professionals' initiatives, organizations and networks

This section draws from the insights from the literary review undertaken as part of the study, as well as the series of focus group discussions held with UK-based Sierra Leonean health professionals. The first focus group was made up of six interviewees comprising four females and two males. The second one had seven interviewees consisting of five females and two males and the third had six

<sup>9</sup> These figures are provided at national level only and do not give a geographical breakdown.

<sup>10</sup> 29 April 2001.

<sup>11</sup> Source: 2011, Northern Ireland Statistics and Research Agency, Country of Birth - Full Detail\_QS206NI.

interviewees; two of whom were female. All three focus group discussions were moderated by the Lead Researcher while the Outreach and Support Investigator took notes. (See Annex V for participants' profile).

Sierra Leonean health professionals were quite aware of the state of health care within the country, and even more acutely following a home country visit. Sierra Leone is an African country often singled out for its poor health sector performance. A recent UNICEF study ranked it the worst country in the world for child survival, with the under-five mortality rate standing at 185 per 1,000 live births (UNICEF, 2012). As previously mentioned, the country's devastating civil war between 1991 and 2002 saw up to 70,000 casualties and displaced about one third of the population. The war also contributed to the shortage of health workers in the country.

## **a) Diaspora initiatives to improve Sierra Leone's health sector**

### **Individual initiatives**

A number of diaspora initiatives have been ongoing to support the health sector in Sierra Leone. Most of these have however been at individual level due to personal sentiments to help particular communities. Most respondents agreed that the health sectors in Sierra Leone and in the United Kingdom were incomparable. Among the most cited differences was the perceived low level of professionalism in the Sierra Leonean health system, together with low level of commitment and poor infrastructure.

*"...Once I was volunteering at a health centre in Sierra Leone and witnessed with shock how the doctor kept inspecting one patient after the other with his bare hands without gloves or use of sanitizer. When I asked him whether he did not care about possible safety risks to him or to his patients, he simply shrugged and said there was no equipment available to him",* narrated one nurse.

Other respondents had witnessed similar scenarios during their visits.

When probed to elaborate further, most respondents agreed that the solution lay in attitude change and that this could be achieved through awareness raising, training and mentorship. They also agreed that diaspora professionals were best equipped to do this if only they could get organized and develop a common approach.

One midwife has been regularly taking her holiday breaks to take some basic supplies like surgical gloves to health units in Sierra Leone.

Another respondent said, *"... I was deeply touched when I visited a missionary mental health centre and I found mental health patients tied with ropes on trees apparently to keep them restrained ... this was inhuman and I felt I had to do something ..."*. Since then, she has been travelling to Sierra Leone at intervals to provide free services and donate equipment but she feels more needs to be done by her fellow colleagues in the diaspora.

### **Collective initiatives**

Among the key initiatives has been the establishment of The Organization of Sierra Leone Health Professionals Abroad (TOSHPA) which has been coordinating with, and mobilizing diaspora health professionals to contribute services such as training, volunteering and donations to the health sector in Sierra Leone since 1996 when it started as Sierra Leone Nurses and Midwives Association.

Many nurses and midwives are willing to go and apply their skills to support their colleagues back home but have not seen any strong organization among the diaspora that could motivate them to do so. A list of diaspora and non-diaspora organizations making interventions in the Sierra Leonean health-care sector was included in the full country report.

### **Sierra Leone Diaspora Network health conference, 2009**

Driven by the desire to ensure an improved standard of health service delivery in their country of origin, the Sierra Leonean Diaspora Network (SLDN), a diaspora group exploring sustainable solutions to development in Sierra Leone, held a conference for Sierra Leone health professionals in London in 2009 and identified a number of challenges that needed addressing and at the same time proposed possible solutions (SLDN, 2009). Some of the agreed strategies on a way forward pointed to the need for a more vigorous engagement of individual diaspora members to provide service/expertise to the health sector development in Sierra Leone. At the conference, one of the most prominent Sierra Leonean health professionals, Dr. Radcliffe Lisk, proposed the following options:

- Raising funds for projects
- Exchanging skills on short and long term bases
- Holding consultations before making donations and making sure locals are trained on how to use any equipment donated
- Arranging placements for medical students in Sierra Leone
- Advising on policies
- Working towards transfer of technology
- Training locals to acquire some further competencies<sup>12</sup>

Discussions at the SLDN meeting, coupled with firm resolutions reached, indicated an on-going willingness among diaspora professionals to engage with Sierra Leone. This called for a more focused study to understand the nature of engagements that already exist between Sierra Leonean diaspora health professionals in the UK and their country of origin.

Since 2009 there have been a number of health-related initiatives focused on Sierra Leone with potential for diaspora input. Among these initiatives are a health-care partnership with Sierra Leone King's Sierra Leone Partnership (KSLP), and the UK-Sierra Leone Health Partners Network, a network of organization and partnerships currently working to support the health system in Sierra Leone.

#### ***b) Non-diaspora initiatives***

The King's Sierra Leone Partnership is another active engagement avenue that embarked on a health-care partnership in Sierra Leone in 2012. It has sent a number of volunteers from staff in the three hospitals that constitute King's Health Partners to support the health sector.

The King's Sierra Leone Partnership programme in Sierra Leone focuses on educational institutional capacity and building partnerships. KSLP works to strengthen worker training in Sierra Leone by drawing on staff expertise from across King's Health Partners (King's College Hospital, Guys and St Thomas' and South London and Maudsley NHS Trusts) to support teaching hospitals and training institutions across the country. KSLP's two main partners in Sierra Leone are the College of Medicine and Allied Sciences, the country's only medical and pharmacy school and largest nursing college, and Connaught Hospital, the main adult referral and teaching hospital in Sierra Leone.

KSLP is coordinated by Dr Oliver Johnson, with Prof John Rees overseeing the work on undergraduate training and Dr Susie Whitwell leading on mental health. King's Partnership has been working on mental health in Somaliland and is seeking to extend this programme to Sierra Leone.<sup>13</sup>

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<sup>12</sup> *Health in Sierra Leone; a Diaspora Intervention: Summary Report* by the Sierra Leone Diaspora Network, Sierra Leone Diaspora Network (2009).

<sup>13</sup> KSLP is the beneficiary of funding awarded by the UK Department for International Development (DFID) under the Health Partnership Scheme. The programme is managed by The Tropical Health and Education Trust (THET), a specialist global health organization that educates, trains and supports health workers through partnerships, strengthening health systems in Africa and Asia.



Although KSLP is not a diaspora initiative, many Sierra Leonean health-care professionals work in the three hospitals that constitute King’s Health Partners. These hospitals also serve areas with high densities of Sierra Leoneans in London. Some Sierra Leoneans are already part of the King’s Global Health network – and this initiative offers opportunities for diaspora members to volunteer in their home country.

### **3.1.2.3 Diaspora engagement – drivers, challenges and recommendations**

#### **Drivers**

Different diaspora members interviewed were motivated by unique factors although with some commonalities among them. The majority of them had witnessed a family member or loved one suffering with a particular disease which sensitized them to the inadequacies of the Sierra Leonean health system.

*“... When I lost my mother to cancer”, said one gentleman, “I realized I needed to do something to address the problem. Ever since then, I have been actively engaged in the fight against cancer and I am a trustee of Sierra Leonean cancer charity.”*

Such bold commitments have been a great source of inspiration to many people in the diaspora who have long since become involved in similar causes. One example is the creation of the Sierra Leone Cancer Charity which was formed by family and friends of a Sierra Leonean who died from cancer in the UK.<sup>14</sup>

Awareness raising and prevention was stressed as an important area that the diaspora could add value. One Sickle Cell Counsellor and Advocate is now a specialist in saving children from the stigma associated with sickle cell. She narrated that,

*“Two of my children were diagnosed with sickle cell; the experience was extremely difficult for me but I had to remain strong. People believed it had to do with witchcraft. With the knowledge I have acquired about this kind of condition I now volunteer my time and other resources supporting people who are faced with similar challenges”.*

For some respondents, the motivation came from the realization their education in Sierra Leone was good enough for them to run a robust health system if only people had the right attitude. One nurse noted,

*“...when I came here (to the UK – Ed.), I realized that the skills and knowledge I had learnt back home was the same being applied at the workplace, save for a slight difference in terminologies. I had to do further training just to adapt to the new way of doing things but I found that my previous knowledge would have been good enough”.*

Since then she has been actively engaged in looking for ways to find solutions to what she saw as growing unprofessionalism and poor training among health staff in Sierra Leone. She hopes that with concerted efforts from members of the diaspora, a lot could be achieved in the long run.

#### **Challenges**

Although individual Sierra Leonean health workers have ventured to provide services to their country of origin, their experiences were not always positive and in some instances their interventions have been met with resistance. Respondents enumerated a number of challenges they encountered, including:

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<sup>14</sup> SLCC was set up in memory of Verna Iscandari-Johnson who fought a courageous battle against breast cancer. SLCC oversees the Verna Iscandari-Johnson Initiative (VIJI) - a female oncology ward named in her memory at Connaught Hospital.

- a. Partnerships/relationships with home country counterparts
  - i. Initial mistrust and suspicion from their counterparts in Sierra Leone especially from health workers in the public sector who see them as competitors.
  - ii. A perception that members of the diaspora approach issues with ‘elitist’ and arrogant attitudes and fail to grasp the realities on the ground. Sometimes, diaspora professionals are seen as patronizing and difficult to work with.
- b. Lack of a strong base back home in the form of housing and other establishments that could facilitate their stay in the country and reduce the overheads of a visit.
- c. Corruption on the ground in Sierra Leone which demotivates anyone who is going to considerable trouble to contribute free equipment and other resources, only to see donated goods diverted, stolen or sold on by local staff.
- d. Lack of a strong mobilizing factor in the United Kingdom to bring Sierra Leoneans together and discuss how to improve the health situation in the home country.
- e. The rigid and bureaucratic system in Sierra Leonean institutions that is insufficiently flexible to adapt to changing global dynamics. One of the participants lamented that although her skills as a specialist nurse are highly recognized in the United Kingdom and that she can even be allowed to teach at higher institution levels, she gets frustrated in Sierra Leone where they insist on people having formal traditional qualifications before they can teach.
- f. Childcare: Most diaspora health workers have established families in the United Kingdom with children going to school; hence taking time away to go on long-term engagements in Sierra Leone may not be practical. However, most of them were willing to get involved in short-term placements.
- g. Financial outgoings: The majority of the Sierra Leonean diaspora have regular financial obligations such as mortgages. Provision for such obligations would be a prerequisite for them to engage in long-term volunteering.

## Recommendations

There was a common view among respondents that some level of facilitation was necessary if they were to be involved in such programmes. Such facilitation could take the form of financial, logistical and preparatory support.

- a. Financial: A minimum living package needs to be worked out by whichever agency that is going to run a prospective diaspora volunteer programme. Financial support for things like airfare and daily upkeep while in the field should be properly planned for. When probed further however, respondents could not decide the exact amount of remuneration they would settle for, insisting that this should be worked out in the same way as international volunteer packages.

One interviewee proposed investigating whether a deal could be struck with a major airline like British Airways, whereby discount fares and vouchers could be offered to diaspora members wishing to travel to volunteer in Sierra Leone. This could be worked out around a corporate social responsibility type of scheme.

- b. Logistical: It also emerged through discussions that some members of the diaspora would need accommodation arrangements in Sierra Leone, since they have been away for too long and no longer have any residences of their own. This, again, was expected to be worked out at going local rates and systems.
- c. Preparation: One respondent who was very familiar with running volunteer schemes and a seasoned trainer herself emphasized the need to take prospective volunteers through some training techniques, noting that not all good specialists are necessarily good trainers. This has to be done with consideration of the Sierra Leonean human resource landscape in mind.

- d. Structured facilitation: It further emerged that there is need for a structured facilitation in the form of endorsements from organizations promoting diaspora engagement programmes, employing hospitals and institutions, and governments. Making available such official levels of support would make it easier for members of the diaspora to make appropriate decisions about volunteering abroad.

#### **3.2.1.4 Key informant interview highlights**

This section contains some of the insights gleaned from the two key informant interviews held with individuals of Sierra Leonean origin based on their level of involvement in the UK health sector, and supplements some of the information gleaned through the focus groups. Profile of interviewees:

##### **Key informant one**

Works in public health nursing; discharge advisor; private practice. Formerly a member of Sierra Leonean Nurses and Midwives Association – now runs a diaspora health professionals umbrella organization which has been running since 1996 trying to help people affected by the civil war.

##### **Key informant two**

Mental Health Worker currently based in Sierra Leone but formerly working in the UK health sector. He was a member of the pan-London dual diagnosis network and Mental Health Educators in the Diaspora and his specialization is addiction and interest is dual diagnosis mental health and addiction.

Formerly a Manager of the Greenwich Ferry View Mental Health Nurse Practitioner Team, Oxleas NHS Foundation Trust, he resigned in September 2011 after deciding to be part of the transformation of Sierra Leone. Contributions to date have included:

- Leading the Health System Strengthening programme of the National AIDS Secretariat
- Serving on the Ministry of Health and Sanitation (MoHS) payroll steering committee
- Acting as Head of Department of Specialised Nursing, College of Medicine and Allied Health Sciences (COMAHS), which has now produced guidelines for study leave and indicators to monitor staff attendance and performance.
- Completing the review of the Mental Health Nursing Curriculum for all cadres of nurses and Community Health Officers
- Presenting on the topic of stigma and discrimination at the Second National Mental Health Conference in the presence of the First Lady as Guest Speaker<sup>15</sup>
- Participating in the training of 21 mental health nurses with a certificate in mental health at COMAHS and assisted in the basic training to Community Health Officers in mental health.

#### **Comparison between Sierra Leonean and UK health systems**

The key informants observed that there would be an adequate workforce in Sierra Leone except that there is shortage of skills and people are not committed to work. One of them noted that people work without serious commitment unlike in the United Kingdom.

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<sup>15</sup> March 2013. This followed on from the first National Mental Health Conference held in October 2012 at which a National Mental Health Policy and Strategic Plan was launched.

**a) Key challenges in the Sierra Leone health system**

- I. Poor infrastructure
- II. Highly bureaucratic systems that do not get work done but can cause lots of problems if bypassed

**b) Willingness to contribute to development of health sector in Sierra Leone**

There was overwhelming evidence that members of the diaspora are very interested in engaging with their home country and even willing to volunteer. The missing link has been the bonding factor and some framework of incentives and organization that could be a central coordination point. They note that most diaspora members are willing to spend their holidays in Sierra Leone to provide free services to their people.

**c) Areas of interest**

Most health-care workers resident in the UK would prefer to work in four main areas in Sierra Leone and these are:

- I. Clinical Practice especially mental health
- II. Management
- III. Training
- IV. Public Health information and awareness raising

**d) Incentives that would encourage diaspora volunteering**

- I. Provide accommodation for health workers on placement. This was recognized to be a very strong incentive because this has been a big challenge in the past.
- II. Enable volunteers to be able to spend a productive amount of time in-country. They also suggested that placement opportunities should last from a few months to one year. They noted that most diaspora health workers are willing to take leave as long as they are guaranteed to be able to return to their jobs; hence there is need for some official arrangement.

**e) Suggested improvements to the Sierra Leonean health system**

- I. Attitude change: There is a need to pursue programmes that target changing health workers' mindsets in Sierra Leone. Noting that attitude is everything, they observed that unlike in the United Kingdom where there are sometimes acute manpower shortages, Sierra Leone still has adequate numbers of personnel but they need to be trained and mentored to adopt a better professional work ethos.
- II. Flexibility from diaspora counterparts: Attitude change however goes both ways in that while Sierra Leone-based health workers need to acquire more professional attitudes, people in the diaspora intending to work in Sierra Leone should also be flexible enough to recognize difficulties on the ground. These, they observe, are the rubrics of a successful engagement scheme.
- III. Commitment: Individuals in the diaspora need to recognize the need for commitment and unity of purpose in order to cause real change in the health system. Any intervention programme, they observe; should target working through diaspora apex bodies with potential to mobilize members for collective action.
- IV. Focus on health as a business: One of the key informants noted that currently, health provision is largely left in the hands of the state with a few private sector actors running small clinics. It was suggested that there is huge potential for investment by people in the diaspora to run health businesses in Sierra Leone. This would not only bridge quality service provision but also provide points of excellence around which some of the country's health initiatives could be built.

### 3.2.2 United States and Canada

#### 3.2.2.1 Overview of Sierra Leonean diaspora in Canada and United States

##### a) Sierra Leonean diaspora in Canada

According to the 2006 Census, Canada’s immigrant population totaled 6,452,305.

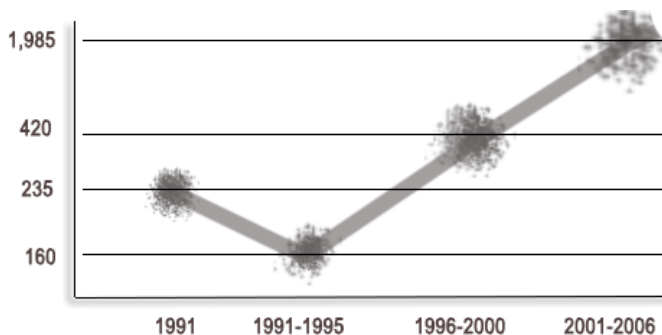
The total population that emigrated from Africa was estimated for about 398,100. Immigrants from West Africa numbered 48,640.<sup>16</sup>

In 2006, immigrants from Sierra Leone totaled 2,950.<sup>17</sup> Sierra Leonean migration to Canada does not present a steady increase. From 1991 to 1995, 160 Sierra Leoneans arrived in Canada. This number clearly contrasts with those registered in 1991 (235) and those who arrived between 1996 and 2000 (420). The period from 2001 to 2006 presents the highest number of entries with 1,985 entries registered.

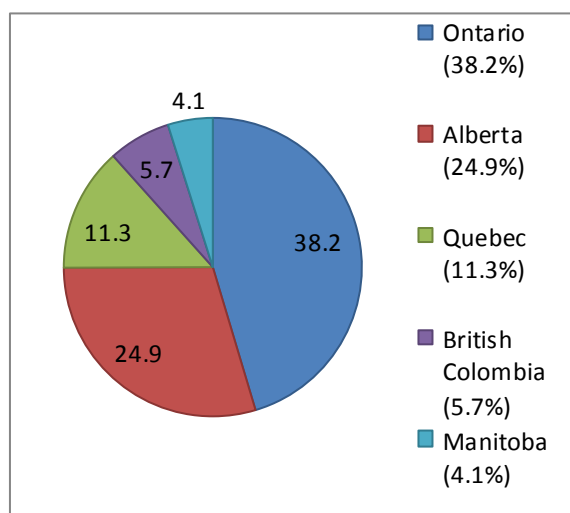
By 2011, Canada’s National Household Survey registered a total of 2,505 people born in Sierra Leone. Accordingly, 1,805 had Canadian citizenship and 700 who did not were permanent residents and non-immigrants.<sup>18</sup> Between 2006 and 2011, about 145,700 immigrants arrived from Africa. The population from Africa totaled 522,970.

The vast majority of Canada’s foreign-born population lives in four provinces: Ontario, British Columbia, Quebec and Alberta. In 2006, the provinces with the largest Sierra Leonean diaspora concentrations were Ontario: 1,225, followed by Alberta: 570, British Columbia: 145 and Quebec: 135.

**Figure 3: Immigration trends of Sierra Leoneans to Canada by year (1991-2006)**



**Figure 4: Distribution of the Sierra Leonean diaspora by Province (est. 2011)**



<sup>16</sup> Source: 2006 Census Statistics Canada. “Place of birth for the immigrant population by period of immigration, 2006 counts and percentage distribution, for Canada, provinces and territories - 20% sample data.”

<sup>17</sup> This number results from the combination of non-permanent residents plus data compiled from the inflows of Sierra Leoneans to Canada: before 1991, from 1991 to 1995, 1996 to 2000 and 2001 to 2006.

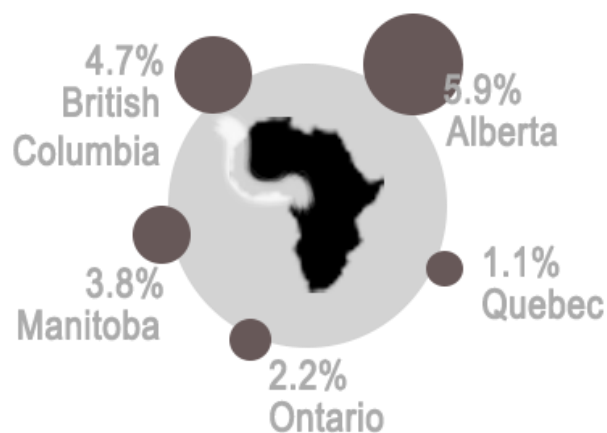
<sup>18</sup> This category includes the non-immigrants, defined as people from another country who, at the time of the survey, have a work or study permit or who are refugee claimants.

Sierra Leoneans living in Ontario constituted 3.9 per cent of the total number of West African immigrants living in Ontario. In Alberta they constituted 12.9%, in British Columbia 6.5 per cent and in Quebec 1.05 per cent.

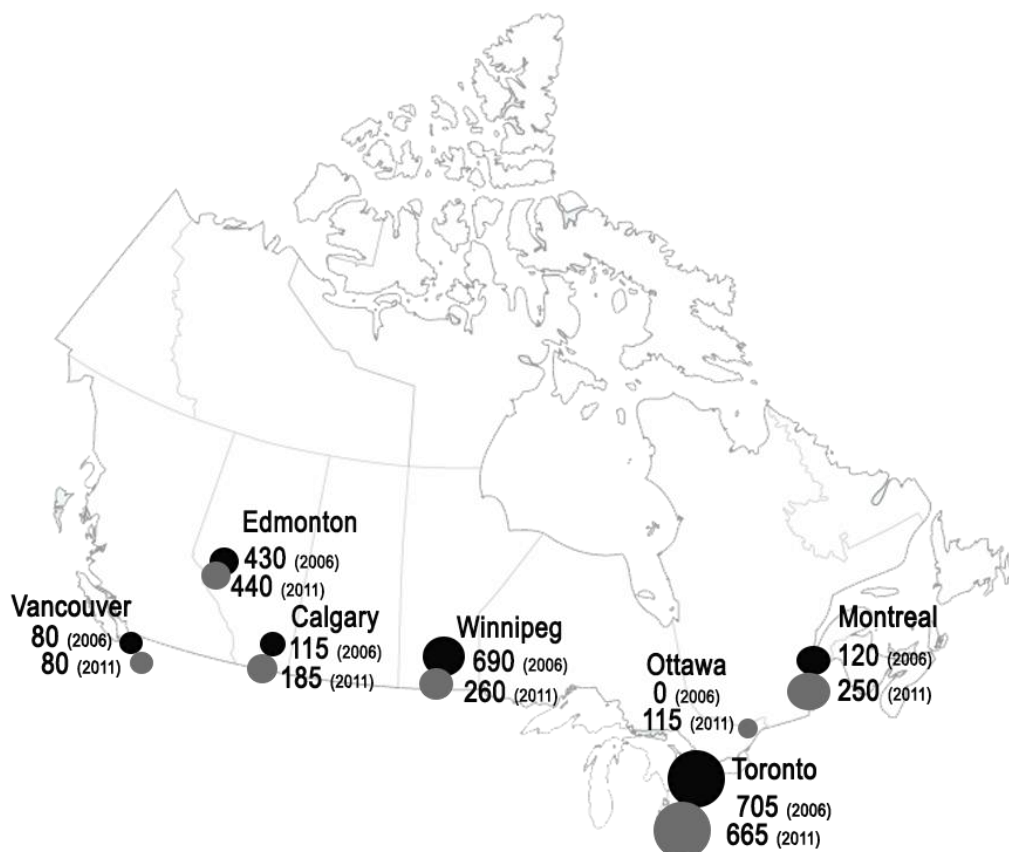
The vast majority of the foreign-born population lives in Canada’s largest urban centre. At the metropolitan region level, the city of Toronto registered 775 people from Sierra Leone, followed by: Edmonton: 450, Montreal: 135, Calgary: 120 and Vancouver: 85.

By 2011, Toronto and Edmonton were the largest hubs for the Sierra Leonean diaspora. There were more Sierra Leoneans living in Montreal’s metropolitan region than those who lived in Calgary. Vancouver presented the smallest concentration.

**Figure 5: Proportion of the Sierra Leonean diaspora compared to the total West African immigrant population in each province (2011)**



**Figure 6: Trends of the Sierra Leonean population in metropolitan regions with the largest concentrations of Sierra Leoneans (2006-2011)**

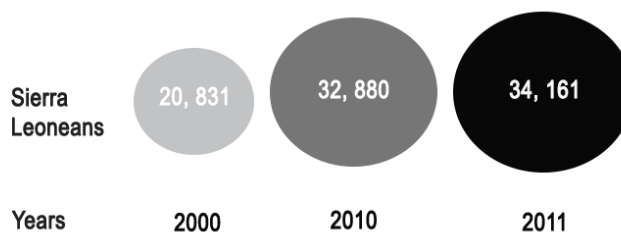


*Source:* Place of birth for the immigrant population by period of immigration, 2006 counts and percentage distribution, for Canada, provinces and territories - 20% sample data. Citizenship (5), Place of Birth (236), Immigrant Status and Period of Immigration (11), Age Groups (10) and Sex (3) for the Population in Private Households of Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomerations, 2011 National Household Survey.

**b) Sierra Leonean diaspora in the United States**

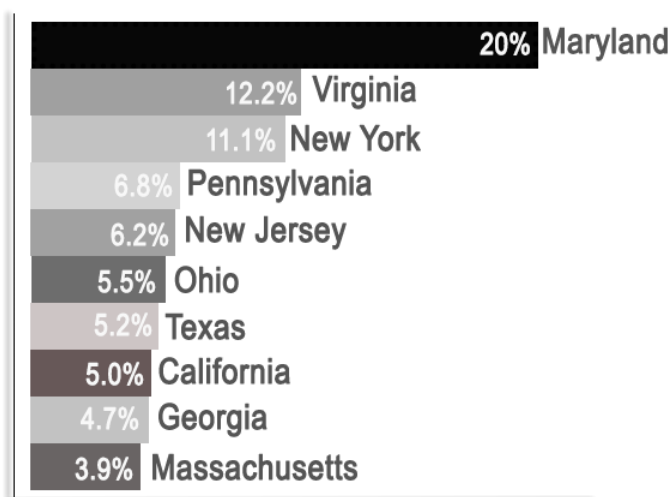
According to the 2000 Census, there were 20,831 immigrants from Sierra Leone living in the United States. The population of Sierra Leoneans living in the United States increased 57.8 per cent from 2000 to 2010. The American Communities Survey estimated 32,880 Sierra Leoneans in 2010. In 2011, the total number increased to 34,161, a growth of 3.8 per cent in a one year span.<sup>19</sup>

**Figure 7: Trends on the estimated population of Sierra Leoneans in the US (2000-2011)**



The South registered the highest numbers of immigrants born in Sierra Leone. In 2000, 57 per cent of Sierra Leoneans were living in southern states. The South was followed by the Northeast (25.6%), the Midwest (8.7%) and the West (8.7%)<sup>20</sup>

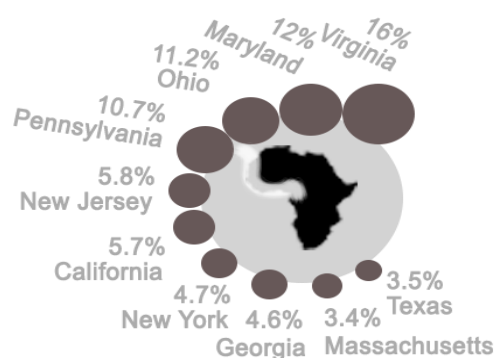
**Figure 8: Distribution of the total Sierra Leonean diaspora by state (2011)**



In 2000, out of the ten states with the largest Sierra Leonean populations, two states alone accounted for 37.2 per cent of the total population of Sierra Leoneans: Maryland and Virginia. New York, New Jersey, California and Georgia shared 30 per cent of the Sierra Leonean population. Finally, 15.2 per cent of the diaspora lived in Texas, Pennsylvania, Massachusetts and North Carolina.

By 2011, almost half of the Sierra Leonean diaspora in the United States resided in three states: Maryland (20%), Virginia (12.2%) and New York (11.1%). The rest of the states registered variations. New Jersey, Pennsylvania, Ohio, Texas, California, Georgia, and Massachusetts combined accounted for 37.3 per cent of the total Sierra Leonean diaspora.<sup>21</sup>

**Figure 9: Proportion of the Sierra Leonean diaspora compared to the total West African immigrant population in each state (2001)**



Sierra Leoneans living in Maryland represent 12 per cent of the total West African immigrant population. In Virginia they account for 16 per cent.

The majority of Sierra Leoneans living in Maryland and Virginia are located in counties surrounding the

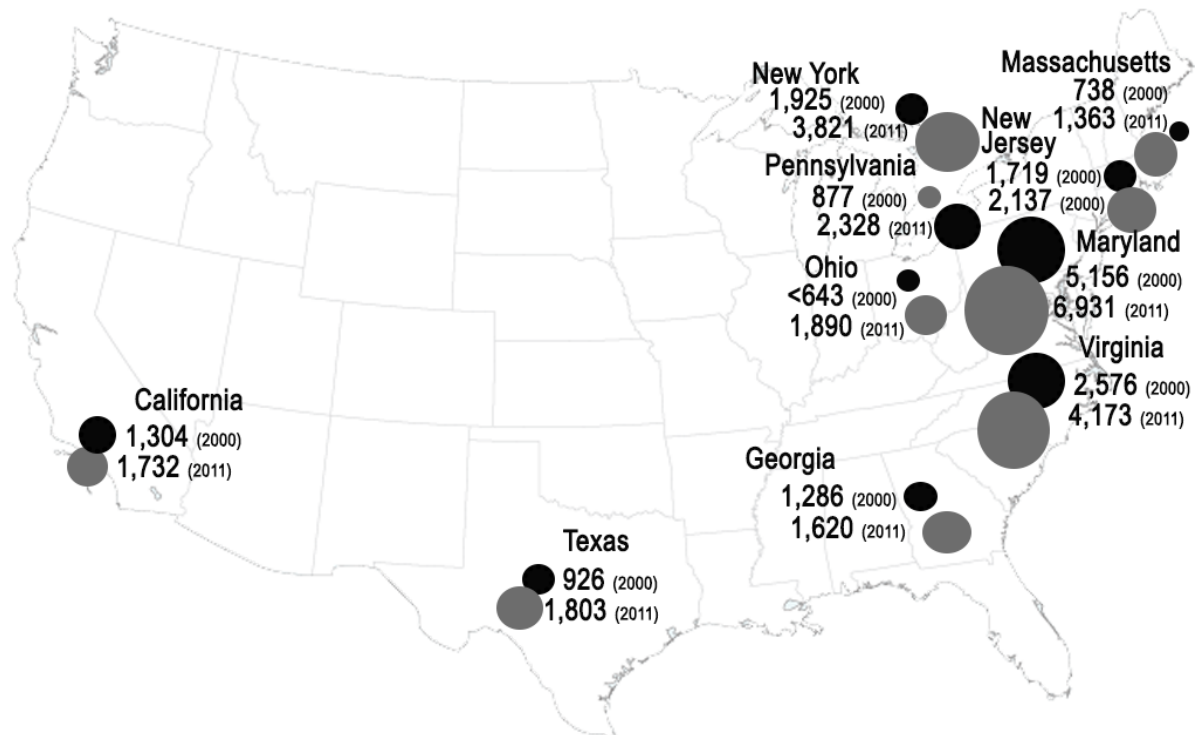
<sup>19</sup> Migration Policy Institute Data Hub. "Who's Where?" The foreign born from Sierra Leone in the United States, Based on the 2000 Census.

<sup>20</sup> Ibid.

<sup>21</sup> US Census Bureau. Place of Birth for the Foreign-Born Population in the United States Universe: Foreign-born population excluding population born at sea, 2007-2011 American Community Survey 5-Year Estimates.

District of Columbia. In Maryland, Prince George’s county (3,723) and Montgomery (2,207) registered the largest concentrations. In Virginia, the vast majority lived in Fairfax (1,684) and Alexandria (656). Additionally, the US census has records of 518 Sierra Leoneans living in D.C.

**Figure 10: Trends of Sierra Leonean population in the states with the largest concentrations of Sierra Leoneans (2000-2011)**



*Source:* US Census Bureau. Place of Birth for the Foreign-Born Population in the United States Universe: Foreign-born population, excluding population born at sea 2007-2011 American Community Survey 5-Year Estimates. Accessed September 16<sup>h</sup> 2013. Available at: <http://factfinder2.census.gov/faces/tableservices/jsf/pages/produ>.



### ***c) Migratory trends - emigration of Sub-Saharan African health professionals***

Estimating the numbers, characteristics and migratory trends of Sub-Saharan African (SSA) health professionals to developed countries is a challenging endeavour. Researchers in the field often make reference to the incomplete available information due to the absence of systematic data (Clemens and Pettersson, 2008). Moreover, given that African countries rely on destination countries' data to calculate their emigration numbers, it is difficult to measure the impact of migration on countries of origin (Hagopian et al., 2004).

In addition, researchers argue whether available datasets are limited for the purposes of providing an accurate picture of the numbers of the African health professional diaspora. For instance, Clemens and Pettersson pointed out the tendency to count only physicians or being narrowly focused on the country of training (Clemens and Petterson, 2008). Likewise, Tankwanchi et al. had stressed the necessity to account all émigré physicians, including those educated internationally but training in host countries (Tankwanchi et al., 2013).

#### **Sub-Saharan African health professional immigration to United States and Canada**

##### **a. United States**

The two most prominent destination choices for Sub-Saharan African (SSA) health professionals are the United Kingdom and the United States.

In 2000, findings indicated that the United States was the second destination of SSA medical emigrants with 8,558 SSA-born physicians and 19,545 nurses. The United Kingdom headed the list with a total number of 20,372 nurses and 13,350 physicians. Canada was the fourth largest destination after France, with 2,800 physicians and 1,690 nurses (Clemens and Petterson, 2008).

Recent findings from an analysis of the American Medical Association Physician Masterfile (AMA-PM) estimate 10,377 SSA-émigrés physicians in the United States. Of those, 68 per cent (7,130) graduated from medical schools located in SSA; 20 per cent (2,953) were born in SSA but attended a US-based medical school and 12 per cent (1,194) graduated from a medical school located outside the SSA and the United States (Tankwanchi et al., 2013. p. 3).

In 2011, the number of International Medical Graduates (SSA-IMG) increased by over 38 per cent since 2002. Nigerian-trained IMG make up almost 50 per cent of this increase. Similarly, Cameroon, Sudan, Ethiopia and Kenya had the largest percentage increases of SSA-IMGs in the US-physician workforce since 2002 (Tankwanchi et al. 2013., p. 5).

##### **b. Canada**

In the case of Canada, the majority of health professionals trained in SSA countries come from South Africa. South African trained physicians working in the Canadian health sector account for nearly 10 per cent of Canada's total population of foreign-trained physicians. Between 1993 and 2003, their numbers increased over 60 per cent (Lebonte et al., 2006). The inflow of South African-trained health professionals has increasingly gained importance over traditional sending countries such as the United Kingdom, Ireland and the Unites States (Lebonte et al., 2006. p.2). In 2006, the three main countries of origin of immigrant doctors were the United Kingdom, India and South Africa. Immigrant nurses came principally from the Philippines, the United Kingdom and Jamaica (Dumont, JC. et al, 2008).

Other SSA-trained physicians and nurses who were present in the Canadian health workforce are: Nigeria, Zimbabwe, Zambia, Uganda, Ghana and Sudan. Their numbers have been slowly increasing, except for those health professionals trained in Nigeria, and do not compare with those of the South African-trained health workforce (Lebonte et al., 2006. p.2).

### **Incentives for emigration**

This report found the most commonly identified incentives for SSA health professionals to migrate to developed countries to be the following: (a) low salaries and poor working conditions exacerbated by dysfunctional structural adjustment programmes (SAPs); (b) insufficient appropriate employment; (c) poor infrastructure and technology; (d) lower social status and recognition; and (e) repressive governments (Tankwanchi et al., 2013. p. 17; Hagopian et al., 2004. p.4).

No less important is the fact that SSA medical schools struggle to retain medical graduates. The low number of medical schools, low enrollments and the tendency towards graduate emigration hampers the African health sector expansion (Chen et al., 2012. p.2). Even among SSA countries with positive net growth rates of physicians and nurses, only two out of twelve selected SSA countries seem to have a chance of meeting current unmet demands “by virtue of unequivocally having a faster-growing number of health workers than inhabitants” (Kinfu et al., 2012. p. 227).

In addition, high-income country’s policies and structural factors for physician immigration had incentivized the permanent residency of health professionals from less developed countries. Public medical expenses and rapidly ageing populations in high-income countries have created an increased demand for physicians in the labour markets (Tankwanchi, 2013. p.23). It has been argued that US inner-city hospitals’ reliance on the foreign health workforce prevented narrowing the admission of health professionals émigrés to residency programs (Hagopian et al., 2004. p.2). The same trend is seen in Canada, where foreign-trained physicians are more likely to work in rural areas, where fewer domestically-trained physicians are willing to work and demand for family practitioners is high (Lebonte et al., 2006).

#### **3.2.2.2 Health professionals’ initiatives, organizations and networks**

The section draws from the insights from a series of focus group discussions with Sierra Leonean health professionals based in the United States and Canada. The focus group discussions involved a total number of 23 participants, of which 12 were from the United States and 11 were from Canada (See Annex V for participants’ profile).

US-based participants had an average age of 41 and 15.6 years of residence in the United States. Canada-based participants had an average age of 32 and 7.7 years of residence in Canada.

Respondents showed a high level mobility within their respective countries of residence with regard to their education and professional experiences. Interviewees tended to have worked or held a medical residence in at least one different state to their current state of residence.

##### **a) Diaspora initiatives to improve Sierra Leone’s health sector**

The majority of the respondents were current or former members of Sierra Leonean community or charitable organizations. Respondents admitted that there was little knowledge about Sierra Leonean health professional organizations in the United States. They observed that most of the health-care workers’ contributions to their home country occur unilaterally. There are no visible health professional organizations that support a concerted effort to bring aid to Sierra Leone.

Every participant was involved individually or collectively in assisting the development of Sierra Leone’s health sector. Health professionals’ entrepreneurial spirit and financial support has made them seek more formal ways of giving back to their country, such as associating themselves and forming non-profits or running clinics in Sierra Leonean communities to establish a continued contribution.

## Individual initiatives

Respondents with more years practicing their profession before the break of the civil war were involved in some kind of medical missions through non-profit organizations. Some US-based health professional associations like the Sierra Leone Nurses' Association in New York started in Sierra Leone; it is a branch of the Sierra Leone Nurses' Association (SLNA) based in Freetown.

Individual efforts from diaspora members are financed out of their own pockets and consist of sending basic medical supplies to hospitals in Sierra Leone's provinces. Their travel to Sierra Leone usually takes place once or twice a year.

Most of the time respondents carry out their health missions in their vacation time. They admitted feeling supported by the hospitals for which they work. Normally hospitals donate medical supplies and equipment. Respondents ship the medical equipment to a location in Sierra Leone that they trust. Some frequent challenges that individual initiatives face include taking care of their family while they are away and raising money for medical equipment.

*"My hospital is very supportive to what I am doing, they donate medical supplies [...] My hospital is a teaching hospital so they do encourage missions."*

*"Basically what I am doing right now is establishing partnerships in Freetown and supplying basic medical supplies like blood pressure machines, thermometers, I.V kits, masks [...] a lot of them are donated from the hospital I am working. I ship all of those supplies to Freetown and while I'm flying I take basic supplies with me as well [...] that's entirely funded by me."*

*"I decided to open a resource center in Sierra Leone, I will go for two weeks to do that in Kono hospital, near the school. I shipped the stuff that I am going to be using already."*

## Collective initiatives

Collective efforts are usually undertaken through associations of health practitioners that organize health missions to Sierra Leone once a year. Collective efforts usually originate when interested health professionals working in the same hospital or recently graduated medical students come together to develop health missions to Sierra Leone.

Health professionals' associations organize fundraising events among community members for purchasing supplies for their interventions as well as for covering logistical expenses. Respondents pointed out common challenges in terms of organizing themselves for the health missions such as difficulty in coordinating the members' schedules; raising money for doctors; fragmentation among the community and lack of trust; and lack of availability of community members to participate in health missions.

*"Most of the health missions are financed by the individual participants; doctors pay their own way to travel. Sometimes we are able to get churches' funding, most of them come from the Roman Catholic Church and the United Methodist churches."*

*"A couple of my colleagues, when they graduated they decided to volunteer before starting work, I arranged for them to go to Sierra Leone, they were there for two weeks. They volunteered in Connaught hospital."*

*"I had a challenge to raise funds for health missions from Sierra Leoneans. I tried to bring them together, send out flyers, invited them, but I only receive response from a handful [...] a lot of people refused to give us money thinking that we were collecting money for our own benefit."*

### 3.2.2.3 Diaspora engagement – drivers, challenges and recommendations

#### Drivers

In most cases, the health professionals' engagement with Sierra Leone's health sector occurred after witnessing the precarious state of health facilities during their trips to the country. The most common drivers or incentives were the willingness to improve the well-being of Sierra Leoneans, especially those directly affected by the civil war and to improve the infrastructure of the health facilities.

The need to educate the population about basic health measures to prevent diseases, as well as developing ways to provide training to health professionals in Sierra Leone are among the common drivers of the diaspora engagement with the Sierra Leonean health sector. As stated in one questionnaire,

*"We are planning to develop a television program in educating people. A lot of times when I go for vacation to Sierra Leone, I see a lot of things that the lack of knowledge affects people there, even the basics for hand-washing."*

Children and women are their most common target populations. The respondents had developed expertise in the following areas of interest: mental health and education, public health policies, infant mortality and women, non-communicable diseases and infections.

*"I go to Sierra Leone every year since 2005. It was one of those visits in which I did some focus groups with traumatized people after the civil war. I asked somebody who is resident in Sierra Leone to walk with me and I saw a lot of problems of course. When I got back [to the United States] I was encouraged to write a book chapter, making an initial assessment of Sierra Leone's health sector."*

*"When I spent some time in Freetown I started to visit some hospitals, especially Connaught Hospital, because I was thinking about ways I can make potential contributions back to Sierra Leone. I was just appalled at the lack of infrastructure and basic medical equipment available in the main hospital. That started my thought process of, 'Wow you cannot just sit down and criticize ... anything will be a positive contribution'."*

Interest in a permanent or temporary return to Sierra Leone appears to be affected by the respondent's age and his or her perceived well-being in the country of residence. Permanent return was more commonly envisaged among older health professionals than younger ones. Moreover, diaspora health professionals are conscious of the advantages of living in a developed country. The financial and medical resources (for instance, medical equipment and supplies) coupled with social resources (such as peers and organizations) that they access in their country of residence allows them to sustain their medical missions in Sierra Leone.

*"I've done my cause here [the US] and I think is time for me to go back and continue what I started in Sierra Leone and help my people [...] Because just going [to Sierra Leone] like a stranger, helping them and come back, is not my focus or my goal. My goal is to be with my people and see how I can help."*

*"I am in my early thirties [...] and I am by no means wealthy [...] so going back to Freetown permanently, in many ways I will be looking for my own survival, looking for income and even though my interest will be providing health care for people, there will be an obvious self interest in terms of looking for an own income."*

*"I know Sierra Leoneans medical doctors who have left this place [the US] and went back to work in Sierra Leone who had a stroke. They come to the US to be treated and then go back because there is no physical therapy or other services that can really help sustain them. If there are no health care delivery systems in place in Sierra Leone, and you have an emergency, you cannot take your families there."*

## Challenges

Special attention was given to identifying common challenges encountered during health professionals' medical interventions in Sierra Leone.

### a. Sustainability

Most of the respondents were concerned about the sustainability of their interventions. Interviewees showed dissatisfaction with medical missions lacking an institutional strengthening component or a heavy focus on providing immediate relief. The precarious conditions of Sierra Leone's health facilities and its weak delivery services have made diaspora members aware of a much needed holistic approach to improve the health sector. As reiterated below,

*"If you take all the sophisticated medical technologies from the US and take them to Sierra Leone and give it to the people, is not going to work. The thing is how to help people to manage them and help them to sustain."*

*"How should we collaborate to improve standardized operational procedures? We need to strengthen the understanding of Sierra Leone NGOs and health professionals [...] The priorities and needs in Sierra Leone are so diverse that "piece meals" are not going to help [...]"*

*"If Sierra Leoneans living in the US, UK and Canada just go to Sierra Leone because they are feeling frustrated [about the precarious conditions in Sierra Leone], and spend their dollars [for the benefit of the people] ... But you go back there and we still have the same problems ... no infrastructure. We are trying to put just bandages to potential threats."*

### b. Partnerships/relationships with home country counterparts

Interviewees pointed out the importance of collaboration among interested parties. As an example, participants suggested that formal agreements between US- and Canada-based and Sierra Leone hospitals should be established. Furthermore, an enabling environment with the local population needs to be attained for medical interventions to bear fruit.

*"Instead of having a big program that is going to be launched without having done some seed work and to see who is going to be in Sierra Leone supporting this effort, we have to have those arrangements and Memoranda of Understanding (MoUs) to make sure that we can actually cooperate with our colleagues."*

*"When we treat patients [in Sierra Leone] and leave, the patients are there ... they do not have their continuous supply of drugs, and we did not network with the local health care providers, so we don't have reliable diagnostic services in place to follow up and develop comparative studies."*

Likewise, participants stressed that the relations and type of collaboration between health professionals abroad and those in the home country need to be clear and reasonable. Respondents bore in mind that cooperation with physicians in Sierra Leone is sometimes difficult and their initiatives not always welcomed.

*"Some of the reasons why Sierra Leonean based organizations are reluctant to support diasporans' initiatives are because diasporans make grandiose promises on things that are not accomplishable."*

*"Jealousies can come into play. The good thing is that if you have here [the US] people who are committed to go out there not to brandish their credentials and qualifications, and if you go in with humility, work with people and tell them that you don't come here to take someone else's job, that can be an approach to work with Sierra Leoneans."*

*"When we got to Sierra Leone, the doctors get so angry with us because we were giving stethoscopes to the nurses, "why you are giving nurses stethoscopes?, they are not doctors" - they said - [...] Doctors refused to come to our conferences..."*

## Recommendations

Interviewees shared some initiatives that either they are undertaking on their own or they would like to see implemented in the long term.

a. Specialized training centres

Some of the initiatives from the respondents converged in promoting a system to provide mentorship to health professionals in Sierra Leone on a regular basis. Participants pointed out that government, NGOs, and international organizations should invest in this idea.

*“For example, having a centre for excellence in terms of women health care for a specific region. Then you can make Connaught Hospital, where a lot of the traumas are going on, a centre for excellence in emergency care. Then hopefully, once you start lining those different centers for excellence whether in women’s health, pediatric, emergency, we can then hopefully try to implement what learned in those different areas in all hospitals.”*

b. Incentivize the use of broadcast media to promote health education

Participants showed interest in using media channels to promote health education activities. One health professional shared an initiative to run a television program to educate the population on prevention, diagnosis and management of non-communicable diseases as well as pre and postnatal care.

c. Create a diaspora network to improve the health-care system

The idea of bringing together diaspora health professionals interested in improving Sierra Leone’s health sector motivated some participants to establish more organized mechanisms to obtain support. For instance, health professionals were interested in establishing a network of peers to coordinate field health missions. They also suggested setting up a think tank to find sustaining means for a viable health-care system.

### 3.2.2.4 Other considerations

Particular attention was paid to respondents’ perceptions regarding the involvement of the Government and the Sierra Leonean community organizations in the United States, Canada and Sierra Leone in improving the health sector.

#### a) Perceptions on the role of the Government

Government buy-in on supporting health interventions from the diaspora is necessary. Interviewees frequently commented that maintaining contact with government officials to make sure that diaspora members are constantly connected was key. Diaspora health professionals considered government officials people they could rely on to help advocate on their behalf at the time of their interventions.

*“Efforts like this may be supported by the government. Bring the initiative to the attention of government officials. Perhaps if the initiative gets government assurance we may have senior members from the civil service able to help this initiative forward.”*

#### b) Perceptions on the role of diaspora community organizations

Respondents acknowledged the increasing efforts of community organizations to address Sierra Leone’s health-care problems, although they pointed out some of the organizations’ weaknesses such as: limited capacity of health professionals and a tendency to be inward-oriented.

*“Most of the Sierra Leonean organizations in the diaspora are trying to address their own survival, sustainability and their own relationships. There is so much stress between the communities that diaspora organizations tend to be focusing to provide an outlet to address their local needs.”*

*“In certain way, a lot of these organizations, for good or for bad, are mostly created for themselves, they do help the population but the impact that they have is limited.”*

### 3.2.3 Germany

#### 3.2.3.1. Overview of the Sierra Leonean diaspora in Germany

##### a) Migratory trends

The civil war in Sierra Leone (1991–2002) had far-reaching repercussions on the country and gave rise to a massive wave of migration. While most Sierra Leoneans sought refuge in neighbouring Mano River Union countries (Guinea and Liberia)<sup>22</sup> a significant number migrated to the West. English-speaking countries such as the United Kingdom, Canada and the United States have been particularly attractive to Sierra Leoneans. This destination preference of migrants from Sierra Leone is largely attributed to language and the historical ties especially with the United Kingdom.

Compared to the United Kingdom and North America, Germany has not seen a great influx of Sierra Leonean migrants although there has been an upward trend over the years. According to results of the micro-census conducted by the Federal Statistical Office in April 2012, there were 2,479 Sierra Leoneans legally living in Germany at the end of 2011 (Destatis, 2012).<sup>23</sup> The Sierra Leoneans in Germany largely vary in their gender and age compositions. About 69 per cent of Sierra Leoneans in Germany are male, with only 31 per cent females. As Table 2 below shows, the average age of Sierra Leoneans in Germany is 29.9 and the average length of stay in Germany is 10.5 years.

**Table 1: Sierra Leoneans living in Germany as at 31 December 2011**

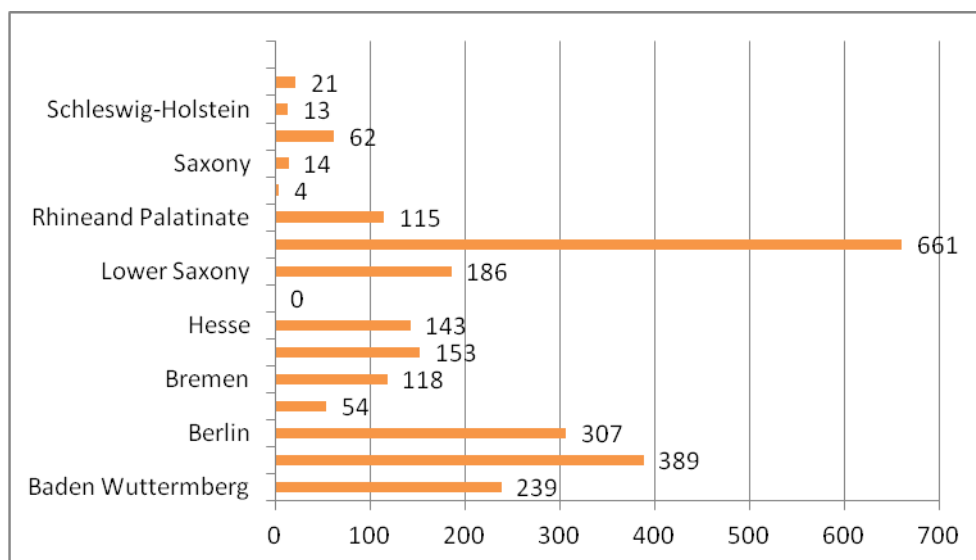
Gender	Number	Average Age	Average stay	Unmarried (%)	Married (%)	Born in Germany (%)
Male	1,713	32.1	11.2	60.0	22.6	8.0
Female	766	27.2	9.0	58.0	24.8	19.3
<b>Total</b>	<b>2,479</b>	<b>29.9</b>	<b>10.5</b>	<b>59.3</b>	<b>23.3</b>	<b>11.5</b>

Source: Central Register of Foreigners, Federal Statistical Office, April 2012.

##### b) Census statistics

**Figure 11: Distribution of Sierra Leoneans by region**

Most Sierra Leoneans in Germany live in the states of North Rhine-Westphalia (27%), Bavaria (16%) and Berlin (12%) (See Figure 11).



Source: Federal Statistical Office, 2012.

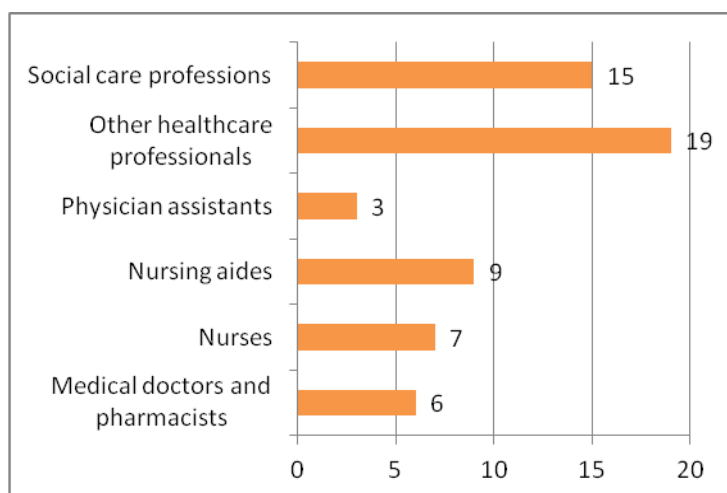
<sup>22</sup> Côte d'Ivoire subsequently joined the Mano River Union in 2008.

<sup>23</sup> These figures do not include Sierra Leoneans who have naturalized as Germans, asylum seekers whose cases have not been concluded and those living illegally in the country.

### c) Sierra Leonean Health Professionals in Germany

One major finding of this research project is that there are a number of health professionals from Sierra Leone with diverse qualifications and specializations working in the German health system. From 1999–2011 the number of Sierra Leoneans working in the German health system increased from 22 to 59 (37).<sup>24</sup> In 2011, there were 59 health-care professionals of Sierra Leonean nationality working in the health sector in Germany as depicted in Figure 12. Of these 15 (about 25%) were working in the social care professions,<sup>25</sup> 6 were employed as medical doctors and pharmacists, 7 as nurses, 9 as nursing aides, 3 as physician assistants and 19 (approximately 32%) work in other health-care professions (laboratory technicians, pharmaceutical technical assistants, etc.).

**Figure 12: Sierra Leonean health professionals working in Germany's health sector as of 2011**



**Table 2: Health professionals from Sierra Leone from living in Germany from 1999–2011**

Year	Doctors/Pharmacists	Other Health-care Professions <sup>26</sup>	Social Care Professions	Nurses/Midwives	Nursing Aids	Physician assistants/Clinical
June 1999	8	11	3	-	-	-
Dec.2000	6	13	5	-	-	-
Dec.2001	8	17	11	-	-	-
Dec.2002	7	19	7	-	-	-
Dec.2003	5	12	11	-	-	-
Dec. 2004	7	10	8	-	-	-
Dec. 2005	9	11	13	-	-	-
Dec. 2006	8	9	9	-	-	-
Dec. 2007	9	14	13	-	-	-
Dec. 2008	9	12	6	-	-	-
Dec. 2009	9	10	13	-	-	-
Dec. 2010	8	17	15	-	-	-
June 2011	6	19	15	7	9	3

Source: Statistics of the Federal Employment Office (*Bundesagentur*) 2013.

<sup>24</sup> Data was obtained from the Federal Employment Office (*Bundesagentur für Arbeit*) in Nuremberg. Figures do not include Sierra Leoneans who have taken up the German nationality.

<sup>25</sup> These include family counsellors, child protection workers, old peoples' homes workers, etc.

<sup>26</sup> This includes laboratory technicians, pharmaceutical technical assistants, nutritionists, physiotherapists, etc.



Table 2 shows year on year fluctuations in the number of medical professionals between June 1999 and June 2011. Most of these fluctuations are explained by the number of health professionals from Sierra Leone who acquired German citizenship and who were consequently removed from the statistics capturing Sierra Leone nationals within the health sector.

As shown in the Table 2, the post civil war period saw a greater influx of Sierra Leonean health professionals into Germany. The number of nurses and social care professionals increased from 3 to 15 from 1999 to 2011; however this cannot be viewed as a massive influx. Moreover, the migration of medical doctors to Germany cannot be directly attributed to the war; 70 per cent of doctors contacted for this study had migrated to Germany before the outbreak of violence in 1991. About 30 per cent of physicians who qualified in Germany claim they were pushed to migrate especially after they returned to Sierra Leone in the pre-war years and were not given any incentives or were not satisfied with local working conditions. The most common reason advanced by the Ministry of Health for not hiring these medical doctors at the time was that the state already had a specialists working in their area of expertise and could therefore not afford itself the luxury of hiring more specialists. Several key informants mentioned that the system in place pushed them to migrate.<sup>27</sup>

### **Medical doctors**

Table 3 shows that there are 23 medical doctors from Sierra Leone currently working in the German health system. Of these 17 medical doctors (74%) were working as medical practitioners while 6 doctors (26%) were working in a non-medical capacity.

The high proportion of medical doctors not practicing medicine or working in the health sector may be attributable to strict employment conditions and the difficulty for foreigners to access to German labour market. German policy on labour migration is still very restrictive and instruments to manage the needed immigration of qualified labour force are still missing (Medical Association of German Doctors (WIAD), 2011:11). The existing legal framework dictates the occupation in which foreigners may work within the health-care sector in Germany. In addition to the generally applicable legal requirements relating to migrant access to the labour market, foreign doctors must obtain permission to practice their profession from the competent health authority in the region in which they wish to establish themselves. Foreign nurses also need to meet equivalent German legal and professional requirements and also have a good command of the German language. Some respondents mentioned that race and the stigmatization of Africans played an important role in the hiring process in Germany.

About 26 per cent of the medical doctors were employees in different German hospitals, while another 26 per cent were established as resident doctors. About 74 per cent of medical doctors (17 out of 23) of Sierra Leonean origin in Germany have naturalized as Germans with only about 4 per cent holding dual German-Sierra Leonean citizenship. This category of the diaspora in Germany is not included in the official statistics of Sierra Leoneans published by the Federal Statistical Office. Added to the figures in Table 3 this study counts 76 health professionals of the Sierra Leonean diaspora working in the health sector in Germany.<sup>28</sup>

Almost all the medical doctors interviewed for this project completed their professional training outside Sierra Leone. Over 90 per cent (21 medical doctors) attended universities or professional schools in Germany while the remaining 10 per cent trained in other European Union countries. All medical doctors interviewed for this study were fluent in German, English and Krio. Some have language skills in Russian and Bulgarian. Less than eight per cent of medical doctors have extensive professional experience in Sierra Leone. About 30 per cent of them (7 doctors) have experience in

<sup>27</sup> This information was obtained from an interview with medical specialists who completed their studies in Germany in the 1960–1970s.

<sup>28</sup> Table 3 excludes Sierra Leoneans who have acquired German citizenship and those who are self employed whereas Table 4 includes doctors of Sierra Leoneans origin who have taken up German citizenship.

teaching and training and are willing to assume such functions in Sierra Leone albeit on a short-term basis.

**Table 3: Regional breakdown of medical doctors from Sierra Leone by region<sup>29</sup>**

Medical Association	No. of Doctors	Not engaged in medical activity	Engaged in medical activity	Working in hospital	Resident doctor	Employed in other sectors
Baden-Württemberg	-	-	-	-	-	-
Bavaria	-	-	-	-	-	-
Berlin	1	1	-	-	-	-
Brandenburg	-	-	-	-	-	-
Bremen	3	-	3	2	1	-
Hamburg	-	-	-	-	-	-
Hesse	3	1	2	1	-	1
Mecklenburg-Pomerania	0	0	0	0	0	0
Lower Saxony	6	0	6	1	2	3
North Rhine Westphalia	3	2	1	0	1	0
Rhineland-Palatinate	0	0	0	0	0	0
Saarland	0	0	0	0	0	0
Saxony	3	0	3	2	0	1
Saxony-Anhalt	0	0	0	0	0	0
Schleswig-Holstein	0	0	0	0	0	0
Thuringia	0	0	0	0	0	0
Westphalia-Lippe	4	2	2	0	2	0
<b>Total Germany</b>	<b>23</b>	<b>6</b>	<b>17</b>	<b>6</b>	<b>6</b>	<b>5</b>

Source: German Medical Association, 2013.

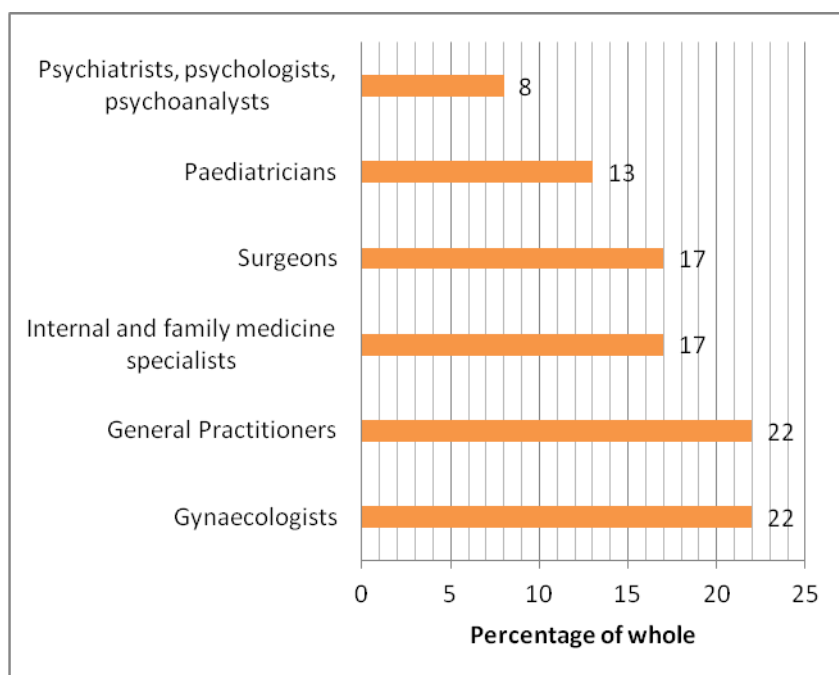
Medical doctors of Sierra Leonean origin are concentrated within six federal states in Germany; 6 doctors (26%) work in the state of Lower Saxony alone. Also, there is an explicit disparity between the new States of former East Germany and those of the former West Germany. About 83 per cent of medical doctors from Sierra Leone live and working in states of former West Germany (Bremen, Hesse, Lower Saxony, North Rhine Westphalia and Westphalia-Lippe) while 17 per cent live in the new federal states.

The doctors can be grouped into various specializations. About 22 per cent of the Sierra Leonean medical doctors in Germany are gynaecologists, 22 per cent general practitioners, 17 per cent internal and family medicine specialists, 17 per cent surgeons, 13 per cent pediatricians, 8 per cent psychiatrists, psychologist and psychoanalysts.

<sup>29</sup> Figures used here include Sierra Leoneans who have taken up German citizenship.

Figure 13 below illustrates these disciplines in terms of percentages.

**Figure 13: Specializations of medical doctors**



### ***Immigration status***

All health professionals considered for this study had regular immigration status in Germany. Most data for the project was obtained from official sources which do not take illegal immigrants into consideration. Although the German policy on labour immigration is still very restrictive foreign health professionals easily attain citizenship. Of professionals contacted for this study about 60 per cent had obtained German citizenship; the remaining 40 per cent had permanent residence status. The figures were even higher amongst medical doctors with 17 out of 23 (about 74%) medical doctors holding German nationality. The situation was different amongst nurses with about 78 per cent having permanent resident status.

### ***3.2.3.2 Health professionals' initiatives, organizations and networks***

#### ***a) Diaspora initiatives to improve Sierra Leone's health sector***

This section draws from the insights from the literary review undertaken as part of the study, as well as the series of focus group discussions and key informant interviews held with Sierra Leonean health professionals.

Sierra Leoneans spread in different states in Germany have grouped themselves into different solidarity associations in order to enhance information sharing, provide support and facilitate contributions to their country of origin. Some of these organizations with people of diverse educational and professional backgrounds have actively been contributing to development in Sierra Leone especially in the health-care sector.

A good example is the Community Care for Kids based in Munich which actively works to promote health and access to education for children in Sierra Leone.<sup>30</sup> Similarly, the United National Peoples Organisation of Sierra Leone in Germany has been providing medical equipment and medicines to medical facilities in Sierra Leone since 1994.

<sup>30</sup> For details <http://www.communitycare4kids.de/>.

### **Individual initiatives**

Approximately 60 per cent of respondents in this study had contributed skills in a variety of ways, for example through short-term clinical assistance in hospitals and donations of medication, clothes and medical equipments to facilities in their homeland.

### **Collective initiatives**

Diaspora members themselves are involved in what is happening back home, and have created organizations to draw together their expertise to provide medical assistance to deprived communities in the homeland. Some Sierra Leonean health professionals in Germany have developed individual networks through which they volunteer in hospitals located in their areas of origin during their vacations in Sierra Leone.

#### ***Sierra Leonean diaspora associations in Germany***

Organizations such as the Bintumani German–Sierra Leone Friendship Association based in Berlin have become important stakeholders providing much needed clinical assistance and donating equipment to hospitals. Under the stewardship of Dr Morley Wright and Dr Ladipoh the association has been rallying German doctors to volunteer for short periods in Sierra Leone. In 2012 a team of eight medical doctors from Germany led by Dr Wright volunteered in Sierra Leone where they conducted 61 operations in four weeks at various medical institutions (Wright, 2012). The Bintumani association has been helping the Mattru-Jong Hospital as their only regional hospital in expanding both its basic features as well as its service capacity. Through regular shipments of supplies Bintumani members provide medical and technical equipment to the Mattru-Jong Hospital which provides medical care to the people of Bonthe District. In March 2010, two pediatric surgeons, Dr Ibrahim Al-Naieb and Dr Tilman Gresing working in collaboration with local colleagues successfully carried out paediatric surgery in Freetown on behalf of Bintumani. About 40 specially selected and complicated paediatric cases were treated.<sup>31</sup> This exercise was followed by the training of local hospital staff. In 2012 Dr Ladipoh singlehandedly donated one ENT Examination Unit to the Connaught Hospital in Freetown.

Similarly, since its inception in 1994, the United National Peoples Organisation of Sierra Leone e.V. (UNPO e.V) has been working to supply medical equipment to hospitals, health centers and clinics in Sierra Leone. The organization with the support of some pharmaceutical companies in Germany including Fresenius Gabi, Firma Merck of Darmstadt, STADA Pharm in Hessen as well as the German Defence Ministry in Berlin donated medical supplies blood banks, fridges, theatre equipment, hospital beds, chairs and medicines to different health facilities in Sierra Leone. The organization is presently working on a project to establish a diagnostics center in Sierra Leone. Membership of the UNPO e.V includes some medical doctors of Sierra Leonean origin.

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<sup>31</sup> Bintumani German-Sierra Leone Society (2012) *Auszug aus dem Jahresbericht des Vereins Bitumani D-SL e.V über das Geschäftsjahr 2011/2012*. <http://www.bintumani.de/seite3.htm> accessed 06.07.2103.

### 3.2.3.3 Diaspora engagement – drivers, challenges and recommendations

#### Drivers

Although respondents advanced different motivating factors underlying their voluntary activities, they were unanimous on two counts. Most health professionals in Germany engage in voluntary activities because of their humanitarian and altruistic concerns for the population in Sierra Leone. They are keen to put their skills and competences to serve the needs of the population. They also wish to reverse the trend of diseases such as HIV/AIDS, malaria and tuberculosis that have been decimating local communities in Sierra Leone. They provide medical assistance to the needy out of genuine concern (Akintola, 2011).

Most Sierra Leonean health professionals are comfortably situated in Germany and would only be available for short-term engagements. Whereas most of the younger professionals prefer to provide short-term assistance to patients at medical institutions in Sierra Leone there is a growing interest amongst elderly professionals to help build capacity in medical schools. About 78 per cent of medical doctors aged 55+ expressed a willingness to offer training to medical students in Sierra Leone in specializations such general medicine, surgery, ENT surgery, internal and family medicine, radiography, psychotherapy, psychoanalysis and health management. About 98 per cent of pensioned doctors were ready to train younger Sierra Leoneans on condition that this renewed effort from the IOM would be consequential.

However, the embassy was disappointed with the response from some health professionals, particularly the younger generation. The desire and readiness to volunteer for the amelioration of the health-care delivery system in Sierra Leone was stronger in the older generation, especially amongst the pensioners. Over 70 per cent of the volunteer projects in Sierra Leone are organized by health professionals aged above 60.

#### Challenges

Reasons articulated to explain the lethargy or reluctance to return to Sierra Leone included working culture, infrastructure, health system governance, remuneration and the standard of living working in Germany. Most Germany-based health professionals who have volunteered in a medical establishment in Sierra Leone find the work climate, especially related to work ethics in the health system extremely challenging. Challenges encountered included:

- a. Attitudes and professionalism: The reported lack of professionalism and the attitude of health personnel towards work, especially amongst nurses, have often frustrated diaspora volunteers. Respondents observed it was 'normal practice' for nurses and doctors in Sierra Leone to arrive late for work; this makes it quite hard for the professionals from Germany to integrate in the system.
- b. Poor reception from home country counterparts: Volunteers from Germany were not always well received in the medical system in Sierra Leone. Most medical doctors interviewed for this project complained about the absence of any encouragement from the Ministry of Health and Sanitation and the feeling of rejection expressed towards them by the medical staff in Sierra Leone. Local colleagues at health facilities in Sierra Leone often see professionals as threats to their income and reputation. This often affects the working environment and has dampened many professionals in Germany's enthusiasm for volunteering.
- c. Poor hospital infrastructure: The deteriorating situation in most hospitals in Sierra Leone coupled with the absence of materials, medicines and broken equipment are some of the discouraging factors for health professionals in Germany.
- d. Health-care governance: Despite the recent reforms, most respondents still perceive health-care governance in Sierra Leone as being corrupt and not transparent. The issue of corruption in Sierra Leone's health system is endemic and a serious challenge to the Ministry

of Health and Sanitation. In March 2013, Sierra Leone's 29 top health officials were indicted by the country's Anti-Corruption Commission for misappropriating half a million US dollars from the Global Alliance for Vaccines and Immunization (GAVI Alliance).<sup>32</sup> Diaspora professionals believe that there are still no efficient measures in place to ensure that state resources are effectively used and that objectives and priorities set by the competent authorities are met.

- e. Skepticism based on past experience: Experience from previous voluntary work in Sierra Leone has proven that the government never honours its obligations. Some professionals from Germany who left to go back to Sierra Leone got there to encounter a pile of empty promises. Most diaspora professionals maintain that there has been little support from the Ministry of Health for the work and contributions of individuals and organizations. Promises made to cover accommodation and other basic costs were never honoured.
- f. Remuneration: Another major issue raised by the German-based health professionals relates to remuneration, considering that pay packages in Sierra Leone are so low, especially in the health sector. They need to maintain established living standards for their immediate families and this cannot be attained with the current salary scales in Sierra Leone.
- g. Difficulty in obtaining time off and funding: Over 80 per cent of younger professionals interviewed for this study expressed their readiness to volunteer in Sierra Leone but are faced with the difficult problem of obtaining permission from their employers, especially as most of them are in permanent contracts and not everybody can afford to take a sabbatical holiday. Approximately the same percentage were not ready to consider permanently relocating to Sierra Leone. It is even more difficult for medical doctors who own their private medical practice to volunteer as they would have to find a replacement to cater for their patients in their absence.
- h. Perceived well-being in Germany: Whilst living in Germany might not be ideal, many Sierra Leonean health professionals perceive this as the safer option. Although some Sierra Leonean health professionals have gone back and been quite successful, this is still a very difficult proposition for some professionals in Germany. This is particularly true of the younger generation of health professionals especially the medical doctors who have well remunerated jobs in Germany. For them Sierra Leone remains a great risk.

## Recommendations

Diaspora professionals contacted for this study expressed a strong desire to actively contribute to the development of the health-care delivery system in Sierra Leone. However, they argue that such return programmes cannot effectively function under the present conditions. Most respondents were unanimous on a set of conditions that would make the return programmes more attractive.

- a. Use a trusted third party to facilitate return programmes: Respondents expressed the view that return programmes would be more appealing if the IOM or any other international body would offer to cover logistical costs (transportation, lodging) for short-term volunteers. This would build more confidence on the part volunteers especially as they do not trust their own government based on their previous experiences.
- b. Strengthen the relationship between diaspora and home government: The often difficult relationship between the diaspora and the home government is a common phenomenon in Africa. Trust in the government is not very strong among Sierra Leonean health professionals in Germany. This kind of intervention is more urgent at this time that the Sierra Leonean government cannot meet all the financial obligations of the project.
- c. Structure a comprehensive volunteering package: Health-care professionals in Germany believe that an effective way of luring them would be to present a comprehensive volunteering package for diasporas, inclusive of flight, accommodation and travel in Sierra

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<sup>32</sup> *Sierra Leone's Health Care becomes a Cautionary Tale for Doctors*, New York Times, 13 April 2013.

Leone. Volunteers need transparent offers such as cover for health and social insurance during the period of stay in Sierra Leone. This should also include a reintegration package for returning volunteers, especially as most volunteers face severe difficulties reintegrating into their jobs when they eventually return to Europe.

- d. Improve health-care governance and curb corruption: Respondents see an urgent need to improve on health-care governance and reduce corruption in the Ministry of Health and Sanitation as well as in other health institutions as this often frustrates health professionals at home. Reducing corrupt practices of senior officials in the health sector might be an incentive for the diaspora professionals to start considering relocation programmes to Sierra Leone.
- e. Promote better performance amongst health professionals in-country: Sierra Leonean authorities must set appropriate accountabilities, standards and incentives. Such measures could discourage corruption and enhance returns to public health in Sierra Leone if effectively enacted.
- f. Improve in-country conditions for health professionals: The authorities in Sierra Leone equally have to improve on the working conditions for professionals back home in order to avoid the rivalry with diaspora based professionals. The government must tackle poor working conditions such inadequate medicine supplies, heavy workloads, delayed salaries especially in the public health sector (WIAD, 2012).
- g. Promote diaspora participation in-country with key health stakeholders and institutions: The Government needs to embark on more civic education programmes for local health professionals with the goal of educating them on the necessity to have German-based professionals and especially on the enormous personal sacrifices they make. This would require organizing briefings and information sessions at the different medical institutions in the country.
- h. Support an enabling environment for returning professionals: Many respondents would be willing to consider volunteering in Sierra Leone in future, if the Ministry of Health and Sanitation creates an enabling environment for the returning professionals by putting in place effective health governance measures in order to raise the levels of health outputs.

The challenge should not be to discourage diaspora health professionals, but rather to encourage them to transfer their skills to build up Sierra Leone's health sector.

## 4. CONCLUSION

At the request of the Government of Sierra Leone, the IOM is developing a national strategy to facilitate short term placements of Sierra Leonean health professionals in the diaspora in selected health facilities in Sierra Leone. This consolidated report is based on three individual mapping studies which were undertaken to assess diaspora-based Sierra Leonean health professionals' skills and level of engagement with, and willingness to contribute to, their home country's health sector.

The studies showed an overwhelming readiness on the part of Sierra Leonean diaspora health professionals from the target countries to participate in a skills transfer programme. They demonstrated that diaspora Sierra Leonean health professionals with varied specializations have been committing time and energy to provide health assistance in various communities in their country of origin without material reward, paid for either via raised funds or out of their own pocket. Of the UK respondents surveyed, all were willing to contribute in some way. Of the German respondents, about 90 per cent were willing to consider a short-term engagement, with 10 per cent considering the possibility of relocating permanently to Sierra Leone.

Respondents from the various countries echoed the same broad themes, which are evident from the Challenges and Recommendations sub-sections in Section 3.2 of this report. The recommendations were set within a context of supporting diaspora professionals' interventions so that these have a long-term sustainable impact on the state of the country's health care.

Common challenges encountered by health-care professionals in relation to their interventions in the home country included:

- a. Difficulty in obtaining time off, funding and accommodation: Obtaining permission from employers was an issue. The cost of the airfare home precluded regular visits. Lack of housing or affordable alternative accommodation to facilitate the stay in-country was also sometimes an issue. Putting in place formal arrangements to secure time away for volunteers during the course of their employment would give prospective volunteers a greater sense of job security.
- b. Poor reception from home country counterparts: Many respondents noted the absence of encouragement from the Ministry of Health and Sanitation and a feeling of rejection expressed towards them by the medical staff in Sierra Leone. Often local colleagues saw diaspora professionals as threats to their income and reputation, sometimes perceiving them as elitist or arrogant, or accusing them of failing to grasp on the ground realities. Diaspora members' in turn sometimes felt their efforts were being sabotaged or frustrated.
- c. Remuneration levels: Pay packages in Sierra Leone are low, especially in the health sector. This is a consideration for those health professionals who were contemplating a longer stay, and need to maintain established living standards for their immediate families.
- d. Lack of a strong mobilizing factor to bring Sierra Leoneans together to discuss how to improve the health situation in the home country.
- e. Health-care governance: Most respondents perceive health-care governance in Sierra Leone as being corrupt and not transparent. There were reports of free equipment and other donated resources being diverted from intended beneficiaries, stolen or sold on by local staff.
- f. Attitudes and professionalism: The reported lack of professionalism and the attitude of health personnel towards work, including working culture, level of commitment, work ethics and motivation.
- g. Poor hospital infrastructure: Poor working conditions were often coupled with the absence of materials, medicines and broken equipment.



The range of recommendations included promoting better performance amongst, and improving local conditions for, in-country health professionals; improving health-care governance and curbing corruption. However the recommendations with the potential for bringing the most immediate improvements are:

**For development partners:**

- a. Structure a comprehensive volunteering package: Include financial, logistical and preparatory support, on a par with international volunteer packages, inclusive of flight, accommodation and travel in Sierra Leone as well as daily stipend in the field. Particular features to incorporate:
  - i. Cater for short-term as well as longer term engagements.
  - ii. Secure endorsement by IOM or an international organization of similar standing would facilitate obtaining leave of absence from employers.
  - iii. Include induction/preliminary training for prospective volunteers. Prospective volunteers need to go through some training techniques, given that not all good specialists are necessarily good trainers and as a prerequisite to their deployment for fieldwork.

**For Sierra Leone authorities:**

- b. Develop a framework and strategy to incorporate diaspora input and ensure that Sierra Leonean professionals and institutions recognize and support diaspora initiatives.
  - i. Promote diaspora participation in-country with key health stakeholders and institutions: Embark on civic education programmes to help local health professionals appreciate the role diaspora professionals can play. Organize briefings and information sessions at different medical institutions in the country.
  - ii. Build bridges with and for diaspora by reducing some of the bureaucracy they face, including facilitating fast-tracking of recognition of diaspora professionals' qualifications to enable them to practice in their home country.
  - iii. Strengthen the relationship between diaspora and home government by leveraging the role of the Diaspora Office. Promote direct communication with the representatives of the Diaspora Office in Freetown or relevant officials involved in diaspora affairs. Having a designated Health Liaison Officer within the Office of Diaspora in Sierra Leone would enable that unit to monitor in-country diaspora activity, articulate requests for skills where shortages arise, and match diaspora health-care personnel to existing needs.

**For diaspora health-care professionals**

- c. Adopt a consortium approach and develop an over-arching strategy to coordinate their efforts, enhance collaboration and share learning. There are numerous initiatives but efforts tend to be fragmented, and individualized. Working together would minimize unnecessary duplication and enhance sustainability and impact. There are existing umbrella organizations such as The Organisation for Sierra Leonean Health Professionals Abroad that can be strengthened and supported.
- d. Build bridges with local professionals. Government authorities can promote relations and collaboration between health professionals abroad and their in-country counterparts. Diaspora members in turn can enter with an attitude of humility, and work with colleagues to reduce the mutual sense of suspicion.

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# Annexes

## ANNEX I: WORKING DEFINITION OF HEALTH PROFESSIONALS/WORKFORCE

Below are the nine broad WHO categories as amended for the purpose of this study:

### **Physicians**

Includes generalist medical practitioners and specialist medical practitioners.

### **Nursing and midwifery personnel**

Includes nursing professionals, midwifery professionals, nursing associate professionals and midwifery associate professionals.<sup>33</sup> Traditional midwives are not classified here, but as community/traditional health workers (see below).

### **Dentistry personnel**

Includes dentists, dental assistants, dental technicians and related occupations.

### **Pharmaceutical personnel**

Includes pharmacists, pharmaceutical assistants, pharmaceutical technicians and related occupations.

### **Laboratory health workers**

Includes laboratory scientists, laboratory assistants, laboratory technicians, radiographers and related occupations.

### **Environment and public health workers**

Includes environmental and public health officers, environmental and public health technicians, sanitarians, hygienists, district health officers, public health inspectors, food sanitation and safety inspectors and related occupations.

### **Community and traditional health workers**

Includes community health officers, community health-education workers, family health workers, traditional and complementary medicine practitioners, traditional midwives and related occupations.

### **Other health workers**

Includes a large range of other cadres of health service providers such as medical assistants, dieticians, nutritionists, occupational therapists, medical imaging and therapeutic equipment technicians, optometrists, ophthalmic opticians, physiotherapists, personal care workers, speech pathologists and medical trainees.<sup>34</sup>

### **Health management and support workers**

Includes other categories of health systems personnel, such as managers of health and personal-care services, health economists, health statisticians, health policy lawyers, medical records technicians, health information technicians, ambulance drivers, building maintenance staff,<sup>35</sup> and other general management and support staff.

**Source:** WHO, available at: <http://www.who.int/hrh/statistics/TechnicalNotes.pdf>

**NB:** Professional health sector workers like non-clinical administrators are also considered due to their specialist knowledge and skills of working in the sector.

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<sup>33</sup> These include nursing aides.

<sup>34</sup> Includes medical students who already informally work in the health service sector as trainees and interns

<sup>35</sup> "Ambulance drivers and building maintenance staff" shall be excluded in our mapping survey although they fall under the WHO broad definition.

## ANNEX II: QUESTIONNAIRE

### Mapping of Sierra Leonean Diaspora Health Professionals in Germany

#### Questionnaire for Individuals in the Diaspora Working in the Health Sector

The International Organization for Migration (IOM) is undertaking a survey to identify health professionals from Sierra Leone who presently work in the health sector in Germany. This questionnaire is intended to collect information on areas of specialization amongst health professionals from Sierra Leone presently working in the health sector, their areas of interest and their willingness to contribute to the development of the health sector in Sierra Leone. The database will be used subsequently to facilitate identified health professionals' contribution to implementing the National Health Sector Strategic Plan (NHSP 2010–2015).

#### A. Personal Information

Surname:

Name:

Address:

City/ Town:

E-mail:

Phone:

Number:

#### B. Demographic Information

1. What is your gender?

Male

Female

2. How old are you?

3. Where were you born?

Sierra Leone

Other Please specify \_\_\_\_\_

4. What is/are your nationality/ties?

Sierra Leonean

Other Please specify \_\_\_\_\_

5. Where within Germany do you currently live?

Baden-Württemberg  Bavaria (Bayern)

Berlin

Brandenburg

Bremen

Hamburg

Hessen

Lower Saxony (Niedersachsen)

Mecklenburg-Western Pomerania (Mecklenburg-Vorpommern)

North Rhine-Westphalia

Rhineland-Palatinate (Rheinland-Falls)

Saarland

Saxony (Sachsen)

Saxony Anhalt (Sachsenanhalt)

Schleswig-Holstein  Thuringia (Thüringen)

6. For how many years in total have you been resident in Germany?

Under 1 year

1-4 years

5-9 years

- 10-19 years
- 20 years plus

**C. Educational and professional background**

7. Please tell us about your language abilities?

- Basic
- Proficient
- Fluent

8. What is the highest level of educational qualification you have attained?

- PhD
- Masters
- Bachelor
- Other Please specify \_\_\_\_\_

9. Where did you obtain your qualifications?

Basic level qualification

- In Germany
- Other EU member states
- Sierra Leone
- Other Please specify \_\_\_\_\_

10 a) Do you have work experience in your profession?

- Yes
- No

b) If yes, how many years experience do you have?

- Less than 1 year
- 1-2 years
- 3- 4 years
- 5 years plus

11. In which of the following areas of the health sector have you received education?

- Nursing
- Surgeon
- Gynaecology
- Pharmacology
- Dental health
- Psychological therapies
- Nutrition/diet
- Physiotherapy
- Administration/ Policy
- Medical Doctor
- Other Please specify \_\_\_\_\_

12. What is your current employment status?

- Self-employed
- Employed (temporary contract)
- Employed (permanent contract)
- Seeking employment
- Student/Trainee
- Other Please specify \_\_\_\_\_

13. What area of the health sector do you currently, or recently, work in?

- Nursing
- Surgeon
- Gynaecology

- Pharmacology
- Nutrition/diet
- Medical Doctor
- Dental health
- Physiotherapy
- Other Please specify \_\_\_\_\_
- Psychological therapies
- Administration/ Policy

14. What is your current job title? \_\_\_\_\_

15. Do you have work experience in Sierra Leone?

- Yes
- No

16. Do you have work experience anywhere else?

- Yes
- No

#### **D. Level of engagement with Sierra Leone**

17. To what extent do you feel connected with Sierra Leone?

- Not at all
- Somewhat
- A lot

Please explain why: \_\_\_\_\_

18. In what ways do you receive information and stay in touch with people in Sierra Leone?

- Telephone
- Internet
- Newspapers
- Television
- Radio
- Other Please specify \_\_\_\_\_

19. a) Since you left Sierra Leone, have you returned to visit the country?

- Yes
- No

If 'no', what would you say is the reason for this? \_\_\_\_\_

b) On average, for how long do you stay?

- Under a month
- 1- 3 months
- 4 -7 months
- 8 -11 months
- 12+ months

c) What were the main reason(s) for your visit(s)?

- To visit family and friends
- To invest
- To work
- To study
- To share my knowledge with colleagues in Sierra Leone
- Charity work



- Politics/lobbying
- Others Please specify \_\_\_\_\_

**E. Knowledge and skills transfer schemes**

20. a) Have you ever taken part in a similar program where you shared your knowledge with Sierra Leoneans?

- Yes
- No

b) If yes, how long was this for?

- Less than a month
- 1 - 3 months
- 4 - 7 months
- 8 -11 months
- 12 months plus

21. a) Have you engaged in other forms of voluntary work in Sierra Leone?

- Yes
- No

22. a) Are you interested to contribute to the development of the health sector in Sierra Leone?

- Yes
- No

b) If yes, in what ways would you like to be involved?

- By working there (private or public sector)
- By making investments. If so, in what particular field or what kind of investment?

\_\_\_\_\_

- By participating in a skills transfer scheme

If so, in what area of the health sector? \_\_\_\_\_

- By offering consulting and mentoring services

If so, in what area of the health sector? \_\_\_\_\_

- Other, please specify:

23. Thinking specifically about short term skills transfer schemes, how interested would you be in participating?

- Uninterested
- Somewhat interested
- Very interested

24. If you are interested in participating in such a scheme, how long would you like to go for?

- Less than a month
- 1-3 months
- 4-7 months
- 8-11 months
- 12 months plus

25. Will you be willing to work in Sierra Leone without your family accompanying you?

Yes

No

**F. Information about Sierra Leonean Network**

26. a) Are you a member of any Sierra Leonean diaspora group/organization/association?

Yes

No

b) If yes, what is its name and objective? \_\_\_\_\_

27. a) Do you know any Sierra Leonean health professional organization in Germany?

Yes

No

b) If yes, what is its name \_\_\_\_\_

and objective? \_\_\_\_\_

28. Do you know other Sierra Leonean health professionals who may be interested in being part of this project?

Name \_\_\_\_\_

Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

If you have any particular comments, insights, questions or suggestions you would like to make that have not been covered in this survey, please feel free to write these below:

Comments:

Thank you for your participation.

## ANNEX III: FOCUS GROUP DISCUSSION GUIDE

### Context

People's health represents an essential dimension and a prerequisite to any country's development potential - economic, social or cultural. Most studies indicate a dwindling trend in Africa's health infrastructure and much of this has been attributed to outmigration, coupled with poor incentives to medical workers.

You are aware of the scourge of AIDS, malaria and other tropical diseases which account for high morbidity and mortality rates in Africa and their impact on development. There is an acute shortage of expertise within the health service sector in Africa and Sierra Leone in particular. Many African health professionals have migrated, either training or working in Europe and the UK.

The exodus triggered by these factors worsen the deficit in qualified African staff in the country of origin; even while the expertise and qualifications gained abroad represent a development potential for Africa. It is generally estimated that a sizable proportion of Sierra Leonean health professionals live and work abroad.

Generally speaking, what has been your experience as health professionals from Sierra Leone living and working in the UK?

(a) In your own view, in what sectors, and where would you most likely find the majority of Sierra Leonean health professionals working in the UK?

(b) Has there been a trend of some of them going back to their country of origin? If so, what do you believe is behind the trend and knowledge of what happened?

(a) Can we discuss any initiatives that have been pursued by members of your community (diaspora health professionals) that would potentially contribute to the development of the health sector in Sierra Leone?

(b) If there were any, what was the experience like?

In what ways can we harness the best skills and experiences of Sierra Leonean health-care professionals living here in the UK for the benefit of their country of origin?

(a) Would such inputs/promotions/initiatives require a return to Sierra Leone?

(b) Would you be interested in returning temporarily or permanently to Sierra Leone for this purpose?

(c) What are the drivers/motivations and incentives needed to encourage a wider participation by Sierra Leonean health professionals in this kind of scheme?

Can you enumerate areas within the health sector whose development you are most interested in?

According to you what measures do you think can be implemented by political decision-makers (in Sierra Leone and in the UK) in order to maximise the input of the health-care professionals for the development of the health sector in Sierra Leone?

Given the time you have spent in the UK, do you foresee any challenges if you were to return to work in Sierra Leone? If so, what are they?

How do you think you should prepare for them? What should IOM do to help facilitate the process?

What else do you think should be done to encourage more diaspora health professional engagement for development in Sierra Leone? Is there anything you wish to add?

## **ANNEX IV: KEY INFORMANT INTERVIEW GUIDE**

Context:

Sierra Leone is experiencing acute human resource shortages within its health sector. In a bid to address the above a mapping exercise is being undertaken to explore the challenges and opportunities for engaging Sierra Leone diaspora health-care professionals in both short and long term return placements. This project will aim to identify the location, skills and practices of these professionals, as well as their experiences of supporting training and human resource gaps and opportunities in the Sierra Leonean health sector training institutions.

We consider your extensive knowledge and experience of research/ working with Sierra Leonean health professionals within the diaspora community invaluable to the outcome of this survey and we are very interested in hearing your views.

Name:

Profession:

Place of Employment:

Position/Title

Work Experience:

Contacts: Telephone/E-mail/Website

Brief Profile:

### **Questions**

From your own experience can you comment on the magnitude of Sierra Leonean Health professionals working in the United Kingdom? Are you for instance aware of any going statistics regarding this phenomenon?

Drawing from your experience, is it possible that there has been a particular pattern in the way health professionals of Sierra Leonean origin have been engaged with the health sector in the UK. What has this trend been like?

How do these professionals come into the country?

In which geographical location within the UK do they commonly live? Are there clusters of Sierra Leoneans in certain areas?

Looking at the trend of their migration, would you say they are mostly temporary, permanent or cyclical (back and forth movements)?

Do you think these professionals are enthusiastic about contributing to the development of the health sector in Sierra Leone? Have there been any initiatives to that effect that you know of?

What are the core areas of interest that Sierra Leonean health professionals in the UK would like to contribute to the development in their country of origin? Would you say they are more interested in clinical work, teaching, health management or health as a business?

Do you think most of them would rather contribute to the development of their home country's health sector through temporary placements or would they prefer a permanent return? Why do you think so?

What likely factors/incentives do you think would motivate health professionals of Sierra Leonean origin to return and help streamline the health sector in their country of origin?

Do you know of any Sierra Leonean diaspora associations, networks or organizations here in the UK or elsewhere?

What is your overall thinking on the subject of diaspora health professionals supporting health sector development in their home countries? What are the challenges?

Do you have access/knowledge of any relevant literature, contacts or links that you think might be useful to this study?

Is there anything we might have overlooked that you would like to add?

Thank you for your time!

## ANNEX V: PROFILE OF FOCUS GROUP DISCUSSION PARTICIPANTS

**Table 4: Profile of focus group discussion participants (United Kingdom)**

Profession	Specialty	Gender
Administrator	Clinical governance	F
Administrator	Ward manager	M
Cancer charity trustee	Health management	M
Cancer charity trustee	Health management	F
Counsellor	Counselling Therapist	F
Counsellor	Sickle Cell	M
Counsellor	Counsellor	F
Health economist	Mental health	M
Medical doctor	Obstetrics & Gynaecology	F
Midwife	General	F
Midwife	General	F
Midwife	General	F
Nurse	Mental health	F
Nurse	Occupational health	M
Nurse	General	F
Nurse	Mental health	M
Nurse	Diabetes	M
Social worker	Mental health	M
Therapist	Therapist	F

**Table 5: Profile of focus group discussion participants (United States and Canada)**

Profession	Sex	Age	Location	Years of residence in United States/Canada
Professor	Male	45	Tennessee	16
Counsellor	Female	47	New York	24
Physician	Male	62	Illinois	-
Health policy or Public Health administrator	Female	56	Tennessee	15
Retired	Male	65	Maryland	25
Physician	Male	32	North Carolina	14
Nurse	Female	42	Georgia	-
Nurse	Female	52	Massachusetts	26
Nurse	Female	-	New York	18
Nurse	Female	-	-	20
Nurse	Female	43	Maryland	18
Health management	Female	57	Maryland	27
Nurse	Female	27	Edmonton	9
Nurse	Male	31	Edmonton	-
Health policy and public health administration	Female	27	Edmonton	-
Social Worker	Female	44	Ottawa	10
Health management	Male	49	Ottawa	-
Health management	Female	53	Toronto	16
Pharmacist	Female	49	Ottawa	8
Nurse	Female	37	Ottawa	13
Nurse	Male	45	Winnipeg	13
Pharmacist	Female	27	New Brunswick	8
Health management	Female	-	Ottawa	10







International Organization for Migration (IOM)