**Reviewer’s report**

**Title:** MEDICAL DIASPORA: AN UNDERUSED ENTITY IN LOW- AND MIDDLE-INCOME COUNTRIES’ HEALTH SYSTEM DEVELOPMENT

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**Reviewer:** Abel Chikanda

**Reviewer's report:**

Summary

The migration of medical doctors has long been an issue of concern for migrant-sending countries. The 'medical diaspora' option, as advanced in this paper, offers an opportunity for countries that lose their medical doctors through migration to benefit from these emigrant professionals. The paper provides evidence on the operations of medical diaspora organizations drawn from four main destination countries of medical doctors worldwide (the United States, the United Kingdom and Australia). It demonstrates a wide range of actual interventions being made by diaspora organizations in their countries of origin. It further demonstrates some of the efforts that have been made by the migrant-sending countries to facilitate the process of medical diaspora engagement.

The paper is probably the first of its kind to extend the issue of medical diaspora engagement beyond the national level limit by adopting a global-level focus. Researchers interested in studying medical diaspora organizations worldwide will have a useful starting point, with a comprehensive listing of medical diaspora organizations provided on Table 1. Furthermore, researchers interested in diaspora institutions will have access to a comprehensive listing of country-level diaspora offices of most migrant-sending countries worldwide.

Without doubt, the paper makes a huge contribution to the literature on diaspora engagement. I highlight the following areas in this review that may require attention before the paper can be published:

a) First, the introduction presents the 'medical diaspora' concept without making a case for its importance/utility. One would have expected a statement or two in the introductory paragraph that highlights the need for migrant-sending countries to engage their diasporas. There is a well-developed body of literature that examines the migration of medical doctors from LMIC and the impact of such movements on their health care
systems. The diaspora option could then be advanced as a way of countering the negative impacts created by medical migration.

b) The introduction also assumes that every member of the diaspora is interested in developing their country of origin. This point also emerges in the authors' discussion of the South African case where no medical diaspora associations could not be found. The paper titled "The Disengagement of the South African Medical Diaspora in Canada" by Crush, Chikanda and Pendleton (2012) (in the Journal of Southern African Studies, Volume 38, Issue 4) precisely addresses this question. The article shows that even though the South African medical diaspora, who are mainly white, continue to assert their South African identity, they constitute a profoundly disengaged diaspora who are dissatisfied with the post-apartheid South African state. Chikanda and Dodson's study (2015) also showed that dissatisfaction with the political environment in the country of origin can have an adverse impact on the medical doctors' desire to engage positively with the country of origin [Chikanda, A., & Dodson, B. (2015). Medical Migration from Zimbabwe: Towards New Solutions? In N. I. Luginaah & R. Bezner-Kerr (Eds.), Geographies of Health and Development (pp. 281-295). Farnham, Surrey: Ashgate].

c) In the Methods section, there is at least need to acknowledge the possible existence of some medical diaspora organizations without an online presence. This could also cited as a limitation for the study. Because the study was limited only to online searches, the statement in the discussion on p.18 which states that "Discovering which countries did not have medical diaspora groups was also sometimes interesting…" could be misleading.

d) On p.5 line 11 (Methods section), the statement "Qualitative analysis was done to identify main themes using content analysis" should be reworded to clearly specify what was being analysed, e.g. web pages.

e) On p.7, could there be a reason why most medical diaspora associations are found in California, Illinois and New York?

f) In the results sections, there are opportunities to assess the effectiveness of some diaspora-initiated programmes. For instance, reference is made to the Sudanese Medical Association on p.9 and a study by Abdalla et al (2016) see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4943508/ found the contribution of the Sudanese medical diaspora to be of 'a small magnitude, infrequent and not organized'. Research by Wojczewski et al (2015) (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676361/) has shown that African
medical doctors who left their home countries as refugees cannot engage in any form of return initiatives, either short or long-term.

g) On pages 11 and 12, the word "diaspora" is spelt with a capital "D". Please note that the word can only be spelt with a capital "D" when used as a proposer noun.

h) The section titled "Diaspora Engagement: Government Level" should at least acknowledge some of the established literature on this subject. The paper by Alan Gamlen (2014) "Diaspora Institutions and Diaspora Governance" in International Migration Review, 48(S1) is a good starting point.

i) On page 16, The Commission on Overseas Filipinos Abroad plays a crucial role in diaspora engagement. Their website is https://cfo.gov.ph

j) The argument that researchers should go "beyond remittances" when examining the range of contributions by the diaspora was first attributed to Kathleen Newland (2004) https://www.issuelab.org/resource/beyond-remittances-the-role-of-diaspora-in-poverty-reduction-in-their-countries-of-origin.html and should be acknowledged as such in the paper (p.19, line 39).

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