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Editorial

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Could Diaspora Surgeons be Key to Sustainable Impact in Global Surgery? The UK-Nigeria ENT corridor.

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There is limited funding for global surgery, therefore resources need to be used efficiently and sustainably.[1] Global Surgery (GS) initiatives have grappled with the same challenges that bedevil Global Health (GH), including failure of interventions due in part to lack of understanding of context and the importation of expensive technology not amenable to local maintenance.[2] There is also mistrust of some global organizations due to ethical issues including lack of credit for local contributors to projects.[3]

Medical migration has become the norm in our modern world and many Low- and Middle-Income countries (LMICs), including Nigeria ,have a huge medical diaspora community (a diaspora is a population that is scattered across regions which are separate from its geographic place of origin).[4,5] Migration of healthcare workers can negatively affect healthcare in LMICs,[5] although amongst these workers, there remains a desire to contribute to their source healthcare systems.[4] Indeed, many such surgeons do contribute to their countries of origin and are an important but overlooked group of global health actors. Their contributions include remittances and investments in the health sector including surgical and research training. These contributions are often long-running due to an intimate knowledge of local systems, camaraderie with colleagues practicing at home, acceptance in the community, and a feeling of safety due to local ownership of the facilities. This creates the opportunity for frugal innovation as colleagues in high income countries with access to expensive technologies and those in LMICs co-operate for knowledge and technology transfer in a context specific way.[2,5]

Many migrant healthcare workers from LMICs are specialist surgeons.[5] This causes a shortage of surgical services, driving up both wait times in public hospitals and prices in the private sector. One of the core indicators for monitoring access to safe surgical and anesthesia care is surgical specialist density with a target of 20/100000 population by 2030.[1,5] Nigeria's surgical specialist density is 1.8 per 100,000.[6] The country is now trying to harness their vast medical diaspora to improve healthcare in the country with the formation of a Public Private Practice/ Diaspora Unit in the Federal Ministry of Health.

The UK-Nigeria ENT (ear, nose, and throat) surgery corridor is a busy one with a long history.[7] It consists of Nigerian ENT surgeons who trained in the UK and those working in the UK following training in Nigeria. These Diaspora surgeons have helped set-up ENT residency programmes and in conjunction with the Otorhinolaryngological society of Nigeria (ORLSON), the post-graduate medical colleges, and some state governments, have joined in the provision of training in temporal bone dissection, functional endoscopic sinus surgery, and cochlear implantation alongside colleagues in Nigeria. Some have returned to the country to practice.[7] Many programmes co-facilitated in Nigeria in partnership with their Nigeria-based colleagues remain well established years later independent of the initiators. One of these is the ENT Department in the Federal Medical Centre, Yola, started in partnership between a UK-based ENT surgeon and the local public hospital management in response to a dearth of ENT services in the area. This service, which initially involved twice yearly, two weekly visits over a 12-year period, has now morphed into a fully functional ENT department with four consultants, three residents, and regular theatres with a full scope of secondary care service provision integrated with primary and tertiary care.

Remittances to Nigeria from its diaspora are currently more than all foreign aid and foreign direct investments to the country.[8] Innovation could potentially facilitate knowledge transfer, funding, collaboration, sustainable growth and private sector investment rivalling or even outpacing donor agencies.

As with any approach, there are limitations. Diaspora will be drawn to their area of training which may result in a skew of investments, with poorest areas less likely to benefit. There is also the possibility of parallel programme development leading to redundant investments in some areas. It is therefore important that ministries of health actively engage with this diaspora community to define geographic and clinical areas of need and encourage investments accordingly. There is a need to facilitate more public-private investments with enough flexibility to accommodate a range of schedules and capital. It is noteworthy that local surgeons may still be short-changed when dealing with diaspora surgeons especially in terms of remuneration or recognition. Checks to ensure fairness in reward for work done are critical. Political instability and weak systems have been a deterrent.[7] Clear legislation and detailed contractual agreement between parties may facilitate trust between local communities, health ministries, and diaspora surgeons for increased engagement and investment.

There is consensus that GH and GS need to change for greater impact, equity and justice. The recognition and incorporation of new players and stakeholders like diaspora surgeons may help facilitate more equitable and sustainable Global Surgery.

References

1. Quene TM, Bust L, Louw J, Mwandri M, Chu KM. Global surgery is an essential component of global health. Surgeon 2022; 20: 9–15. DOI:10.1016/j.surge.2021.10.001.

2. Raykar NP, Yorlets RR, Liu C, et al. The How Project: understanding contextual challenges to global surgical care provision in low-resource settings. BMJ Glob Health 2016; 1: e000075. DOI:10.1136/bmjgh-2016-000075.

3. Bolton WS, Aruparayil N, Quyn A, et al. Disseminating technology in global surgery. Br J Surg 2019; 106: e34–e43. DOI:10.1002/bjs.11036.

4. Velin L, Lantz A, Ameh EA, et al. Systematic review of low-income and middle-income country perceptions of visiting surgical teams from high-income countries. BMJ Glob Health 2022; 7: e008791. DOI:10.1136/bmjgh-2022-008791.

5. Toyin-Thomas P, Wariri O, Ikhurionan P. Harnessing peer mentorship as a tool to turn human resource for health brain drain into brain gain: a case study of a Nigerian peer-mentored research group. Hum Resour Health 2024; 22: 46. DOI:10.1186/s12960-024-00932-x.

6. Meara JG, Leather AJ, Hagander L, et al. Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. Int J Obstet Anesth 2016; 25: 75–8. DOI:10.1016/j.ijoa.2015.09.006.

7. Seyi-Olajide J, Anderson J, Williams O, et al. National surgical, obstetric, anaesthesia and nursing plan Nigeria. Bull World Health Organ 2021; 99: 883–91. DOI:10.2471/BLT.21.285586.

8. Irune EK. Migration and training: a British-Nigerian surgeon's perspective. ENT Audiol News 2018; 27: 36–9.

9. Nevin AS, Omosomi O. Strength from abroad: the economic power of Nigeria's diaspora. PricewaterhouseCoopers Limited 2019. Available at: https://www.pwc.com/ng/en/publications/strength-from-abroad.html. Accessed Aug 3, 2024.