

Thomas Lothar Weiss (editor)

Migration for Development in the Horn of Africa

Health expertise from the Somali diaspora in Finland



IOM International Organization for Migration

The opinions expressed in the publication do not necessarily reflect the views of the International Organization for Migration. The designations employed and the presentation of material throughout the report do not imply the expression of any opinion whatsoever on the part of IOM concerning the legal status of any country, territory, city or area, or of its authorities, or concerning its frontiers or boundaries.

The International Organization for Migration (IOM) is committed to the principle that humane and orderly migration benefits migrants and society. As the leading international organization for migration, IOM acts with its partners in the international community to:

- » assist in meeting the growing operational challenges of migration management;
- » advance understanding of migration issues;
- » encourage social and economic development through migration;
- » uphold the human dignity and well-being of migrants.

These are the broad guidelines, shared by all Member States, which set the framework for IOM's response to migration challenges.

IOM International Organization for Migration
Regional Office for the Nordic and Baltic States,
and the European Neighbourhood countries (East)
P.O. Box 851
FIN-00101 Helsinki
Internet: <http://www.iom.fi>

© 2009 International Organization for Migration (IOM)



IOM • OIM

This publication has received financial support from the Ministry for Foreign Affairs of Finland. The ideas, opinions and conclusions expressed in this report are those of the authors only, and do not necessarily represent the views of the Ministry for Foreign Affairs of Finland.



IOM International Organization for Migration

Migration for Development in the Horn of Africa

Health expertise from the Somali diaspora in Finland

Thomas Lothar Weiss (ed.)
in cooperation with Juan Daniel Reyes
and Tobias van Treeck



**MINISTRY FOR FOREIGN
AFFAIRS OF FINLAND**

This publication has received financial support from the
Ministry for Foreign Affairs of Finland.

CONTENTS

Acknowledgements

Chapter 1 - Migration for Development in the Horn of Africa. Health expertise from the Somali diaspora in Finland

Introduction and presentation

Thomas Lothar Weiss

15

Chapter 2 - Understanding the links between migration and development

Migration and development: from theories to practice

Thomas Lothar Weiss

27

Economic migration and its connection with economic and social development

Arno Tanner

36

IOM's Migration for Development and the EU policy framework

Elizabeth Warn

52

IOM's Migration for Development in Africa framework – lessons learned and future prospects

David Appiah, Susanne Melde, Abibatou Wane

55

Chapter 3 - The Somali crisis and Finland's development approach to Somalia

Political developments in post-1991 Somalia

Maria Brons

61

Finland's humanitarian and development policy for Somalia

Pauliina Hellman-Field

69

The Finland-based Somali diaspora – associations and their involvement in co-development

Päivi Pirkkalainen

74

Chapter 4 - Challenges and benefits of mobility in the Somali context

Historical Somali migration and the Somali workforce at home and in the diaspora <i>Bradley David, Abdi Jama Ghedi</i>	95
IOM Hargeisa: Health sector assessment of Somaliland December 2008 <i>IOM Hargeisa</i>	107
Migration for Development in Africa (MIDA) assessment mission of Awdal, Sahil and Togdheer health institutions in Somaliland <i>IOM Hargeisa</i>	123
Folk medicine: An invisible side of the Somaliland health sector <i>Marja Tiilikainen</i>	132

Chapter 5 - Reinforcing Somalia's health sector

MIDA Health Somaliland-Puntland and its role in addressing the human resource gaps of Somalia's health sector <i>Juan Daniel Reyes, Tobias van Treeck</i>	139
MIDA Health Somaliland-Puntland: What has been achieved so far – Perspectives from IOM field staff <i>Shukri Sheikh Ali, Elena Giannini</i>	154
Taking stock: The MIDA health workshop in Hargeisa, organized by IOM Hargeisa on 1 July 2009 <i>IOM Hargeisa</i>	157
Finnish Civil Society Organisations and the fight against tuberculosis in Somalia <i>Lennart Brander, Simo Granat</i>	163
MIDA Health in action: Testimonies from diaspora experts and host institutions <i>Dr Ahmed Y. Guled: Experiences as a voluntary expert</i>	170
<i>Dr Mulki Mölsä Elmi: My experience as a MIDA Health voluntary expert</i>	172

<i>Interview with MIDA Health voluntary expert Dr. Mohamed Yusuf Elmi</i>	174
<i>Interview with MIDA Health voluntary expert Mr. Ahmed Weli Haddi</i>	176
<i>A testimony from the Edna Adan Maternity Hospital in Hargeisa</i>	178
<i>A testimony from the Hargeisa Institute of Health Sciences</i>	180

Chapter 6 - Conclusions

The Diaspora: A hidden source of hope in Somalia <i>Thomas Lothar Weiss</i>	185
Authors	188
Accronyms and Abbreviatons	190

ACKNOWLEDGEMENTS

We would like to express our gratitude to the following people without whom MIDA Health Somalia, and this book, would not have seen the light:

Representatives from the Somali diaspora in Finland, the association SOMHELP - *Somali health care professionals in the Nordic countries*, and particularly Dr. Mohamed Mohamud Abillahi, Dr. Omar Ismail Mohamed, Dr. Artan Mohamud Mohamed, Dr. Mustafa Yusuf Nur, Dr. Mulki Mölsä Elmi, Ms. Batulo Essak, Ms. Saido Mohammed for their desire to cooperate with IOM in a MIDA project for Somalia;

Ms. Virginia Martinez, Regional Project Development Officer at IOM Nairobi, who planned the very first assessment visits by IOM Helsinki to Somaliland and Puntland and drafted, together with Ms. Lucy Laitinen, Project Development Officer at IOM Helsinki, the initial project document;

Mr. Teemu Tanner, Director General, and Dr. Anu Eskonheimo, Desk Officer for Somalia, from the Department for Africa and the Middle East, Ministry for Foreign Affairs of Finland, who approved the project proposal for funding;

Mr. Jukka Siukosaari and Dr. Tom Klaile from the Finnish Medical Association (*Suomen Lääkäriliitto*), who contributed to the project with in-kind donations and training;

Ms. Jillyanne Redpath-Cross, Senior Legal Affairs Officer at IOM Geneva, and Ms. Elizabeth Warn, Programme Officer at IOM Geneva, who provided legal and technical assistance throughout the different stages of the project;

Ms. Shukri Sheikh Ali, Ms. Elena Giannini, Ms. Lisa Mackey and Ms. Adrienne Testa at IOM Hargeisa, who implemented the project in northern Somalia; as well as Mr. Ashraf El Nour and Mr. William Lorenz at IOM Nairobi;

Mr. Saed Guled, MIDA Project Coordinator, Mr. Juan Daniel Reyes, Mr. Tobias van Treeck, Ms Carolina Frisenette-Fich and Ms. Yanina Druzhinina at IOM Helsinki, who implemented the project in Finland;

Our immense gratitude goes to all authors of the various contributions to the book, who have made this publication possible. They represent policymaking, practice as well as academia working in the migration, development and medical fields. Some of the authors participated in MIDA Health as voluntary experts, some represent host

institutions in Somaliland and Puntland as well as diaspora associations or NGOs in Finland. Special thanks to Mr. Juan Daniel Reyes for his editorial assistance in the preparation of the book, and Mr. Tobias van Treeck for the lay-out.

A handwritten signature in blue ink, appearing to read 'Thomas Weiss', with a stylized, sweeping flourish extending from the end of the name.

Dr. Thomas Lothar Weiss - Editor

Chapter 1

Migration for Development in the
Horn of Africa.

Health expertise from the Somali
diaspora in Finland

INTRODUCTION AND PRESENTATION

Thomas Lothar Weiss

In recent years, debates at international migration conferences, research on the phenomenon of migration and well-meaning journalists have shaped the notion of migrants as “heroes for development”, a notion which seemingly contradicts the mainstream point of view many people in destination countries continue to hold about migrants.

“Huddled masses”, migrants from Africa, Asia and Latin America, and especially the lower skilled, the refugees and the asylum seekers, are still seen by destination countries in the “developed” world as a challenge and an obstacle to maintaining high standards of living. Not the least since 9/11, migrants are also often considered as a threat to security, stability and national coherence.

However, in light of the powerful demographic, economic and political factors at play in both South and North, and the inevitable consequences of globalization, which motivate people to move in search of better opportunities, there is an understanding that - more than ever - migration cannot be prevented or stopped.

The concept of “migration management” as a tool to manage the unpreventable in an orderly and humane way, and to maximize the benefits of international migration for all, has started to make its way into migration policy and practice.

Migration management can only be successful if it involves, through way of participation and cooperation, policymakers and societies at origin and destination, as well as the migrants themselves. The real and the potential benefits of migration must be understood and shared by all countries with common migration realities. The conceptual and practical link between migration and development is a means to achieving this (Castles and Wise, 2008), and also a good way to ensuring cooperation between governments.

Considerable efforts have been made by states and international organizations to pinpoint benefits and positive effects of migration on development. An optimistic view based on the assumption that knowledge and skills transfers as much as migrant’s remittances can actually reinvigorate development has now established. The latest Human Development Report (UNDP, 2009) bears witness to this. An opposite more pessimistic perspective focused on perils for development because of brain drain and loss of human resources.

To be sustainable, the optimistic view requires to be endorsed by the major catalysts of migration and development, the migrants themselves. In this sense, the developmental impact of mobility stems directly from its contribution to the creation and diffusion of knowledge (OECD, 2008).

Considering and making use of migrants, migrant communities and migrant associations in the diaspora as agents for national development in countries of origin is still relatively new, but appears more and more as an effective and sustainable way to “operationalize” the linkages between migration and development, to transform the concept into practice.

Out of Somalia ...

Somalia is one of the countries most seriously struck by a long-lasting brain drain. Not even included in the Human Development Report rankings, the country has been devastated by 20 years of a murderous civil war and is not in the position to provide the most basic services to all its citizens. Health, education, jobs - all is precarious. Somalia has seen massive emigration, two to three million people have left the country, and Somali diasporas can be found nearly everywhere in the world, including in the Nordic region.

One of the sectors most severely affected by the human resources shortage is Somalia's health sector. The most common health interventions are often made impossible by the absence of qualified medical doctors, nurses or other health personnel. Hospitals, dispensaries and other public and private health infrastructures are underfinanced, inadequate or simply missing. Instruments, drugs and materials are often not available (WHO, 2006). In this context, reaching the health-related Millennium Development Goals remains wishful. The needs for qualified professionals to rehabilitate, reconstruct and develop local health care in Somalia are overwhelming.

In the context of the failure of the Somali State and the handicapping effect of the emigration of professionals, the importance of engaging the diaspora to strengthen the local services and development efforts back home cannot be overemphasized.

... and into Finland

The Somali diaspora in Finland currently counts some 10,000 individuals, roughly half of whom are Finnish citizens. Within this diaspora, there is a tiny but active group of some 200 medical professionals, both women and men, including medical doctors with a variety of specializations, nurses, midwives, laboratory technicians and pharmacists.

These represent a league of skills and knowledge with enthusiasm and interest in engaging themselves in Somalia.

As a major humanitarian player and an important host country for migrants from Somalia, and many other countries of origin, Finland looks back on an excellent track record in supporting the integration of mobility into national development strategies *here* and *there*.

Diaspora associations established in Finland are financially and logistically supported by Finnish authorities to work in co-development initiatives to be implemented back home. The integration of migrants, migrant communities and diaspora associations into Finnish society is actively pursued by policymakers and practitioners at national and local levels.

Decision-makers in Finnish politics and the private sector have long been conscious that the inflow of skilled migrants into Finland has positive effects, including in terms of increase in economic activities due to availability of skilled workers, improved knowledge flows and enrolment in graduate programmes, job creation by immigrant entrepreneurs and collaboration with countries of origin (OECD, 2008).

These skilled migrants can also serve as intermediaries between their *new* and *old* homes.

Building bridges between Somalia and Finland

To date, IOM offices have implemented more than 20 MIDA projects in Sub-Saharan Africa – MIDA being the acronym for “Migration for Development in Africa”, which is an IOM brand name. MIDA is matching professional vacancies identified in countries of origin, which are critically lacking locally available human resources, with skills on the part of representatives of the highly qualified diaspora. As these diaspora experts return home on short-term assignments to teach, train and treat in their areas of expertise, MIDA enables migrants to link *new* and *old* homes, to connect migration and development.

Following an assessment mission to Somaliland and Puntland by IOM Helsinki and IOM Nairobi in 2005, in which discussions with government authorities, NGOs and health professionals were held, the need and added value of an IOM MIDA project focussing on the health sector was clearly established. Hence, a first project proposal was prepared. This proposal coincided with an interest expressed to IOM Helsinki by the Somali diaspora in favour of a Somalia-specific migration and development project.

A number of medical professionals gathered in the Finnish NGO SOMHELP (Somali health care professionals in the Nordic countries) had heard of IOM's MIDA programme and were keen to exploring ways to establish a specific MIDA project for Somalis in Finland. They wanted to find a conduit for their desire to offer their professional contribution to the rehabilitation of the Somali health sector.

Contacts established in Somalia also enabled the IOM office in Helsinki to receive a number of high-ranking Somali government delegations at the occasion of their visits to Finland and other Nordic countries. Somali policymakers representing the Transitional Federal Government, but also from Somaliland and Puntland, reiterated here in Helsinki their desire to see IOM help the diaspora extend professional training services to specialists and trainees back home. In this context, MIDA was considered a welcome way to transform brain drain into brain gain and make a productive development-oriented use of traditional Somali circular migration patterns.

MIDA Health Somaliland-Puntland

Building bridges between the diaspora and the country of origin, the pilot project dubbed "MIDA Health Somaliland-Puntland", funded by the Finnish Ministry for Foreign Affairs and implemented by IOM, has enabled a representative group of highly qualified representatives from the Somali health sector in Finland to return back home temporarily in order to inject their professional expertise into development processes.

While IOM's MIDA project portfolio includes all regions of Sub-Saharan Africa, the Finnish MIDA Health project has been the very first project of its kind in Somalia.

Spanning a period of 18-months, from June 2008 to December 2009, the project initially targeted both the Somaliland and Puntland regions in northern Somalia. However, due to local insecurity following terrorist bomb attacks in October 2008, and related travel restrictions for humanitarian agencies and their staff, the project had to focus its efforts mainly on Somaliland.

As a tangible outcome, MIDA Health Somaliland-Puntland deployed 22 female and male medical doctors and nurses to go on temporary assignments in the public or private health sector in Somaliland and Puntland, treating patients and training students *in situ*. Their assignments were based on a needs assessment performed by the IOM office in Hargeisa, analyzing the human resources and infrastructural shortages in Somaliland and identifying health institutions in which the professionals from the diaspora could be hosted as voluntary experts. Capacity-building, sharing of knowledge, quality contribution to the health sector, demonstrating solidarity with their country of origin, these were the key words for each and every assignment.

The reaction to the project by participating voluntary experts from the diaspora has been most encouraging, especially considering that almost half of all participants were female experts. There were more requests for participation than available slots.

The reactions and feedback received from Somalia, by locally-based health professionals, students, health authorities and patients with whom the voluntary experts were interacting and who benefitted from their technical assistance and training, were overwhelming in expressing their gratitude, support and encouragement.

With all the limitations inherent to such projects - which are, among others, relatively small target populations, modest funding, but also risks related to security - they demonstrate that migrants are powerful agents of development in their countries of origin. Diaspora representatives are especially motivated and capable to blend into and understand local situations.

In addition, migration has not only the potential to benefit countries of origin. Host countries also benefit greatly from the often qualified foreign-born workforce, which is precious in times of demographic downturn. Cultural and social diversity in the host country is another positive effect of immigration, as much as its broader economic benefits, including higher rates of innovation as well as higher labour force participation among locally born females (UNDP, 2009). At term, Finland as a host country is bound to benefit from a vibrant and self-confident Somali diaspora.

With an increasing number of examples of successful “straddling of two different worlds”, the Somali community in Finland has produced and will continue to produce role models that will be useful in the process of socialization and adjustment to Finland. It will also help towards increasing the levels of acceptance of this minority by the Finnish society, and enhance integration.

“Heroes for development”

Migration in the Somali context is characterized by a multitude of situations, stories and practices. What most have in common is circularity; circular migration as the “back and forth” between the homeland and the host country to invest in small-scale business, to construct houses, to celebrate marriages, to visit family and friends, and to stay in touch with the realities back home without returning definitely (Hansen, 2007). These are patterns that also fit most members of the Somali diaspora in Finland.

There is a qualitative difference, however, between regular private circular migration from Finland to Somalia and professional engagement and expectations as a voluntary expert under the auspices of IOM’s MIDA. MIDA not only promotes the production

and dissemination of structured knowledge, but also allows the transmission of tacit knowledge, which cannot be planned or transmitted as rigid information through papers, lectures, conferences in a one-way communication (OECD, 2008). Through MIDA, knowledge and skills are actively shared and transmitted among professionals, or from the professional to the student, within a common social and professional context as well as physical proximity.

In joining the project, diaspora professionals in Finland were driven by a strong desire to contribute to development back home and to give something back to Somalia from what they have experienced and learned in Finland. Many consider themselves as agents of change and are proud to offer their contribution to a homeland that is deprived of the most basic services. In that sense, each and every single medical professional of the Somali diaspora here in Finland who has participated as voluntary expert in the MIDA Health Somaliland-Puntland pilot project is a true “hero for development”.

This book aims to capture the context in Finland and Somalia which has led to the development and the implementation of the very first MIDA project for Somalia.

While implementing projects that connect migration and development in the specific and most challenging context of Somalia remains an important work in progress, given the sheer scale of the needs on the ground, MIDA Health Somaliland-Puntland has shown that it is possible and meaningful to engage the diaspora for development activities back home. The project has also demonstrated that authorities in Finland and in Somalia are very interested in and supportive of this type of engagement.

In addition, from the lessons learned of the pilot project a set of recommendations has been drawn to enable the diaspora and the Finnish government to undertake necessary adjustments in view of continued work on connecting the diaspora with development efforts in the Horn of Africa.

Directed to a diverse audience of policymakers and practitioners in migration and development as much as the larger public interested in contemporary transnational issues, we hope that this book will be a modest contribution towards further promoting the leadership role that Somali health professionals in Finland have assumed in the rehabilitation of a critically underdeveloped service sector in their homeland.

Outline of the book

Through a general introduction to the role of diaspora as bridge-builders between worlds and the specific role of the Somali diaspora in Finland, **Chapter 1 - Migration for Development in the Horn of Africa. Health expertise from the Somali diaspora in Finland** presents the rationale of the book.

In **Chapter 2 – Understanding the link between migration and development**, WEISS and TANNER provide an overview of the conceptual framework within which the debate on migration and development has been evolving in recent years. Co-development as a means of involving migrants and diasporas into development processes in countries of origin represents a shift from theory to practice. In her contribution, WARN points towards the emergence of a European Union policy framework on migration and development that is largely inspired by IOM's MIDA programme. APPIAH, MELDE and WANE develop general lessons learned and prospects derived from IOM's implementations of MIDA projects since 2001.

Chapter 3 - The Somali crisis and Finland's development approach to Somalia, analyses the specific context of the on-going Somali crisis situation that, since the early 1990's, has provoked the mass emigration of Somalis. It examines the development policy approach of Finland, as a host country to an important Somali diaspora. BRONS' contribution gives an overview of the political developments in Somalia over the last two decades. In her contribution, HELLMAN-FIELD explains the genesis and different expressions of Finland's humanitarian and development aid response to the Somali crisis. PIRKKALAINEN examines the vibrant Somali diaspora associations in Finland and positions their work within the framework of Finnish Ministry for Foreign Affairs-funded efforts to favour co-development through the diaspora.

Chapter 4 - Challenges and Benefits of Mobility in the Somali Context, revolves around the characteristics of Somali migration and its multiple consequences. DAVID and JAMA GHEDI reconstruct the successive migration waves Somalia has witnessed since the 19th century as well as their impact on the Somali workforce at home and abroad. The following contributions describe in detail the situation of the Somali health sector. Through two assessment mission reports from 2008 and 2009, IOM HARGEISA dresses a dire picture of the devastated health infrastructure and human resources in the Somaliland region. TIILIKAINEN reminds us of a less visible but nevertheless important "folk medicine" in the Somali health sector which, as a result of the continued brain drain of health professionals, remains particularly important.

Chapter 5 - Reinforcing Somalia's Health Sector, is dedicated to the Finland-driven efforts to rehabilitate the health sector in Somalia. Two major co-development initiatives, IOM's MIDA Health project for Somalis from the Finnish diaspora and the work of Finnish Civil Society Organizations in Somalia's health sector, are presented here. VAN TREECK and REYES retrace the history of IOM's first MIDA Health project for Somalia before describing its implementation and the multiple challenges and lessons learned of this pilot project. SHEIKH ALI and GIANNINI dress an inventory of what has worked well in the project from the Somali perspective, and what remains to be improved. Interviews with three MIDA Health Somaliland-Puntland voluntary experts, and testimonies from representatives of two of the beneficiary institutions hosting health professionals from the Somali diaspora as well as the Somaliland Ministry of Health and Labour complete the picture. GRANT and BRANDER's contribution bears witness to the historic efforts of Finland's civil society organisations contributing to the reconstruction of the Somali health sector.

The **Chapter 6 - Conclusion** is a reminder that MIDA Health Somaliland-Puntland is a vital contribution towards closing the gap between migration and development policy and practice. WEISS underlines that the empowerment through MIDA of Somali health professionals from the Finnish diaspora as actors of change has shown positive effects on development back home. By supporting this empowerment, Finland through its Ministry for Foreign Affairs is sending out a message of hope for Somalia.

References

- Castles, S. and R. Wise
2008 *Migration and Development. Perspectives from the South*. IOM, Geneva.
- Hansen, P.
2008 "Revolving returnees in Somaliland". in Nyberg Sørensen. *Living across worlds: diaspora, development and transnational engagement*. IOM, Geneva.
- IOM
2008 *World Migration 2008 - Managing labour mobility in the evolving global economy*. Geneva
- OECD
2008 *The global competition for talent. Mobility of the highly skilled*. OECD, Paris.
- UNDP
2009 *Overcoming barriers: Human mobility and development*, Human Development Report, UNDP, New York.
- WHO
2006 *World Health Report: Working together for Health*, Geneva.

Chapter 2

Understanding the links between
migration and development

MIGRATION AND DEVELOPMENT: FROM THEORIES TO PRACTICE

Thomas Lothar Weiss

Migration has the potential to make a vital contribution to a country's development. The close relationship between migration and socio-economic development has been clearly recognized for some time now by policymakers, academia and practitioners operating in the area of migration management as well as development.

A two-way positive and negative connection between migration and development is often pointed to in literature: migration can be both a cause and a result of underdevelopment, while underdevelopment can be either alleviated or exacerbated by migration. While defenders of neo-classical approaches have been insisting on human mobility as a way to minimize risks and maximize benefits for those who move, proponents of structuralist interpretations have emphasized the role of migration as a drain on local and national societies adversely impacting on development.

Migration cannot be categorically seen as either an obstacle to development or a strategy for its achievement (IOM, 2006). Actions to eradicate poverty and achieve the Millennium Development Goals can address some of the structural causes of migration, and migration can positively influence the achievement of the MDGs (EU Council, 2006).

In recent years, globalization and its opportunities and illusions, the growing scale, the diversified routings and the complexity of international migration have led to a steady increase in human mobility. In parallel to this increase, there has been a rising interest in how the effects of migration can be understood and optimized. The challenge for policy and practice is how to ensure that migration does not hurt the poorest countries or, better still, how to ensure that migration actually benefits those countries, while remaining attractive for the richer destination countries.

The last five years have witnessed a growing recognition by the international community of the development potential of migration. The 2005 Report of the Global Commission on International Migration, the 2006 United Nations High Level Dialogue, and the annual meetings of the Global Forum on Migration and Development since 2007 are nothing less than testimonies to this international recognition.

Working on the operational, programmatic, but also policy aspects of the migration and development nexus - in close partnership with the UN and other intergovernmental or non-governmental organizations - IOM has observed that there is a significant shift of the paradigm regarding the link between migration and development over the last 20 years.

From a predominantly negative approach which emphasized the need to eradicate the root causes of migration, brain drain, rural exodus or the depletion of labour force, we now see a greater interest among all our stakeholders in the positive effects of migration for development. This more positive approach considers the economic, social and cultural contributions of migrants and the alleviation of demographic and labour market pressures in both countries of origin and destination.

The demographic decline in many industrialized countries is contrasting sharply with the demographic explosion in most developing countries. Shrinking labour forces in the developed world lead to imbalances in supply and demand in areas such as health care or education, or economic sectors such as the services or construction. At the other end, numerous developing countries cannot cope anymore with an oversupply of labour relative to local or national employment opportunities.

The question is how to better match labour supply with labour demand on a global scale. Here, many policymakers see the need for mechanisms to channel labour migration into safe, legal and humane avenues in order to maximize the development potential of labour mobility. If countries fail to do so, global economic growth could be impacted negatively, fuelling irregular migration, including human trafficking and smuggling.

Impact of skills, money and diaspora flows

The development of policy and project interventions that will help to realize the full potential of international migration is a huge task for policymakers and practitioners, as:

- 7 it requires measures to harness the development potential that emigration from countries of origin could bring. At the same time, it must ensure that the exodus of highly skilled workers does not damage development outcomes and guarantee that migration remains a positive force also for countries of destination;
- 7 it requires finding ways of how to make migrant remittances more effective as a tool for poverty reduction and economic development;
- 7 it calls for new and better ways to facilitate the involvement of migrant diasporas in the development of their home countries.

Skilled people flows. The most frequently discussed development effect of international migration is brain drain. It refers to situations in which the emigration of skilled workers has adverse economic impacts. Nearly 10 % of all tertiary educated adults born in the developing world and some 50 % of the developing world's science and technology personnel today live in the developed world (Lowell et al., 2004), including more and more women.

However, whether these flows are always detrimental to a country of origin depends on one's school of thought. Since the 1960's, proponents of a "zero-sum analysis" believe that reduced numbers of educated people in a country lower the average level of education and generate a loss for those left behind, leading to wage deflation for unskilled workers or lesser levels of attractiveness for foreign direct investment.

Another, more recent school of thought, rejects the notion that skilled migration has detrimental consequences for less developed countries. It argues that the prospect of migration itself may lead to greater incentives for workers to become skilled, encouraging brain gain. When overseas, the migrants can be of benefit to their home through remittances and the creation of trade and business networks. Once returned, temporarily or for good, migrants are a potential source of growth through diffusion of knowledge and technology – the so-called brain circulation.

Brain circulation may either lead to definitive return of skilled migrants to their home country after time spent abroad or a pattern of temporary and circular migration between home and abroad. Professionals diffuse knowledge they acquire abroad to their home countries. They create and maintain networks which facilitate continued knowledge exchange. However, and this is a crucial caveat in the debate about migration and development, to make most of brain circulation, countries of origin need to have sufficient absorptive capacities for returning professionals to enter local labour markets at levels that are commensurate with their skills, knowledge and expectations (OECD, 2008).

In sum, while there are potential costs, movement of the skilled can often provide benefits for all those involved. Moreover, migration does not always imply one-way or permanent flows as there are increasing numbers of returning and circulating migrants. This has implications for policymakers who need to understand when brain drain is an issue of concern and how to promote the positive aspects of brain circulation. Some authors argue that a new circulation paradigm has emerged, and the notion of "brain gain" came to the forefront in the 1990s with two options: return or diaspora (UNRISD, 2008), that are in balance and do not to exclude one another.

Money flows. Remittances from migrant workers to developing countries are large and rising, i.e. some USD 287 billion in 2008, up more than 80 % from 2001.

IOM'S AIMS, COMPETENCIES AND STRATEGIES

Remittances are, above all, private funds, but which also offer development possibilities for entire communities and countries. IOM, in partnership with governments, migrants, migrant associations, financial institutions, NGOs, academic partners, development agencies and donors seeks to facilitate the development of policies and mechanisms that:

1. Improve remittance services to migrants, and
2. Enhance their development impact.

IOM's distinctive competence in the area of remittances and development includes:

- A global presence and vast migration experience – IOM has 120 member states and over 200 offices worldwide;
- Strong partnerships with governments responsible for migration and remittance policies, services and initiatives;
- Direct contact with migrants in both sending and receiving countries;
- Involvement in global remittances-and-development initiatives;
- A growing portfolio of remittance-linked research, policy dialogue and pilot projects in different countries and regions around the world.

To achieve these aims and make the most of these existing competencies, IOM works in three areas: research, policy dialogue and pilot projects, and employs the following strategies:

- ▶ Provide information to migrants about available remittance transfer services and costs, as well as savings and investment opportunities available to them in host and origin countries.
- ▶ Facilitate partnerships between banks, money transfer organizations (MTOs), microfinance institutions (MFIs), postal services, credit unions and other community-based service providers to improve the quality of remittance transfer services, reduce costs, and expand access to formal transfer services for more migrants and remittance recipients, particularly in underserved areas.
- ▶ Build the capacity of consular services in migrant host countries to support and promote the use of formal remittance transfer channels, and the use of remittances for savings and productive investments in initiatives such as housing, small business development and education, in migrant countries of origin.
- ▶ Help to create new remittance-linked savings and investment opportunities for migrants and households receiving remittances through partnerships with banks, micro-lending organizations and other financial institutions.
- ▶ Strengthen the capacity of migrant/diaspora groups, government agencies and other relevant partner institutions in origin and host countries to engage more effectively together on development-enhancing philanthropic and investment-oriented transnational initiatives.
- ▶ Contribute to improved data collection and research on remittances and help put into place mechanisms for sustainable data collection and information sharing. Link research to policy and programme development.
- ▶ Support good governance and sound economic policy initiatives which promote a quality, competitive remittance transfer service market and which stimulate new savings and investment opportunities for migrants and their families to support development.
- ▶ Provide forums for transnational dialogue, information exchange, sharing of best practices and remittance-linked development planning among government agencies, policymakers, migrant groups and other institutional partners.

For developing countries, remittances are now double the size of net official aid and rising relative to FDI. Informal channels of remittances might well add at least 50 % to these official estimates. In the wake of the current crisis, however, remittances have declined in 2009, especially those from migrants in the US and Europe to Latin America and Africa, although funds from migrants in the Gulf states, for instance, seem to have remained stable (The Economist, 2009).

Remittances have numerous benefits for the development process. They are a source of income and foreign exchange for many countries. For those developing countries confronted with a persistent labour market slack, exporting labour in return of remittances is a welcome development strategy. Remittances are less volatile than private capital flows that tend to move pro-cyclically, and may even rise during recessions, helping to stimulate vulnerable economies (Ratha, 2004), although the current recession does not seem to confirm this view.

In addition, there seems to have been a rather one-sided focus on remittances and their direct economic consequences. In this context, UNRISD underlines that more attention should be paid to the non-pecuniary impacts of remittances, such as on health, education, gender, care arrangements, social structures and ethnic hierarchies in migrant communities (UNRISD, 2008).

An important problem related to remittances is the usually high transfer cost, although there are variations depending on origin and destination country and the amounts involved. The question of how to make a more productive use of remittances is another issue policymakers should reflect upon.

Diaspora flows. Migrant communities or diasporas can play an important role in the economic, social and political development of their countries of origin. Diasporas can be a source of ideas, identities and social capital that flows between countries; the so-called social remittances. Similarly, migrants can transfer knowledge and skills, the technological remittances, or even political identities and practices (i.e. the political remittances). The contacts and networks that diasporas retain with their host country could act as an important channel for enhancing the positive impacts of emigration on the country of origin.

The diaspora option has emerged as a way to mitigate brain drain and the shortage of adequate human resources in the South. A challenge inherent to this option is, on one hand, to “convince southern diaspora leaders in northern countries to prioritize the diaspora option as a bottom-up strategy of development” and, on the other hand, “to convince host countries [...] about the merits of the diaspora option vis-à-vis the return option” (UNRISD, 2008).

However, concrete benefits of the diasporas and instruments used to channel these benefits are context-specific. To a large extent, the differences in diaspora involvement reflect differences in home country economies more than they reflect differences in migration modalities. In the context of low-income countries, it is likely that the obstacles to investment such as poor infrastructure, inadequate legal frameworks and poor human capital, will discourage diasporas from investing in their home country.

For policymakers and practitioners, further systematic evidence of the role played by diasporas in contributing to development back home is needed. This applies especially to diaspora-induced capital flows and transnational networks which contribute towards a “de-territorialization” of political and sociological identities. Migration has effects on transnational identities, cultural changes, social structures and, ultimately, political culture in both countries of origin and destination.

Challenges for policymakers and practitioners

As we have seen, the effects of migration on economic and social development are multifaceted. An unequal distribution of the costs and benefits of migration between countries of origin and destination has the potential for divisiveness, especially in relation to skills, money and diaspora flows.

While development constitutes the most promising response, in terms of sustainability, to the increasing movement of people, there are still significant policy, research and information gaps that should be filled in order for the developmental potential of migration to be fully realized. The difficult availability, accuracy and comparability of migration data continue to be obstacles to better migration policies.

The latest call on how better policies towards mobility can enhance socio-economic development is stemming from the 2009 Human Development Report. Entitled *Overcoming barriers: human mobility and development*, UNDP’s flagship publication reiterates that migration can be hugely effective in improving the income, education and participation of individuals and families, and enhancing their children’s future prospects (UNDP, 2009).

The report points to the large gains from movement but also to the substantial risks faced by many who move. Where migration is a reaction to threat and denial of choice, human mobility can be a risk to human development. The report also underlines that mobility, even if managed well, is not a substitute for broader development efforts.

The key message that large gains to human development can be achieved by lowering the barriers to movement and improving the treatment of movers is timely, given that the

current recession has led many countries to raise rather than lower barriers to mobility. The report is a reminder that these restrictions can be harmful to development¹.

In practical terms and voicing many of IOM's traditional calls for action, the Human Development Report proposes a six-point package which calls for the opening of existing channels to more workers and ensuring worker protection and rights. This includes less red tape, lowering of transaction costs for migrants, easing restrictions on internal migration, boosting cooperation between host and home communities and the inclusion of migration into national development strategies.

Five key areas for migration and development

To establish a comprehensive policy and project infrastructure on migration and development, which would link theory and practice, progress in five key areas need to be considered by policymakers:

First, there is a need for a better evidence base and research on data and statistics to understand the effects of migration on economy and society - only then can policymakers work out the most effective interventions to ensure that migration actually benefits development. More consideration should also be given to the integration of migration into poverty reduction strategies, or other national development strategies, and on how donors can support priorities of their partners into this respect.

Second, better policy coherence and coordination at national and international levels in developed and developing countries are required. Given that migration is intertwined with areas such as trade, employment, environment, health, security, agriculture, urbanization, regional planning – to mention just a few – there is considerable potential for conflicting policy priorities.

Harmonized and coherent strategies for intra-governmental dialogue and coordination are therefore necessary, as much as an enabling environment conducive to the promotion of investment, trade, employment and sustainable economic growth. Migration can benefit poverty reduction and development through increased income potential of remittances and the skills of returning migrants.

Third, progress in research and policy coherence will also need to be matched by a better mapping out of the processes and means by which policy objectives will be achieved. Suitable actors for implementing policies, appropriate communication channels and effective evaluation models will also need to be clearly identified.

All of this beckons the inclusion of a gender sensitive perspective in policies and projects on migration and development so as to enhance the positive contribution of migrant women, whose prominent role in international migration has led to the notion of feminization of migration.

Fourth, greater international dialogue and cooperation will be necessary to ensure that measures taken in one country are not undermined elsewhere. Policymakers will need to work out appropriate policy aims, identify the means by which those aims can be achieved, collaborate within and between governments to ensure their effective implementation and agree on methods to evaluate their success.

This also includes the promotion of better information on the possibilities of legal migration and the risks of irregular migration.

Fifth, the diaspora option should be better understood by governments and societies in countries of origin and destination. Targeted state involvement and facilitation in order to reinforce socio-economic and developmental orientation of diaspora efforts should be undertaken and, not the least because migration occurs in the context of “decentralized and decentralizing policies”, should be coordinated also with actors representing the civil society.

The key challenge in the future will be how to address each of these key areas. Migration is a complex and multifaceted reality which impacts on transformation processes in institutions, societies, welfare and social relations in origin and destination countries. But, migration is not yet fully mainstreamed into development agendas. Much has been written about the linkages between migration and development, more needs to be done to transforming them from theories to practice.

Notes

- 1 According to an unpublished analysis of the 2009 HDR by IOM's Research Department in Geneva.

References

- European Union Council
2006 *Preparation of the UN High Level Dialogue on International Migration and Development*, draft EU position, document 11470/06, Council of the European Union, Brussels.
- IOM
2006 *International Development and Migration. Perspectives and Experiences of the International Organization for Migration*, Geneva.
- IOM
2006 *Migration and Development: Opportunities and Challenges for Policymakers*. IOM Migration Research Series, no.22, Geneva.
- Lowell, B., et al.
2004 "Brain strain: Optimizing highly skilled migration from developing countries", *Asylum and Migration Working Papers 3*, IPPR, London.
- OECD
2008 *The global competition for talent. Mobility of the highly skilled*. OECD, Paris.
- Ratha, D.
2003 "Worker's remittances: An important and stable source of external finance", *Global Development Finance Report 2003*, World Bank, Washington D.C.
- The Economist
2009 "The aid workers who really help". 8 October 2009.
- World Bank
2005 *Global Economic Prospect: The Economic Implications of Remittances and Migration*, Washington D.C.
- UNDP
2009 *Overcoming barriers: Human mobility and development*, Human Development Report, New York.
- UNRISD
2008 *Conference News. Social Policy and Migration*. UNRISD, IOM, IFS, Geneva.

ECONOMIC MIGRATION AND ITS CONNECTION WITH ECONOMIC AND SOCIAL DEVELOPMENT

Arno Tanner

What causes people to migrate and why?

Based on Zelinsky's push and pull theories of international migration, let us look at different angles of emigration:

What is brain drain, what happens if there is domestic brain waste, and what are the ways to limit and manage brain drain?

Development as a push and pull factor

One of the major theorists on international migration, Wilbur Zelinsky, argued in 1971 that emigration occurs particularly from "early transitional societies", where birth rates are still high but mortality is on the decline (Zelinsky, 1971). In other words, it is neither the poorest and weakest societies (where mortality is typically high), nor the most developed societies (where birth rates are low), but the developing societies in between that represent the countries of origin of most emigrants. The state of societal development determines the push and pull factors that drive international migration.

Similarly, John Harris, et al. (1970), in their widely accepted theory, argue that "migrants are rational beings who [migrate] toward favourable regions, where their needs for a secure or better life can be met" (Harris and Todaro, 1970). Four major patterns in international economic migration support Zelinsky's and Harris' ideas:

a) Obstacles to development push the emigration of the middle classes

Lack of or stagnated development can refer to a range of social, political, cultural, human rights and demographic aspects. The absence of development or downright depression in the country of origin increase individual migration push factors. Lack of economic progress, poverty or economic dissatisfaction, political uncertainty or state instability, including societal upheavals with refugee crises, inequality and human rights problems, have all been seen as factors that increase the propensity to emigrate.

Still, absolute poverty in itself is typically not a sufficient cause for leaving, rather there is often a complex mix of developmental reasons involved (Black, et al., 2006). Studies (e. g. Sirkeci, et al. on Turkish emigration), provide further evidence that negative or halted development leads to a higher propensity to emigrate (Icduygu, et al., 2001).

Nor do the poorest individuals typically emigrate, but rather those with information about the relative lack of development of the country of origin compared to that of the destination country, as Piore argues (1980). This is quite visible in African emigration: migrants and refugees typically have some education and work experience, as well as at least some monetary assets to travel. Rather than fleeing absolute poverty and famine, migrants tend to depart from economically less desperate conditions in search of greener pastures. The poorest persons, those living in refugee camps, seldom initiate long journeys to other continents.

b) Not only rich countries but also “advancing” countries pull immigration

Favourable development in a country contributes obviously towards making it interesting as potential country of destination. Destination country development increases its attractiveness and individual pull factor. “Advanced societies” with low mortality and “controlled” birth rates entice both semi-skilled and skilled workers (Zelinsky, 1971).

Certainly, much of today’s migration occurs, in absolute terms, towards rich societies: about 4 million new immigrants entered OECD¹ countries in 2005, an increase of 10 % from 2004 (OECD, 2007). Indeed, immigration to OECD countries has surged in recent years; current estimates are that 11.4 % of the residents of developed countries are foreign-born, compared to 6.2 % in 1980. Particularly OECD countries, which rank high in the Human Development Index (UNDP), often see high immigration levels, either through active state-sponsored immigration schemes (Canada, Australia, New Zealand) or by sheer power of attraction in the absence of well developed legal immigration schemes.

Not only rich countries with their often high level of development but also well “advancing” developing countries attract semi-skilled and skilled labour. Advancing countries attract immigrants due to strengthened industries, increased GDP and improved living standards. As a historic example, countries in the Arabian Peninsula have, alongside the increase in oil revenues and skyrocketing economies, been transformed to become major importers of foreign labour.

More recently, new democracies with steadily improving market economies, welfare, quality of life and human rights² (such as Slovenia or the Czech Republic) are increasingly becoming attractive for immigrants. A positive tendency towards further immigration is also seen among many Asian countries, such as South Korea and Taiwan. Their

development has accelerated considerably in recent years, and they are enticing an ever increasing number of migrants from the surrounding, less advanced countries. These “advancing” developing countries are increasing their “pull” or “favourability” factor.

c) Development in the country of origin may pull back the expatriate

Migration is seldom a permanent or final event. Many migrants return back to the country of origin, whether as circular migrants or definitive returnees. Return migration to the country of origin is often caused by positive developments there, which then work as pull factor. Development from a “transitional” to an “advanced” society significantly increases the probability of return migration, either directly or in the form of circular migration. Such returns become more probable the more the birth rate is controlled and the more the mortality rate has declined in the country of origin (Zelinsky, 1971). In Harris’ words (Harris and Todaro, 1970), countries of origin are becoming more favourable, i.e. meeting expatriates’ desire for a secure or better life back home.

Countries such as South Korea and many Eastern European states have progressed in human rights, social well-being and economic development, and have seen an increase in return and circular migration, whereas countries such as Somalia or Myanmar are lacking return and circular migration of their émigrés - which would be essential for country development - due to stagnated or reverse development in politics and human rights.

India attracts expatriates back from abroad, as the expatriate contacts and assets are valued and seen as a means of achieving well-being and ongoing growth. Few Turkish nationals return to Turkey, partly due to the lack of positive economic avenues (as is the case with the *Gastarbeiter* in Germany)³, or due to a negatively perceived political situation (i.e. of the Kurds in Eastern Turkey).⁴

d) Halted or negative development in the destination country pushes towards further migration

Circular or return migration may also be caused by halted, negative or backward development in the country of destination, i.e. a push factor. If an advanced country with high development, a stable economy, a controlled birth rate and a stabilised mortality rate regresses due to a conflict-induced increase in mortality, famine, disease, or a strong economic downturn, then emigration from that destination country may start to increase. Negative development in the initial country of destination may mean changes in politics and public attitude that would weaken the position of immigrants.

Countries that earlier had higher immigrant populations, such as Kenya and Nigeria, have seen a decrease in immigration figures, due to stagnation in economic and human

rights development, civil conflicts, etc. Traditional, rich countries of immigration, such as Denmark, have registered higher return migration levels of their immigrants due to currently less favourable attitudes towards immigrants, a clear push factor, causing further circular or definitive return migration.

How does emigration influence country of origin development

There is a natural connection between international migration and development. Migration, as a natural equilibrium-seeking process, as well as individual and state action, has an influence on contemporary international migration. State interests concerning international migration vary in subject, space and time, and states may therefore act or react to migration with policies that reflect their current and long-term interests. In spite of this, policies that include both migration and development are still rare.

Let us go deeper into today's reality on the migration-development nexus. First, what are the main consequences of skilled emigration for the country of origin? The starting point is that appropriate and *bond-sustaining* emigration enhances country-of-origin development in the long run. Appropriate emigration refers to both quantity and quality. Quantitatively appropriate emigration can relieve overpopulation and excessive workforce, whereas excessive emigration leads to brain drain. Qualitatively appropriate refers to workforce that as is not critically needed in the domestic market and has not strongly strained domestic educational resources.

Bond-sustaining means that the expatriate maintains long-term tangible or intangible contacts with the country of origin. Optimally, sustaining bonds means return migration to productive work and bringing new experience and material, social, occupational assets, or to consuming the assets accumulated during the active career.

a) Brain drain continues to ruin countries of origin

Let us take a brief look at the possible negative consequences of emigration. Africa is taken as the initial reference point, as it has suffered from emigration-related development problems for several decades. Excessive or a qualitatively detrimental emigration may critically hamper country of origin development. Brain drain is, according to Lowell: "A loss of trained professional personnel to another nation that offers greater opportunity" (2003). Or, even more succinctly, brain drain can be defined by a "depletion or loss of intellectual and technical personnel" (Wordnet, 2009). "Brain drain occurs with significant losses of the highly skilled, and few offsetting economic feedbacks". First,

there must be a significant loss of highly-educated labour; secondly, adverse economic consequences must follow (Lowell, 2003).

There is a clear link between brain drain and slowing or halted development. Examples of the problems caused by brain drain are multifold⁵, and some are particularly detrimental to sustainable development. African researchers have remarked that only a stable, educated African middle class will ensure that political power is transferred "...by ballots instead of bullets." However, the constant emigration of professionals with technical, entrepreneurial, managerial, and medical skills makes it difficult to create an African middle class. The remaining two-class system is an African problem, resulting in a "...massive underclass that is largely unemployed and very poor, and few very rich people that are mostly corrupt military and government officials" (Emeagwali, 2003).

The restless international mobility of educated people may thus give rise to a drastic halt and reversal of political development with ensuing instability, poor leadership, endemic corruption and, in the worst case, increasing vulnerability of democratically elected governments.

In addition to halting political development, the OECD makes the point that the emigration of highly skilled workers may adversely affect the economies of small African countries, preventing them from reaching the critical mass of human resources necessary to foster long-term economic development. According to IOM, there are currently only 20.000 scientists and engineers in Africa (or 3.6% of the world's scientific population) to serve a population of about 700 million. Africa would need at least one million more scientists and engineers to sustain the continent's development goals (Nwosu, 2005).

Brain drain results in a direct budget burden because it makes it necessary to hire a replacement workforce. As African professionals leave the continent, an estimated USD 4 billion is spent each year, mostly through overseas aid programs, on hiring some 100.000 skilled expatriates to replace them (Nwosu, 2005).

Even more important is the effect brain drain has on Africa's industries and their competitiveness. According to Lall, manufacturing is vital for Africa's growth.⁶ One of the conditions for a thriving industrial sector is a good investment climate with sound macroeconomic policies and property rights. But this also requires a range of technological, managerial, and institutional abilities. East Asian countries have developed the capabilities necessary for success in an increasingly competitive global market; Africa has not. In Africa, low wages as such are no longer the main competitive factor in manufacturing; rather, it is low wages for skilled, disciplined, and capable labour. Africa has low wages but also low skills and trained competencies. The stock of formally educated workers is small relative to other regions⁷, and further shrinking, due to brain drain.

According to Lall, the gap between Africa and the rest of the world widened in the 1980s and 1990s, and is likely to continue widening if the poorest countries are deprived of the workers that can make their industries internationally successful. Of even greater importance is the danger that Africa will be pegged as a mere supplier of natural resources to the West. It is practically off the map when one considers the most dynamic and technologically rewarding areas of manufacturing. Not only is Africa becoming marginal to the dynamics of the global economy, it shows little sign of a technological response to the new challenges. Low market access to rich countries is due to low productivity and a lack of industrial capability.⁸

Brain drain is also an increasingly European phenomenon, affecting many new European Union and neighbourhood countries: countries such as Ukraine, Poland and Bulgaria are at odds with a shrinking educated workforce. Although estimates that some 30 % of all Ukrainian scientists may have left might be exaggerated, the problem is that the outflow concentrates on mid-career scientists. Only the very old and very young scientists are still at home, impeding progress in some academic fields (CPCFPU, 2006). From Bulgaria, over 500.000 persons with a university degree have left in the course of the last decade. In 2005 and 2006 alone, over 30 academics left the Bulgarian Academy of Sciences, mainly settling and integrating in the US.⁹

b) The curse of unrelieved emigration pressures

Another development challenge comparable to brain drain is the problem of unused workforce, or skills waste, in the country of origin. At its sharpest, such problems are seen in countries such as Cuba or North Korea, where exit visas are reluctantly or not at all given, even in a situation where the country cannot provide work commensurate with qualifications. In a different situation, where emigration is freer, there still can be a pool of unemployed persons wishing to emigrate but having no chance to do so – legally or illegally – due to lack of assets needed, a lack of knowledge of possible employment avenues abroad, or for some other reason.

Such a pool of unused or non-optimally used workforce, willing to emigrate, but not having the right, assets or knowledge to do it, is an obstacle for country of origin development. Possibly as a frustrated, even bitter part of the society, this pool is prone to antisocial behaviour, and to functioning as a breeding ground for anti-government activity.

c) Bond-sustaining emigration can enhance development

As seen above, both excessive, uncompensated emigration of workforce, as well as the inability of extra workforce to emigrate, are both harmful for the country of origin

development. But, there is also a huge potential for enhanced country of origin development through the diasporas and through returning and circular migration.

Before discussing the aspects of potential development for the country of origin, a few words on an additional opportunity for development: migrant remittances, charity and the direct investments of expatriates into their countries of origin. Global remittances to countries of origin are a vast and increasing phenomenon.

Let us call these ways of potential country of origin development bond-sustaining aspects. A contact, or bond, is maintained to the country of origin, and this contact is positive for country of origin development.

Concerning remittances, in 1999, officially registered remittances to developing and formerly socialist countries totalled over USD 65 billion.¹⁰ In 2002, this amount had risen to USD 80 billion. With estimates of unofficial flows included, the total amount might have been between USD 100 and 200 billion (Sander, 2003).

In 2001, all officially transferred remittances were 40 % higher than all official development aid (Obadina, 2003). Remittances have grown both in nominal terms and in terms relative to source country GDPs, far outpacing the growth of official development assistance (O'Neil, 2003). Remittances have also been growing relative to other sources of external finance (Kapur, 2003). In 36 out of 153 developing countries, remittances are larger than all capital flows, public and private (Ratha, 2004).

What is more, some scholars consider remittances the most stable source of external finance for providing crucial social insurance to people in developing countries afflicted by economic and political crises. According to Kapur, remittances are critical for personal consumption for people in many conflict-torn states. In Haiti, remittances accounted for approximately 17 % of GDP. In Somalia, following the collapse of a formal government in the early 1990s, remittances from the Somali diaspora based in the Gulf States, several European countries, the US and Canada became a critical survival resource for many families. In particular, remittances helped many urban families during the harsh years of the 1990s (Salah and Taylor, 1999).

In addition remittances count for significant revenue for many Eastern European countries. According to Poland's Ministry of Economics statistics, the transfer from Polish people working abroad is around EURO 6 billion per year.¹¹ Ukraine has seen incoming remittances increase by a factor of 18 in six years, from USD 33 million in 2000 to USD 595 million in 2005, according to the Christian Science Monitor citing World Bank (CSM, 2007). More than 40 % of the Moldovan population belonged to a remittance-receiving household (IOM, 2007).

Despite these positive aspects and high volumes, it should be stressed that remittance flows are no “democratic” way of fighting poverty and inequalities. Remittances typically originate from better-off elites and reach better-off elites in the countries of origin. Without deliberate national and international cooperation, no morally sustainable plan, nor a coherent development program, is guiding these assets, but they are private-to-private by nature. Therefore, their general benefit for the poor of the countries of origin is, at best, only indirect and secondary. What is more, their ultimate use in the country of origin determines whether they are of any fair avail at all. At worst, increased money in the system raises the prices of e.g. medicine or construction material, stimulating inflation, further troubling the situation of the worse-off part of the population.

New discourse even questions the sole long-term existence and continuity of remittances, particularly those of the highly skilled. Lowell, Constant and Massey, as well as Faini have recently taken a critical stance. Indeed, Faini argues that the propensity of the highly skilled to remit is relatively low, presumably reflecting the fact that they are keener (and more able) to bring their closest relatives with them in the host country. Faini’s research shows that skilled migration is unlikely to boost and may actually depress the flow of remittances to the country of origin. Whether in turn the negative impact on remittances of the brain drain also affects development is a rather unexplored but urgent area of research (Faini, 2006).

Given the risks and limitations of remittances – they are not equitably distributed, they may decrease or simply end over time, and they might foster unhealthy dependency – they nevertheless give great hope to many people in many countries.

Finally, the growth of the volume of remittances should not be a reason to reduce official development assistance (ODA). Official development aid is more “democratic” and takes the needs of the poor better into consideration. Rather than decreasing ODA, because of increased remittances, efforts should be directed towards fighting corruption and inefficiency in ODA.

d) With reservations, diaspora contacts are valuable

Diaspora contacts - the activities of groups of expatriates directed towards the country of origin - are often considered very valuable for development. Let us first, however, look at four limitations of diaspora contact before considering their positive potential.

First, diaspora contacts may be an overvalued phenomenon. Studies by sociologist Portes reveal that only 5 to 10 % of the Dominican, Salvadoran, and Colombian migrants surveyed in the US regularly participated in transnational economic and political activities; even occasional involvement is not particularly common. While some see migrants as a force for greater democratization and accountability in the Dominican

Republic, others hold them responsible for rising materialism and individualism (Faini, 2006).

Second, it is a fact that diasporas and their ability to function in a continuous and stable fashion are often subject to restrictions and uncertainties in destination countries. The stronger the diaspora is politically and economically the more likely it is that the host country will attempt to control the diaspora, in the name of security interests. Even when a diaspora does not represent a political threat, diaspora stability, strength, and ability to actually be helpful for the country of origin may be challenged by domestic political priorities and turbulences of the destination country.

For example, Sweden has long preferred to maintain the *folkhem* idea of well-integrated and even assimilated immigrants. This has been considered a way to produce the most beneficial and socially stable outcomes. The point systems of Canada and New Zealand have traditionally stressed the integrative abilities of the immigrant. Language skills, family reunification, and a positive attitude towards becoming a full citizen of Canada or New Zealand have been considered more important than having contacts with the country of origin.

Third, in addition to sometimes being considered a threat and lacking the benefit of clear integration or assimilation policies, it has been the case that the longer an immigrant stays in a country, the less remittances they will send to the country of origin. For integrating Turkish *Gastarbeiter* in Germany or Mexicans in the United States (Lowell and De la Garza, 2000), this might suggest a decline of other types of contact as well, although more research is required on this.

Fourth, it is in doubt whether diaspora contacts actually do lead to development, or whether they in fact lead to the contrary, i.e. further emigration. This pattern is visible between Africa and the United States. According to Hatton and Williamson, there were merely a handful of African immigrants in the US between 1955 and 1964, whereas today African immigrants constitute 9 % of total US immigration. About 48.000 people emigrated from Africa to the US in 1997 alone, and most importantly, roughly a third of contemporary immigrants are close relatives of US citizens (Hatton and Williamson, 1998). While one reason for this is perhaps increasing income disparities, due to incipient or outright brain drain, other strong causes of increasing family immigration include the steady flow of real-time information about job opportunities and other immigration-facilitating factors that diaspora contacts provide.

Nevertheless, diasporas may be of great benefit in conveying “social remittances” to the country of origin, thereby contributing to overall development. Social remittances can be defined as the exchange of information and knowledge between emigrants and their countries of origin that maintain or even enhance country-of-origin development in

the long run. Economist Devesh Kapur describes social remittances as non-quantifiable and intangible remittances (Kapur, 2003), while the American sociologist Levitt regards them as “the ideas, practices, identities, and social capital that are transmitted through the migration circuit. Social remittances are carried by migrants and travellers or they are exchanged by letter, video, or phone. They travel through well-marked pathways – be they formal or informal organizational structures” (Levit, 1996).

Diaspora social remittances include ideas about democracy, health, and community organisation. They differ from “normal” global cultural exchange in that it is possible to identify the migration-related channels through which they are disseminated and the determinants of their impact. Together, they can transform the economy, culture, and everyday life of entire regions of origin. They challenge notions about gender relations, democracy, and what authorities should or should not do.

For example, migration has completely transformed life in the Dominican village of Miraflores. Young women no longer want to marry men who have never migrated because they want husbands who share in the housework and take care of the children in a way those men who have been to the United States do (Levit, 1996). In Africa, internet cafes, along with Music Television and Coca-Cola, have reached the most remote corners of Morocco and Algeria, transmitting information about the values and way of life in Europe and the US.

Diaspora contacts and social remittances still have a clear potential for positive and normative information exchange. This in turn could lead to positive development: better human rights and political conditions, as well as new economic and business opportunities may follow.

e) Circular and return migration also encourage bond-sustaining temporarity

Return and circular migration may occur when the country of origin increases in relative attraction (return), some other country increases in attraction (circular), or when the initial destination country decreases in attraction either in country or in chronological relation (return and circular). All of the options are positive to the extent they make forward progress towards equilibrium, if only the movement happens voluntarily and if the migrant’s human rights are respected.

Appropriate circular and return migration fosters country of origin development. However, there is one crucial prerequisite for return and circularity to happen. If the country of destination is to encourage the return of immigrants, this means that not all immigration shall be subject to integrative measures. The country of destination needs a variety of different kinds of immigration types in order to contribute to country of origin development. Perfect integration and ultimate (exclusive) citizenship, such

as in Canada, mean decreasing returns, and could mean impeding country of origin development.

Partly because of this reason, the intensity of return migration depends on a number of factors. Recent research shows that immigrants often wish to remain in the host country if the preconditions for positive integration are in place: employment, family, social networking, and a feeling of belonging to the host country.

For example, Lowell and De La Garza have noticed that, as time goes by, the probability of a Mexican worker returning to Mexico decreases. Integration and citizenship status also affect the probability of return (Lowell and De La Garza, 2000). Hjarnø has come to a similar conclusion in his decade-long surveys of Kurds from Turkey in Denmark. The majority of the emigrants did not return due to, among other factors, better employment opportunities in Denmark (Hjarnø, 1998).

Countries such as Canada, Australia, and New Zealand, have found that an integrated immigrant is the most productive immigrant, and therefore systematically do their best to find immigrants that will integrate and succeed. In these countries' point systems, increasingly preferred characteristics of family members who wish to immigrate, include a secure job and personal abilities, such as language skills and likely contribution to optimal integration.

These are the factors that Constant and Massey see as diminishing the chances of guest workers returning home from Germany (Constant and Massey, 2002). Even in such a high-profile labour-immigrant country as the United States, factors concerning how well one is expected to integrate are important. Mexicans send ever less money back to Mexico (Lowell, 2000). This is a serious note, jeopardizing the long-term benefits of migration for the country of origin.

A future question will be the dilemma of enhancing immigrant integration and diminishing benefits for the country of origin. It is worth researching, to which extent remittances, returns and positive diaspora contacts systematically diminish, as migrant integration intensifies. Could immigrant integration in the country of destination be a systematic cause for constant brain drain?

The future: co-development schemes as viable options ?

Co-development policy has emerged as a way of involving migrants as active actors of development, thereby strengthening cooperation between countries of origin and destination. International organizations have listed ways how countries of origin can benefit from co-development, e.g. better access to visas, better use of remittances and economic investments, and more returns to the country of origin. Meanwhile, the destination country can have labour market, demographic and other benefits from co-development projects. Concrete co-development measures can range from helping businesses through training to outright financial aid.

The idea of treating the migrant as an agent of development is good. What is also positive is linking of development policy to the active input of the migrant. Migration is here implicitly seen as a potential win-win-win phenomenon. Migrants can thrive, through having contacts to their country of origin, and this does not necessarily hamper integration in the country of destination.

However, two factors in the co-development theme need to be further elaborated. First, both integration and co-development face challenges when going hand-in-hand on the long run. An extreme example is Canada, where, from the outset, the point system selects candidates for immigration who are most capable and willing to integrate, i.e. to become Canadian citizens. What is more, many scholars argue, that the more time goes by, the less the contacts, remittances and propensity to return to the country of origin will be developed. In other words, successful co-development requires efforts and assets for the adverse to happen: migrants to sustain good contacts with the country of origin. One solution could be a from the outset *diversity of immigration categories*: some immigrants would be subject to integration measures, whereas others, presumably more temporary ones, would be subject to a co-development category.

Another challenge is the diversity of elements making up co-development. In addition to the huge resources needed, particularly if equality among immigrants is desired, what institution would be able to govern the system effectively: to create reasonable and cost-effective processes, to implement them and to evaluate and revise accordingly?

As development and foreign aid projects have often proven inefficient for country of origin development, how much more effective could an even more complex and hard-to-handle system be ? Repatriates could bring local knowledge to the process, but what if everything had changed during their years abroad ? Also the equality and transparency of chosen projects to support could be a challenge, particularly as corruption already is a problem in these countries. Instead of bringing equal prosperity to the country of origin,

unwisely and unfairly run co-development projects might bring further inequality to these countries.

Notes

- 1 Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, United Kingdom and United States.
- 2 See e.g. Freedom House Democracy Score Rankings for Consolidated Democracies, at <http://www.freedomhouse.org/template.cfm?page=263&year=2006>
- 3 See e.g. Constant, A. and Massey, D. 2002. "Return Migration by German Guestworkers: Neoclassical versus New Economic Theories," *International Migration* 40(4).
- 4 See e.g. Hjarnø, J. 1998. "Relationship between Migration and Development Policy in Denmark." Esbjerg : South Jutland University Press. http://www.emz-berlin.de/projekte_e/pj41_pdf/Hjarno.pdf
- 5 See e.g. Black, R. 2003. "Soaring Remittances Raise New Issues," *Migration Information Source* (June 1). <http://www.migrationinformation.org/Feature/display.cfm?ID=127> and 2004. "Migration and Pro-Poor Policy in Africa," Working Paper C6. Brighton: University of Sussex Development Research Centre on Migration, Globalisation and Poverty. http://www.migrationdrc.org/publications/working_papers/WPC6.pdf
- 6 See for example the Guardian, Dec, 6, 2004
- 7 Ibid.
- 8 Ibid.
- 9 Radio Bulgaria, 2006
- 10 See e.g. Dayton-Johnson, Jeff, Louka T. Katseli, Gregory Maniatis, Rainer Münz, Demetrios Papademetriou, *Gaining from Migration - Towards A New Mobility System*, OECD, 2007, Stalker, P. 1994. *The Work of Strangers - A Survey of International Labour Migration*. Geneva: International Labour Organization.
- 11 See e.g. http://www.workpermit.com/news/2007_03_02/poland/remittances_migrant_worker_money.htm

References

- Barretta, D.
2007 "Italy's alternative to nursing homes: Ukrainian caregivers", *The Christian Science Monitor*.
- Black, R., et al.
2006 "Migration and Development: Causes and Consequences" in Penninx, R., et al, *The Dynamics of International Migration and Settlement in Europe*, Amsterdam University Press, Amsterdam.
- Centre for Peace, Conversion and Foreign Policy in Ukraine
2006 "Brain Drain from Ukraine: Current Situation and Future Challenges", *Ukrainian Monitor*, 6/2006.
- Constant, A. and D. Massey
2002 "Return Migration by German Guestworkers: Neoclassical versus New Economic Theories", *International Migration*, 40(4).
- Emeagwali, P.
2003 "How Do We Reverse the Brain Drain?" Speech given at the Pan-African Conference on Brain Drain, held in Elsayh, Illinois, <http://emeagwali.com/speeches/brain-drain/to-brain-gain/reverse-brain-drain-from-africa-2.pdf>.
- Faini, R.
2003 "The Brain Drain – An Unmitigated Blessing?" Working Paper No. 173, Centro Studi Luca d'Agliano Development Studies, Rome.
2006 "Remittances and the Brain Drain", Discussion Paper 2155, Institute for the Study of Labor (IZA), Bonn.
- Harris, J. and M. Todaro
1970 "Migration, unemployment and development: a two-sector analysis", *The American Economic Review*, vol. LX, n°1, 1970.
- Hatton, T. and J. Williamson
1998 "Demographic and Economic Pressure on Emigration out of Africa.", Discussion Paper No. 250, Institute for the Study of Labour (IZA), Bonn.
- Hjarnø, J.
1998 *Relationship between Migration and Development Policy in Denmark*, South Jutland University Press, Esbjerg.
- Icduygu, A., et al.
2001 "Socio-economic Development and International Migration: A Turkish Study", *International Migration*, vol. 39(4) 2001.
- IOM
2007 *Remittances in the Republic of Moldova - Patterns, Trends and Effects*, International Organization for Migration, Chisinau.

- Kapur, D.
2003 "Remittances: The New Development Mantra?" Paper prepared for the G-24 Technical Group Meeting, Harvard University and Centre for Global Development, Boston and Washington D. C.
- Levitt, P.
1996 "Social Remittances: A Conceptual Tool for Understanding Migration for Development", Working Paper No. 96. 04, Harvard Center for Population and Development Studies, Cambridge.
- Lowell, B.
2003 "Skilled Migration Abroad or Human Capital Flight?" *Migration Information Source* (June 1).
- Lowell, B. and R. De La Garza
2000 *The Developmental Role of Remittances in U. S. Latino Communities and in Latin American Countries*, The Inter-American Dialogue, Washington D.C.
- Nwosu, O.
2005 "Brain Drain is an Euphemism for Modern Slavery", *International Migration Outlook.*, OECD, Paris.
- O'Neil, K.
2003 "Using Remittances and Circular Migration to Drive Development", *Migration Information Source*(June 1),<http://www.migrationinformation.org>
- O'Neil, K.
2004 "Labor Export as Government Policy: The Case of the Philippines", *Migration Information Source*, <http://www.migrationinformation.org/Feature/display.cfm?ID=191>.
- Piore, M.
1980 *Birds of Passage: Migrant Labor and Industrial Societies*, Cambridge University Press, Cambridge.
- Ratha, D.
2004 "Understanding the Importance of Remittances", *Migration Information Source* (October), <http://www.migrationinformation.org/feature/display.cfm?ID=256>.
- Salah, I. and B. Taylor
1999 "Peace and Development in Northern Somalia: Opportunities and Challenges, ", Som-Can Institute for Research and Development and Ontario: Partnership Africa Canada, Ontario.
- Sander, C.
2003 "Migrant Remittances to Developing Countries - A Scoping Study: Overview and Introduction to Issues for Pro-Poor Financial Services", prepared for the UK Department of International Development, Bannock Consulting, London.

- Tanner, A.
- 2002 "Argumentation on Brain Drain and Domestic Racism in National Labour Immigration Policies", Conference paper for UN/WIDER Conference on Poverty, International Migration and Asylum, 27 - 28 September 2002, Helsinki.
- 2003 "Siirtolaisuus, Valtio Ja Poliitiikka - Kanadan, Sveitsin Ja Uuden-Seelannin Työvoiman Maahanmuutto Ja Poliitiikka 1975-2001", (Migration, Policy And The State - Labor Immigration And Policy In Canada, New Zealand And Switzerland 1975-2001), Directorate of Immigration and Ministry of Labor, Helsinki.
- 2005 "Brain Drain and Beyond: Returns and Remittances of Highly Skilled Migrants", *Global Migration Perspective No. 24*, Global Commission on International Migration, Geneva.
- 2005 "Limitations to Win-win in Global Labor Migration - Acute emigration, migrant return and money remittances in developing country development", *Finnish Population Yearbook 2005*, Helsinki.
- 2005 *Emigration, brain drain and development – The case of Sub-Saharan Africa.*, Migration Policy Institute and East-West Books, Helsinki and Washington DC.
- 2006 *The Future of International Migration Governance*, East-West Books, Helsinki.
- UNDP
- 2007 *Human Development Report*, UNDP, New York.
- Zelinsky, W.
- 1971 "The Hypothesis of the Mobility Transition", *The Geographical Review* (61).

IOM'S MIGRATION FOR DEVELOPMENT AND THE EU POLICY FRAMEWORK

Elizabeth Warn

Migration and Development has been high on the European agenda since 2005 when the European Commission (EC) in its Communication suggested a key number of initiatives aimed at promoting coherence between the two policy areas. The Communication called for identifying and engaging diaspora organizations in development strategies and mapping of diasporas, and with the support of the Commission, to establish databases where diasporas could register on a voluntary basis (European Commission, 2005). Enhancing the role of diaspora members in European Member States has also been regarded as a means of promoting the integration and citizenship of third country nationals into the European Union.

Since 2005, both the Euro-African Ministerial Conference on Migration and Development in November 2008, and the European Council Conclusions of December 2008, have highlighted the need for a more systematic focus on the role of diasporas in the development of their countries of origin. Some of the suggested measures in the three-year cooperation programme from 2009 to 2011 have included countries of origin and destination acknowledging the roles of diasporas as development actors and “playing a useful role in fostering the transfer of skills to the developing world, together with other forms of brain circulation” (European Commission, 2005).

At the end of 2009, the Stockholm Programme - the new five-year EU programme in the area of Justice, Freedom and Security - will be launched. Migration will form an important component of this programme, and a key question that will be asked is how the European Union should develop its common migration policy over the next five years with a view to maximising its contribution to economic and social development both in member states and third countries.

The MIDA framework provides a comprehensive response to the emerging European Union Policy on Migration and Development, through support to the medium and long-term development strategies of beneficiary countries and through the active engagement of diaspora members in harnessing both social and financial remittances. In this regard IOM's MIDA programme meets the wider EC political objectives in view of social and economic development in origin countries through a strategy which

combines capacity building through the transfer of competences, financial assets and technology with strategies ranging from co-development, brain gain, virtual transfers, to private sector initiatives.

At the same time the MIDA programme contributes to the integration and citizenship of third country nationals. It aims at the establishment of transnational networks in which participating diaspora members increase the positive image of migrants in the countries of destination through their engagement with the local community by collaborating, for instance, with the private sector which can engage in financial contributions to projects back home.

In recent years the number and range of IOM-led MIDA programmes has increased, most of which commence with the mapping of the diaspora to establish their individual profiles, skills sets, aptitude and availability to contribute to their home countries. The data obtained provide not only an up-to-date picture of the diasporas abroad, but can also be used as a valuable tool for policy making in both origin and destination countries.

How can MIDA help to continue to support the European agenda? One recommendation made by IOM to the formulation of the Stockholm programme is that policies targeting diaspora need to recognize the expectations, skills levels and experiences of the diaspora. Mapping and profiling diaspora members show that diasporas are not homogenous, and therefore require tailored interventions. At the same time, policy makers should also focus on collective actions, such as helping diasporas link up with home countries or channelling collective remittance funds into community projects without neglecting the individual level.

References

European Commission

- 2005 COM (2005) 390, Final Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the regions: Migration and development: some concrete orientations, <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2005:0390:FIN:EN:PDF>

IOM

- 2004 'Towards an IOM Strategy: Migration and Development', Conference Room Paper 1/2 88th Session of the COUNCIL, 30 November - 3 December 2004, Geneva, <http://www.iemed.org/cd1/documents/Documents%20a%20linkar/International%20Organis/IOM%20Towards%20an%20IOM%20Strategy%20MIgration%20and%20Development.pdf>

Government of Sweden

- 2009 Working Document No.2, Informal meeting of Ministers for Justice and Home Affairs, 15 - 17 July 2009, Stockholm, <http://www.statewatch.org/news/2009/jul/eu-jha-informal-stockholm-wd2-immigration-and-asylum.pdf>

IOM'S MIGRATION FOR DEVELOPMENT IN AFRICA FRAMEWORK – LESSONS LEARNED AND FUTURE PROSPECTS

David Appiah
Susanne Melde
Abibatou Wane

IOM has been exploring opportunities to engage diasporas for development efforts in countries of origin since 1974. Based on the experiences with Return of Qualified Nationals (RQN) programmes first implemented in Latin America and subsequently extended to Africa in 1983 and Asia in 1989, the Migration for Development in Africa (MIDA) framework has been designed with a more specific focus on development since 2001. This holistic and innovative approach combines capacity building through the transfer of competences, financial assets and technology with strategies ranging from co-development, brain gain and virtual transfer to private sector initiatives. MIDA aims to support the medium and long-term development strategies of beneficiary countries through the active engagement of diaspora members in key sectors and beyond financial remittances.

Recently a stock-taking assessment of MIDA has taken place by IOM to widely share insights gained since the inception of this programmatic framework and to offer practical examples for future policy and operational planning and implementation in the field of migration for development.¹ Some of the key recommendations are highlighted below:

At the macro level, an enabling policy environment encouraging the contribution of migration to development can acknowledge and strengthen the role of diasporas. To date only few countries have started to formally integrate and institutionalize the positive potential of migration in national development planning tools. Embedding programmes such as MIDA in the existing national institutional frameworks can support this mainstreaming process. The establishment or designation of specific government institutions to actively coordinate diasporas' development engagements in the country of origin enhances the full potential of the diasporas and creates a receptive environment for collaboration.

Future prospects of a country under reconstruction are counting on human capital formation. Educational attainment, in particular at tertiary level, can foster socio-economic development. Universities thus have a key role to play in development. To foster higher education as a development tool, skilled expatriates can support teaching, train trainers and update curricula in origin countries. E-learning tools need to be further developed. To increase the knowledge on the complex interlinks between migration and development, IOM is currently exploring options to promote courses on migration at tertiary level as well as to support further knowledge and skills transfer by the diaspora in countries of origin.

New thematic possibilities and mechanisms to strengthen the involvement of diaspora members in the development efforts of African countries as well as their crucial role in times of crisis need to be further explored and analysed. Prominent examples for the former include the MIDA Great Lakes programme promoting in its already fourth phase the physical and virtual transfer of human capital in health, education and rural development to institutions in Burundi, the Democratic Republic of Congo and Rwanda, as well as the MIDA Italy programme encouraging private sector development in Ghana and Senegal. Much remains to be done to fully realize the development potential of contributions by diasporas for the benefit of origin countries.

The MIDA Health Somaliland-Puntland project presented in this publication offers an important example of the added value of the willingness and commitment of diaspora members to contribute to peace-building and reconstruction efforts. Other existing initiatives applying the MIDA concept have contributed to peace building but it was not necessarily specified as such. Under a Temporary Return of Qualified Nationals programme implemented by IOM The Hague many participants contributed indirectly to peace-building processes by training staff of local organizations working in the area of reconciliation and community-building in countries such as Afghanistan, Sierra Leone and Sudan. Reflecting the increased attention paid by the international community to the role of diasporas in peace-building, this area is likely to be strengthened further and expanded in the future of MIDA and similar programming. Insights are needed on how to best and in which stage during the transition to peace diaspora members can support capacity-building in critical sectors, both public and private.

With a view to reflecting the importance of South-South migration in operational approaches, including diasporas living in the South, intra-regional migration patterns and their development potential could receive more attention. As migratory flows in sub-Saharan Africa predominantly occur within the region (63.2%, Ratha and Xu, 2008), the feasibility of mobilizing diaspora members living in neighbouring countries of their origin countries could be assessed further. An example of a programme building on expertise in the region was the MIDA Guinea project where women residing in the ECOWAS region trained rural Guinean women in enterprise creation and management.

In addition, bilateral labour arrangements with a development component of circular return migration can offer benefits to origin and destination countries as well as diasporas.

Comprehensive human resource strategies are needed to address challenges such as the impact of the current global economic downturn. The decrease of the remittance flows will impact on poverty reduction in origin countries.² Especially progress towards the realization of the UN Millennium Development Goals might be hampered by the recent economic crisis (UN, 2009). At the same time the efforts and capacity of developing countries to tackle the global economic crisis might be jeopardized by skills shortages in key sectors due to emigration of skilled professionals. However, this does not mean that development cannot exist. Especially with lower economic growth rates, development can benefit from innovative opportunities through the human capital, financial and social contributions by diasporas. Existing and future MIDA programmes therefore need to take account of and address opportunities and challenges.

Notes

- 1 IOM, forthcoming publication: *The MIDA experience and beyond. Operationalizing Migration for Development Across Regions*
- 2 According to the World Bank (2009), 328 billion USD were sent back to developing countries, out of a total of 433 billion USD remittances worldwide. In 2009, remittances to developing countries are expected to fall by 7.3 %, which is higher than the World Bank's first estimate of -5 %.

References

- Ratha, D. and Z. Xu,
2008. *Migration and Remittances Factbook 2008*, Migration and Remittances Team, Development Prospects Group, World Bank, <http://www.worldbank.org/prospects/migrationandremittances>
- Ratha, D., et al.
2009 "Outlook for Remittance Flows 2009-2011: Remittances expected to fall by 7-10 per cent in 2009," *Migration and Development Brief 10*, Migration and Remittances Team, Development Prospects Group, World Bank, 13 July 2009, <http://siteresources.worldbank.org/INTPROSPECTS/Resources/Migration&DevelopmentBrief10.pdf>
- UN
2009 *The Millennium Development Goals Report 2009*, UN, New York, http://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2009/MDG_Report_2009_En.pdf

Chapter 3

The Somali crisis and Finland's
development approach to Somalia

POLITICAL DEVELOPMENTS IN POST-1991 SOMALIA

Maria Brons

Historical background

Originally, the Somali society was a stateless society, the majority living as nomads and a minority living as farmers in the Southern inter-riverine lands of today's Somalia. Society was structured according to the nomadic-farming divide and a sophisticated clan belonging (Brons, 2001). In the coastal areas there were trading communities with international connections reaching back to ancient times. The wealth of the Somali lands evolved around livestock (camels and goats), frankincense, salt and leather. Farming activities were economically of a lesser importance. Apart from the Somali nomads, it were the traders in the harbor towns of Mogadishu (Xamar Weyne), Kismayo, Bossaso, Berbera and Zeila/Djibouti, who were famous in the regions of Eastern Africa and Arabia and beyond.

The colonial era brought about far-reaching changes to the Somalis living in the Horn of Africa. They became subjects of four different colonial states, namely French Somaliland, British Somaliland, Italian Somaliland and the Northern Frontier District of British ruled Kenya. In addition, the Ogaden region became formally part of the Ethiopian Empire. While on one hand, the division into separate state entities was rather artificial for most Somali people and counterproductive for the original migration patterns of the Somali nomads in the Horn of Africa region, on the other hand this era marked the beginning of modernization, industrial development, formal education and the creation of a public domain.

In 1960, British and Italian Somaliland both gained independence and decided to merge, forming the independent Republic of Somalia. Until today, the Northern Frontier District, populated by Somalis, remains part of Kenya and the Ogaden region part of Ethiopia. In 1977, French Somaliland became the independent state of Djibouti.

From 1960 onward the Republic of Somalia was considered a modern nation state, and – as a matter of fact – one of the most ethnically homogenous nation states in Africa. Culture, language, religion, all factors that divided so many African sister nations, were in the Somali case, and particularly from the point of view of an outsider, a uniting

factor. Particularly in the immediate decades after independence, in the 1960s and 1970s, many Somalis aimed at unification of all the five areas. The Somali national flag, a white five-cornered star on a light blue background, expressed that wish of the young Somali nation.

However, the common factors did not outweigh the dividing lines between various factions of Somali politics. Politicians in powerful positions were corrupting the parliamentary system and tried to gain as much wealth and opportunities as possible for themselves and their constituencies who were based on the clan affiliation of their “man in Mogadishu”. The political system in the Republic of Somalia changed in the mid 1970s from a multi-party democracy into a socialist one-party system with a military coup headed by General Siyad Barre. Polarization within that state became increasingly structured along clan lines and one of the strategies of the Siyad Barre regime was to “divide and rule”.

The 1980s in contemporary Somali history can be characterized as a decade when the state turned to become the worst enemy of its own citizens, and numerous opposition movements were created on the basis of clan affiliation. The movements gained in political importance and military capacity and – starting from the northwestern region¹ – they turned the page and openly attacked military garrisons and police stations. In the eve of the total collapse of the central state during the last months of the year 1990, opposition movements cooperated and rallied behind the political agenda of overthrowing the hated Barre regime. They succeeded when, in early 1991, the then president Barre, his family and select political entourage were left with no other option than to flee their residence “Villa Somalia” in the capital Mogadishu.

The collapse of the state in 1991

However, the numerous clan-affiliated factions which had collaborated to take control of most of the country, and which finally won the battle for Mogadishu, were not able to unite in forming a new government. As a result, the territory of the former Somali state was controlled by different military factions and fell apart into various territorial units. Nevertheless, from an international legal point of view the physical base of the Somali state has officially not been changed and the borders of the ex-Somali state are still considered as a referent point.

The collapse of the state in 1991 revealed the fundamental crisis of Somali political and social identity, a crisis reflected in the breakdown of social conscience and the apocalyptic experiences of a cruel civil war. The violence spread all over the country and clan-related hatred but also the pure struggle for survival brought about a ruthless regime where whoever had a gun claimed the authority to decide over life and death. State

institutions, which carried the executive, legislative and judicial powers of the Somali state, stopped functioning in 1991. Government employees, most of who were in one way or another related to the politically powerful clans dominating the Barre regime, fled from violence that was fueled by emotions of hatred and revenge. Government offices, ministries, the national Bank, army and police, courts, postal services and educational institutions disintegrated. Indeed, not only did the state institutions cease to function, but also buildings and equipment were looted beyond recognition. Arms, money, office files, books, furniture, technical apparatus, telephones and wires, water pipes, roofs, window frames – everything was taken, sold or destroyed. The extreme devastation of the institutional framework of the Somali state must be taken into account when evaluating the successes and failures of state reconstruction on Somali soil during the last two decades.

State formation in the North versus continuous civil war in the South

Since these events in the early months of 1991, Somalia has experienced a variety of developments. In the northwestern part of the country the situation was most favorable in order to allow peace and stability to return back. That area had formerly been a state entity in its own right, namely British Somaliland with Hargeisa as its capital. Apart from this colonial past offering a “modern” identity to this emerging state, the area is also relatively homogenous considering clan affiliation. One of the first and most powerful and determined opposition movements, the Somali National Movement (SNM), was widely recognized as the liberator of the northwestern areas. When they realized that they could not find common ground with the other opposition movements in the South, they retreated back to their home areas and – in close coordination and consultation with the clan elders – decided to go their own way. A national reconciliation conference that took several months finally established the Republic of **Somaliland**. This already happened in 1991.

However, it took the political leadership and clan elders another two years to resolve some differences in opinion on how the new political system should be structured and to identify the best persons to run the affairs of the newly established state. One of the success factors of the Somaliland state formation was that the culturally inherited political authority of the elders as peace negotiators and agents of conflict reconciliation could be incorporated into the governmental structure. A first chamber, the ‘*guurti*’, provides this political space to the elders who are advising the government on all running affairs.

Without going too much into detail one can confidently state that Somaliland has seen an increasing peace and stability throughout the last 15 years. Several presidential elections have taken place, political power was peacefully transferred from one government to the next, law and order have been established and control regained over the armed youngsters who ravaged and blackmailed the whole country in the immediate aftermath of the civil war. The judicial, educational and health system have been reconstructed and even a university established in Hargeisa. Currently, in autumn 2009, Somaliland faces the challenge of conducting presidential elections that have been postponed twice by the president in power. However, the majority of commentators are confident that Somaliland will not fall back into severe crisis but prove to be a stable democratic system.

Somaliland's independent status as a state has formally not been recognized until today. In the early years, foreign governments were very cautious in contacting, addressing or otherwise indirectly recognizing a sort of state authority. The international community, and in particular the development aid donor community, was hesitant and at times therefore also not welcome in Somaliland. However, times have changed and as there are many governments throughout the world "de facto" interacting with the Somaliland Government on various matters and international agencies actively supporting the reconstruction and development of Somaliland society, the issue of independence is less of an immediate problem for development cooperation. For the reconstruction of Somaliland however, the early reluctance of the international donor community meant that the country relied heavily on the Somali(land) communities living abroad. Remittances of Somaliland citizens still provide the majority of revenue and funding for Somaliland's economic and political survival.

The second most peaceful region in today's Somalia is **Puntland**, situated in the northeastern tip of the Horn with Bossaso as its capital. The Puntland region did not experience severe fighting during the civil war. Different from its neighbor, it has never been a politically recognized entity in modern times. In ancient times, however, the sultanate of Majertein formed an early political entity. The formation of the Puntland autonomous regional state was officially solemnized in June 1998. The decision of the Somali Salvation Democratic Front (SSDF), the opposition movement representing this part of Somalia, to opt for a regional state formation process in the North-East was born out of the failure in accomplishing a national solution for the whole of Somalia, the then called Sodere initiative. In May 1998, a constitutional conference began in Garowe, similar to the process that had taken place in Hargeisa, Somaliland, seven years earlier. Political and clan leaders participated and, after several months of consultation, decided on a presidential system for the Puntland autonomous region and agreed on who the first president should be. Since that time, Puntland has experienced relative stability. The border dispute between Somaliland and Puntland – crossing the home area of two clans, could be solved in a relatively peaceful way. Bossaso regained its importance as

a trading post and important harbor town. However, Puntland also became the safe-haven for many internally displaced Somalis who reached the northern tip of the Horn fleeing from fighting in the South. Due to clan affiliation it is safe for them to come to Puntland. Although many internally displaced try to continue their journey to Yemen and other Arab countries, the extra population is an enormous burden on that already scarcely resourced part of Somalia.

The **southern region** continued to be covered by conflict and violence. Reasons can be seen in the variety of clan affiliations presented in the South, the resourcefulness of the capital Mogadishu and several other towns in the area, the political pressure of reinventing a central Somali state (thereby theoretically also including the other two regions) and the availability of arms and therefore continuous power of warlords. Clan elders have a lesser influence in the southern region, or are sometimes themselves too much part of the conflict therefore hampering their contribution to finding solutions. Since 1991, some fifteen reconciliation meetings took place in Ethiopia, Sudan, Kenya, Djibouti, supported by the international community. So far none of them succeeded in establishing a government that would be accepted by all parties. After 1991, the first president of Somalia was elected in the year 2000, followed by another presidential election in 2004 and lately in January 2009. None of these formally recognized governments ever stretched its sovereign control over the whole territory, not even over the whole capital. The very recent developments in the first months of 2009 are not promising. During the first half of 2009 fighting intensified again to a level of intensity not seen in Mogadishu for several years.

Due to these circumstances, the southern part of Somalia is considered a high security risk area, a fact that hampers humanitarian relief operations tremendously. One third of the population is at high risk and fully dependent on food aid. In addition to the fighting the area was also struck by flooding and by recurrent drought over the last few years. All in all a situation that provides no space for any sustainable development efforts; the southern region is in a status of continuous humanitarian crisis. Since the collapse of the state in 1991, UN agencies took over providing basic security to the Somali population. Food aid, health services, educational facilities, housing for internally displaced, all are coordinated from Nairobi by the UN country team for Somalia. Various international and local NGOs are partners of the UN in its effort of enabling the Somali people to survive under such harsh living conditions. The UN peace keeping attempts during the 1990s largely failed; from 2006 to 2008 Ethiopian troops backed the formal government, but pulled out in January 2009. Currently, a small number of African Union (AU) peacekeeping forces is stationed in Somalia.

The Somali exodus – three levels of displacement and migration movements

The civil war before the fall of the Barre regime, continuous political instability and open conflict in the southern parts of Somalia as well as environmental insecurity caused by draught and flooding prompted a huge number of Somali people to flee. There are three major migration movements to be recognized, determined by residence, clan affiliation, economic resources and the international immigration regime.

First, Somali's who had the means to leave the country, fled to Arab countries, European countries, Canada, the United States or Australia. While political refugees from Somalia already fled the dictatorial regime of Siyad Barre in the 1980s, the refugee exodus gained momentum in early and the mid-1990s. Many Somali asylum seekers were recognized as refugees. In Europe, most Somali's went to the Scandinavian countries, the United Kingdom, the Netherlands and Italy. There, the Somali organized themselves, and today there are numerous Somali migrant organizations who are actively involved in the political discussions (referring to Somaliland, Puntland and Somalia) but also in developmental activities in their respective home areas. In addition, remittances, personal money transfers to family members back in Somalia, are the major lifeline for the Somali society in all regions of the country.

Second, there are those who remained within the Horn of Africa region or its close vicinity. Already during the civil war Somalis fled to neighboring countries, in particular Kenya, Ethiopia and Yemen. UNHCR administers huge refugee camps in the Kenyan border region, the biggest being Daadab with a population of 275.000 refugees. The Kenyan government recently provided additional land for the establishment of more camps; as the current camps are heavily overcrowded and the flow of refugees from Somalia increased in the first half of 2009. The flight to Yemen took the lives of thousands of Somali as the crossing of the Red Sea by boat is organized by human smugglers and extremely dangerous. Yemen hosts several huge refugee camps. A recent study researched the onward irregular migration of Somalis through Kenya and adjacent East African countries with the final destination in Southern Africa. Again, depending on resources, immigration policies and "good luck" some Somali migrants achieve their goal and find residence in Southern Africa; others end up in jails without prospect of legal stay. The ongoing crisis in Somalia will definitely continue to be a major push factor for numerous Somali citizens.

The third group is made up of those who have had no other means but to remain in their own country, the internally displaced persons. According to latest figures from UN agencies, there are currently 1.3 million IDPs in Somalia. While most of them remain within the Southern region, there are also large IDP camps in both Somaliland

and Puntland. UN agencies and international humanitarian organizations work on delivering emergency aid to them. However the populations who remained in their home areas, too, are in need of food aid. An estimated 3.2 million persons in Somlia in currently urgent need of humanitarian assistance.

Conclusion

The Somali people have gone though very difficult times over the last centuries. Natural conditions have always been harsh in the Horn of Africa and droughts and floods are an integral part of the environmental cycles. Nomadism has been an adaptation strategy for life in the dry lands and could be exercised as long as there was relative peace and stability in the Horn. The farming communities in the South had their own adaptation strategies to deal with seasonal changes and problems.

The political conditions during the last two centuries impacted on this relative balance - a balance that enabled people to survive in dignity and respect of social order. The colonial states imposed on the Somali society, and thereafter the “modern” democratic and socialist state structures, did not fulfill their promises of political stability and socio-economic well-being. The civil war brought liberation from dictatorship. But so far only in the Somaliland and Puntland regions the liberation brought about new political systems that ensured peace and stability and enabled the Somali people to regain their freedom and opportunities to sustain their livelihood.

During the last 20 years, the situation in the South has changed from bad to worse, putting pressure on the whole region as well as the international community in order to face the humanitarian crisis. A whole generation of Somali people grew up in a crisis situation, and it will take a long time to revert to a sense of normality in Somalia.

Notes

1 today's Somaliland

References

- Brons, M.
2001 *Society, Security, Sovereignty and the State: Somalia. From Statelessness to Statelessness*, International Books, Utrecht.
- Farah, O., et al.
2007 *Somalia: Diaspora and State Reconstruction in the Horn of Africa*, Adonis & Abbey Publishers Ltd, London.
- Horwood, C.
2009 *In Pursuit of the Southern Dream: Victims of Necessity. Assessment of the irregular movement of men from East Africa and the Horn to South Africa*, International Organization for Migration, Geneva.
- Little, P.
2003 *Somalia: Economy without State*, Indiana University Press, Bloomington.
- Osman, A. and I. Souare
2007 *Somalia at the crossroads: challenges and perspectives in reconstituting a Failed State*, Adonis& Abbey Publishers Ltd, London.

Internet References

- BBC
2009 <http://www.bbc.co.uk>
- UNHCR
2009 <http://www.unhcr.org>

FINLAND'S HUMANITARIAN AND DEVELOPMENT POLICY FOR SOMALIA

Pauliina Hellman-Field

On the 27th of July 2009 the Council of the European Union called for “quick, yet sustainable, results to promote peace and recovery for the Somali people” (Council of the European Union, 2009). The task is everything but easy. In spite of the calls for inclusiveness, staying outside of the Djibouti peace process, numerous armed opposition groups continue to fight the Transitional Federal Government (TFG) and the African Union (AU) troops. Many areas in Mogadishu and most of central and southern Somalia remain under the control of these groups. As a consequence of the growing instability, insecurity and the drought, the humanitarian situation in Somalia has further deteriorated.

Within the on-going efforts to promote peace and stability, the European Union policy framework provides the most effective way for Finland to stay engaged in Somalia. The EU and its member states emphasize the importance of a comprehensive approach to the country. This means “linking security with development, rule of law and respect for human rights, gender related aspects and international humanitarian law” (Council of the European Union, 2009). However, peace is a prerequisite for lasting, sustainable development and the Council concluded that, “long term assistance from international partners cannot be effective without stabilization of the security situation”.

For the international partners, the Djibouti Peace Process represents the foundation for a resolution of the conflict. In order to support the Djibouti process, the EU is committed to exploring ways to increase assistance to the TFG. Priority is given to building the capacity of the Somali security sector and other institutions. The EU has pledged a total of 73 million Euros in support for AMISOM (African Union Mission to Somalia) and to Somali transitional security institutions, and is looking into possibilities for additional support, for example, through the training of security forces. The EU also considers appointing a Special Representative to the Horn of Africa in order to further enhance EU policy and activities in the region. The EU and its member states will continue close collaboration with the United Nations (UN), the African Union, regional institutions and with Somalia's neighbours to amplify the effects of international assistance.

While supporting development of the security sector is the first priority on a road towards sustainable peace and reconstruction of the state, the humanitarian crisis remains of great concern. The number of people in need of humanitarian assistance has doubled, from 1.8 million in January 2008 to 3.6 million in 2009 (Somalia Humanitarian Overview, 2009). Because of the fighting in Mogadishu, since May approximately 255.000 people have fled from the capital and more than 1.5 million Somalis have been displaced since early 2007 (UN, 2009). In 2008, the EU and its member states have responded to the humanitarian crisis with an overall aid envelope of 130 million Euros. The assistance provided by ECHO (European Union Humanitarian Aid) amounted to 46 million Euros in 2008, and the intention is to provide the same level of assistance in 2009.

The bilateral relations between Finland and Somalia were most active in the 1980s. Finland was one of the first countries to recognize independent Somalia on 3rd July 1960. Diplomatic relations were established in 1971. During the first decades of Somali independence, the cooperation was relatively modest: a few individual Finnish experts were working in UN assignments and a few Somali scholarship students were educated in Finland. Also, the Finnish Red Cross started cooperation aimed at developing the capacity of the Somali Red Crescent.

The year 1982 marked a turning point in the bilateral relations when Somalia became one of the main recipients of Finnish aid. The cooperation concentrated on health, food supply, forestry development, electrification and women's education. The Tuberculosis Control Programme was the first – and by far most extensive – development cooperation project between Finland and Somalia. It aimed at developing the skills and capabilities of Somali health personnel, increasing public awareness and knowledge of tuberculosis prevention, and improving facilities through renovation and construction of new buildings.

Due to an increasingly instable security situation in Somalia with the onset of the civil war, in 1991 the bilateral cooperation was suspended. At present, after decades of unrest and war, and several failed peace initiatives, Somalia is in the middle of the one of the worst humanitarian crises in 20 years and Finland, like the rest of the international community, is faced with the question of what can be done to promote peace, prosperity and reconciliation in Somalia.

The European Union provides the main policy framework for Finland's support to the peace process in Somalia. As a member state of the EU, Finland participates fully in EU external policy formulation and funding.

While Finland engages in multilateral cooperation and dialogue on Somalia as part of the UN-led Somalia peace process, the country provides on-going humanitarian assistance and supports the work of NGO's. As a sign of Finland's increased interest in

Somalia, Mr. Alexander Stubb, the Finnish Minister for Foreign Affairs, has nominated Mr. Pekka Haavisto as his Special Envoy to the Horn of Africa and Sudan. Finland also supports the peace processes through regional entities such as the Inter-Governmental Authority for Development (IGAD) and the African Union through capacity-building in crisis management.

Throughout the last two decades Finland has given significant amounts of humanitarian assistance to Somalia. Finland's humanitarian policy is rooted in the 23 principles of Good Humanitarian Donorship, which have been agreed upon by all OECD as well as EU member states. In addition to Finnish humanitarian policy, these principles lay out the strategies for humanitarian assistance. Decisions about funding are made in response to needs validated by thorough assessments. Humanity, neutrality, impartiality and independence represent the key words for these decisions.

The United Nations has a leading role in the provision of humanitarian assistance and thus, most of the Finnish aid goes through multilateral channels. In the 1990s, Finland's humanitarian assistance to Somalia was close to the equivalent of 12 million Euros. From the beginning of 2008, Finland has allocated approximately 16,2 million Euros to Somalia directly or indirectly through regional programmes aimed at alleviating the humanitarian crisis in Somalia and in the Horn of Africa. The aid is mostly coordinated through the UN system and agencies such as the World Food Programme and the United Nations Refugee Agency. In addition, the International Organization for Migration, the Finnish Church Aid, the Finnish Red Cross and UNICEF have received official development aid in support of their work. In 2009 Finland will provide 2,85 million Euros in humanitarian assistance directly to Somalia and 4,7 million Euros regionally to the Horn of Africa.

Whereas humanitarian aid is provided on the basis of need, Finland's development cooperation policy is rooted in the "Development Policy Programme 2007". The programme determines eight long-term partner countries for focused bilateral support from Finland. Five of these countries are in Africa: Ethiopia, Kenya, Tanzania, Mozambique and Zambia. While Finland is supporting partner countries which are recovering from violent conflict, the chronic lack of stability in Somalia has not yet enabled Finland to take steps in supporting the country's development directly on a bilateral basis.

However, Finland is prepared to support the stabilization and reconstruction of Somalia as a part of a UN-led process. In February 2009 the United Nations proposed five priority interventions to the International Contact Group on Somalia in order to provide resources and mechanisms for continued momentum of the Djibouti peace process. These interventions concentrate on 1) political elements and supporting the new government, justice and national reconciliation, 2) governance and assistance in

drafting a new Constitution as well as enhancement of the capacity of local governments, 3) security, 4) rule of law including support to the establishment of a police force, and 5) recovery, which would include employment creation, provision of priority social services and promotion of livelihoods and enhanced productivity in rural areas. Finland has stated its readiness to support the UN programme as soon as the conditions would allow.

In addition to official governmental organisations, the diaspora communities also play an important role in participating constructively in peace-building and the development of Somalia. In relation to its total population, Finland has one of the largest Somali diasporas in Europe. The Ministry for Foreign Affairs of Finland has supported several successful projects implemented in Somalia by active Finnish NGOs, their Somali partner organisations and diaspora members. In 2009, the Ministry will support the work of NGOs in Somalia with almost 2,5 million Euros. The aid is directed to 18 different organizations, approximately half of which are established and actively managed by diaspora members. The Ministry for Foreign Affairs encourages the diaspora members to take an active and constructive part in the reconstruction of Somalia. Sound principles of management, networking and coordination are key elements for NGOs to fully benefit from available funding.

While Finland, the EU, the United Nations and other international partners are committed to promote peace and stability in Somalia, in the end, outsiders can only help as facilitators. It is the people of Somalia who have to find the way towards lasting peace. Characterized by a spirit of reconciliation and political inclusiveness, the Djibouti Peace Agreement needs to be kept alive.

References

- Council of the European Union
2009 Council Conclusions on Somalia; 2958th External Relations Council meeting, Brussels, 27th July 2009.
- Kehityksmaantieteen yhdistys
1984 Somalia: maakatsaus. Kehityksmaantieteen yhdistyksen toimitteita no: 12.
- Ministry for Foreign Affairs, Finland
2007 Development Policy Programme 2007. Towards a Sustainable and just World Community, Government Decision-in-Principle.
- UN
2009 Report of the Secretary-General on Somalia pursuant to Security Council resolution 1872.
- UN OCHA
2009 Somalia Humanitarian Overview, Vol 2, Issue 9.

THE FINLAND-BASED SOMALI DIASPORA – ASSOCIATIONS AND THEIR INVOLVEMENT IN CO- DEVELOPMENT

Päivi Pirkkalainen

Diaspora engagement in the country of origin is a dynamic and context-specific phenomenon, particularly in light of on-going conflicts in countries of origin. In the literature discussing the diaspora-conflict nexus, the negative impact of diasporas on conflicts is often emphasized. However, in recent years, research focusing on the positive aspects of diaspora involvement in the conflict has emerged and balances the picture.¹ Due to their heterogeneity, it is certainly questionable to generally state whether diasporas are “risk factors” fuelling conflict or elements of stability. Depending on a country-specific conflict cycle, a diaspora can be both “peace-wrecker” and “peace-maker” in different periods. In addition, the definition of “peace” is problematic as all aspire to peace but might not be willing to pay the price that often comes along with it (Smith, 2007).

In order to understand the engagement of a diaspora in the country of origin, it is essential to look at specific and illustrative examples with due consideration to the situation in the country of origin as well as the host country. This chapter examines the case of Somali associations in Finland working towards development in Somalia. In addition to presenting an overview of the Somali diaspora associations in Finland and their involvement in co-development initiatives², the chapter aims at explaining how the Finnish institutional context shapes diaspora associations and, in turn, how the current situation in Somalia defines the work of these associations. In addition, it also analyses the general challenges of diaspora involvement in the context of Somalia.

Concerning the Finnish context, a special focus is placed on existing funding structures within the Ministry for Foreign Affairs of Finland (MFA) for NGO development cooperation, which a few Finland-based Somali associations have managed to access. Support to NGO development cooperation is part of Finland’s official development aid and represents the third largest yearly share out of the nine overseas-development aid budget lines³. It will be argued in the chapter that access to such funding and available capacity building measures have shaped the associations to become more professional.

Concerning Somalia, while research on transnational⁴ activities and the role of diaspora in development and peace building in the country of origin has been carried out in recent years, most of this research focuses on the individual level, such as on individual/family remittances.⁵ Remittances sent by the diaspora exceed official development aid and direct investments and are very important livelihood strategies for families.⁶ Collective activities of Somali diaspora associations remain however rather unexplored.⁷ Diaspora associations are important actors through which development activities are carried out. Studies on migrant/diaspora associations have been focusing on Home Town Associations (HTAs)⁸, and on the political opportunity structures in the host country as well as their impact on migrants' organization structures⁹. However, much of the literature, in particular on HTAs, is concentrating on the USA and migrants from Latin America. Much less has been written on African diaspora associations (Kleist, 2009).

The chapter defines the concept of diaspora, followed by a short introduction on Somalia and Somalis in Finland, a general description on civil society and migrant associations in Finland, as well as an overview of Somali diaspora associations and their development projects. It finishes on the existing co-development initiatives under the MFA's NGO development support structures and the challenges of diaspora involvement in the Somali context.

The chapter is based on 16 semi-structured interviews with representatives of the Somali diaspora associations in Finland (2 women, 14 men), an interview with a representative of the Ministry for Foreign Affairs, as well as an extensive mapping of Somali diaspora associations through internet, association databases¹⁰, and reports¹¹.

Diaspora and mobilisation

The concept of diaspora has been analyzed extensively in migration studies in recent years, leading to a variety of definitions and interpretations. The classical approach is to refer to diaspora as a community outside of a homeland and yearning for it.¹² Diaspora can also be understood as a particular form of consciousness or identity. This view challenges the first one by claiming that diasporas are not always defined by their focus on a singular national homeland, but individuals' own narratives and perceptions of their own identity (Hall, 1993; Brah, 1996; Clifford, 1994). The third way of analyzing the concept is to examine claims made in the name of diaspora, in other words "to perceive diaspora as a concept of a political nature that might be at once claimed by and attributed to different groups and subjects, rather than migrant communities defined by dispersion" (Kleist, 2008). As Sökefeld (2006) puts it; "the development of diaspora identity is not simply a natural and inevitable result of migration but a historical contingency that frequently develops out of mobilization in response to specific critical events. Diaspora [...] is not

an issue of naturally felt roots but of specific political circumstances that suggest the mobilization of a transnational imagined community”.

Thus diaspora communities are as much growing out of differences than out of solidarity or cohesion. Diasporas are involved in continuous construction processes; they are about negotiations, claiming, positioning and power struggling. While much has been written on diaspora cultures and consciousness, there has been a lesser focus on organizations that shape the consciousness, drive development and in a way embody diaspora consciousness (Leroy and Mohan 2003; Oussatcheva, 2001; Sökefeld and Schwalgin, 2000).

A brief history of Somalia

Somali-inhabited lands were colonized by Britain (Northern parts of Somalia), Italy (Southern parts) and France (Djibouti). The British-administered northwestern region and the Italian administered southern region merged in 1960 to form the independent Somali Republic. French-administered Djibouti became independent later, in 1977. Ethnic Somalis also inhabit the Ogaden region of Ethiopia and the Northern Frontier District of Kenya.¹³

After nine years of civilian rule, General Siyad Barre arranged a bloodless coup in 1969.¹⁴ In 1977, the Somali army attacked Ethiopia in the name of pan-Somali unity trying to conquer the Ogaden region. Somalia lost the war leading to massive refugee flows from Ethiopia to Somalia (Waldron and Hasci, 1995). After the loss of the Ogaden war dissatisfaction with the Barre regime grew and a general economic and political breakdown became apparent. Organized opposition to Barre's regime started to grow in particular in the northwestern region, and political movements such as the Somali Salvation Democratic Front (SSDF) and the Somali National Movement (SNM) were formed in 1981. The SNM and government forces clashed in the North in 1988, and a civil war spread from there throughout the country. Siyad Barre was removed from power by the United Somalia Congress, and the Republic of Somalia collapsed in 1991.

Later in 1991, the northwestern region of Somalia proclaimed the independent Republic of Somaliland which, however, has not received international recognition. The northeastern region of Puntland declared its autonomy in 1998, but is not secessionist.¹⁵ Various attempts have been made during the past two decades to halt the violence and reconstruct Somalia, but so far unsuccessfully. The ongoing conflict in southern and central parts of Somalia has evolved in recent years and seen the intervention of external players such as Ethiopia which sent troops in 2006 in order to halt the Islamic Courts Union. At present, the situation in Somalia is characterized by clashes in the southern and central parts of the country between the Transitional Federal Government, under

Sheikh Sharif Sheikh Ahmed who was elected President in 2009, and the opposition consisting of the radical Islamic movements Al-Shabaab and Hisbul-Islam.

Somalis in Finland

The conflict in Somalia has caused massive refugee movements and led to the dispersal of an estimated one million Somalis all around the world. Somalis started to enter Finland in the early 1990's as asylum seekers, many of them arriving via the then Soviet Union (Aallas, 1991). One factor linking Somalis and Finland was Finland's geographic proximity to the Soviet Union. When the Somali civil war broke out, Somalis studying in the former Soviet Union represented a pull factor for other Somalis who were seeking asylum. When the Soviet Union eventually collapsed and was therefore no longer able to host Somalis, Finland was the closest Western country. It has been claimed that the majority of Somalis who entered Finland between 1990 and 1992 did not consider Finland as their primary destination (Alitolppa-Niitamo, 2004). Somalis arriving from the early 1990s onwards have been the largest single ethnic group applying for asylum in Finland and this period forms a milestone in the Finnish history of immigration (ibid.). After 1992, more Somalis have entered Finland through official family reunification programmes (ibid.) or as asylum seekers, although small in numbers¹⁶. With 1.181 applications in 2008, there was a considerable increase in Somali asylum applications compared to earlier years, turning this group into the second largest group of asylum seekers after Iraqis (1.255) (FIS, 2009).

In 2008, Finland had a community of 10.647 (SF, 2008) people who spoke Somali as their mother tongue, and 4.919 (SF, 2008b) citizens of Somali descent. Somalis are the fourth largest group of immigrants in Finland, and the largest group of immigrants originating from Africa (SF, 2007). A considerable part of the Somali community in Finland consists of youth and children (Tiilikainen, 2003; Hautaniemi, 2004). Most Somalis live in the capital area of Finland in the cities of Helsinki, Espoo, and Vantaa, and with a few exceptions, most Somali associations are based in these cities.

The context in Finland: civil society and diaspora associations

The host country provides the context within which migrant groups can organize themselves.¹⁷ Regarding social and political participation, social capital and associational memberships, Finland and the other Nordic countries, have common characteristics that distinguish them from many other countries. In Nordic countries, state institutions and the public sector have played an important role in creating high levels of social

trust embodied in participation in voluntary associations. The Nordic region counts a high number of voluntary associations compared to other countries.¹⁸ As opposed to views claiming that close state–civil society relations “damage” critical associational life, Nordic welfare states being “strong, open, inclusionary and corporate states are among the most favorable contexts for the development of high level of social capital and trust” (Siisiäinen, 2008; Schofer and Fourcade-Courinchas, 2001).

These characteristics of Finnish society may have contributed towards the fact that immigrants in general have been active in establishing associations in Finland. It is estimated that some 700 migrant or diaspora associations were established between 1980 and 2007 (Saksela, 2003; Pyykkönen, 2005). Most of these associations are established by refugees, such as Iranians, Iraqis, Afghans, Somalis and Vietnamese. According to Pyykkönen (2007) the status of the individual is one of the most important factors leading to association establishment: refugees being far more active than labour migrants. The reasons for refugees’ particular associational activity may partly lie in their marginalized position in Finnish labour markets. The unemployment rate of Somalis, for example, is considerably higher than for the rest of the population: 59 % in 2005 (MoL, 2007). Somalis have also had problems in finding work corresponding to their education and qualifications. Other reasons for associational activity of people with refugee status include their feeling of exclusion from the Finnish society. Linking up with representatives of their own ethnic groups may function as a survival strategy or defense mechanism in the host country. In addition, many refugees have been active members of society in their countries of origin and find it natural to engage in associational life in Finland, although with different modes of organization and different goals (Pyykkönen, 2007).

Somali Diaspora Associations in Finland – an overview

The mapping exercise carried out through association registers, reports, internet sites and existing contacts identified over 100 Somali associations in Finland. On the basis of the mapping, however, it was not possible to ascertain that all of these associations were indeed actively functioning. It can be assumed that a sizeable number are not operating any longer, and a conservative estimate is that only around 50 % of those associations mapped are indeed fully operational.

- Size and activities

The 16 associations interviewed represent a variety of organizational forms and sizes regarding their members and activities. Associations vary from about 30 members in Finland to about 200 to 300 members; the largest one counting around 900 members.

Many associations have, in addition to members in Finland, members or supporters in other countries around the world.

Activities of Somali associations in Finland concentrate on supporting the Somali community in Finland and on humanitarian and development work in Somalia. The distinction of these two activity levels is however not clear-cut as many associations engage on both levels simultaneously. Activities in Finland include training in language (Finnish and Somali) and computers, sport activities, arranging multicultural events, seminars on Somalia, youth work and homework clubs. Activities in Somalia support a variety of beneficiaries such as orphans, farmers, universities, schools and other educational institutions, hospitals (including for example maternity and tuberculosis clinics) and support for the democratisation of the country of origin. There are also examples of associations that have previously supported peace talks and reconciliation between different clans. All interviewed associations claim to be of a non-political nature and emphasise their purely humanitarian and development focus.

A few associations are not able to carry out any longer-term projects in Somalia due to the poor security situation. They do, however, maintain links with locals in the areas of origin and try to support them as much as they can, for example by pooling money among supporters and sending donations and equipments to schools and hospitals. Another form of engagement with the country of origin is lobbying and information dissemination in Finland about the situation in Somalia.

Funding mechanisms of the interviewed associations, for activities in Finland and in Somalia, vary from 100% own funding by membership fees or funds raised to external project funding from Finnish authorities, such as the MFA, for development projects in Somalia and Ministry of Education, municipalities and other public sources for activities in Finland.

- Patterns of Organisation – Regional and Clan Affiliations

Regarding activities in Somalia, the development projects or activities by diaspora associations are often carried out in regions or towns of origin of the chairperson or the majority of members. There are, however, exceptions to this as outlined by the interviewees: two associations carry out projects outside of their “home area” in areas selected on the basis of a needs assessment.

There are very practical reasons for selecting the site of development projects: clan sensitivities and security. Many of the interviewees stated that they have a privileged access to certain areas in Somalia where their relatives¹⁹ live. Organising diaspora interventions around clan lineages or regional affiliations has therefore much to do with

relations of trust. Clan lineages may also be compounded by the absence of a legitimate central state authority (Kleist, 2007), and the security guarantees it normally provides.

However, as “the Somali clan system is inherently flexible and characterized by ongoing tensions between fragmentation and collaboration” (Kleist, 2007) one cannot claim the Somali associational field to be solely based on clan lineage. Some of those associations, for example, that have started their activities by pooling money among people from a certain region and clan, have widened the networks to officials and to other NGOs, and have extended their membership to native Finnish members. Hence, they can no longer be defined as exclusively clan-based associations. Moreover, even if clan affiliation and regional affiliation in some cases go hand in hand, there is also some evidence to underline that while diaspora associations carry out assistance activities in the region of origin of their members, they more often than not emphasise that they assist everyone living there, not only representatives of a specific clan.

Clan and regional affiliations are by no means the only lines of fragmentation among Somali diaspora community in Finland. Other lines include, for example, gender and generation.

- Networks and collaboration

Despite the fragmentation of the Somali associational field in Finland, it is characterised also by collaboration. All the interviewed associations have extensive networks on different levels. Cooperation with other Somali associations in Finland takes place mainly in the framework of the Finnish Somalia Network (FSN), which brings together those native Finnish and Somali associations that are involved in development cooperation activities in Somalia. The network, the only of its kind in Finland, has been established in 2004 and is receiving funding from the MFA since 2005. It is coordinated by a Finnish NGO (International Solidarity Foundation). The main aims of the network are to build the competence and capacity of the NGOs by providing courses on topics such as accounting, reporting, development project planning, etc., to share information on the development activities in Somalia, to facilitate cooperation between NGOs working in Somalia, and to share general information on the situation of Somalia (FSN, 2009). At the moment, the network has 18 member associations out of which 16 are Somali and 2 native Finnish associations. As the numbers indicate, not all Somali associations active in development work in Somalia belong to the network and, therefore, it cannot be claimed to function as a truly representative umbrella body of development-focused Somali associations. Moreover, not all interviewees were satisfied with the network and questioned its usefulness.

Collaboration between associations involved in development activities in different regions in Somalia takes place mainly in the form of exchanging information, knowledge

and “best practices” to carry out development work. Although the situation has changed since the early years 1990, when the trauma of the civil war still reflected in communities in Finland causing even some clashes between members from different clans, according to one respondent some associations still engage in politics according to clan lines which makes collaboration difficult. Politics of Somalia have been kept out on purpose from the agenda of the Finnish Somalia Network, in order to enhance collaboration and dialogue around non-political themes.

In addition to collaboration between different Somali associations in Finland, the interviewed Somali associations maintain widespread contacts with Finnish NGOs, both relating to the activities in Somalia and to integration activities in Finland. Among the interviewed associations, there is no organisational level networking or cooperation with political parties in Finland, but contacts at individual level. For example the chairpersons of a few associations are active in a Finnish political party through which some support in terms of networking – without financial support – is obtained. Many of the interviewed associations have also important transnational networks with Somali associations in different countries worldwide, or have members in different countries. A few well-established and long-standing associations have managed to network with international organisations, and receive support from organisations such as WHO and UNICEF for their development projects in Somalia.

In general, when diaspora groups are engaging in development activities they require local contacts and references and it is important to note that “diaspora projects are not one-way flows, but rather part of a dialectical process where the local context cannot be overlooked” (Kleist, 2008b). All of the interviewed associations engaging in development or humanitarian work in Somalia have a local partner, either permanent or ad hoc contacts depending on the activity and the form of project work. Several forms of partnerships were found: a local association established by local people as a partner, a local association established by a diaspora returnee as a partner, an individual functioning as a “focal point” or a local branch of the diaspora association (established by the association). All associations receiving support from the MFA are obliged to partner with a local organisation.

MFA support to NGO development projects and Somali associations

With the exception of IOM’s MIDA Health project for Somali professionals, no other specific co-development programme targeting the Somali diaspora and financed by Finnish authorities exists at the present moment. However, several Somali associations have accessed funding for their development projects in Somalia from the Ministry for Foreign Affairs of Finland, especially under the Ministry’s NGO development

cooperation budget line, which can be considered as a prompter for co-development initiatives.

The official development cooperation aid provided by Finland is divided in nine budget lines. The share for support to NGO development represents some 12.7 % of the total yearly budget in 2008 (MFA, 2009). Co-development cooperation carried out by NGOs complements Finnish multi- and bilateral cooperation as well as the EU's own development cooperation. The overarching objective of NGO development cooperation is to further the UN Millennium Development Goals and to strengthen the civil society in developing countries. A total of some 200 Finnish NGOs are currently involved in implementing development cooperation projects in over 80 different countries, or in sharing of information on development subjects (MFA, 2009).

NGO development funding is disbursed to NGOs responding to specific calls for proposals. Somali associations are therefore openly competing with other development NGOs. Some Somali associations have managed to create trustful and close contact with the MFA and have developed capacities in producing good quality applications as well as efficient and professional organization and project management.

In order to access MFA NGO development funding, associations need to fulfil several requirements. An organisation: (1) needs to have been registered at least for a year at the time of applying for project funding; (2) needs to have enough expertise to implement and administer the project; (3) needs to have a professional accounting, monitoring and reporting system; (4) needs its own co-funding of at least 15 % of the total yearly budget of the project, co-funding needs to originate in Finland and its origins have to be known; and (5) needs to have a local partner which is responsible for implementing the project locally, on the basis of a written contract between the Finnish and the local NGO (MFA, 2005).

According to the MFA²⁰ the first development project carried out by a Somali association in Somalia received funding in 2000. Since then, and until 2007, 16 different Somali associations have received funding for a total of 29 development projects. Funded projects have been in the sectors of health (12), education (9), support for women, children (mainly orphans) and youth (5), rural development (2) and one project covering several sectors. Out of 16 organisations interviewed, 7 had received funding from the MFA at some period during the past years, 6 had applied unsuccessfully, and the remaining 3 expressed interest in applying in the future.

The interviewed MFA representative confirmed that Somali diaspora associations are by far the most active migrant communities in Finland in applying funding for development projects and maintaining open channels for communication. Taking into account the situation in Somalia and the difficulties in delivering development aid to

the country (in particular to central and southern Somalia), the MFA considers that Somali diaspora associations are important actors in key positions to deliver Finnish development aid to Somalia. Thanks to their number, and high visibility in Finland, Somali diaspora associations are recognized by the MFA as custodians of local knowledge and expertise on Somalia. A few challenges, however, remain: applications to MFA have to be written in either Finnish or English language which is not always readily available among association's members; many associations still have to catch-up in acquiring formal bureaucratic procedures of associational work; many associations remain weak on project cycle management experience. Those associations, whose applications have been rejected, are usually invited by the MFA to participate in various trainings and capacity-building exercises, generally provided by the Finland Somalia Network, but funded by MFA.

The availability of MFA funding has partly contributed to the transformation of Somali diaspora associations. Many associations have developed capacities in response to MFA requirements and conditions, many more have become formally organized and registered associations, many of their members have enhanced their professionalism in view of development cooperation work (Warnecke, et al.). When associations register, they subject themselves to associational rules and regulations of the host country.²¹ In addition, registration opens up possibilities for a group to negotiate with officials as a collective actor, and to better "plead a case". Moreover, registering a group as an association paths the way for funding applications.²² According to the empirical data, most associations interviewed had been established years before the actual registration and succeeded in pooling money contributed by members to finance small-scale development activities in the country of origin. Additional and regularly available MFA funding offer opportunities for more, better and bigger projects implemented by the diaspora in Somalia.

Challenges to diaspora involvement

Involvement of the diaspora associations in development of the country of origin presents a number of challenges related to the country of origin, the host country as well as the international community.

Regarding the country of settlement level, in this case Finland, Somali associations and individuals active in them have had to face, and are facing, various challenges such as little resources, both relating to available time and money. First of all, funding is rather difficult to obtain, and in order to get it one has to know the Finnish bureaucratic system and procedures, which are not easy to learn. Secondly, as all of the respondents engage in associational work on a purely voluntary basis, free time is very limited as one needs to work and take care of the family. Thirdly, the creation of a trusted position on

one hand among the authorities and on the other hand among the Somali community is also a challenge. One respondent expresses the difficulty to get partners and members to the association. He expressed that it is difficult to convince people that the association is “doing good work”, and that “the aid is delivered to where it is supposed to”. In the words of another interviewee: “some associations have misused money, and they have “badmouthed” other associations, and this makes it difficult to obtain funding for associations who really want to help Somalia.”

Relating to the challenges on the associational involvement in Finland, in particular the need to learn the Finnish system, it is important to pay some attention to the question of who is actually involved in the associations. All of the interviewees, who are either founders and/or chairpersons of the respective associations, hold Finnish citizenship, and have lived in Finland at least for ten years, most for about 17 to 18 years. They are well integrated in the Finnish society in terms of knowing the Finnish language, culture and administrative/bureaucratic procedures. They are well educated (having at least a bachelor level degree), however not all of them have managed to find employment that corresponds to their qualifications.

It is clear that one needs, in addition to motivation and commitment, resources to establish an association. As noted above, the successful running of an association requires knowledge of the Finnish system as well as social networks. As previous studies show, there is no contradiction between transnational involvement and process of integration to the country of settlement; in fact, to the contrary²³. It is not the most disadvantaged who engage transnationally in the organizational level, but those who have knowledge, resources and / or social networks through which resources can be drawn.

Challenges concerning the country of origin are related in particular to the poor security situation and the limited access to areas lying within the conflict regions of Somalia. As outlined earlier, poor security in many parts of the country also means that, often, projects can only be implemented in locations where, due to specific clan linkages with diaspora members, the clan network provides safe access and protection in situ.

A further challenge in the case of Somali diaspora associations is a growing suspicion among ‘Western’ officials and media vis-à-vis Muslim groups. A few Somali associations have faced suspicions concerning money transfers for development projects in Somalia through the Somali money transfer system, *hawala*²⁴, which caused delays and disrupted projects.

Conclusion

The large number of Somali associations in Finland, which are embodiments of the commitment of the Somalis as much as a reflex of the fragmentation of the society reflected in the diaspora, illustrate the lines of fraction in the Somali society, along clan and regional affiliation, generation and gender. The Finnish-Somali diaspora context reveals that “clans” are only referred to in terms of security for and access to development activities in the country of origin. While none of the associations interviewed defines themselves as clan-based or clan-driven. When working towards peace and development in the country of origin, clan lineage often provides certain guarantees and entries.

The diaspora associations also reveal a “generation gap” between first generation and second generation Somalis, as well as dividing lines along gender. Although, Somali women groups exist in Finland, the Finland-based Somali associations remain largely dominated by male participants, reflecting – to a certain extent – the traditional gender-based roles in Somali society.

The situation in Somalia sets and defines the opportunities and limits to Somali diaspora engagement back home. Development activities are carried out by Somali associations in a variety of forms, ranging from informal, ad hoc, clan or town-level assistance to well-established sustainable projects. Through these development activities, skills, knowhow, materials, resources, ideas, visions and values are transferred to the country of origin.

The lack of security and the ongoing conflict in many parts of Somalia remain the core concerns for most interviewees. The absence of functional and legitimate state structures forces Somali associations to engage in development work mainly through their own networks; often based on clan or regional affiliations and leading to generally highly localized contributions. The poor security situation in central and southern Somalia has made the delivery of official international humanitarian and development aid very difficult, if not impossible. This, in turn, has turned the Somali diaspora into an indispensable key actor in delivering aid to people in need, explaining MFA’s interest in funding Somali associations’ development projects. In Finland, institutional frameworks, existing funding structures, available partners and institutions’ disposition towards diaspora groups shape diaspora engagement. There is direct link between MFA’s interest and funding in Somalia-based development work, and the development of expertise, capacity and institutional strengths of Somali diaspora associations in Finland.

This link refers directly to the relationship between integration and transnational engagement. In many cases, leaders of diaspora associations are well-integrated in the host country in terms of language, social networks and cultural sensitivities and knowledge. Associational involvement and transnational activities also foster integration as diaspora associations often look out for cooperation partners and funding mechanisms

in the host country, establishing contacts between associations and other stakeholders (Warnecke, et al.).

It is however essential to note, that Somali diaspora associations in Finland are not “just” responding to existing frameworks and opportunities, but are themselves setting agendas. Many associations are capable and resourceful in pooling resources among members and supporters and fund development initiatives with these resources. Such networks help increase their members’ capacity to undertake development projects in the country of origin.

Those Somali associations that have accessed funding from MFA in Finland represent examples of resourceful centers that have started activities out of their own initiative and subsequently accessed external funding from MFA in order to open-up and widen their scope of intervention. In the best case scenario, co-development initiatives build and improve the capacity of diaspora associations and strengthen their own networks in countries of origin. Support for migrant-driven development can thus lead to sustainable development of diaspora associations, in particular those that entertain close contacts with the country of origin and that have a deep and thorough knowledge of local needs and prospects in order to establish targeted projects and create sustainable links with local community back home.

Notes

- 1 See more of this discussion in the literature review on The Diaspora-Conflict-Peace-Nexus by Pirkkalainen and Abdile 2009
- 2 Co-development refers to a phenomenon in which migrants are seen as a “factor” contributing to development of their countries of origin. The term “co-development” was proposed for the first time by the French scholar Sami Nair in 1997 in his paper for the French Ministry of Foreign Affairs titled “Balance and orientation about policies of development linked to the flow of immigration” (Vidal, P. and Martinez, S. 2008).
- 3 The appropriations (in 2008 total of 600, 3 million euros) of development cooperation administered by the MFA are allocated to nine budget lines: 1) Multilateral development cooperation (30,7% of the total budget); 2) Country- and region-specific development cooperation (29,2%); 3) European Development Fund (9,0%); 4) Non-country specific development cooperation (4,4%); 5) Humanitarian aid (11,0%); 6) Planning, support functions and development information (1,1%); 7) Evaluation and internal audit of development cooperation (0,2%); 8) Support to NGO development cooperation (12,7%); 9) Interest subsidies (1,8%), (Ministry for Foreign Affairs of Finland, Development policy website: <http://www.formin.fi/Public/default.aspx?nodeid=15392&contentlan=2&culture=en-US>)
- 4 Basch et al. (1994, 7) define transnationalism as consisting of “the processes by which immigrants forge and sustain multi- stranded social relations that link together their societies of origin and settlement. We call these processes transnationalism to emphasise that many immigrants today build social fields that cross geographic, cultural and political borders.”
- 5 See for example Gundel 2002; Lindley 2007
- 6 Ibid.
- 7 One of a very few studies on Somali associations in the European context and their role in development and reconstruction of Somalia is carried out by Nauja Kleist 2007; 2008; 2008b.

- 8 HTAs are defined as “*organizations made by and for migrants from the same town or parish in the country of origin who congregate primarily for social and mutual-aid purposes*”(Caglar 2006). Somali diaspora associations in Finland can not be defined as home town associations as their scope and membership profile go beyond the town level (more on this later in the article), but the literature on HTAs can be applied to the discussion in general on the role of migrant “driven” associations in the development of the country of origin.
- 9 See for example Hooghe 2005; Vermeulen 2005
- 10 National Board of Patents and Registers. AssociationNet: <http://yhdistysrekisteri.prh.fi/ryhaku.htm>.
- 11 The mapping exercise was conducted between May and August 2008, and the interviews were collected in three main phases of field work (a period of four weeks in Helsinki, Vantaa and Espoo in August 2008, one week period again in the capital area of Finland in January 2009 and again one week period in April 2009). Out of 16 Somali interviewees two were women and 14 men. Data has been collected as part of the ongoing research project DIASPEACE which is a multi-disciplinary research project seeking to generate evidence-based and policy-relevant knowledge about the ways in which diasporas play into the dynamics of conflict and peace in their countries of origin. The empirical focus of the project is on the Horn of Africa, in particular Somalia/Somaliland, Ethiopia and Eritrea. See more information at: www.diaspeace.org.
- 12 See for example Safran 1990; Wahlbeck 1999
- 13 See for example Cassanelli, 1993
- 14 See for example DeLancey *et al.* 1988
- 15 See for example Gundel 2002
- 16 Number of Somali asylum applications: 1997: 113, 1998: 126, 1999: 111, 2000:129, 2001: 102, 2002: 63, 2003: 93, 2004: 168, 2005: 267, 2006: 210, 2007, 244. Source: Finnish Immigration Service statistics 1997-2007.
- 17 See for example Hooghe 2005; see also Soysal (1994, 235); Odmalm (2004, 474)
- 18 See for example Siisiäinen 2008
- 19 In many cases affiliation to certain region was described as one having relatives there, instead of referring to a clan.
- 20 These data have been collected from the yearly published book on funded NGO projects by Ministry for Foreign Affairs of Finland (Kansalaisjärjestöhankeluettelo). The books each year from 1995 till 2007 (the 1999 issue was not available) have been gone through. MFA does not differentiate associations on the basis of the country of origin of the establishers/members, as there are no quotas for migrant associations, but as I know the names of the most Somali associations in Finland I have been able to pick them up from the lists.
- 21 See for example Siisiäinen 1998
- 22 See for example Pyykkönen (2007)
- 23 See Levitt and Glick-Schiller 2004; Itzigsohn and Saucedo 2002; Kleist 2007
- 24 Hawala, or hawilad (xawala, xawilad) is a Somali money transfer system currently operating nearly every part of the world, and run by many companies.

References

- Aallas, E.
1991 Somalishokki, Suomen pakolaisavun julkaisusarja 2, Finnish Refugee Council, Helsinki.
- Alitolppa-Niitamo, A.
2004 The icebreakers: Somali-speaking youth in metropolitan Helsinki with a focus on the context of formal education, The Family Federation of Finland, Helsinki.
- Brah, A.
1996 Cartographies of diaspora; Contesting identities, Routledge, London and New York.
- Clifford, J.
1994. "Diasporas". *Cultural Anthropology*, 9 (3): 302-338.
- Finnish Immigration Service (FIS)
2009 Statistics on asylum seekers and asylums granted 1997-2007.
2009b Asylum seekers 1.1.-31.12.2008, <http://www.migri.fi/>
- Hall, S.
1993 "Cultural Identity and Diaspora", in Williams, P. and L. Chrisman (eds.) *Colonial discourse and post-colonial theory. A Reader*, Harvester Wheatsheaf, New York.
- Hautaniemi, P.
2004 *Pojat! Somalipoikien kiistanalainen nuoruus Suomessa*. Nuorisotutkimusseuran julkaisu 41. Youth Research Association, Helsinki.
- Kleist, N.
2007 *Spaces of Recognition. An analysis of Somali-Danish associational engagements and diasporic mobilization*, PhD dissertation, University of Copenhagen, Copenhagen.
2008 "Mobilising 'The Diaspora': Somali Transnational Political Engagement". *Journal of Ethnic and Migration Studies*, 34 (2): 307-323.
2008b "Agents of Development and Change: The Somali Diaspora at Work", in R. Bardouille, et al, *Africa's Finances: The Contribution of Remittances*, Cambridge Scholars Publishing, Newcastle.
2009 "African Diaspora Organizations and Homeland Development: The case of Somali and Ghanaian associations in Denmark." Paper presented at the DIIS seminar: Agents of Change? African diaspora organizations and homeland development, 3 April, 2009.
- Leroy, H. and G. Mohan
2003 "Making homes: The Ghanaian Diaspora, institutions and development", *Journal of International Development*, 15: 611-622.

- Ministry for Foreign Affairs, Finland
 2005 Hanketuen käsikirja. Osa II: Hakuopas. Kansalaisjärjestöjen kehitysyhteistyö, Unit for Development Policy, Helsinki.
- Ministry of Labour, Finland
 2007 Unemployment Rate among Foreigners in 2001 - 30.4.2007, http://www.mol.fi/mol/fi/99_pdf/fi/04_maahanmuutto/08_maahanmuuttotilastot
- Oussatcheva, M.
 2001 *Institutions in Diaspora: The Case of Armenian Community in Russia*. WPTC-01-09, Institute of Social & Cultural Anthropology, University of Oxford, Oxford
- Pyykkönen, M.
 2005 “Pyhiinvaeltajia, kotoutujia vai nomadeja: Maahanmuuttajayhdistysten kolme diskurssia diasporisesta etnisyydestä”, in Paasonen S., *Aktivismi: verkostoja, järjestöjä ja arjen taitoja*, Nykykulttuurin tutkimuskeskuksen julkaisuja, 108-136, Jyväskylä.
- 2007 Järjestäytyvät diasporat. Etnisyys, kansalaisuus, integraatio ja hallinta maahanmuuttajien yhdistystoiminnassa. *Jyväskylä Studies in Education, Psychology and Social Research* 306. University of Jyväskylä, Jyväskylä.
- Saksela, S.
 2003 “Mångkulturella organisationer och invandrарorganisationer i Finland” in F. Mikkelsen, *Invandrарorganisationer i Norden*, 235-281. Nordic Council of Ministers, Copenhagen.
- Schofer, E. and M. Fourcade-Gourinchas
 2001 “The Structural contexts of civic engagement: Voluntary association membership in comparative perspective”, *American Sociological Review*, vol. 66, pp. 806-828.
- Siisiäinen, M.
 1998 “*Vapaaehtoiset organisaatiot ja taistelu luokista*”, in Kinnunen P. and R. Laitinen, *Näkymätön kolmas sektori*, Sosiaali- ja terveysturvan keskusliitto, Helsinki.
- 2008 “New and old associations as trusting networks: tracing social capital in Jyväskylä”, in Häkli, J. & C. Minca, *Social Capital and Urban Networks of Trust*, Ashgate, Hampshire.
- Smith, H.
 2007 “Diasporas in international conflict”, in Smith H. and P. Stares, *Diasporas in Conflict: Peace-makers of Peace-wreckers?*, United Nations University Press, Tokyo.
- Statistics Finland (SF)
 2007 Suurimmat vieraskieliset ryhmät 1997 ja 2007, <http://www.stat.fi/til/vaerak/>.

- 2008 Kieli iän ja sukupuolen mukaan maakunnittain, <http://pxweb2.stat.fi/Dialog/Saveshow.asp>
- 2008b. Kansalaisuus iän ja sukupuolen mukaan maakunnittain, <http://pxweb2.stat.fi/Dialog/Saveshow.asp>
- Sökefeld, M.
2006 “Mobilizing in transnational space: a social movement approach to the formation of diaspora”, *Global networks*, (6) 3: 265-284.
- Sökefeld, M. and S. Schwalgin
2000 “Institutions and their Agents in Diaspora: A Comparison of Armenians in Athens and Alevis in Germany”, Working Papers of the Transnational Communities Programme (WPTC-2K-11).
- Tiilikainen, M.
2003 *Arjen islam. Somalinaisten elämää Suomessa.*, Vastapaino, Vantaa
- Waldron, S. and N. Hasci
1995 *Somali Refugees in the Horn of Africa: State of the Art Literature Review.* Nordiske Afrikainstitutet, Uppsala
- Warnecke, A., et al.
Forthcoming “Towards a comparative assessment of factors determining diaspora intervention in conflict settings. Somali and Ethiopian diasporas in Europe”, DIASPEACE Working paper 2.

Internet resources

- DIASPEACE research project:
2009 <http://www.diaspeace.org>
- The Finnish Somalia Network
2009 <http://www.somaliaverkosto.net/>
- National Board of Patents and Registers
2009 AssociationNet: <http://yhdistysrekisteri.prh.fi/ryhaku.htm>
- Ministry for Foreign Affairs of Finland
2008 <http://www.formin.fi/Public/default.aspx?nodeid=15392&contentlan=2&culture=en-US>

Chapter 4

Challenges and benefits of mobility
in the Somali context

HISTORICAL SOMALI MIGRATION AND THE SOMALI WORKFORCE AT HOME AND IN THE DIASPORA

Bradley David
Abdi Jama Ghedi

The dictionary refers to diaspora in three different definitions: a) the movement, migration, or scattering of a people away from an established or ancestral homeland, b) people who settled far from their ancestral homelands, or c) the place where these people live (Merriam-Webster, 2009).

Considering the case of Somalia, not only has the “scattering” occurred on a massive scale over many years, especially in relation to the size of the country’s population, but it continues today because of recent and ongoing conflict and lack of domestic opportunities. Literature suggests that there are “as many as two million” Somalis in the diaspora, which points to the lack of existing or accurate data (Lewis, 2008).

The scale on which the Somali diaspora has developed in the 20th century has led many authors to refer to different periods of Somali migration as “waves” (Sheikh and Healy, 2009). The image of “waves” alludes to the size of migration movements as opposed to smaller “ripples” of migration.

Observing the main events in Somali history across the 19th and 20th centuries: colonialism, independence, centralized government, and civil war, successive Somali migration waves can be observed through a historic prism. Following the path of different groups of migrants throughout the last two centuries – sailors and soldiers in the British and Italian Armies during and after colonialism; students and professionals migrating to the colonial countries for studies and work; trainees to the former Soviet bloc up to 1977 and to the West after 1977; workers in the Gulf States attracted by the oil boom in the 1970s; refugees following the outbreak of civil war in 1988, and refugees and migrants fleeing the lawlessness of post-civil war Somalia – allows to establish a chronology of migration “waves”. These “waves” have always been of a mixed nature, combining regular migrants such as students or professionals, economic migrants, family reunification migrants, asylum seekers and refugees, etc.

The “waves” described below are of a general nature in so far as they depict mainstream movements during the periods outlined. A more detailed descriptions of migrant stories would have illustrated much more multi-dimensional aspects, a mix of situations and motives and, finally, a width of migratory experiences underlining the mobility of the Somali society.

Still, there is value in generalizing motivations and trends because they offer understanding of some of the general characteristics of Somali diaspora communities. Also, as we discuss in the final section, there is a lack of quality data on Somali migration patterns. More will need to be done to quantitatively analyze the Somali diaspora and workforce in view of the formulation of strategies linking the diaspora with the country of origin.

The 1st wave - colonial economy

The 19th and early 20th centuries witnessed the “scramble” for Africa. European powers and their armies created new frontiers. Somalis experienced three different colonial administrations. For the British and their vast naval empire, Somalia’s coastline held strategic significance in a vast region that hosted multiple British interests, including Egypt and the Suez canal to the north and India to the east. Italy’s attempt to build its own colonies focused on the southern part of Somalia, and France controlled the area now known as Djibouti.

The two major socio-economic developments in Somalia during the colonial era were the establishment of industrial cash-crop plantations in the riverine areas in the South and the creation of a bureaucratic administration with salaried officials. In southern Somalia, Italy developed banana plantations along its fertile river valleys through the creation of plantations and irrigation systems. Somali livestock fed British troops in the region, and taxes levied on northern Somalis went to the administration of the giant Indian colonial administration. Somalis became civil servants, teachers and soldiers, petty traders in coastal cities, and small-business proprietors within this new economic order.

Both the British and Italian colonial administrations recruited Somalis for their military endeavors. Somali soldiers within the British administration were transferred to Yemen, Egypt or India. The Italian campaign used Somalis to fight in Libya and Ethiopia. These soldiers often came home to become officers within the Somali ranks, especially during the “trusteeship” period of the 1950s and Independence after 1960.

Also during this era, UK-driven industrialization was booming. There was a high demand for labour within the coal industry and British and Greek merchant ships sought after sailors and laborers. Somali semi-skilled and “blue-collar” workers who filled the ships

and factories of the British industrial age formed the first Somali settlements among the industrial towns of Liverpool, Cardiff and London.

Somali interactions with the global economy from the colonial period have arguably had both negative and positive effects on the Somali workforce. Colonial economy was never about benefiting African economies, but rather to create wealth in Europe through mass exports of resources and the use of cheap labor. Colonial exports have had devastating environmental and cultural effects on local communities.

One major benefit of the linkage to the global colonial economy was a diversification of the Somali economy. The traditional economic activity in Somalia is herding livestock – mostly camels, sheep and goats. There has also always been fishing along the coastline and farming in the riverine valleys in the south, but these activities were small-scale compared to livestock agriculture, which is glorified in the cultural rhetoric, poems and stories of the Somali clans. Plantation economies brought new types of jobs in processing, transport and trade; skills in trade and an entrepreneurial spirit that continues to characterize the Somali business class to this day.

Somali economic interactions with the colonial economy led to the establishment of some of the earliest Somali communities in the United Kingdom and Italy. The colonial experiment was waning in the mid-twentieth century as European powers were struggling to maintain their expensive global networks while recovering from costly European wars. Meanwhile, a flurry of independence movements spread as new nations were birthed across the African continent including the Republic of Somalia which became independent in 1960. Somalis were being trained to run the state civil service, the military and businesses; the Somali workforce grew and diversified. And early on, many Somalis from the diaspora returned home because there were opportunities in Somalia's public sector.

The 2nd wave - students

During the 1950s and 1960s, the colonial powers started to train an elite class to take over the colonial economy following independence. Realizing the inevitable and eventual end of their rule, they saw the need to train a class of leaders who would become the custodians of the export economies that had been created. Many northern Somalis went to the UK and Egypt for technical training, and many southern Somalis went to Italy. Also, during this period, Egyptian nationalist President Nasser received students from all over Africa to support a pan-African agenda.

Somalia received grants and loans from countries both in the East and the West. This aid established an ambitious development plan by 1963, a five-year plan with a budget

of more than US\$100 million focusing on investment in infrastructure. This period was the high point for highly skilled Somalis to find work opportunities in Somalia.

Students who sought education abroad returned during the early years of independence. As in other African countries, there were competing visions for a new Somalia, with the world's superpowers competing for the hearts and minds of the Africans. The Soviet Union received the bulk of Somali students from 1960 up to 1977. The United States ran smaller teacher training projects; Germany supported training of Somali police forces. Many Somali students in the Soviet Union were trained to become military officers, but also medical doctors, engineers or civil servants. Numerous Somalis received specialized university and professional training abroad. Among many of the older skilled Somalis in the diaspora, there are representatives of this class in many sectors.

The 3rd wave - regional labour movements

In the 1970's, the oil boom was the determining factor in Somali emigration patterns. Many Somalis went to work in Saudi Arabia, and the other Gulf States, in the services, oil and construction industries. Many Somali men served as construction workers and drivers, and some women in the household service industry. Somali businessmen also arranged livestock trade.

While the export of livestock to the Gulf had a long tradition, a new group of Somali wage-earners created the earliest forms of the modern Somali money-transfer business. Somalis, mostly men, were sending cash remittances back home and a few entrepreneurial Somalis who traded in livestock recognized the opportunity. They had lots of cash available, and the Somali state-run bank was too slow and costly to provide reliable money transfer services. Thus, newly established Somali money-transfer companies deriving a modest profit from each transfer served the needs of thousands of Somali low-wage earners sending money back home. Since the 1970's many Somali entrepreneurs developed business skills and networks in the Gulf region (ILO, 1989). Today, Somali business communities can be found in very large numbers throughout the Gulf, with Dubai at the center.

The 4th wave - refugees

Both the weakening of the Siyad Barre government and a growing disinterest of the Cold War powers in Somalia at the end of the 1980's led to eventual state collapse. "Tyranny," or centralized violence of the Barre regime gave way to decentralized violence or "anarchy" (Mazrui, 1997). Without functioning state structures, insecurity became

the norm and public sector job opportunities disappeared gradually, resulting in an unprecedented flight of Somalis within and outside of the country.

The war against Ethiopia over the Ogaden region in 1977, fighting in the region of Somaliland in 1988, the fall of Barre's government in January 1991 - and continued insecurity ever since - has made this 4th migratory wave the largest of all. In addition to all the man-made push factors, the onset of drought provoked additional emigration. The perpetual state of insecurity in Somalia has prevented the development of job opportunities and fed into an ever-increasing diaspora. The numbers of those who take the risky journey across the Gulf of Aden north to Yemen and the Gulf States have increased in recent years. It is very difficult to assess the skills' level of these migrants, but - according to interviews of asylum-seekers, most of these identify themselves as farmers, although some as students, teachers and day-labourers or mechanics (IOM, 2006). The fact that so many are willing to make this perilous journey is a testament to the dire situation in the country.

Migration's winners and losers

Before 1991, many Somalis who were educated abroad returned home to opportunities in the vast public sector and the export economies linked to it. With the collapse of the state, opportunities at home decreased, resulting in a further scattering of Somalia's skilled workforce and a growth of the informal economy. Although the demise of the massive Somali state swept away the largest provider of jobs in the country, there are those who now thrive in the unregulated informal economy. What has been a tragedy for most Somalis, has resulted in opportunities for some. Coastal bandits and pirates in the longest stretch of sea border of any country in Africa, regional clan leaders, warlords and their security forces controlling access to trade of livestock, *khat*, food, fuel and household goods, but also land speculators who are thriving in the urban areas across the country, as well as a few local politicians and authorities who permit these activities - all these form part of the "winners" of the disappearance of "law and order" in Somalia.

However, and this is the flipside of the current situation, there are also considerable amounts of legitimate trade and investment going on in Somalia today. It has been documented that the livestock trade is probably doing even better in the aftermath of the collapse of the state than it did under the predatory Barre government (Little, 2003). Today, nearly all of Somalia is linked to the world by sophisticated telecommunications networks. For example, mobile phones have replaced radio communications as the necessary tool for the Somali remittance system. In the larger towns, there are competing mobile phone networks, and private companies coordinate services with local authorities to provide 24-hour electric power, many through investments by the diaspora. Among the Somali youth especially, many have developed expertise and competence in information

technology and communications. The IT and remittance sectors in Somalia have greatly benefitted from the dynamic business approaches of younger Somalis and will remain central in Somalia's future development.

The Somali diaspora is one of the most active remitters of money worldwide and remains engaged in active circular migration to set up or share in businesses, community-based organizations, hospitals or educations of higher learning back home. A well-known problem is, however, that many graduates - once their education completed - leave home to find better and safer opportunities to use their newly acquired skills.

Today, most job opportunities in government, business, as well as the security sector, are supported through targeted involvement of the diaspora. In addition, many elected officials in Somalia's local and regional governance institutions come directly from the diaspora. Just as there is diversity in clan and political alliances throughout the country, the same applies to structures in the diaspora. Diaspora communities and individuals are financially supporting politics back home.

A unique characteristic of Somali culture is the so-called *xeer*. *Xeer* refers to the traditional Somali way of social interaction, to greet one another, to treat a guest, to seek assistance and respect elders. *Xeer* is the key to networking and means that Somalis themselves are best positioned to bring business into Somalia. Outsiders, and perhaps some of the younger second and third generation Somalis from the diaspora may find difficulty doing business in Somalia if they do not know how to abide by the traditions of *xeer*.¹

In sum, a historically mobile population, Somalia's workforce was particularly poised to use migration as a strategy to seek opportunities that the modern global economy provides.

Gender and the work force

Roles between men and women in different parts of Somalia and in the diaspora have changed greatly over time. The traditional pastoralist society saw men taking care of camels, sometimes traveling great distances. Women were in charge of the household, as well as caring for other livestock, such as sheep and goats. Men were hierarchically in charge, polygamy widespread and the "vulnerability and chastity of women" emphasized (Lewis, 2008).

The veiling of women and the suppression of women's voices is only a relatively recently imported phenomenon that has come with a particular brand of Islam from the Gulf States. Singing, poetry and dancing are traditional forms of expression that have been

prohibited by a strict version of Islam enforced by militias competing with warlords in certain parts of the country.

Women have been made to bear the brunt of the consequences of war, many have been exposed to sexual and gender-based violence. With the loss of so many men to war and migration, women have often become the sole bread-winners, hence the traditional gender roles have changed. Women can be found as traders in urban centers, women are now admitted to most universities and women from the diaspora come back to engage in leadership roles, especially in community-based and non-governmental organizations (UN-INSTRAW, 2008).

Although the roles between men and women and within the family are still quite rigid, experiences of Somalis in the diaspora have brought about “gender transformations” (Kusow 2007, p 37). Especially the economic empowerment of women has led to a change of roles in the family and, as a result, many Somali marriages in the diaspora have not lasted long. Many women are too the direct receivers of remittances from family members abroad, often giving them more economic power over male low-wage earners.

The consequences of these dynamics have resulted in a more egalitarian social framework, particular in the diaspora. However, in some cases, the effects have been a harsher treatment of women based on religious or traditional beliefs. The United Nations and the donor community have attempted to enforce the selection of women in leadership positions at the local levels, but with mixed results. In some cases, district councils have elected women representatives (Kelly, 1997; UN-INSTRAW, 2008).

Diaspora Engagement in Somalia

Globalization and the globalized economy have created tremendous opportunities for many Somali migrants. If supported, these migrants can do a great deal to reverse the damaging effects of the “brain drain” and to contribute significantly towards the development of Somalia.

There is nothing new to the idea of Somalis from the diaspora working towards the development of their home country. Diaspora Somalis run for elected office, start businesses, support community development projects, build hospitals, and send remittances to their families, and have for many generations. The diaspora accumulates human, financial, and social capital, and often repatriates it to Somalia in the form of remittances or direct investments that benefit individuals and the population at large. “In countries where remittances are important, the political effects are not inconsequential” (Kapur and McHale, 2005).

As Kapur and McHale also note, remittances are a source of “international political intrigue” as well. Senders of remittances are often interested in the security and development implications of their monies. In the Somali context, when the Bush administration froze the assets of several well-known Somali money transmitting companies, or *hawalas*, under the assumption that some remitters were involved in terrorist activities in the Horn of Africa and possibly beyond, it might be reasonable to suggest that many Somalis are now less likely to use the formal remittances systems. This makes it difficult to estimate the scale and scope of Somali remittances and their effect on development. Although it is assumed that remittances in general are spent mostly on domestic or household consumption, it is argued that these remittances have great “multiplier effects” and can be “leveraged for broader economic development” (Kapur and McHale, 2005).

Human capital is the sum that results from higher education, training and work experience. Migrants can offer their human capital to the development of the home country through transfer of skills by return migration, or “virtually” through communications technologies in the host country. Social capital in the form of migrant networks with links to both host and home communities can provide developing countries with access to more developed markets. Access can be instrumental in orienting foreign direct investment towards the home country. Diasporas often organize themselves and form associations that are able to promote the flow of investments and know-how to their home countries. This has occurred especially through joint investments, such as mobile phone technologies, from investors from Arab countries.

Through investments in health centers, universities, communications and mobile technologies and infrastructure, diaspora investments have diversified the Somali economy. The diaspora has introduced innovation and entrepreneurship from China, Malaysia, the Middle East, Europe, North America, Australia and Sub-Sahara Africa. Today, many rural and isolated areas can afford internet or mobile phone technology, especially owing to the younger Somali entrepreneurs. Using Somali trust based on *xeer*, they have built cheap and reliable mobile phone and internet networks as well as money transfer systems.

There are numerous projects implemented by the international community that support diaspora initiatives, encouraging them to add to the recovery, rebuilding and development of their home country: the World Bank’s initiative for low income countries under stress, Distance Learning and Connectivity Project in East Africa University in Bossaso, the Puntland State University in Garowe, the Somali Institute of Management and Administration Development in Mogadishu, Mogadishu University, University of Hargeisa, and Amoud University in Boroma, UNDP’s transfer of knowledge through

expatriate nationals, IOM's Migration for Development in Africa and Return of Qualified Nationals programmes, UNDP and IOM's joint QUESTS-MIDA project.

Some diaspora-induced success stories

The following are success stories through Somalia diaspora contributions thanks to the knowledge, investment, donations and scientific networks of Somalis abroad.

- **Mogadishu University** is the biggest university in Somalia with a capacity of 3000 students spread across the following faculties: Education, Economics and Management Science, Law and Sharia, Arts and Humanities, High Institute of Nursing, Computer Science and Information Technology, Center for Community Services and Continuing Education. Mogadishu University has mobilized funding through the Arab Development Bank, the African Development Bank and the World Bank's virtual university program.²

- **The Somali Institute of Management and Administration Development (SIMAD)** in Mogadishu, is currently offering Business Administration, IT courses, Accounting and Languages at diploma and bachelor levels. In addition, the institution designs, develops and implements customized courses for the private and business enterprises. SIMAD has a functional distance-learning center.³

- **Amoud University** in Boroma, Awdal, Somaliland. Established in 1994, the university has the following faculties: Education, Business and Public Administration, Medicine and Nursing, Agriculture and Environment, Information Technology and Distance Learning, Law and Sharia. The Amoud University's Faculty of Medicine and Surgery was established at the beginning of 2001 and a first group of 20 medical doctors graduated in 2008, helping to fill gaps in the chronically understaffed health sector in Somalia.⁴

- **Benadir University** in Mogadishu. Representing the biggest urban population in the country and the very center of two decades of conflict, Mogadishu's inhabitants have disproportionally suffered from the violence. A large number of qualified Somali doctors have fallen victims of the civil war or fled in search of better security and livelihood. In 2002, a group of Somali doctors decided to establish the Benadir University which now has the following faculties: Medicine, Engineering, IT and Computer Science, Education. Benadir University has established international relations with several other universities: Al-Jazeera University in Sudan, Alexandria University in Egypt, and Karolinska Institute in Sweden. It is also registered with the World Health Organization and the World Health Foundation. The first group of 25 medical doctors has graduated in 2008 and most of them work in Mogadishu hospitals (Medina, Geysaney and Benadir), but also with INGO's, such as MSF or ICRC.⁵

- **Arafat Hospital** is a good example of what the Somali diaspora can do with minimal financial investment. Three years ago, two Somali doctors gave up their lucrative practices and comfortable lives in the Gulf and returned to Mogadishu to set up the hospital. The two doctors brought with them much-needed skills to treat tuberculosis, malaria and respiratory diseases. While the doctors could not afford to build a brand new hospital, working with friends, they pooled enough resources to purchase high-tech diagnostic equipment to support their work in gynecology, urology, and obstetrics (Ryu, 2004).

- **Information technology** is increasingly used to strengthen the links between the diaspora and Somalia. An interesting case is the new satellite TV station, Universal TV. This station showcases a typical global Somali business venture as the station is owned by a businessman based in the UK and Dubai, running businesses in satellite telecommunications (Farah, 2009).

Diaspora engagement in Somalia remains relatively unknown outside of Somali media circles. Most media channels display the conflict, the piracy and the poverty. However, skilled Somalis who are part of a global workforce have been contributing to the development of Somalia in spite of insecurity and in the absence of a strong central state authority. Efforts to facilitate and support this positive engagement of the skilled Somali workforce should be considered by the donor community, as it is the Somalis themselves who are best equipped to be agents of change in Somalia.

One of the key challenges when writing about Somalia is the lack of data. In the absence of reliable data and national records, one can only speculate about the numbers of qualified Somalis still in the country. And due to the lack of a coherent system to gather and analyze data related to the various Somali diasporas all over the world, the socio-economic profile of Somalis in the diaspora is sketchy at best. Further statistical research must be done to document the Somali diaspora and the skilled workforce back home and abroad, especially in view of the search for viable strategies aimed at engaging the diaspora for the development of Somalia.

Notes

- 1 It is well known that recent conflict in the southern or south-central region of Somalia has been experiencing conflict with Islamist extremists and insurgents who have taken over large sections of territory. Apparently, these groups have been attempting to abolish the old ways of xeer.
- 2 see <http://www.mogadishuuniversity.com>
- 3 Somali Institute of Management and Administration Development , see <http://www.simadsom.org>
- 4 see <http://www.amouduniversity.net>
- 5 see <http://www.benadiruniversity.net>

References

- Farah, A.
2009 "Diaspora involvement in the development of Somalia", *DIIPER Research Series*, Working Paper No. 13, Aalborg University, Denmark.
- Ghedi, A.J.
2007 "Diaspora Contribution to Innovative Sectors: The Horn of Africa's Experience", in Johansson, D., *The Role of Diasporas in Peace, Democracy and Development in the Horn of Africa*, Sociologiska Institutionen, Lund.
- ILO
1989 "Generating Employment and Incomes in Somalia", Jobs and Skills Programmed for Africa, International Labour Office, Addis Ababa.
- IOM
2006 "Stranded Migrants in Bossasso, North East Somalia/Puntland", Field Report. International Organization for Migration, Nairobi.
- Kapur, D. and J. McHale
2005 *Give Us Your Best and Brightest: The Global Hunt for Talent and Its Impact on the Developing World*, Center for Global Development, Washington, D.C.
- Kelly, H.
1997 "The Potential Role of Women's Groups in Reconstruction", in Hussein, M. and R. Ford, *Mending Rips in the Sky: Options for Somali Communities in the 21st Century*, The Red Sea Press, Asmara.
- Kusow, A.
2007 "From Mogadishu to Dixon: Conceptualizing the Somali Diaspora", in Farah, O. et al., *Somalia: Diaspora and State Reconstruction in the Horn of Africa*, Adonis & Abbey Publishers Ltd, London.
- Lacey, M.
2006 "Amid Somalia's troubles, Coca-Cola hangs on", *International Herald Tribune: Africa and the Middle East*. 10 July, 2006.
- Lewis, I.
2008 *Understanding Somalia and Somaliland*, HURST Publishers Ltd, London.
- Little, P.
2003 *Somalia: Economy Without a State*, The International African Institute, Oxford.

- Mazrui, A.
1997 "Crisis in Somalia: From Tyranny to Anarchy", in Hussien M. and R. Ford, *Mending Rips in the Sky: Options for Somali Communities in the 21st Century*, The Red Sea Press., Asmara.
- Merriam-Webster
2009 *Merriam-Webster's Online Dictionary*, [http:// www.merriam-webster.com](http://www.merriam-webster.com)
- Ryu, A.
2004 "Foreign-Educated Somalis Give Up Lucrative Incomes Abroad to Serve Homeland", *VOA New*, 18 February, 2004, Mogadishu.
- Sheikh, H. and S. Heally
2009 *Somalia's Missing Million: The Somali Diaspora and its Role in Development*, United Nations Development Programme, March 2009, Nairobi.
- UN-INSTRAW
2008 *Women, Peace and Security in Somalia: Implementation of UN Security Council Resolution 1325*, United Nations International Research and Training Institute for the Advancement of Women (UN-INSTRAW), Santo Domingo.

IOM HARGEISA: HEALTH SECTOR ASSESSMENT OF SOMALILAND DECEMBER 2008

IOM Hargeisa

General Country Context

Somaliland is situated in the eastern part of the Horn of Africa. It shares borders with the Republic of Djibouti to the west, the Federal Republic of Ethiopia to the south and Puntland to the east. Somaliland has a coastal line which extends 460 miles along the Red Sea. The international community has not recognized Somaliland's independence; however, several countries keep an unofficial diplomatic presence in Somaliland's capital Hargeisa. One major step in the country's democratic development was the adoption of a Constitution for Somaliland in a general referendum held in 2001.

The population of Somaliland is estimated at around 3.5 million. The average population growth rate is 3.1 %. Population density is estimated at approximately 25 persons per square kilometer. Fifty-five % of the population is either nomadic or semi-nomadic, while 45 % live in urban centers or rural towns. The mobile lifestyle of pastoralist communities is a challenge to accessing health services in rural areas. The average life expectancy for males is 50 years and 55 years for females, one of the lowest globally (Somaliland Government - SG, 2001). In contrast, the average life expectancy in Finland for both males and females is 81 years (UN, 1999). Poverty and seasonal disease outbreaks caused by poor hygiene and sanitation practices (i.e. cholera, malaria and diarrheal disease) contribute to high morbidity and mortality rates mostly among children under 5 years (MoHL, 2006). Somaliland has not had a census so far, thus making population estimates very unreliable. Furthermore, Somaliland is one of the main transit regions for migrants coming from Ethiopia and other parts of Africa, and internally displaced persons from South Central Somalia on route towards the Gulf States.

Hargeisa is the capital of Somaliland with an estimated population of 450,000 (SG, 2001). The other main towns and their estimated populations are Burao (290,000), Borama (215,000), Berbera (61,000), Erigavo (115,000) and Las Anod (75,000) (UNDP, 2006).

Map 1: Map of Somaliland and major towns.



Healthcare Facilities and Services

Healthcare services and policies are managed by the Somaliland Ministry of Health and Labour (MoHL). However, as a result of years of war, famines and underinvestment, its capacity remains very weak and the MoHL is unable to provide and guarantee adequate health services for the population. Somaliland's healthcare system is characterized by a severe shortage of skilled healthcare workers, limited medical supplies, and growing healthcare needs among the population. As mentioned above, Somaliland is experiencing an increase in the number of internally displaced people (IDPs), refugees and economic migrants that further exacerbates the pressure on the health sector.¹ The 2007 United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) Somaliland Assistance Bulletin reports 40,000 IDPs living in Somaliland, in extremely poor conditions. The majority of the IDPs are in urban areas with inadequate water and sanitation facilities and without access to basic social services. UNOCHA further states that the number of IDPs in Somaliland is probably growing due to unrest in South Central Somalia (UNOCHA, 2007).

Most healthcare facilities and services are accessible only in urban areas, leaving the rural population facing major difficulties in obtaining healthcare assistance. Furthermore, scarce resources impede collection and analysis of health information data in order to plan effective responses. As a result, during the drafting of this needs assessment report major challenges were encountered due to lack of reliable information and data.

Public Hospitals

Table 1 presents the distribution of public hospitals and health posts in Somaliland. There are 6 regional referral hospitals and 5 district hospitals. The regional hospitals are critical to the delivery of secondary healthcare services to the population. Hargeisa Group Hospital (HGH) plays a fundamental role as the national referral hospital. Unfortunately these institutions are characterized by a severe lack of equipment including Magnetic Resonance Imaging (MRI), Computerized Tomography Scan (CT Scan), dialysis machines, and equipment and drugs for cardiovascular emergencies. Furthermore HGH, the biggest in Somaliland, does not have an appropriate medical emergency facility.² A minority of the population travels to neighbouring countries such as Djibouti, Ethiopia, the United Arab Emirates and Kenya for healthcare services that are not available in Somaliland. However, in most emergency cases this is not an option.

As shown in table 1 , there are entire regions and districts which are not equipped with any health posts to facilitate population access to healthcare services. This is the case, for example, in Awdal Region. There is no further available information regarding the geographical distribution of these healthcare infrastructures.

Table 1: Number and location of Somaliland public hospitals and health posts in 2006³

Region/ District	Regional Hospital	Mental Health Hospital	District Hospital	TB Centre	MCH	Health Posts	Total
Region Maroodi-Jeh (Hargeisa)	1	1	0	1	21	21	45
District Gebelay	0	0	1	1	3	0	5
District Alaybaday	0	0	0	0	1	0	1
Region Awdal	1	0	0	1	17	0	19
District Saylac	0	0	1	0	0	0	1
Region Sahil	1	1	0	1	6	11	20
District Sheikh	0	0	1	1	0	0	2
Region Togdheer	1	1	0	1	6	30	39

District Odweyne	0	0	1	0	0	0	1
Region Sanag	1	0	0	1	8	30	40
District Badhan	0	0	1	0	0	0	1
Region Sool	1	0	0	1	8	30	40
Total	6	3	5	8	70	122	214

Beside the lack of technical equipment and infrastructure, from different interviews held with the MoHL and healthcare professionals it was reported that there is a widespread lack of specialized physicians and other medics, especially:

- 7 Ear Nose and Throat (ENT) Specialists;
- 7 Neurologists;
- 7 Cardiologists;
- 7 Gastroenterologists;
- 7 Gynaecologists;
- 7 Haematologists;
- 7 Dermatologists;
- 7 Dentists;
- 7 Endocrinologists;
- 7 Orthopaedic Surgeons;
- 7 Physiotherapists;
- 7 Pathologists;
- 7 Public Health Specialists;
- 7 Radiologists;
- 7 Laboratory Technicians;
- 7 Midwives;
- 7 Qualified Nurses.⁴

Private Clinics

While in the urban centers private health clinics are common, services are expensive. Patients are charged US\$2.50 for each visit which is five times higher than in public hospitals.⁵ Many families would not be able to pay the amount requested for a visit at either a public or private hospital, particularly if we consider that the UNDP/WB 2002 Socio-Economic Survey estimated the average annual income in Somalia to around

225 US\$ per capita (UNDP/WB, 2002). Unfortunately there is no disaggregated data concerning Somaliland specifically.

The average monthly salary of doctors employed in the public sector is approximately US\$51 while matrons, qualified nurses, and midwives receive the equivalent of US\$42. In the private sector, doctors on average earn US\$500 and qualified nurses US\$115.⁶ There is therefore more incentive for qualified personnel to work in private institutions. At this time, no reliable data is available on the distribution of healthcare staff practicing in public and private clinics in Somaliland.

Pharmacies

Since the collapse of the Somali central government in 1991, dispensaries or pharmacies became profit-oriented drug-supply shops run by unqualified personnel. Pharmacy staff does not require prescriptions to dispense medications and cannot advise patients on potential side effects and contraindications. In Somaliland, there is no quality control of imported medication, and the distribution and availability of drugs remain problematic in all regions. Unregulated drugs are on sale in all privately run pharmacies.⁷

Maternity and Gynecology Services

There is no available routine health data collection in Somaliland. Table 2 shows the number of births in 2006 in four main Somaliland hospitals, including type of delivery.

Table 2: Number and percentage of deliveries by type at 4 Somaliland hospitals⁸

	Hargeisa Group Hospital		Gabiley Hospital		Burao Hospital		Borama Hospital	
Vaginal deliveries	2825	90%	261	95%	248	78%	1123	91%
Caesarean section deliveries	314	10%	12	5%	71	22%	111	9%
Total deliveries	3139	100%	273	100%	319	100%	1234	100%

Scarce information is available regarding complications most commonly encountered during delivery or other events necessary for service delivery planning. The HGH General Director highlighted that at HGH in 2006 common problems faced during delivery

were the use of vacuum/forceps in 6% of total deliveries and still births accounting for 2% of deliveries.

Miscarriage is prevalent in Somaliland and heavy labour tasks performed by women during pregnancy; malaria and poor sanitation are considered to be associated.⁹ According to the 2004 MoHL annual report, the total numbers of qualified midwives employed in the public sector is 18 for Somaliland. Seven midwives are based at HGH with no other female health professional available in the field of gynecology and reproductive health.¹⁰ Anecdotally, the lack of female clinicians is considered to be a barrier among pregnant women to accessing gynecological healthcare.

As highlighted earlier, there is a lack of disaggregated data for Somaliland. However, UNICEF provides information on the situation in Somalia as a whole. Table 3 shows that Somalia reports among the highest maternal, infant and child mortality rates globally. Somalia's maternal mortality rate is 200 times higher than Finland and child mortality rate is 39 times higher. In Somalia, only 33 % of child births are attended by skilled personnel, in most cases among educated women. A very negative impact on maternal health is also provoked by anemia and female genital mutilation (UNICEF, 2006).

Table 3: Annual maternal, infant and child mortality rates in Somalia (1994 – 2006) and Finland¹¹

	Year	Somalia	Year	Finland
Maternal mortality rate (per 100,000 live births)	1994-2006	1,013	2004	5
Infant mortality rate (per 1,000 live births)	2003-2006	96	NA	NA
Child mortality rate (per 1,000 live births)	2003-2006	156	2004	4

Children Health Status

The UNICEF “Somalia Consolidated Emergency Thematic Report” (2006) provides some basic data on the status of child health in Somalia as a whole. For example, 35 % of the child population under the age of five has been classified as moderately or severely underweight.¹² The high rates of infant and child mortality (see Table 4) are a combination of different factors including malnutrition, low immunization coverage, disease outbreaks and poor sanitation. In 2006 among children under one year of age,

only 35 % were immunized for **Bacillus Calmette-Guérin** (TB Vaccination) BCG, 20% for Diphtheria, Pertussis, Tetanus (DPT3/Polio3) and 22% for measles.¹³

Table 4: Percentage of immunization coverage among children under 1 year of age in Somalia and Finland in 2003 and 2006¹⁴

Percentage of children vaccinated under 1 year of age	Year	Somalia	Year	Finland
BCG Vaccination	2006	35%	2003	97.4%
DPT3/Polio3 Vaccination	2006	20%	2003	97.4%
Measles Vaccination	2006	22%	2003	97.5%

Mental Health Facilities and Services

In Somaliland, there are only three institutions providing mental healthcare services: Hargeisa Group Hospital mental ward, Berbera Mental Hospital and Burao Hospital mental ward (Vivo Foundation, 2002). In 2002, a study was conducted by Vivo Foundation, an alliance of professionals experienced in the fields of psycho-traumatology, in collaboration with the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), on psychiatric disorders in Somaliland.¹⁵ The high prevalence of mental disorders (2.8 % acute schizophrenia-like psychosis) is considered to be associated with psychological trauma caused by the conflict and high consumption of Khat.¹⁶ Furthermore, the main caretakers of patients are their families, who commonly seek help from traditional or religious leaders, who have no clinical or medical background in treating mental health disorders.¹⁷

Healthcare Human Resources

Table 5 shows the number of healthcare professionals employed in the public health sector in 2006. The majority of medical staff is concentrated in Maroodijeh region, where Hargeisa is located, indicating particular shortages outside of the capital region. Unfortunately the table does not indicate the healthcare professionals' categories and qualification. During consultation, Somaliland health institutions reported to IOM Hargeisa priority healthcare human resource needs (see table 6). The information collected highlights an evident need of specialized physicians and other medical staff. In addition to increasing the number and type of specializations among healthcare workers, a need for further training to improve skills was reported. Strengthening public health expertise at the population level, for example in the fields of epidemiology, services

planning and health economics, were cited as key areas for capacity-building within MoHL.

Table 5: Number of public sector healthcare workers by region in Somaliland in 2006 (MoHL, 2006)

Staff	Central MoHL	Maroodijeh Region	Awdal Region	Sahil Region	Togdheer Region	Sanaag Region	Sool Region
Medical Doctors	20	20	11	3	12	4	2
Qualified Nurses	10	130	17	10	46	24	4
Midwives	15	20	9	5	10	5	1
Laboratory Technicians	5	7	2	1	3	1	1
X-Ray Technicians	0	2	1	0	1	0	0
Auxiliary Nurses	33	111	46	51	68	40	9
Dental Technicians	0	1	0	0	0	0	0
Physio-therapists	0	1	1	0	0	0	0
Pharmacists	1	1	0	0	0	0	0
Total	142	361	148	104	176	92	19

Table 6: Requests for healthcare professional placements by specialization and location in Somaliland in 2008^{18 19}

Specialization	Location	Hosting Institution	Start Date	Finish Date
Anesthetic trainer	Hargeisa	Manahal Specialist Hospital	December 2008	February 2009
Clinical instructor	Hargeisa	Adna Edan Maternity Hospital	December 2008	February 2009
Dentist	Hargeisa	Manahal Specialist Hospital	October 2008	December 2009
Dental nurse	Hargeisa	Manahal Specialist Hospital	October 2008	December 2009

ENT specialist	Hargeisa	Hargeisa University	January 2009	March 2009
ENT specialist	Hargeisa	Arafat Specialist Hospital	January 2009	March 2009
Neurologist	Hargeisa	Hargeisa University	December 2008	February 2009
Neurologist	Borama	Amoud University	December 2008	February 2009
Radiologist	Borama	Amoud University	January 2009	March 2009
Gastro-enterologist	Borama	Amoud University	February 2009	April 2009
Hematologist	Hargeisa	Hargeisa University	February 2009	April 2009
Physiotherapist	Hargeisa	Amoud University	December 2008	February 2009
Physiotherapist	Hargeisa	Arafat Specialist Hospital	December 2008	February 2009
Lab. Technician Trainer	Hargeisa	Shifa Training School	December 2008	February 2009
University First Year Medicine Instructor	Hargeisa	Hope Medical and Technology University	December 2008	February 2009
Pediatric Cardiologist	Hargeisa	Nasrudin Clinic	December 2008	February 2009
Pediatric Neurologist	Hargeisa	Nasrudin Clinic	February 2009	April 2009
Gynecologist	Hargeisa	Magan Maternity Hospital	December 2008	February 2009
Hospital Administrator	Hargeisa	Hargeisa Group Hospital	November 2008	January 2009
Lab. Technician Trainer	Hargeisa	Hope Medical and Technology University	December 2008	February 2009
Midwives Trainer	Hargeisa	Magan Maternity Hospital	January 2009	April 2009
Mental health specialist	Hargeisa	Hargeisa Group Hospital	December 2008	February 2009

Mental health worker	Berbera	GAVO NGO	December 2008	February 2009
Pathologist	Hargeisa	Hargeisa Group Hospital	December 2008	February 2009
Senior Matron	Hargeisa	Hargeisa Group Hospital	December 2008	February 2009
Senior Operation Theatre Nurse	Hargeisa	Hargeisa Group Hospital	December 2008	February 2009
HIVCare Nurse Trainer	Hargeisa	Adna Edan Maternity Hospital	December 2008	February 2009
Cardiologist	Hargeisa	Hargeisa University	January 2009	March 2009
Dermatologist	Hargeisa	Hargeisa University	February 2009	April 2009
Epidemiologist	Hargeisa	Ministry of Health and Labour	December 2009	February 2009
Health Economist	Hargeisa	Ministry of Health and Labour	February 2009	April 2009
Legal Medicine	Hargeisa	Ministry of Health and Labour	April 2009	June 2009
Public Health specialist	Hargeisa	Ministry of Health and Labour	February 2009	April 2009
Public Health Designer	Hargeisa	Ministry of Health and Labour	December 2009	February 2009

Healthcare Professional Training Facilities

There are seven teaching health institutions in Somaliland (three medical schools and four basic nursing schools):

- 7 Borama Medical School (Amoud University Faculty of Medicine), Borama;
- 7 Hargeisa Medical School (University of Hargeisa Faculty of Medicine), Hargeisa;
- 7 Hope Medical and Technology University, Hargeisa;
- 7 Hargeisa Institute of Health Sciences (basic nursing), Hargeisa;
- 7 Edna Adan Nursing School, Hargeisa;
- 7 Shifa Health Training School, Hargeisa;
- 7 Burao Nursing School, Burao.

Nursing schools and health training schools provide different types of training, ranging from three-month to three-year courses at secondary school level. With regard to post secondary school trainings, Hargeisa University, Amoud University and Hope Medical and Technology University (HMTU) have medical faculties. However study curricula were developed locally and lack practical training, teaching facilities and human resources.²⁰

In total, the medical faculty of Hargeisa University has 75 enrolled students. The ratio of women enrolled in academic medical studies has been very low but it shows an increasing trend if we look at the first year of enrolment in both universities. The reason for this could be found in an increased level of education of the female population, or it may be due to the fact that many female students abandon their studies before completion. Conversely, table 8 shows an increase during 2006 and 2007 in the number of female students enrolled at Shifa Health Training school, accounting for respectively 29 % and 23 % of the school population.

Table 7: Student enrolment at Hargeisa and Amoud Universities medical faculties by sex in 2007²¹

Year	University of Hargeisa				Amoud University			
	Male Number	Male %	Female Number	Female %	Male Number	Male %	Female Number	Female %
4th	16	18%	3	11%	4	21%	1	10%
3rd	30	35%	7	27%	7	37%	2	20%
2nd	17	20%	8	31%	6	32%	3	30%
1st	23	27%	8	31%	2	10%	4	40%
Total	86	100%	26	100%	19	100%	10	100%

Table 7a: Number and percentage of males and females enrolled at the University of Hargeisa Medical School in 2007²²

	Male		Female	
	Number	Percentage	Number	Percentage
1st Year	23	27%	8	31%
2nd Year	17	20%	8	31%
3rd Year	30	35%	7	27%
4th Year	16	18%	3	11%

Table 7b: Number and percentage of males and females enrolled at Amoud University Medical School in 2007²³

	Male		Female	
	Number	Percentage	Number	Percentage
1st Year	2	10%	4	40%
2nd Year	6	32%	3	30%
3rd Year	7	37%	2	20%
4th Year	4	21%	1	10%

Table 8: Shifa Health Training School annually graduated nurse students by sex from 2003 to 2007²⁴

Year	Male	Male %	Female	Female %	Number Graduated Students	% Graduated Students
2003	0	0	22	35%	22	24%
2004	20	69%	0	0	20	22%
2005	0	0	8	13%	8	9%
2006	0	0	18	29%	18	20%
2007	9	31%	14	23%	23	25%
Total	29	100%	62	100%	91	100%

Table 9 presents the training program currently used at Shifa Health Training School. While attempting to be comprehensive, the school lacks qualified trainers and facilities. Similar challenges are experienced by all other nursing schools in Somaliland. Furthermore, graduating students qualified as nurses have difficulties finding employment in hospitals given the scarce resources available for these institutions.

Table 9: Shifa Health Training school yearly program from 2003 to 2007 ²⁵

	First Year Courses	Second Year Courses	Third Year Courses
1	Islam	Microbiology and Parasitology	Health Education
2	Biology	First aid / Basic life support	Community Health
3	Chemistry	Epidemiology	Adult nursing and gerontology
4	Physics	Nutrition and biochemistry	Psychiatric nursing
5	Medical terminology	Sterilization	Occupational health
6	Communication skills	Child care (Pediatric Nursing)	Maternal health/ gynecology and Female Genital Mutilation (FGM)
7	Anatomy and physiology I	Health statistics	Clinical experience/job training
8	Anatomy and physiology 2	Clinical assist	English
9	Sociology and anthropology		
10	Ethics in nursing		
11	Pharmacology I		
12	Pharmacology 2		
13	Fundamentals of nursing I		
14	Fundamental of nursing 2		
15	Psychology		

Key health challenges in Somaliland and suggestions for MIDA implementation

The poor conditions of the Somaliland healthcare system are caused by various factors that represent major obstacles in developing a well functioning healthcare system. These factors can be summarized as follows:

- 7 Limited financial resources available at government level;
- 7 national health policies and guidelines are in place but not implemented due to a lack of resources and capacity;
- 7 lack of managerial, administrative, research and analytical skills;
- 7 lack of appropriate health facilities, equipment and infrastructure;
- 7 lack of health facilities in rural areas;
- 7 lack of health professionals in all regions of Somaliland;
- 7 underdeveloped healthcare training programs;
- 7 general poor health conditions of the population due to conflict, displacement, droughts, etc.

Regarding MIDA implementation, consultations with key stakeholders highlighted the following suggestions:

- 7 to organize an effective training program, the deployment period of Somali diaspora health professionals should have a duration of ideally between 6 and 12 months;
- 7 Somali diaspora health professionals should have the relevant experience required for the field of expertise requested by host institutions;
- 7 Somali diaspora health professionals should report to the IOM field manager every month, on activities and challenges experienced during their assignment;
- 7 to increase the number of potential healthcare professionals willing to participate in the project by organizing targeted outreach and sharing success stories.

Given the general health situation in Somaliland, MIDA's main interventions should revolve around:

- 7 the provision of capacity-building and training to Ministry of Health and Labour staff members in order to enhance managerial, administrative, research and analytical skills;
- 7 the provision of specialist training to healthcare professionals;
- 7 upgrading of equipment and facilities;

- 7 a prioritization of those public hospitals providing medical assistance to the poorest segments of the population;
- 7 a prioritization of those private hospitals and clinics that provide free-of-charge medical consultations and assistance.

Notes

- 1 Information gathered by IOM in consultation with MoHL and healthcare professionals in Somaliland.
- 2 Information gathered by IOM in consultation with various health care institutions in Somaliland.
- 3 Information provided by Somaliland MoHL, 2006.
- 4 Information gathered by IOM in consultation with MoHL and healthcare professionals in Somaliland.
- 5 Ibid.
- 6 Ibid.
- 7 Ibid.
- 8 Information provided by Somaliland MoHL, 2006.
- 9 Information gathered by IOM in consultation with MoHL and healthcare professionals in Somaliland.
- 10 Information gathered by IOM in consultation with Hargeisa Group Hospital General Director. Currently this is the situation in all of Somaliland hospitals but unfortunately we cannot provide disaggregated data.
- 11 See UNICEF, 2006, WHO 2006.
- 12 See UNICEF, 2006.
- 13 Ibid.
- 14 See UNICEF, 2006 and Finland National Public Health Institute, 2008.
- 15 See Vivo Foundation, 2002.
- 16 Khat is a plant whose leaves and stem tips are chewed for their stimulating effect. The consumers get a feeling of wellbeing, mental alertness and excitement. The after effects are normally insomnia, numbness and lack of concentration. The consumption of this drug is mainly spread among the male population.
- 17 See also Tiilikainen in this publication.
- 18 Information gathered by IOM in consultation with Hargeisa, Berbera and Borama healthcare institutions, 2008.
- 19 This list is not exhaustive and requests for MIDA placements continued to be received and reviewed by IOM in Hargeisa.
- 20 Information gathered by IOM in consultation with Hargeisa University and Amoud University.
- 21 Information gathered by IOM Hargeisa, 2008.
- 22 Information gathered by IOM Hargeisa, 2008.
- 23 Ibid.
- 24 Data provided by Shifa Health Training School.
- 25 2003/2007 Training program provided by Shifa Health Training School, Hargeisa.

References

- Finland National Public Health Institute
2008 “Vaccination Coverage”, Report, FNPHI, Helsinki, http://www.ktl.fi/portal/english/research_people_programs/vaccines/vaccination_coverage/ .
- Ministry of Health and Labour (MoHL), Somaliland
2006 *Annual Health Report*, MoHL, Hargeisa.
- Somaliland Government
2001 *Country Profile*, <http://www.somalilandgov.com>
- UNDP/World Bank
2002 *Somalia Socio-Economic Survey*, UNDP/WB, New York and Washington D.C.
- UNDP
2006 *Somaliland Settlement and Population Figures*, UNDP.
- UNICEF
2006 “Somalia Consolidated Emergency Thematic Report”,. *United Nations Demographic Yearbook*, UN, New York.
- UNOCHA.
2007 *Somaliland Assistance Bulletin*, UNOCHA, [http://www.reliefweb.int/rw/RWFiles2007.nsf/FilesByRWDocUnidFilename/SHES6ZXS63-full_report.pdf/\\$File/full_report.pdf](http://www.reliefweb.int/rw/RWFiles2007.nsf/FilesByRWDocUnidFilename/SHES6ZXS63-full_report.pdf/$File/full_report.pdf) .
- Vivo Foundation
2002 *War-trauma, Khat Abuse and Psychosis: Mental Health in the Demobilization and Reintegration Program Somaliland*, Vivo Foundation, Ancona.
- WHO
2006 “Mortality Country Fact Sheet”, WHO, Geneva, http://www.who.int/whosis/mort/profiles/mort_euro_fin_finland.pdf .

MIGRATION FOR DEVELOPMENT IN AFRICA (MIDA) ASSESSMENT MISSION OF AWDAL, SAHIL AND TOGDHEER HEALTH INSTITUTIONS IN SOMALILAND

IOM Hargeisa

The assessment mission was conducted by the MIDA Health Somaliland-Puntland field manager from 15th to 18h March 2009 as an element of IOM Helsinki's MIDA health project for Somali health professionals from the Finland-based diaspora. It aimed at strengthening the relationship with the healthcare institutions that applied to host MIDA voluntary healthcare professionals in Borama, Berbera and Burao in Somaliland, and at collecting necessary information to facilitate the temporary returns.

Assessment Mission Objectives

1. To assess the current healthcare professional needs and the operational capacity of the healthcare institutions;
2. To inform the management of the healthcare institutions about the MIDA project;
3. To assess current healthcare educational facilities within the institutions.

Healthcare Institutions visited during the Mission

1. Borama Regional Hospital
2. Amoud University And Nursing School
3. Berbera Regional Hospital
4. GAVO Local NGO
5. Burao Regional Hospital
6. Burao Nursing School

Overview of Regions/institutions visited

Borama Regional Hospital

Borama Regional Hospital is the main hospital in Borama city, the capital of the Awdal region of Somaliland. Awdal has land borders with Djibouti and Ethiopia and serves as an important commercial hub. The region has an estimated population of around 215,000 persons.

Borama Regional Hospital has officially been working under the Ministry of Health and Labour since 1993. It is the only hospital of the region and was functioning as referral hospital and as teaching hospital for the Amoud Medical and Nursing School. The hospital was built in 1921 and has gradually expanded its capacity and enhanced medical practices since 2002. The total number of attended patients on a yearly basis is 12,000, with a stationary capacity of 350 beds. As can be seen from the table below the number of qualified healthcare professionals working in the hospital is very limited.

Table 1: Health care professionals at Borama Regional Hospital

Professionals	Male	Female	Total
General Physician Doctors	6	0	6
Physiotherapist		1	1
Gynaecologist	1	0	1
Ophthalmologist Doctors	1	0	1
Qualified Nurse	13	10	23
Auxiliary Nurse	11	5	16
Midwives		1	1
Anaesthetic	1	0	1
Lab Technicians	5	0	5
Orthopaedic Technician	1	0	1
Total	39	17	56

The hospital is supported by Awdal residents and diaspora communities. The management board developed good relationships with local and international agencies. International NGOs have supported the hospital's services by providing drugs, building constructions, staff motivation and hospital consumables. The main funding support for the hospital comes from the Italian organization *Cooperazione Internazionale*.

Amoud University and Nursing School

The Amoud University and Nursing School was formally launched in 1998 and is registered as a non-governmental, non-profit making institution. Amoud is an institute which is deeply rooted in the local community. This University, and particularly its faculty of medicine, is perceived by many Somalis as a symbol of the transition from an era of war and destruction to an era of peace and development. Students from this university support the Borama and Hargeisa regional hospitals as part of their training. Professional healthcare workers have left the country, have been killed or migrated to other regions. Before the war, the existing healthcare services in the country were very limited. The civil war has further deteriorated an already precarious situation. Amoud University established the medical faculty in 2000/2001 and the first group of students graduated in July 2007. In addition, Amoud University has established a nursing faculty in the academic year 2006/2007 in order to respond to the critical need for highly qualified nurses.

Nursing Faculty Study Program: course duration of 3 years, including 4 semesters for basic sciences, social sciences and general education, and 6 semesters for major nursing topics and clinical training.

Training Infrastructure : large hall that can accommodate 60 students at a time, class rooms that can accommodate 20 students at a time, library, 4 office rooms, 8 washrooms, kitchen and small dining hall.

Berbera Regional Hospital

Berbera Regional Hospital is the main hospital in Berbera city which is the capital of Sahil region. Berbera is a sea port with the only sheltered harbour on the south side of the Gulf of Aden. Its population in 2001 was approximately 61,000. The landscape around Berbera, along with Somalia's coastal lowlands, is desert or semi-desert where the temperatures in the summertime can approach 50°C. Most of the city residents are forced to seasonally migrate to the cooler inland cities during the summer.

Berbera Regional Hospital was established 1945 and is working under the Somaliland Ministry of Health and Labour. This hospital is the only referral hospital for the eastern

and central parts of Somaliland as there are two main highways connecting Berbera to the rest of the country. Emergency cases from road accidents that occur on these highways are always referred to Berbera's hospital due to its proximity.

Bedding capacity: general hospital - 190 beds, tuberculosis ward - 67 beds, surgical ward - 43 beds, patient wards - 64 beds, sychiatric hospital - 16 beds (11 male and 5 female).

Table 2: Health care professionals at Berbera Regional Hospital

Professionals	Male	Female	Total
General Physician Doctor	2	0	2
Gynaecologist (vacant for past 5 years)	0	0	0
Obstetrician (vacant for past 5 years)	0	0	0
Paediatric doctors (vacant for past 5 years)	0	0	0
Orthopaedic Surgeon Doctor	1	0	1
Qualified Nurse	3	2	5
Auxiliary Nurse	10	7	17
Midwives	0	3	3
Anaesthetic Nurse	1	0	1
Laboratory Technicians	4	1	5
Total	21	13	33

GAVO NGO

General Assistance and Volunteer Organization (GAVO), is a youth based non-governmental, non-profit humanitarian organization serving the Berbera, Hargeisa and Burao regions. GAVO started in 1993 to improve the mental healthcare assistance provided in Somaliland. Its programmes have made significant contributions in strengthening mental healthcare services. It expanded its scope to reach more patients during 2007. GAVO's activities are concentrated on two of the most vulnerable segments of the society: mentally handicapped and street children. The positive impact of this organization is widely felt and it is highly appreciated by local communities.

GAVO is currently intervening to improve the mental healthcare system of Somaliland by supporting the Hargeisa Group Hospital mental ward and the Berbera Mental Hospital by implementing community-based mental healthcare and awareness raising activities to advocate for the rights of the mentally ill.

Institutional Capacity Support:

The program continued to support Berbera Mental Hospital and Hargeisa Mental Health Ward with incentives, sanitation facilities, management support, training and rehabilitation of minor structural problems. Although support to Burao Mental Hospital is limited as compared to the other two hospitals, GAVO reported that every month about 250 patients are referred to the two existing mental healthcare services as either inpatients or outpatients.

Institutional staffing needs: mental health specialist, mental health administration trainer.

Table 3: Number of in-patients (December 2006)

	male	female	total
Hargeisa mental ward	75	25	100
Berbera mental hospital	37	6	43
Total	112	31	143

Burao Regional Hospital

Burao is the capital city of Togdheer region. In terms of population, it is the second largest city in Somaliland after the capital Hargeisa. Its population in 2001 was approximately 290,000. The Burao Regional Hospital was established in 1945. The hospital counts 7 wards, operation theatre, laboratory, pharmacy and administration offices. The hospital has 110 beds, including a TB ward with 50 patient beds.

Many of the TB patients are ethnical Somali, but arriving from Ethiopia which is only 70 km away. The hospital's pharmacy needs upgrading and supplies are scarce. It serves 21 health posts and 14 mother and child health (MCH) clinics, which require physical means as well as managerial skills. The hospital is experiencing a severe lack of surgical instruments. The Somaliland diaspora has supported the hospital through the donation of equipment. These efforts have resulted in the arrival of a brand-new X-ray machine, which has not been used due to the lack of training and the unstable supply of electrical

power in Burao. The hospital laboratory is currently paralyzed due to insufficient equipment.

Table 4: Health care professionals at Burao Regional Hospital

Professionals	Male	Female	Total
General Physician Doctors	7	0	7
Paediatric Doctors	1	0	1
Gynaecologist	1	0	1
Qualified Nurses	4	39	43
Auxiliary Nurses	19	5	24
Midwives	5	1	6
Anaesthetic Nurses	2	0	2
Laboratory Technicians	4	4	8
Physiotherapists	1	0	1
Orthopaedic Technicians	1	0	1
Total	45	49	94

Burao Nursing School

The Burao Nursing School was established in June 2006. The first students who graduated in June 2008 were 21 female students and 10 male students. The school has been funded through community contribution and by the Tropical Health and Educational Trust (THET), a UK based charity NGO.

Available Infrastructure: 2 classrooms, 2 office rooms, 1 library.

Key Findings

In the section below we illustrate the specific needs in terms of facilities, equipment and personnel reported by every institution visited during the mission. While equipment

and facilities will not be provided by IOM Helsinki's MIDA Health project, there is a need to highlight these deficiencies.

Burao Regional Hospital

The hospital underlined the need of specialist doctors like paediatricians, orthopaedic surgeons, and many other important specialties to facilitate and care for the patient in the best possible way. Capacity-building and training for the hospital staff in different sectors is also strongly required. Below is a list of the equipment and instruments that are currently required by the Burao Regional Hospital.

- 7 Laparoscopy
- 7 Endoscopy
- 7 Anaesthesia machine and cardio-respiratory monitoring machines
- 7 Dialysis machine
- 7 Incubators for newborn
- 7 Nebulizer machines
- 7 Autoclaves
- 7 Orthopaedic, general surgery and delivery sets
- 7 Electrocardiograms
- 7 Ultra sonogram
- 7 Oxygen generating machine
- 7 Oscopes / auriscope
- 7 Proctoscopes
- 7 Sphygmomanometer / blood pressure meter
- 7 Stethoscopes
- 7 Thermometers
- 7 Upper and lower limb strengthening bicycles
- 7 Surgical stand lamps
- 7 Mobile operation table
- 7 Surgical electro-cauterization tools
- 7 Suction machines

Amoud University and Nursing School

- 7 Intravenous (IV) and blood pressure training arm (3)
- 7 IV stands (2)
- 7 Suction machine (2)
- 7 Oxygen tanks (2)
- 7 Cardiopulmonary resuscitation (CPR) models (3)
- 7 Complete skeleton model (2)
- 7 Anatomical charts

- 7 Growth charts, CPR charts
- 7 Anatomical atlas
- 7 Pregnancy series atlas
- 7 Health promotion charts
- 7 Physical examination sets: Ear Nose and Throat (ENT) sets, and laryngoscope
- 7 Infant weighing scale
- 7 Linen hampers (4)
- 7 Dressing trolleys (2)
- 7 Autoclave
- 7 Laryngoscope training model
- 7 Adult intubation training model
- 7 Reference books, and nursing and medical journals
- 7 Portable doppler (ultrasound) machine
- 7 Pulse oximeter

Bebera Regional Hospital

Surgical department:

- 7 Steam autoclaves (big and small)
- 7 Surgical lights (big)
- 7 ECG diagnostic machine
- 7 Gastroscopy
- 7 ENT diagnostic set
- 7 Hip prosthesis (Thompson's endoprosthesis)
- 7 (Orthopaedic) electronic bone drill with cord
- 7 (Orthopaedic) electronic bone saw with cord
- 7 Ultrasound machine
- 7 Mobile X-ray machine
- 7 Electric plaster cast saw with cord
- 7 KUNTSCHER extraction instrument
- 7 Bed side screen
- 7 Vacuum fetus extraction machine

Burao Regional Hospital

There is a shortage of medical equipments and instruments. The Hospital further highlighted the need for capacity building in any of the following subjects:

- 7 Ultrasound
- 7 ECG
- 7 Echography
- 7 General laboratory equipment

- 7 Blood bank instruments

Burao Nursing School

- 7 Paediatric tutor
- 7 Medical and surgical tutor

Summary Recommendations

1. It is recommended that the MIDA Health Somaliland-Puntland project encourages and prioritizes temporary returns with duration of at least three months (possibly six months). It is understood that the length of the assignments directly determines the impact the voluntary experts can have.
2. Voluntary experts on assignment should seek to train groups of local professionals instead of single individuals.
3. The MIDA Health Somaliland-Puntland project should take into consideration – when selecting the participating voluntary experts – the considerable lack of local hospital and health administrators. Training and trainers in these areas is greatly needed.
4. As local healthcare institutions are suffering from a shortage of medical and surgery equipments, it is suggested that in the future funds should be specifically allocated to the purchase of essential instruments such as those presented in this report.
5. In addition to practical medical equipment, it is recommended that the project facilitates the acquisition of training materials that the voluntary experts can take back and use to train local practitioners. Training tools are not easily obtained in Somalia.

FOLK MEDICINE: AN INVISIBLE SIDE OF THE SOMALILAND HEALTH SECTOR

Marja Tiilikainen

In the Somaliland Health Sector Assessment Report¹, prepared by IOM Hargeisa (IOM, 2008), the serious challenges regarding the Somaliland health care sector are well documented. However, something seems to be missing. The role of traditional and Islamic healers in the post-conflict Somaliland has been pointed to by mentioning that in mental health disorders patients and their families often consult traditional or religious healers. The report does not address, however, why this may happen. Somali healers are invisible in the official statistics regarding healthcare resources, but significant from the point of view of health service users. Hence, adherence to the lack of health posts or educated health care staff does not give a complete picture of the health sector in Somaliland.²

According to Somali cultural understanding, conditions that by Western psychiatry are regarded as mental disorders are commonly seen as caused by spirits such as *jinn*, *mingis* or *wadaaddo*, by evil eye (*isha*) or witchcraft (*sixir*). Hence, an effective treatment does not consist of Western-style psycho-pharmaceuticals or psychotherapy, but of reciting the Koran, herbal medication or *saar* spirit possession rituals, depending on the condition of the patient and the preferences of the family.

A mental hospital is the last resort where a family takes a mentally-ill family member. At that point, the family has already gone through numerous healers and treatments, and is tired of taking care of a possibly violent patient at home. Moreover, a patient who resides in a mental hospital is not believed to recover, but to be incurably 'crazy', *waalli*. Mental health institutions in Somaliland – at least the mental hospital in Berbera and the mental ward at the Hargeisa Group Hospital that I have frequently visited as part of my recent fieldwork – suffer from the lack of trained staff and adequate medication. For example, chaining of mentally-ill patients can be observed not only at homes, but also in the mental health institutions. In the whole of Somaliland, there are no professional psychiatrists.

In the towns of Somaliland, a large variety of Somali healers is available. The existence of folk healers in Somalia *per se* is not unique; folk medicine is part of the health care sector even in industrialised countries. However, it is important to realise that traditional

healing is never "frozen" in a distant time. In Somaliland, recent changes in healing practices are connected to the post-war social conditions and wider politico-religious transformations in the Horn of Africa. Healing in general has become business. One of the reasons for working as a healer is to earn income and maintain a family. In particular religious healers assure that they treat and give medication even for free if a patient cannot not afford to pay, but certain traditional treatments such as *saar* rituals may cost several hundreds of US dollars, which far exceeds the fees in the public health care. Not only professional medical staff prefers to work in private clinics, but also traditional healers have established clinics which have been organized in a similar way as general medical clinics. In particular, a new type of Koranic healers who distance themselves from previous *Sufi* healing practices and claim to heal by 'purely' Islamic methods, derived from the Koran and the Prophet's *sunna*, have opened several popular clinics in Hargeisa and other towns since 1991, when the Somali National Movement (SNM) declared the independence of Somaliland. In the clinics sheikhs provide personal and group treatments as well as rooms for in-patients. In these clinics even Somali migrants from Europe, North America and Australia who return to Somaliland in order to find proper treatment can be found. Most of the patients suffer from illnesses which have been caused by spirits, evil eye or witchcraft, but patients may also have "normal" physical illnesses.

In many cases, Somali healers, in particular Islamic healers, are trusted more than medical doctors. Even though most of the healers do not have any medical background, they may still use medical technologies in their practice: for example, some healers send patients to x-ray or laboratory tests, and sometimes they refer patients to medical doctors. In some cases even medical doctors may send patients to traditional healers whom they know. Nevertheless, most medical doctors have quite negative views on traditional healers and traditional healers may advise, for example, a patient to stop taking medication prescribed by a medical doctor.

Thus, on one hand the key findings and recommendations of IOM Hargeisa are right on target; the health sector of Somaliland severely suffers from the lack of resources, health facilities and professional staff. On the other hand, a focus on public health care reveals only one side of the coin and shades the health practices and health service realities of many ordinary Somalis. Folk healers continue to have an important role in the overall health care in Somaliland, and the power of religious and cultural concepts behind illness behaviour should not be underestimated.

Notes

- 1 Contained in chapter 4 of this publication.

- 2 This contribution is based on ethnographic data collected as part of the author's on-going postdoctoral research project entitled *Suffering, Healing and Health-care: The Transnational Lives of Somalis in Exile*. The research has been funded by the Academy of Finland. The author spent in total four months in the summers of 2005 and 2006 and December 2007 in Somaliland where she observed and interviewed several traditional healers and their patients, collected data from mental health institutions, and participated in religious and healing rituals.

References

IOM

2008 'Somaliland Health Sector Assessment Report', MIDA Health
Somaliland-Puntland, IOM, Helsinki and Hargeisa.

Chapter 5

Reinforcing Somalia's health sector

MIDA HEALTH SOMALILAND- PUNTLAND AND ITS ROLE IN ADDRESSING THE HUMAN RESOURCE GAPS OF SOMALIA'S HEALTH SECTOR

Juan Daniel Reyes
Tobias van Treeck

The genesis of the project “MIDA Health Somaliland-Puntland”

The WHO 2006 World Health Report¹ identified a critical shortage of doctors, midwives, nurses and support workers in 36 African countries. These shortages severely undermine these countries' capacities to carry out essential health interventions and achieve the health-related Millennium Development Goals (MDGs). In line with the findings of this report, Somalia has for long been recognised as a country in which the health sector is under severe pressure due to a general lack of qualified health professionals, inadequate infrastructure, and lack of financial and other resources. At the same time, support to the health sector, both through rehabilitation and capacity-building, is crucial to the reconstruction of the country.

Despite these findings, health remains a severely underfunded sector, according to the UN, which is illustrated, for example, by the fact that less than half of the needed funds for the health sector had been committed in 2008 in response to the UN's Consolidated Appeals Process for Somalia².

The same WHO report also highlights the need for managed migration so as to alleviate the consequences of high emigration of health professionals from less developed countries. The need for qualified professionals to assist in reconstruction, development and capacity-building in Somalia is high, while there is also a general lack of public health care facilities in the whole Horn of Africa region. Furthermore, the movement of internally displaced persons and irregular migrants from neighbouring countries such as Ethiopia has increased pressures on the health sector in Somalia.

Against this backdrop, the IOM Regional Office in Helsinki developed a pilot project aiming at strengthening the capacities of local health sector professionals in northern Somalia through the transfer of skills and knowledge of highly qualified health professionals from the Finland-based Somali diaspora. The development of this innovative and unprecedented initiative was based on – and greatly benefited from – three major elements.

Firstly, IOM Helsinki’s long-standing engagement with the Somali diaspora in Finland contributed considerably to the development of a viable project. IOM Helsinki has over the past years consulted the Finnish Somali diaspora in view of developing projects that contribute to the development of Somalia. Resulting from such consultations, the MIDA Health project was developed after inputs from, among others, the Association of Somali Healthcare Professionals in the Nordic countries (later registered as: SOMHELP). In general, health professionals with a Somali background showed great interest in returning to work on a temporary basis in Somalia to assist alleviating the strains on the country’s health sector and train local staff in their respective fields of expertise. Furthermore, IOM Helsinki also discussed the possible participation in the project with female health professionals of Somali background residing in Finland. A majority of these women expressed keen interest in participating, too.

Secondly, the project was designed in accordance with a wider institutional programme, IOM’s “Migration for Development in Africa” framework (MIDA). Initiated in 2001, MIDA is a capacity-building programme, that focuses on the circulation of competencies, expertise and experience of migrants and diaspora, without jeopardizing their legal status in their host countries or newly adopted home countries. Through carrying out needs assessments in countries of origin, in cooperation with governmental bodies and relevant authorities, the MIDA framework assures that the countries of origin participate in and are able to influence the implementation of projects.

Being embedded in the wider MIDA programme, IOM Helsinki’s MIDA Health project benefitted not only from an established and readily available conceptual framework but also from the availability of institutional expertise within IOM, based on the organization’s earlier experiences with MIDA activities in a range of countries and professional areas.

Thirdly, the MIDA Health project was developed in response to interest voiced by Somali health care institutions and authorities. For example, Somaliland authorities had on different occasions approached the IOM Regional Office in Helsinki to discuss possibilities for the engagement of IOM in the framework of temporary return of qualified and highly qualified nationals under a MIDA project to promote brain circulation while mitigating the effects of brain drain in the region. Such inputs from Somali decision makers had a positive impact on the development of the MIDA Health project in that

they confirmed, on a general level, that IOM's contribution to strengthening the health sector was indeed much needed and welcome; while also being helpful for planning and fine-tuning project activities "on the ground".

Having thus established that a MIDA project focussing on the health sector in Somalia and targeting the Somali diaspora in Finland would indeed be a meaningful and viable initiative, IOM Helsinki, in close coordination with the Ministry for Foreign Affairs of Finland (as the project's donor), nevertheless decided that the MIDA Health project would – at least in its pilot phase – cover only the regions of Somaliland and Puntland. This decision was made due to the fragile security situation in southern and central parts of Somalia, which renders the presence of IOM staff and/or project participants impossible. Having opened an office in Hargeisa in 2007, while consolidating the organisation's presence in Puntland, allowed IOM to reasonably assume that project activities on the ground in these two regions could be quickly and rather smoothly implemented while receiving all the necessary support from local IOM staff.

Project summary

MIDA Health Somaliland-Puntland project represents an unprecedented and highly innovative endeavour because it is the very first time that IOM's MIDA programme was targeting the health sector in Somalia. It also constitutes a "première" in offering the Finland-based Somali diaspora the possibility for temporary professional assignments in their country of origin.

The pilot project was supported by a broad range of partners and stakeholders and included the following major activities:

1. Assessing the existing human resource in Somalia's health sector and identifying the broader determinants of health in northern Somalia;
2. Identifying the skills available in the Somali diaspora in Finland and reaching out to the target group to motivate their participation in the project;
3. Facilitating opportunities for health professionals from the Finland-based Somali diaspora to transfer their skills and knowledge to the health sector through temporary assignments;
4. Laying the basis for a larger MIDA framework for Somalia that would in the future include additional professionals from the Finland-based Somali diaspora.

Donor, partners and partnerships

In order to ensure effective and sustainable delivery, IOM Helsinki established a wide range of partnerships both in Finland and in northern Somalia.

Ministry for Foreign Affairs of Finland: As the principal donor of the MIDA Health project, the Ministry for Foreign Affairs of Finland continues its support for rehabilitation and reconstruction efforts in Somalia. Official Finnish development cooperation with Somalia began in 1980 with a project on tuberculosis prevention, and the provision of assistance has continued and grown ever since. Following the suspension of bilateral cooperation in 1985, due to the collapse of the Somali state and the resulting unstable domestic situation, Finland has continued to support United Nations initiatives in Somalia as well as smaller projects run by NGOs, which have become important players in the field of development cooperation.

The IOM Regional Office in Helsinki acted as the lead implementing agency of the MIDA Health project. As such, IOM Helsinki was in charge of the overall management of this project and the implementation of various activities in Finland, such as:

- 7 Mapping of and liaison with diaspora organisations and individuals, including an outreach campaign.
- 7 Receiving and reviewing applications by health care professionals from the Finland-based Somali diaspora, and establishing a database of qualified prospective voluntary experts.
- 7 Selecting suitable candidates for temporary assignments and facilitating pre-departure preparations.
- 7 Assisting voluntary experts in obtaining donations of medical tools, supplies, and pharmaceuticals.
- 7 Making insurance, travel, and luggage arrangements for voluntary experts, as well as disbursing monthly subsistence allowances.
- 7 Providing pre-departure briefings to voluntary experts.
- 7 Arranging a de-briefing of voluntary experts after the end of their assignments.
- 7 Arranging a final conference and compiling a publication in order to share the project's results, lessons learned and recommendations.

The Association of Somali Healthcare Professionals in the Nordic Countries assisted IOM in disseminating information about the project and mapping the available skills of diaspora members, as well as their interest in participating in MIDA Health assignments.

The Finnish Medical Association (*Lääkäriliitto*, FMA) supported the MIDA Health project through expert advice provided by medical specialists with extensive experience in implementing health projects in Africa. Furthermore, FMA assisted voluntary experts in obtaining donations of medical tools, supplies, and pharmaceuticals from Finnish health care institutions and companies.

In addition to the above, IOM cooperated with various Somali diaspora organisations in Finland, as well as Finnish NGOs, through its existing and expanding networks, mainly focusing on mapping and outreach activities.

The IOM sub-offices in Hargeisa/Somaliland and Bossaso/Puntland were in charge of all project activities carried out in their respective regions, including:

- 7 Compiling a Health Sector Assessment Report for the project's target region.
- 7 Outreach to and establishing direct communication channels with health sector institutions and authorities in northern Somalia, in order to secure their participation in the project.
- 7 Assisting in the selection of suitable host institutions for voluntary experts, facilitating the signature of contracts between host institutions and voluntary experts.
- 7 Liaison with immigration and border authorities in order to facilitate voluntary experts' entry into the country.
- 7 Receiving voluntary experts upon arrival and assisting their settling in the location of their assignment, including security briefings and support in finding accommodation.
- 7 Providing assistance to voluntary experts throughout their assignment, such as arrangement of transportation, telecommunications, etc.
- 7 Monitoring of assignments and liaison between voluntary experts and host institutions.
- 7 Collection of feedback and monthly assignment reports from host institutions and voluntary experts.

The IOM Regional Office in Nairobi/Kenia provided technical support and general oversight of activities in northern Somalia, as well as guidance on the security situation in Somalia and its repercussions for the implementation of project activities.

The Somaliland Ministry of Labour and Health and the Ministry of Health, Puntland State of Somalia were the main Somali governmental agencies in the MIDA Health project. The Ministries supported IOM in liaising with health sector institutions.

The MIDA Health project established partnerships with numerous local public and private health institutions in Somaliland and Puntland, including hospitals, academic and training institutions, Civil Society Organizations, and local governmental agencies. These institutions contributed to the *Health Sector Assessment Reports* by providing access and information to the IOM field manager. More importantly, however, committing to a partnership with IOM enabled local health institutions to host MIDA Health voluntary experts and benefit from the transfer of skills and expertise to their own staff.

Activities

Diaspora outreach and mapping in Finland

IOM Helsinki carried out an extensive and targeted outreach campaign to inform the Finland-based Somali diaspora at large and prospective participants about the possibility to participate in temporary return assignments under the project. This outreach targeted especially female healthcare professionals in the Finland-based Somali Diaspora.

In an effort to disseminate the information to the widest possible public, the outreach campaign consisted of:

Face-to-face meetings with healthcare professionals: Focused meetings with individuals and groups of Somali healthcare professionals in Finland were organized. Among others, IOM involved active members of the diaspora to act as multipliers in their respective networks. Particular attention here was paid to female health representatives of the Somali Diaspora, aiming to motivate the participation of a balanced proportion of female professionals in the project.

An official launch ceremony: IOM Helsinki organized the project's official launch ceremony on 20 August 2008. The ceremony took place at the Kanava Youth Centre in Helsinki and was attended by more than 40 members of the Finland-based Somali diaspora, half of whom female professionals. The purpose of the ceremony was to provide prospective participants with an overview of the project and specific information on the application procedures and the practical arrangements relating to the temporary assignments, e.g. subsistence allowances, insurances, accommodation etc. In addition to health professionals as the original target group of the MIDA Health project, Somali with other professional backgrounds also attended to learn about the MIDA framework and possible opportunities for the future.

E-mail and telephone communications: IOM Helsinki opened and maintained communication channels via e-mail and telephone with Somali healthcare professionals living and working in Finland, resulting in a contact list of professionals and multipliers with more than 90 entries.

IOM Helsinki's attendance in Somali Diaspora meetings: Staff of IOM Helsinki regularly attended meetings of the Somali Network Association in order to maintain a channel of communication with the Somali community in Finland, and to provide direct answers to any questions that possible participants could have about the project.

Project Website and Project Info sheet: IOM Helsinki published a MIDA Health Somalia-Puntland project info sheet as well as comprehensive information on the IOM Helsinki website (<http://www.iom.fi/mida>). Both the info-sheet and the website included essential information on the content of the project and the procedures for participation, including an electronic application form.

Media Coverage: IOM Helsinki utilized public media sources to disseminate information on the project to the wider public and to promote the participation of the largest possible number of Somali healthcare professions currently residing in Finland. Information on the MIDA Health project was published in major Finnish publications, such as the newspapers *Hufvudstadsbladet*, *Helsingin Sanomat* or *Helsinki Times*, as well as on the website of the Ministry for Foreign Affairs of Finland.

In addition to coverage in mainstream media, and making use of IOM's close relationship with the wider Somali community in Finland and in the Nordic countries, information on the project was also published on various websites managed by the Somali diaspora. This included major Somali news websites, such as www.hiiraan.com, or websites maintained by Somali umbrella NGOs like the Finnish Somali League and the Finnish Somalia Network. The magazine *Koor-lehti*, a bi-yearly publication by the Finnish Somali Association repeatedly covered the MIDA Health project in detail.

As a result of targeted outreach and wide coverage, IOM Helsinki succeeded in mobilising health care professionals from the Finland-based Somali diaspora. Throughout the project, IOM received expressions of interest from a large number of Nordic-Somali civil society organizations seeking to expand the coverage of the to other Nordic countries and to other professional fields (such as ICT, education, environmental sciences and agricultural development).

Assessment reports and liaison with Somali health institutions

In view of identifying the major human resources gaps in northern Somalia's health sectors, *Health Sector Assessment Reports* were conducted by IOM Hargeisa. Results were utilised in the planning of assignments of health care professionals from the Finland-based Somali diaspora.

Based on various publicly available documents as well as individual consultations with health institutions in Somaliland and Puntland, the assessment reports provide a detailed overview of the operating conditions and current capacities in the target regions. Local authorities, including the regional ministries of Health and Family Affairs, International

Organizations, NGOs, and local private and public health institutions were contacted to define the most essential human resources gaps in Somaliland's health sector.

Alongside an overview of human resources and equipment available, the reports offer an in-depth analysis of the most prevalent shortcomings and needs these institutions face. Among the challenges mentioned by these institutions are the lack of qualified personnel in almost all areas of health care provision, insufficient capacities for educating nursing and medical students, as well as for continuous training of medical staff, and scarcity of medical tools, supplies, and pharmaceuticals. The Assessment Reports also included a detailed list of vacant professional positions that would need to be filled through the project.

In addition to collecting information for the assessment report, liaison with health institutions also served to motivate these institutions to participate in the project and receive voluntary experts. The reception of MIDA Health Somaliland-Puntland by local institutions has been very positive, illustrated by the fact that numerous local public and private health sector institutions expressed their interest in hosting health care professionals from Finland. These institutions included hospitals, academic institutions, and local governmental agencies, who expressed their needs for support through the MIDA Health project in a variety of healthcare and healthcare administration fields. These expressions of interest served to determine the main areas of intervention by professionals from the Somali diaspora.

Pre-departure briefing session

In order to prepare voluntary experts for their assignments in Somalia, IOM Helsinki, in cooperation with the Finnish Medical Association (Lääkäriliitto), arranged a Pre-departure Briefing Session in March 2009.. This event provided 25 prospective project participants with theoretical background knowledge and practical advice on conducting their assignments. Furthermore, the session offered an opportunity to discuss participants' expectations with fellow healthcare professionals possessing extensive experience in implementing health projects in Africa. Finnish experts in the field gave presentations on topics such as "Producing Health Assessments in the Field" and "Training Colleagues in the Field - Best Practices", followed by lively discussions among the audience.

Participants in the briefing session were provided with a booklet on *Security in the Field*, which provides guidelines on personal security and recommendations for reacting in crisis situations, enabling MIDA Health voluntary experts to familiarise themselves well in advance with the necessary security-related information.

The Pre-departure Briefing Session was well-received by participants, greatly increased their confidence and provided them with the necessary skills and knowledge to make their assignments worthwhile, thus enabling them to effectively contribute to achieving the project's overall objectives.

Assignments of voluntary experts in Somali health institutions

The project's core activity was the arrangement of voluntary assignments of diaspora health with Somali host institutions. All other actions, as described above, performed under the project served – directly or indirectly – to support a successful implementation of this main activity.

By December 2009, the target of 22 pilot assignments in Somaliland and Puntland had been fulfilled. In order to ensure maximum benefits and successful outcomes of the project, IOM put into place elaborate – yet flexible – management structures and procedures.

- 7 Matching of needs in Somalia with skills available in Finland: Based on the needs assessments prepared by IOM Hargeisa and the skills database developed by IOM Helsinki, suitable candidates were selected to fill temporary positions in health institutions. The selection process was closely coordinated between the IOM offices in Helsinki and Somalia, on one hand, and the host institutions, on the other.
- 7 Pre-departure arrangements included IOM purchasing a return ticket for each voluntary expert selected to participate in the project, as well as making arrangements for excess luggage for all those voluntary experts who had obtained larger amounts of donated medical supplies, tools, or pharmaceuticals. Each voluntary expert was covered by medical and evacuation insurance purchased by IOM, which included a War Risk Premium, so as to ensure insurance coverage also in case of sudden changes in the security environment in Somalia. IOM furthermore facilitated the signature of contracts between voluntary experts and host institutions, including detailed terms of reference. Following the conclusion of contracts, IOM oversaw the preparation of work plans by voluntary experts, in which they spelled out the main objectives of their individual assignments. Workplans also served to provide an overview of essential resources and expected conditions that voluntary experts would require in order to successfully complete their assignments. Each individual voluntary expert met with IOM Helsinki staff before departure, in order to receive a concise briefing on the upcoming assignment, including security-related information.

- 7 Facilitation of travel and entry into Somaliland: IOM Helsinki staff was present at Helsinki airport when MIDA Health voluntary experts departed on their assignment, so as to provide support with check-in and border control procedures. Further support was provided through IOM's transit assistance service at major transit airports (e.g. Dubai) in order to ensure that passengers and luggage would smoothly transfer to connecting flights. Upon arrival in Somalia, voluntary experts were greeted by IOM staff who facilitated their entry into the country (among others, a visa fee waiver had been agreed with authorities for MIDA Health participants), provided a security briefing, and assisted them in settling in their location of assignment.
- 7 Assignments in health institutions: A total of 22 voluntary experts' assignments in health institutions in Somaliland and Puntland were arranged under the MIDA Health project, which greatly contributed to strengthening these institutions' human resource base. Depending on the availability of voluntary experts and the specific needs expressed by host institutions, the duration of assignments ranged from 3.5 weeks to three months. The project supplied a variety of host institutions with voluntary experts from the Finland-based Somali diaspora, who consequently transferred their skills and knowledge to local staff. Voluntary experts employed a wide range of methods for capacity-building efforts in their respective field of expertise, such as peer-to-peer and on-the-job training, joint patient consultations and/or delivery of treatment, lectures and workshops for a larger group of trainees. IOM staff continuously monitored assignments and offered support to both host institutions and voluntary experts, including the collection of monthly assignment reports and checking these against work plans and terms of reference, so as to ensure the individual assignments' outputs were in line with expectations.
The MIDA Health project was built upon the assumption that members of the diaspora will voluntarily contribute to the reconstruction of their country of origin. Project participants were therefore referred to as "voluntary experts" and did not receive a salary as such. However, in addition to flight tickets and insurance coverage, voluntary experts received a monthly subsistence allowance meant to cover cost of living and related expenses while on assignment.

Achievements and challenges

As a pilot project targeting the Finland-based Somali diaspora, MIDA Health broke new ground in many crucial ways. The project's tangible outcomes did not only have an immediate positive effect on the provision of health care in Somalia, but also offered new, useful insights and experiences in view of implementing future similar activities. Among its most important achievements, the MIDA Health project:

- 7 **Confirmed** that there is huge interest and motivation among the Finland-based Somali diaspora to personally and voluntarily contribute to reconstruction efforts in Somalia through temporary assignments “in the field”.
- 7 **Established** that it is possible to arrange effective temporary assignments in Somaliland and Puntland, despite a prevailing security environment often described as fluid and constantly evolving. As MIDA Health showed, challenges posed by such an environment can be overcome if the implementing agency has a presence on the ground and the experience, capacity and resources to provide constant monitoring and advice to project participants.
- 7 **Demonstrated** that the diaspora’s contributions to capacity-building efforts are received enthusiastically by Somali health sector institutions. Based on institutions’ assignment reports and other feedback collected by IOM, it is safe to say that the MIDA Health project made a real difference in that voluntary experts were able to transfer skills and knowledge to local staff that would otherwise have been impossible for them to obtain. Although on a modest scale, the MIDA Health project thus contributed to alleviating some of the most pressing needs in the Somali health sector.

In terms of concrete outputs, the MIDA Health project:

- 7 Provided assessment reports of the Somaliland and Puntland health sectors, including a detailed description of the most prevalent needs.
- 7 Arranged 22 assignments of voluntary experts, each ranging in duration from 3.5 weeks to 3 months.
- 7 Served some 20 host institutions in different regions of Somaliland and Puntland, increasing the capacities of their staff in various fields of specialisation.
- 7 Reached a total of ca. 500 doctors, hospital nurses, laboratory technicians, nursing and medical students, who were trained in various areas related to their field of work or study, gaining valuable skills for their future work.
- 7 Facilitated the treatment of over 1000 patients by the project’s voluntary experts, in some cases providing specialised therapies unavailable in Somaliland.
- 7 Contributed to the creation of networks and partnerships among IOM, Somali health institutions and authorities, as well as members of the Finland-based Somali diaspora, laying the ground for extending and deepening the cooperation between these partners in the future.

While the project has been a successful pilot initiative which achieved all of its main objectives, a number of challenges emerged during implementation. The most important of these related to security, the availability of voluntary experts, lack of medical supplies

and donations, and the initial reception of some voluntary experts in their host institutions.

Security

The security of MIDA Health voluntary experts and IOM staff in northern Somalia has been the top-most priority throughout the project's implementation. While this prioritisation of security has led to effective measures and kept project participants safe, it has nevertheless caused some delays in project activities, as well as forcing IOM to suspend a total of four assignments.

The very first three MIDA Health assignments were abruptly interrupted by the tragic events that took place across northern Somalia on 29 October 2008. On that day, a series of well coordinated terrorist attacks were conducted in Hargeisa and Bossaso, targeting local governmental institutions, the Ethiopian Consulate and a United Nations Development Programme (UNDP) compound. Two persons lost their lives on this day. The day after these attacks, and in order to ensure personal security of voluntary experts, IOM and the United Nations' security and support structures in Somalia took the decision to evacuate the three project participants from Hargeisa immediately.

In addition to the immediate evacuation of voluntary experts, these attacks triggered a comprehensive re-assessment of MIDA Health project activities in Somaliland and Puntland, because IOM – alongside other international organizations – was forced to restrict its activities on the ground considerably, allowing only absolutely essential duties to be performed. As a result, the following assignments of voluntary experts could only be authorised approximately half a year after the terrorist attacks, and could initially only include host institutions in Somaliland, while Puntland health institutions were able to receive voluntary experts only in November 2009. This forced delay of assignments, in turn, created additional challenges regarding the availability of experts from the Finland-based Somali diaspora.

One additional assignment had to be delayed due to strong security concerns over the political stand-down between government and opposition parties and their supporters in October 2009.

Availability of voluntary experts

The MIDA Health project was warmly welcomed by health professionals from the Finland-based Somali diaspora and IOM received interest for participation by highly qualified candidates. However, owing to the fact that potential project participants do have regular work contracts with Finnish health institutions, it proved difficult for

some to arrange for longer periods of absence from their regular jobs. An additional challenge in this respect was that reliable long-term planning was rendered difficult by the prevailing conditions in Somaliland and Puntland, mainly stemming from concerns over security and the need to temporarily freeze project activities following serious security incidents in October 2008.

At the end, a number of voluntary experts were able to participate in the MIDA Health project by “sacrificing” their contractual annual leave, which meant that their assignments’ duration was shorter than originally envisioned by IOM or wished for by themselves and the receiving Somali health institutions.

Medical supplies and donations

The lack of medical supplies and equipment in the health sector in Somalia as a constraining factor was well-known to the MIDA Health project from the outset. It was therefore also obvious that efforts would need to be undertaken to supply voluntary experts from Finland with at least the most essential tools, equipment, and pharmaceuticals wherever possible. Being experts in the medical field, upon acceptance as project participants, voluntary experts were encouraged to obtain donations from Finnish health institutions and/or companies. IOM and the Finnish Medical Association also supported this process through direct liaison with hospitals and companies, and had some success, for example, in obtaining various donations of pharmaceuticals.

However, despite considerable efforts by all parties involved and a generally positive attitude of potential donors towards the MIDA Health project, it proved rather difficult to obtain functioning medical tools or usable and safe medical equipment in sufficient quantities from Finnish donors. In essence, the project was mainly offered medical supplies that had already been disposed of by hospitals.

Reception of voluntary experts in host institutions

While the MIDA Health project was well received at the management level of northern Somali health institutions after they had been initially contacted and informed about the project by IOM, it appeared that information on the project and the nature of voluntary experts’ assignments did not always trickle down to the staff who were meant to benefit most from the project and the transfer of skills and knowledge, i.e. those in daily contact with voluntary experts.

Resulting from this unawareness of the benefits of the MIDA Health project, the reception of a few voluntary experts was not as warm and welcoming as could have been expected. Rather, some local staff saw MIDA Health assignments critically as they

felt threatened by external medical professionals interfering with their work, or feared “unfair competition” because voluntary experts were treating patients free-of-charge (which was also a strict requirement contained in their assignment contracts). Some also appeared to fear that their own positions would become redundant because their employers would possibly prefer the highly qualified medical expert supplied by the MIDA Health project over locally hired staff.

In the few cases where voluntary experts were confronted with such attitudes, immediate intervention by IOM Hargeisa and senior figures in the host institution was able to rectify the situation by pointing out the temporary nature of MIDA Health assignments, the project’s focus on capacity-building, and the direct benefits for local staff from working closely with and learning from voluntary experts.

Notes

1 World Health Organisation, 2006

2 UN OCHA, 2008

Bibliography

- UN OCHA
2008 Consolidated Appeal: Somalia 2008, table R3sum, http://ocha.unog.ch/fts/reports/daily/ocha_R3sum_A792_0910060204.pdf.
- World Health Organisation
2006 World Health Report – Working together for Health, www.who.int/whr/2006/en/.

MIDA HEALTH SOMALILAND- PUNTLAND:WHAT HAS BEEN ACHIEVED SO FAR – PERSPECTIVES FROM IOM FIELD STAFF

Shukri Sheikh Ali
Elena Giannini

The WHO 2006 World Health Report identified a critical shortage of doctors, midwives, nurses and support workers in 36 African countries, including Somalia. This shortage severely threatens the capacity of these countries to carry out essential interventions and achieve the health-related Millennium Development Goals (MDGs). The same report also highlights the need for managed migration as a means to come to terms with the high emigration of health professionals from less developed countries.

The health sector in Somalia is under severe pressure, due to a general lack of qualified health professionals, inadequate infrastructure, and lack of financial and material resources. The civil war, and continued conflict in Somalia, has led to a massive brain drain of Somali health professionals, putting further strain on those health sector professionals who have remained in the country.

The project's overall objective was to strengthen the capacities of local health sector professionals in Somaliland and Puntland through the transfer of skills and knowledge acquired abroad by qualified and highly qualified health professionals from the Finland-based Somali diaspora, thereby contributing to the reconstruction and capacity-building of the human resource base of northern Somalia's health sector.

During the first months of project implementation, IOM has engaged relevant counterparts from the Somali health authorities, Civil Society Organizations, hospitals, and universities with health-related programmes. In cooperation with these entities IOM has identified the existing human resources based in northern Somalia as well as major human resources gaps in the local health sector.

In parallel to the needs assessment carried out in Somaliland and Puntland, the IOM Regional Office in Helsinki has conducted an information campaign to inform the target group in Finland about the project and the possibilities offered through it. Professionals meeting the selection requirements who are interested in participating in the project

were encouraged to submit their CV's to IOM in order for IOM to identify the available skills in the Finland-based Somali diaspora.

Finally, the project has enabled the temporary return of selected candidates who have filled key vacancies and trained local staff in their own field of expertise. The returnees have offered short-term assistance and expertise in the health sector with particular focus on transferring their skills and thereby strengthening local human resource capacities.

The first temporary returns started in October 2008 but unfortunately because of the terrorist attacks that struck Hargeisa and Bossasso, activities were placed on hold and the three participants present at the time were relocated to Finland. Activities resumed in April 2009 and, by December 2009, altogether 22 participants have completed their assignments within various health institutions

So far the project can look on the following achievements.

- 7 15 host institutions in Somaliland and Puntland have benefited from the services provided by MIDA voluntary experts.
- 7 Over 500 medical doctors, hospital nurses, nursing students and university students, as well as laboratory technicians have been trained in various fields related to their work/study and reported that they gained valuable skills for their future work.
- 7 Approximately 1100 patients have been treated and received specific medication not available in Somaliland through MIDA voluntary experts.

The project received a very warm welcome by the Somali healthcare professionals in Finland, once again proving the commitment and willingness of diaspora members to participate in peace-building and reconstruction efforts in their country of origin. During their temporary assignments in Somaliland and Puntland the MIDA voluntary experts:

- 7 Provided proper theoretical and practical trainings to healthcare professionals/workers, nursing school students and university students.
- 7 Developed training manuals and guidelines on best practices on different topics, for example on orthopedic surgery training or basics of nursing ethics;
- 7 Participated in the planning process of future activities to improve the healthcare system;
- 7 Succeeded providing essential healthcare services that are not provided locally such as orthopedic surgeries.

Host institutions in Somaliland and Puntland benefited from these services and showed a sincere appreciation for the voluntary experts' work. The management of these institutions further stated that the national staff got inspired and energized by the commitment shown by the participants. This has increased self-confidence in these individuals and linkages created with experts from abroad might have an impact in deterring their potential desire to leave the country in search of better opportunities.

The Ministry of Health and Labor in Somaliland as well as the Ministry of Health in Puntland State of Somalia have been very cooperative throughout the project, guaranteeing in this way the smooth implementation of activities. Acknowledging the importance of the links between migration and development, the authorities suggested a continuation of the project in order to guarantee a constant upgrade of staff knowledge and skills. Both host institutions and authorities recommended to further expand MIDA Health, including the upgrading of facilities and equipment that are in need of renovation.

Host communities were glad to be able to access free and high quality services, particularly in those areas of expertise that were not previously available in the region. Despite the many challenges posed by the security situation in the region, the overall implementation of the project has proven very successful and enjoyed a great degree of cooperation from local stakeholders.

TAKING STOCK: THE MIDA HEALTH WORKSHOP IN HARGEISA, ORGANIZED BY IOM HARGEISA ON 1 JULY 2009

IOM Hargeisa

Workshop objectives

- 7 Review the progress of the Migration for Development in Africa (MIDA) Health project in northern Somalia;
- 7 Reiterate to stakeholders the overall objectives, target locations, beneficiaries, activities, outputs and roles/responsibilities;
- 7 Highlight key project achievements so far;
- 7 Collect feedback and recommendations to further improve project outcomes for future implementation;
- 7 Record major challenges encountered during project implementation and how they were addressed;
- 7 Highlight lessons learned during implementation;
- 7 Agree on a coordination framework for future actions.

Workshop methodology

- 7 During one full day of intensive discussions, the workshop participants examined from every angle and perspective the potential role for the diaspora in assisting in the development of their country with a particular focus on the healthcare sector;
- 7 The workshop adopted a participatory approach for sharing ideas, experiences and knowledge;
- 7 Reading materials including copy of presentations were made available to each participants and copies of the MIDA health needs assessment report, powerpoint and flip charts were distributed.

Workshop participants

- 7 Representatives from Government Offices, including Ministry of Education, Ministry of Health and Labour, Ministry of Rehabilitation, Reconstruction and Resettlement,

- Ministry of Information and National Guidance, Ministry of Justice, Ministry of Family Welfare and Social Development, Ministry of the Interior;
- 7 Representatives of IGO's, including IOM, UNDP, UNICEF, UNOCHA, WHO;
 - 7 Representatives of health institutions, including Edna Maternity Hospital, Hargeisa Group Hospital, Berbera Hospital, Borama Hospital, Manhal Hospital, Hargeisa TB Hospital, Arafat Hospital, Magan Hospital, Somaliland National AIDS Commission (SOLNAC), Somaliland Human Rights Commission (SOLHRC), University of Hargeisa (UoH), Somaliland Medical Association (SMA);
 - 7 Media Representatives, including BBC, Somaliland National TV, Somaliland Space Channel, Horn Cable TV, Universal TV, Radio Hargeisa, Jamhuriya, Geeska Africa, Haatuf newspapers;
 - 7 Independent Somalia-based health professionals, including medical doctors, laboratory technicians and qualified nurses;
 - 7 Representatives from TELCOM which provided all MIDA voluntary health experts with free handset-mobile phones during their work assignments in Somaliland.

Keynote speeches

- 7 IOM Head of Sub-Office in Hargeisa, Ms. Lisa Mackey, welcomed the participants on behalf of IOM and expressed appreciation for the good turnout as well as the commitment shown by the Somaliland Ministry of Health and Labour, and especially Director General Dr. Anwar Mohamed Egeh, in facilitating the implementation of the MIDA Health pilot project.
- 7 Director General Dr. Egeh presented greetings on behalf of HE Mr. Abdi Haybe, the Minister of Health and Labour, restated the importance of this project and asked IOM to attract many more Somali health volunteers from other parts of the world. He pointed out that most of the volunteers are / were deployed in the Hargeisa and Awdal regions and recommended that other regions such as Sool and Sanaag should be taken in consideration in future similar projects.
- 7 The Director General assured all participants that the Ministry of Health and Labour will continue supporting the project and a coordination mechanism will be put in place in order to address any forthcoming challenges.
- 7 MIDA field manager, Ms. Shukri Ali from IOM Hargeisa, invited the participants to present themselves and summarized the project's principal objective: strengthening the healthcare sector in Somaliland and Puntland through the engagement of Somali diaspora healthcare professionals from Finland. Main activities are:
 1. Identification of essential gaps in the healthcare sector in northern Somalia;
 2. Identification of available skills among Finland-based Somali healthcare professionals;
 3. Setting-up of a diaspora skills database;
 4. Deployment of 22 Somali health professionals from Finland to identified host institutions in northern Somalia.

- 7 MIDA's main health stakeholders and beneficiaries are Somali health professionals currently residing and working in Finland as well as private and public sector health institutions in Somaliland and Puntland.

Project's progress and key achievements

- 7 Since its inception in July 2008, the project has made substantial progress towards meeting the defined objectives. The first step was to map all health facilities in Somaliland and select institutions interested in hosting diaspora professionals. The first temporary returns have started in October 2008. However, following terrorist attacks that struck Hargeisa and Bossasso, activities were put on hold and the 3 participants present in Somaliland at that time were relocated to Finland. Project activities resumed in April 2009 and up to July 2009, 16 project participants had completed their assignments with various institutions. MIDA voluntary experts providing direct on-the-job training to medical professionals and students as well as medical advisory services and treatment to patients. Patients and representatives of host institutions all confirmed that the MIDA voluntary experts succeeded in providing essential healthcare services currently not available locally.
- 7 By July 2009, almost 80% of the expected MIDA voluntary expert caseload have successfully completed their assignments, all received positive feedback from host institutions. This is very encouraging in view of a potential expansion of the MIDA health pilot project into a larger programme;
- 7 12 host institutions in different regions of Somaliland have benefited from the services provided by MIDA voluntary experts;
- 7 The Somaliland Ministry of Health and Labour, project partners, host institutions and local communities, as well as IOM staff in Helsinki and Hargeisa have been working harmoniously together in order to attain the project goals;
- 7 444 hospital nurses, nursing students and university students have been trained in various fields related to their work/study and reported that they gained valuable skills for their future work;
- 7 513 patients have been treated, and in some cases received specific medication not available in Somaliland through the MIDA voluntary experts.

Project challenges

- 7 The Hargeisa and Bossasso suicide bombing attacks from October 2008 dealt a major strike to the project. All healthcare professionals present in Somaliland at that time had to be relocated to Finland;
- 7 Delays in the delivery of equipment and luggage of voluntary experts upon arrival in Somaliland;
- 7 In a few cases, local healthcare professionals were reluctant to provide the necessary cooperation to voluntary experts wrongly fearing the potential loss of their jobs due to the diaspora expertise. However, the host institution supervisors, MIDA field manager as well as the Ministry of Health and Labour managed to allay these unjustified concerns.

MIDA Health voluntary expert contributions

- 7 Provision of theoretical and practical trainings to healthcare professionals/workers, nursing school students and university students;
- 7 Development of training manuals and guidelines on best practices for different health institutions in areas such as orthopedic surgery or basic nursing ethics;
- 7 Participation in the planning process of future activities to improve the healthcare system and in the implementation of the national health plan;
- 7 Regular provision of personalized treatment of patients and advice to patients in order to avoid malpractice and self-treatment.

MIDA-Health outcomes for Northern Somalia

- 7 Improvement of knowledge and skills of local healthcare professionals;
- 7 Building of local staff's self-confidence in their possibilities to improve the healthcare system in Somaliland (reducing the brain-drain);
- 7 Link diaspora professionals to medical institutions abroad and local institutions;
- 7 Supporting the establishment of a local network of healthcare professionals;
- 7 Creating a referral and consultation system between different institutions and different regions.

MIDA-Health outcomes for voluntary experts

- 7 Raising awareness about weaknesses and strengths of participating health institutions;
- 7 Raising awareness about health risks faced by the population and the type of interventions that they would eventually require;
- 7 Transfer of skills and capacity building to locally-based healthcare professionals;
- 7 Sensitization to Somaliland's current situation and challenges;

- 7 Boosting of self-confidence of voluntary diaspora experts to serve as agents of development and change back home.

MIDA-Health outcomes for host institutions

- 7 Dr. Yassin Arab, the Director of the Hargeisa Group Hospital, underlined how satisfied and grateful the institutions hosting the voluntary experts were. He was particularly grateful not only for the assistance provided by the MIDA voluntary experts during their assignment in the various hospitals but also for the training provided to medical students. He pointed towards the professionalism and commitment of the voluntary experts. Dr. Yasin Arab urged IOM to look into possibilities to further expand the project and investigate ways to improve outcomes and results.
- 7 Dr. Edna Adan, the Director of the Edna Adan Maternity Hospital, expressed gratitude for receiving two MIDA voluntary experts in her hospital. She said that given their exceptional commitment and professionalism, the participants were a source of inspiration for local staff.

Key comments from workshop participants

- 7 The IOM MIDA Health project is very valuable and it should continue seeking support from international donors in Finland or elsewhere;
- 7 Local authorities should provide all the necessary support to facilitate the continuation and expansion of this project;
- 7 More capacity-building activities for local healthcare professionals and their associations should be provided through future assignments;
- 7 Future MIDA health projects should also include the provision of equipment, medicines and potentially financial resources for host institutions;
- 7 Diaspora mobilization should be a key component in the tool box of policy instruments for IOM's MIDA projects;
- 7 Host institutions should provide their full support to the experts in order to maximize outcomes in terms of knowledge and skill transfers to local staff.
- 7 Work assignment of voluntary experts should be longer than 3 months, ideally 6 months;
- 7 Future projects should also seek expertise for the following specific healthcare sectors: emergency, midwifery, psychiatry, biomedical technologies and sanitation;
- 7 Future projects should look into the establishment of cooperation and coordination mechanism among local institutions and institutions from the countries supporting the project through twinning activities;
- 7 Future MIDA health projects should undertake an even more thorough assessment of the material and human resources needs and challenges of the healthcare sector throughout Somaliland;

- 7 IOM should attempt to support study or exchange visits of healthcare professionals from Somaliland to Finland;
- 7 Future MIDA health projects should consider the possibility of financing medical infrastructure rehabilitation or reconstruction.

Conclusions

- 7 Dr. Anwar Mohamed Egeh, Director General of the Ministry of Health and Labour, closed the workshop by stating that in response to the discussions, outcomes and suggestions at the workshop, his Ministry would establish a specific support mechanism to MIDA Health. Dr. Ali Sheikh Omer, the Ministry's public health officer, spoke about the importance of the link between migration and development. He was convinced that many policy makers today acknowledge the added value of partnerships as useful tool for policy making and project implementation. Dr. Omer also reiterated the advantages of making voluntary experts available to additional regions, and in particular the Sool and Sanaag regions.

- 7 Ms. Lisa Mackey, the head of office of IOM Hargeisa, concluded in summarizing the concerns and suggestions expressed by all participants. She stated that the MIDA Health project was initiated by the Somali diaspora in Finland, developed by IOM in Helsinki and generously financed by the Finnish Ministry of Foreign Affairs. She welcomed the good will of the voluntary experts to be deployed to locations in urban and rural areas, with due consideration to security limitations prevailing at the time of temporary deployment. Given the success of this project, IOM will look into possibilities for its further expansion and continuation. Ms. Mackey concluded her speech by thanking all participants, including the Ministry of Health and Labour, the Somali health professionals from Finland and IOM staff.

Media coverage of the workshop

Four Hargeisa-based newspapers published articles and interviews about the workshop, the philosophy as well as the outcomes of the MIDA health project. Three local TV stations as well as Radio Hargeisa aired full coverage of the meeting.

FINNISH CIVIL SOCIETY ORGANISATIONS AND THE FIGHT AGAINST TUBERCULOSIS IN SOMALIA

Lennart Brander
Simo Granat

The historical perspective

The first larger-scale involvement of Finnish civil society organisations in health issues in Somalia goes back to the early 1980's. Tuberculosis was then, and still is, one of the main killer diseases in Somalia, whose TB-situation is one of the worst in the world. The need of assistance in the combat against the disease was acknowledged by a Finnish doctor, working as a WHO consultant in Somalia. This led to the preparation of a TB-project in 1980, and implementation began in January 1981, serving as the run-up to a project by the Finnish Anti-Tuberculosis Association (FATA, nowadays the Finnish Lung Health Association, FILHA), which was to last from the beginning of 1981 up until the end of 1990. The project was supported by the Finnish Ministry for Foreign Affairs and the Somali counterpart was the National Tuberculosis Programme of Somalia (NTP).

The activities started as a humanitarian project in the refugee camps at Qoryooley and expanded to the capital Mogadishu in 1982. The next year Kismayo in the South was included and in 1984 Hargeisa, in the Northwest, and later on several other regions. The project gradually became more comprehensive and emphasized training of health personnel at all levels. The overall development objective was "to support the Ministry of Health at national, regional, district, and community level in developing institutions and capacity to reduce morbidity and mortality of TB" (FATA, 1991).

Hospitals, outpatient departments, laboratories and other facilities were built or renovated in numerous places in the country. Especially the Forlanini hospital in Mogadishu was equipped with renovated wards, laboratory, x-ray department, lecture hall, pharmacy, kitchen and laundry. The ultimate goal was to turn Forlanini into a reference hospital for TB and other pulmonary diseases and, in conjunction with the University of Tampere, Finland, organise training of lung specialists.

The Finnish staff consisted of doctors, nurses, laboratory- and x-ray technicians, administrative and technical personnel. At most about thirty Finnish experts were working in Somalia at the same time and the NTP employed almost five hundred persons. Numerous Somali doctors and other health personnel participated in lectures and seminars over the years and bedside training was an important part of the programme. Moreover, a total of about forty persons of the NTP key staff participated in an international exchange programme of specialization studies, either in Finland or in third countries.

In the diagnosis and treatment of TB-patients, the methods used were in conformity with the World Health Organization's DOTS-system (Directly observed treatment, short course), with an early introduction of modern short-course treatments. By using the most effective TB-drugs available, the treatment period was reduced from twelve to six months. The patients took their medicines under strict supervision of health care personnel, thus avoiding the creation of drug resistant strains of TB-bacteria. The patient compliance was enhanced by an emphasis on health education, awareness-raising, and a community-centred approach. The results were impressive as about 60.000 treatments were started and about 35.000 patients cured. The treatment outcomes improved considerably during the 1980's and the responsibility for the activities was gradually transferred to competent local Somali staff. The intention was to decrease the Finnish presence in Somalia to four advisers and some economical support from 1991 onward.

However, with the onset of the civil war in the North of Somalia in 1988 and its subsequent gradual extension over the central and southern parts of the country, by fall of 1990 the security situation turned also critical in Mogadishu and led to the withdrawal of the expatriate community. The war situation made the presence of the TB-team impossible and the project was stopped at the end of December 1990. In January 1991, the rebel forces conquered Mogadishu and President Siyad Barre was ousted.

During the civil war much of the work done by the project has been devastated. Buildings have been destroyed and looted, equipment has been stolen and all the achievements of the TB-work, established over a period of some 10 years, ruined.

Current engagements

In spite of the absence of a functioning government in Somalia since 1991, TB-work re-started in 1995 with the support of WHO and other international organisations and NGOs. Since then, we have seen remarkably good results.

Many Somali doctors and other health care personnel trained through initial the project are still working in Somalia, many of them in leading positions in the fight against TB.

This fact can be considered the most important long-term impact of the cooperation between Somalia and Finland in the 1980's. From 1980 to 1990, 13 Somali TB-doctors, 4 nurses, 6 laboratory technicians and 5 x-ray technicians were trained in Finland for a duration from six to twelve months.

During the civil war many Somalis left their country, some settling in Finland including four doctors who earlier worked with the project. Since 2000, three of them have helped to rebuild the health sector in their native country, all held important positions in the NTP in the 1980's, contributing significantly to the rebuilding of primary health care and a TB focus in Somalia.

- 7 Dr. Ahmed Mohamed Mahdi has founded, with the help of Somalis in various countries, the Somali Association of Health Care and Education Development (SAHED). He has spent many successful years in Dhusamareeb in Central Somalia, organising a functional primary health care system in the region.
- 7 Dr. Ahmed Yusuf Guled has organised a TB treatment clinic, health education, a TB-laboratory in Mogadishu, and is presently involved in a PSR-Finland project setting up a TB-laboratory in Hargeisa.
- 7 Dr. Ahmed Haji Omar Askar has since 2000 worked in various positions in Hargeisa and especially at the TB-hospital in Borama where he has continued the work of late Annalena Tonelli.

Since 2000, the TB-work in Somalia has in many ways continued to be systematically supported by the Finland-Somalia Association and the Physicians for Social Responsibility (PSR-Finland).

At present, civil society organisations in Finland continue to play a major role within Finland's development contribution to Somalia. A large number of Finnish NGOs implement projects in all parts of the country, in collaboration with their respective local counterparts. The majority of these NGOs are relatively small organisations, whose active members are mainly of Somali descent. In large parts of Somalia, there is no central administration able to provide health services and even in the more stable areas, especially in the North, there is a persistent lack of both material and human resources. In this context, the role of the non-governmental sector is determinant; the work to control the tuberculosis epidemic would be virtually impossible to be carried out without the contribution of the international and national NGOs working in this field in Somalia.

Exploring the role of Finnish civil society organisations in the provision of health services in Somalia, with particular respect to the health professionals of the Somali diaspora in

Finland, a review of the projects currently funded by the Ministry for Foreign Affairs of Finland, as well as an inquiry by means of a questionnaire sent to all NGOs with ongoing health projects in Somalia supported by the Ministry, revealed the following:

- 7 in 2009, 17 Finnish NGOs, with a total of 25 projects in Somalia, were receiving financial support from the Finnish Ministry for Foreign Affairs' allocation for NGO development cooperation;
- 7 8 NGOs were carrying out a total of 10 health-related projects;
- 7 most of these health projects supported by the Finnish Ministry for Foreign Affairs have a modest budget; only 4 of the 10 projects received more than € 50.000 in support in 2009, the largest financial support provided to any of those projects was of € 350.000;
- 7 the total amount of support channelled through Finnish NGOs to health projects in Somalia in 2009 was of approximately € 1.070.000. In addition to the support from the Ministry, Finnish NGOs also provided some 15% of the total project budgets as co-funding, mostly in form of a mixture of cash and voluntary work;
- 7 the health related projects implemented by Finnish NGOs focus on a wide array of topics. Many have a broad agenda incorporating different activities and target multiple fields of health issues. Thus, 4 projects were providing maternal and child health services, 3 included work against tuberculosis, 3 were targeting female genital mutilation, 3 involved efforts against HIV/AIDS and 2 contained a vaccination-component; additional activities in the projects ranged from rehabilitation of healthcare facilities to health education;
- 7 in 6 out of the 10 health projects, the Somali diaspora in Finland was actively involved in the implementation; in an additional 2 projects, members from the diaspora participated in the initiation phase, before project responsibility was handed over to local counterparts. In these cases, monitoring stayed typically with the Finnish NGOs. Only in 2 of the projects, members of the diaspora had not been involved at any stage of the planning, implementation or monitoring.

Due to incomplete available data, it was impossible to establish the exact number of health professionals from the Somali diaspora in Finland participating in the implementation of projects. However, based on the data at hand and on further anecdotal evidence, relatively few health professionals of Somali descent appear to be actively involved. On average, it seems, less than one such individual is part of the project team of each project. This could be due to the relative small financial volumes of the projects. Furthermore, in a few cases, the same health professionals are active in more than one project at a time.

In addition to working with Finnish NGOs, health professionals of the Finland-based Somali diaspora are also working with other organisations, in different parts of Somalia, implementing health projects and programmes. For instance, in the field of tuberculosis, Finland-based professionals are contributing to the provision of health services in Somalia through other organisations than Finnish NGOs. Thus, to focus solely on NGOs registered in Finland when estimating the contribution of health professionals from the Somali diaspora in Finland to health care in Somalia, could lead to underestimated figures.

Apart from the NGOs actively involved in health projects in Somalia, other sectors of Finnish civil society have also been contributing. In this context, the training coordinated and planned by the Finnish Medical Association for health professionals participating in IOM's MIDA Health project prior to their departure to the field, must be singled out.

Pointers for the way ahead

The role of the Finnish civil society organisations in the provision of health services in Somalia could be increased further. The possibility to add even more value through mobilizing the skills of health professionals from the Finland-based Somali diaspora should be explored. The incorporation of trainees and intern positions in future MIDA-type of projects, or NGO activities, should be considered. Such a formula would enable medical students to participate, and to learn under the supervision of more experienced colleagues. A similar system has been used with reasonable success in the development projects of the NGO Physicians for Social Responsibility (PSR Finland). For instance, in the field of tuberculosis work, a positive experience from a model in which the medical team contained Finnish health professionals from both within and outside of the Somali diaspora, together with younger colleagues in trainee positions, has been made recently

PSR-Finland's tuberculosis project started in 2006 with a two-year pilot phase in Mogadishu. From the very start, the project has drawn from the broad expertise of senior project members. The Finnish senior tuberculosis expert, a member of the Somali diaspora in Finland, has vast TB experience in Somalia, while the native Finnish programme director has broad experience in infectious diseases and developmental cooperation. At a later stage, the project team has been joined by a junior team member, who at the point of entry was a last year medical student in the University of Helsinki. Under supervision and guidance from the senior team members, he was gradually been introduced to the project context and taken on more responsibilities. The junior member participated in the work in Finland, and in shorter week field visits and meetings in Kenya and Somaliland. The junior assisted in the drafting of technical documents, evaluation of project progress, and in negotiations with other stakeholders and partners. Unfortunately, we have been unable to identify a candidate for the junior

position who would both be of Somali background and have the relevant academic and medical training background for our project. Identification of suitable candidates of Somali origin for junior positions is probably easier in projects with a less technical focus.

However, a considerable challenge in incorporating trainees/interns in projects is the amount of work represented through supervision. This additional workload should not be underestimated, and could be a great burden for smaller projects with limited human and other resources. One way to overcome this limitation could be to increase the cooperation between and within project clusters implemented by different NGOs, regrouping projects focusing on the same sector of healthcare and/or the same location. In addition to optimising the use of available human resources, this cluster approach could help to augment project efficiency by offering synergies.

References

FATA

- 1991 “Summary Report 1980 – 1990”, Somalia-Finland Tuberculosis Control Support and Training Project, FATA, Helsinki.

MIDA HEALTH IN ACTION: TESTIMONIES FROM DIASPORA EXPERTS AND HOST INSTITUTIONS

MIDA Health Somaliland-Puntland: experiences as a voluntary expert

Dr. Ahmed Y. Guled (Medical Doctor, Hargeisa Tuberculosis Hospital)

“This was not my first trip to Somalia. I have visited before but with other purposes and tasks than this time as a voluntary expert. In many ways, this MIDA trip cannot be compared to previous visits. My specific role as a voluntary health expert, the experiences I gained and the expected longer-term outcomes of my work there made this time in Somalia very special for me...

One of the main roles as a voluntary expert in the MIDA health project was to participate in capacity-building and training of local staff, supporting development of the health sector back home. I participated in the drafting of medical training manuals as well as guidelines for the local partner institution that hosted me during my stay. Acting as a consultant in the host institution, I was also given the opportunity to treat patients requiring care, which was a very satisfactory part of my assignment.

The experiences I gained during this period as a voluntary MIDA expert were both of a medical and a non-medical nature.

I became aware of the health institutions operating at present in the country as well as the weaknesses and the strengths, but also future needs, of each institution. This is insight I did not have prior to my MIDA experience. I noticed that the health gaps in terms of infrastructure and human resources are enormous, there is so much that needs to be re-build or at least improved. More capacity-building addressing not only needs in the health sector, but in many other sectors would also be so beneficial to the country.

My work in Somaliland also helped me to notice how peaceful and secure the country has become over the last few years. As a Somali, I was touched by the generosity of the

local people and their welcoming ways. It is good to be back and witness the vivid culture of our local communities. All of this made me optimistic about Somalia's future.

I believe that I managed to contribute to a very useful upgrading of the knowledge and the skills of the local medical staff, helping to boost their confidence and, I do sincerely hope, reduce the continuing brain drain that my country suffers from. Seeing myself as bridge builder between the professionals of the diaspora and our medical institutions at home, I think that training assignments such as this one should continue in the future. To make it happen and repeat the positive experience, I suggest the development of a national network of medical professionals by creating a referral and consultation system between institutions and regions of Somalia on one side and medical professionals from the diaspora on the other.

Institutionalising the MIDA mechanism would also contribute towards creating trust and confidence between the voluntary experts and the locally-based medical practitioners. Nobody needs to be afraid of losing their jobs, we are here to help and need to have access to the patients who need our services.

I would recommend providing to the local staff working in different host institutions more information about the objectives of the project in order to create a positive cooperation between the local health professionals and the project participants. The Ministry of Health and Labour should encourage professionals in the diaspora to participate more actively in drafting projects like MIDA.

Finally, I would like to conclude that my expectations were fulfilled; I believe that the project was very successful. Since it has largely proven to be useful for the partner institutions, local health personnel, the patients and the country, I expect that the project will not only be continued but also strengthened so as to extend its coverage to other parts of the country. I do hope that even more projects in different fields of professional expertise could be established.”

My experience as a MIDA Health voluntary expert

Dr. Mulki Mölsä Elmi (Medical Doctor, Hargeisa University Hospital)

“MIDA is an IOM pilot project in the Somaliland and Puntland areas of Somalia. The main aim of the project was to strengthen the local health sector through the engagement of Somali diaspora health professionals from Finland.

I left Somalia in 1984, before the civil war, and arrived to live in Finland in 1985, which since then has become my second homeland. From the very beginning, I was involved in Somalia issues here in Finland. One of my dreams was to return back at least once to work in Somalia; I was very much interested in contributing with my skills and knowledge in the development of my first homeland.

As I have been living in Finland for the last 24 years of my life, working in the Finnish health sector, I have no experience of working in Somalia as a medical doctor or even getting first hand experience of what it is like to work in Somalia.

In comparing the two health systems, I was somewhat guessing the difficulties the health sector must go through in Somalia. Under MIDA, I had the opportunity to work in the Hargeisa General Hospital. Prior to leaving, the first challenge I encountered was that, although I knew my work place, I did not know the task I was expected to fulfil there. So before I went there, my attitude was “Am I ready to do anything concerning health?”

So, when I arrived together with four other MIDA voluntary experts, two male doctors and two female nurses, we were delighted and filled with great enthusiasm for going to help our people. What was shocking in the first place were the planes of the local airline that took us to Hargeisa. We flew in an old two-engine Russian plane, with pilots from Eastern Europe. These planes were not only insecure but very dangerous to travel with, the aircraft had no ventilation and the safety belts were not functioning. When we landed safely, we were relieved and greeted by the very welcoming IOM staff in Hargeisa.

I was appointed to teach psychiatry to 5th and 6th year students of the Hargeisa Medical Faculty and also had the opportunity to teach in the Hargeisa Nursing School. My subjects were general medicine, practical on-bed consultations, case discussions, case managements etc. I was really surprised how highly motivated the students were. Although they did not have many instruments, or machines for diagnosis, they still managed well the complete high standard anamnesis of patients. It was a great pleasure for me to offer special classes only to female medical students. They got the opportunity

to learn about sexuality and psychiatric diseases. They told me that it was a challenge to study this subject with the boys.

Together with the students, I investigated the burden of mental illness in Somaliland, especially in the urban environment of Hargeisa. I was surprised to see the living conditions of the patients and the condition of mental health wards in Hargeisa's main general hospital. The overall prevalence for people suffering from severe mental illnesses seemed to be high. Poverty, the "khat" chewing culture and post-war traumata are sad realities in every part of Somalia and especially in Somaliland.

The nurses working in the hospital were particularly motivated as some of them were not paid for three months due to lack of funds by the government. After more than two decades away from home, Somaliland and Hargeisa felt like a strange place, but as we lived in a hotel near the Hargeisa airport, we met Finnish Somalilanders living in Hargeisa who made me feel home. My initial assignment in Hargeisa was of 3 weeks, we were then planning to also spend 3 more weeks in a hospital in Puntland. However, we could not go to Puntland due to security reasons, and I spent all my 6 weeks in the Hargeisa hospital. My experience with the local people was great, I highly appreciated their hospitality.

I would like to convey my gratitude to the local IOM coordinator Ms. Shukhri Sheikh Ali. She was a very effective and competent professional, who helped me more than she was supposed to and made all of us really feel at home.

Many thanks go to the Director of the Hargeisa Hospital, Dr. Yaasiin, to the dean of the Hargeisa University, to all the students, and especially the female medical faculty students. I want to also thank the Somaliland Medical Association, who provided an opportunity to meet local medical doctors and give them a lecture about the Finnish Medical Association. Thanks to the staff of the Star hotel in Hargeisa who made us feel at home.

Thank you to IOM in Finland and to the Finnish Foreign Ministry for making my dream to work as a medical doctor in Somalia come true !"

Interview with MIDA Health voluntary expert Dr. Mohamed Yusuf Elmi (male, 46 years, medical doctor)

1. Why have you chosen to go and temporarily work in Northern Somalia?

I spend a lot of time in Somaliland. I go back and forth between Finland and Somaliland. From June to August 2009 I participated in the IOM MIDA programme. After my contract was finished I still stayed; I haven't gone back to Finland yet. [At the time of the interview, September 2009, the voluntary expert was still in Somalia.] But I have gone back home many times before. The first time I came was in 2002. I come to work in Somaliland because I want to do something. There is a great lack of human resources and I want to help.

2. How did you prepare for your stay in Somaliland?

I am a member of professional diaspora associations in Finland and in Somaliland. That helped me to establish contacts. I did not do a security training such as the one offered by IOM or anything like that before I left, but the security situation wasn't really a problem for me.

3. What did you do during your assignment? How did you experience your work there?

I am a general practitioner. I got my degree in 1989 in Somalia, and then I have been working in Finland. I also did some training in Finland. My focus is on HIV and TB. This is very important in Somalia and addresses the local needs here. The relationship between me and my colleagues and supervisors is good. I also work closely with community representatives. They always have a lot of questions and are very interested. People come to visit me in the hospital or in the communities and ask many questions. Sometimes I cannot answer all of them. So I stay in contact with people and answer their questions by telephone or email later.

4. Which other positive experiences did you have?

People in Somalia are very interested and also very grateful. I have made many new contacts, also new connections with the local administration. I recommend to all diaspora health professionals to return back home with this IOM programme.

5. Which challenges did you face?

The greatest problem is the lack of infrastructure. The war has destroyed the health system so there is no material, no equipment and no personnel. That makes the work

difficult. But, you just do what is possible and help where you can and IOM MIDA is good for that.

Interview with MIDA Health voluntary expert Mr. Ahmed Weli Haddi (male, 44 years, nursing specialist)

1. You went to work in northern Somalia for a short-term assignment. When did you go and why?

I went to Northern Somalia with IOM in July this year [2009] for a period of 6 weeks. But I have gone to do similar type of work before. Actually, it was our Somali health professionals association that initiated this project. We came up with this idea. We want to support health in Somalia and anyway, we go often back to Somalia for holiday and work, so we took this idea to IOM. We already took this to IOM in 2006 knowing that IOM is implementing these migration and development programmes in a number of African countries.

2. How did you prepare for your stay in Somaliland?

We had a one-day education seminar. But that was very short. Until shortly before my assignment, I also did not know where exactly I was going so I found it difficult to prepare. It would be useful to have a longer training and to be informed more in advance where the placement will be. I organized my own accommodation privately. IOM covered my health insurance and took good care of all the logistical arrangements. But, I did not have insurance for my luggage and unfortunately my luggage got lost.

3. What did you do during your assignment? How do you estimate the impact of your work there?

I am a nurse, and I have a Master degree in administration. I applied my knowledge during the assignment through teachings. This was a short-term assignment but I believe it brings a lot of benefit to the people there. I got feedback from my students and it was very positive. They really appreciated the teaching.

4. Which other positive experiences did you have?

Going back after a long time away was a good experience. We were able to offer our knowledge to the students, which is also very good. And they really appreciated it. It is nice to share experiences. I gave my knowledge but I also learned something in return. I also made many new contacts and I am staying in touch with people even when I am in Finland.

5. *Which challenges did you face?*

There is a lack of material and infrastructure and also logistical problems. We teach but then how can people implement what they have learned if there is no material? You need a lot of patience and tolerance. We are neither international nor local staff; so this can be a little bit difficult. The local authorities should also be made aware that you are there, in case something happens. It can be a challenge to re-integrate after having been away for a long time, and also for the locals to accept you. Sometimes there might be a little bit of hesitation amongst some colleagues who work at the hospital. Their salaries are very low and they see other people coming to work for free. So they are afraid that they might lose their jobs.

A testimony from the Edna Adan Maternity Hospital in Hargeisa

Dr. Edna Adan Ismail

“I send you greetings from Somaliland and thank IOM-MIDA for providing us with two Somali voluntary experts; one for one week and one for three weeks during July 2009.

In order to strengthen our collaboration, we need to brief you about the services that our hospital is providing so that you may continue to identify suitable candidates to work with us.

The Edna Adan Maternity and Teaching Hospital is a non-profit Charity which I established after I retired from WHO in 1997. It took four years to build and was opened in March 2002. We became the first Nurse Training School in Somaliland and so far have graduated two groups of nurses, two groups of post-basic midwives, and are now training the third group of nurses. We are also the only Midwife Training School in Somaliland.

Although I initially intended the hospital to be a Maternity Hospital, it has now become a national referral facility that also treats general patients referred from other hospitals in Somaliland as well as those coming from a wide geographical area in the Horn of Africa.

Since we opened, we have so far delivered 8,980 babies, performed over 2,500 surgical interventions, among which 910 C-Sections, repaired over 100 vesicovaginal fistulae, and treated over 10,000 patients in the medical, surgical and paediatric departments of our hospital. We also have a busy out-patients ward where we have provided treatment to over 65,000 men, women and children. We provide immunization coverage to children and women and also do screening and counselling for HIV/AIDS.

Since I personally pioneered the fight against female genital mutilation in 1977, we conduct research on FGM with results being printed for publication soon.

We have given you this briefing about the major activities that our hospital is carrying out because we are confident that we can substantially reduce the Maternal Mortality Rate of women in our part of the world if we obtain the technical support and resources that we need to improve our performance.

IOM's MIDA programme for qualified health professionals from the Somali diaspora is an efficient and sustainable way to help us in our efforts to offer decent medical services

to all people in the country. For this reason, we are appealing to IOM to continue supporting our efforts with the provision of nurses, midwives and doctors who can help us train our own in order to serve our people better.”

A testimony from the Hargeisa Institute of Health Sciences

Dr. Ahmed Mohamed Dirie

“As Somalis, we traditionally attach a great deal of importance to the care of our people, with particular regard for those who are weak, sick, or needy. We also know that it is neither enough for us to just wish the best for our people, nor acceptable to give only medical care without the accompanying kindness, compassion, and respect that the sick deserve as human beings.

The training of nurses and male dressers in our country has been a progressive effort which started in late 1942, when, as part of the British Empire, our country was known as British Somaliland Protectorate. In 1964, with WHO tutors and UNICEF support, the first three-year Basic Nursing Education Programme was established at the Hargeisa School of Nursing.

After the civil war (1988-1991) the nursing school has been re-opened again in 2003 and two groups have graduated since then, with a total number of 111 nurses. We couldn't have achieved much without the support of our friends and the international community.

The International Organization for Migration was one of the leading agencies who came to our aid in terms of providing the most valuable resources we needed: technical support, by encouraging Somali health professionals from the diaspora to work and teach their own people. The importance of this is that it has given our students and health workers a role model to look up to.

IOM has provided Hargeisa Nursing School with expertise who covered various subjects:

- 7 One voluntary expert (female, medical doctor) covered mental health care and management aspects that are mainly related to the national context. The students she taught were very thankful for her contributions to their school. “She was a very nice and kind human being”, “We would love to have her back”, “She has a wonderful and caring personality”, were just some of the many comments that the doctor has received from the students.
- 7 A second voluntary expert (male, nursing specialist) covered medical and surgical nursing care and management both at national and international level. The students frequently commented about his exceptional abilities and his professionalism. “The voluntary expert has been a joy to work with”, “He is a caring hard worker”, and “He has a wonderful personality”.

- 7 The third voluntary expert (female, nurse) contributed greatly towards the clinical training of nurses at hospital level. She was a very kind and compassionate nurse and an excellent role model for the nurses she trained. As a representative from the Somali Diaspora that came to Somaliland to help nursing students at Hargeisa Institute of Health Sciences, she has greatly contributed with her outstanding professional abilities

The International Organization for Migration is to thank for bringing medical professionals from the diaspora to Somaliland. They have done a great job by bringing skilled professionals to contribute to the nursing students of the Hargeisa Institute of Health Sciences.”

Chapter 6

Conclusions

THE DIASPORA: A HIDDEN SOURCE OF HOPE IN SOMALIA'

Thomas Lothar Weiss

Somalia represents one of Africa's most enduring humanitarian and development disasters. For nearly two decades the country and its people have been the victims of violence and untold suffering. Fleeing the chaos, a massive outflow of Somalis to neighbouring countries, Europe, North America and the Middle East has led to an estimated three million Somalis living outside their country of origin and draining Somalia's vital human resources.

In Finland, the Somali diaspora constitutes the largest non-European ethnic minority. While facing challenges related to integration, this group has also become a major source of relief, humanitarian assistance and much needed financial resources for Somalia. Through numerous civil-society and community-based organizations, supported by the Finnish Government and Finnish NGOs, Somalis in Finland have actively pursued voluntary initiatives that help to alleviate the consequences of Somalia's recurrent crises.

But how sustainable are such efforts? Can small-scale development projects that are initiated by migrant communities be integrated into multilateral aid efforts or official development policies?

In recent years an interesting policy debate on the interplay between migration and development has questioned the old assumption that emigration only drains local communities of irreplaceable human resources, the so-called "brain drain". Indeed, while emigration is a cause of brain drain, it also represents - if well managed - a source of prosperity.

Through the United Nations' High Level Dialogue, the Global Forum for Migration and Development, or the Joint Africa-EU Declaration on Migration and Development, the international community has now recognized migrant communities' potential in becoming an active vehicle of change and opportunity for development in respective countries of origin. Financial and non-financial contributions of diasporas represent the hidden face of international investments for development. According to the World Bank, international remittances remain the second-largest financial flow to developing

countries after direct foreign investment, estimated at some USD 287 billion in 2008, which is more than twice the size of net official development assistance.

However - and this must be highlighted - migrants can contribute towards development not only through remittances, but also through the transfer of professional skills, specialized knowledge and entrepreneurial experience. As recognized by an increasing number of donor countries such as Finland, migrants play an important role in the reconstruction of societies ravaged by crises and conflicts through the promotion of sound management and good governance, the respect for human rights and fostering of democratic principles. The practical knowledge and experience gained by migrants studying and working abroad is immeasurable. The recognition of this often under-used resource is essential not only in promoting migrant integration into new home countries but also in strengthening host nations' international development strategies.

Aimed at alleviating the devastating impact of the African brain drain, in 2001 the International Organization for Migration (IOM) launched the Migration for Development in Africa (MIDA) framework programme. Operating in more than 20 countries in Sub-Saharan Africa, MIDA strengthens African economies through the mobilization of skills, knowledge and other resources available within the diaspora.

In close co-operation with the Somali diaspora in Finland, which includes a small but active number of healthcare professionals, the Finnish Government and IOM are today responding to the catastrophic state of Somalia's healthcare services. As many as two dozen doctors, dentists, nurses and laboratory technicians of Somali origin have returned temporarily to their native country to lend a helping hand and become messengers of Finland's commitment to reconstruction and development in Somalia, as well as the wider Horn of Africa region.

In October 2008 the first group of professionals left Helsinki for Hargeisa. Putting divisive politics aside, these doctors and nurses returned to help, bringing with them superior professional skills that will ultimately serve in building the capacities of local authorities, medical centres, NGOs and educational institutions to provide adequate services to the population in need.

These determined women and men, and the ones who followed, have left behind their families, friends and the comfort of Finland's health centres to work in conditions that are difficult to imagine. They have used their unflinching commitment to help and teach to compensate for a health infrastructure that is lacking in practically everything.

In spite of setbacks caused by the security conditions in situ, this initiative illustrates the added value that empowered African migrant communities in the Nordic countries can have for the development of their home continent. Their skills, dedication and

willingness to help must be integrated into the planning and implementation of practical and realistic development strategies.

Today, Finland and its Somali diaspora have started to close the gap between migration and development policy and practice. There are ways to address the chaos by involving the diaspora as an actor of change. Finland can be proud to be one of the few countries that is giving its Somali diaspora the means to contribute towards the rehabilitation of vital services in their homeland and spread a message of hope that remains so elusive for Somalia - an example to follow.

Notes

1 Adapted from an original version published by Helsinki Times, 19 March 2009

AUTHORS

Dr. Thomas Lothar Weiss

Director of IOM Regional Office in Helsinki and Regional Representative for the Nordic and Baltic States and the European Neighborhood countries (East) (from 2003 to 2009)

Dr. Arno Tanner

Researcher, Finnish Immigration Service - Finland

Elizabeth Warn

Programme Officer, IOM Headquarters – Switzerland

Susanne Melde

Project Coordinator, IOM Headquarters – Switzerland

Abibatou Wane

Project Officer, IOM Niamey – Niger

David Appiah

MIDA Field Manager, IOM Accra – Ghana

Dr. Maria Brons

Programme Manager, IOM The Hague – The Netherlands

Pauliina Hellman-Field

Desk Officer, Ministry for Foreign Affairs of Finland

Bradley David

Project Officer, IOM Regional Office for East and Central Africa – Kenya

Abdi Jama Ghedi

Consultant, IOM Regional Office for East and Central Africa – Kenya

Dr. Marja Tiilikainen

Post-doctoral Researcher, University of Helsinki – Finland

Shukri Sheik Ali

MIDA Field Manager, IOM Hargeisa – Somaliland / Somalia

Elenna Giannini

former Project Officer, IOM Regional Office for East and Central Africa – Kenya

Päivi Pirkkalainen

Researcher, University of Jyväskylä – Finland

Tobias van Treeck

Project Coordinator, IOM Regional Office for the Nordic and Baltic States and the European Neighbourhood countries (East) – Finland

Juan Daniel Reyes

Project Assistant, IOM Regional Office for the Nordic and Baltic States and the European Neighbourhood countries (East) – Finland

Dr. Simo Granat

Project Manager, Physicians for Social Responsibility – Finland

Dr. Lennart Brander

former Senior Adviser, Finnish Lung Health Association – Finland

ACCRONYMS AND ABBREVIATIONS

AMISOM	African Union Mission in Somalia
AU	African Union
CPCFPU	Centre for Peace, Conversion and Foreign Policy in Ukraine
CSM	Christian Science Monitor
DOTS	(WHO) Direct Observed Treatment – Short Course
EC	European Commission
ECHO	European Commission Humanitarian Aid
ECOWAS	Economic Community of West African States
EU	European Union
FATA	Finnish Anti-Tuberculosis Association
FDI	Foreign Direct Investment
FILHA	Finnish Lung Health Association
FIS	Finnish Immigration Service
FSN	Finnish Somalia Network
GAVO	General Assistance and Volunteer Organization
GDP	Gross Domestic Product
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HDR	(UNDP) Human Development Report
HGH	Hargeisa Group Hospital

HTA	Home Town Associations
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IGAD	Inter-governmental Authority on Development
INGO	International Non-governmental Organization
INSTRAW	(UN) International Research and Training Institute for the Advancement of Women
IOM	International Organization for Migration
MCH	Mother and Child Health Centre
MDG	Millennium Development Goal(s)
MFA	Ministry for (of) Foreign Affairs
MIDA	Migration for Development in Africa
MoHL	Ministry of Health and Labour (Somaliland)
MoL	Ministry of Labour (Finland)
MSF	Médecins Sans Frontières (Doctors without Borders)
NGO	Non-governmental Organization
NTP	National Tuberculosis Programme (Somalia)
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
PSR	Physicians for Social Responsibility (Finland)
RQN	Return of Qualified Nationals
SF	Statistics Finland

SMA	Somaliland Medical Association
SNM	Somali National Movement
SOLHRC	Somaliland Human Rights Commission
SOLNAC	Somaliland National AIDS Commission
SOMHELP	Somali Health Care Professionals in the Nordic Countries
SSDF	Somali Salvation Democratic Front
TB	Tuberculosis
TFG	Transitional Federal Government
THET	Tropical Health and Education Trust
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
US	United States of America
USD	United States Dollar
WB	World Bank
WHO	World Health Organization



IOM International Organization for Migration

**Regional Office for the Nordic and Baltic States,
and the European Neighbourhood countries (East)**

Unioninkatu 13, 6th floor

P.O.Box 851

FIN-00101 Helsinki

Tel. +358-9-684 1150

Fax. +358-9-684 11511

www.iom.fi / www.iom.int
