UNDERSTANDING MIGRANTS' CONTRIBUTION TO DEVELOPMENT. A CASE STUDY FROM SOMALILAND

Valeria Saggiomo[*]

SUMMARY: 1. Introduction. – 2. Migration and Development Discourse. – 3. How do migrants' projects work? The case-study of *Mandhaye* hospital in Burao. – 4. How do migrants' projects differ from traditional ones? The four distinctive elements. – 5. New development practices?

1. *Introduction*

The migration and development theory, that recognizes and empowers migrants as key development actors, assumes a critical role in the current debate on migration management. Caught between rejection impulses and humanitarian imperatives, the world can hardly build a positive narrative on migrations despite evidences that migrations tend to stimulate local development rather than the opposite. In literature, the contribution of migrants to local development processes remains underresearched and empirical studies in support of the Migration and Development theory are scant.

Instead, it would be useful to understand how and under what conditions migrants can activate positive development processes in their origin countries. In fact, a deeper understanding of the characteristics of migrants' activism for development would inform policy makers on how to encourage and support the Migration and Development paradigm. For instance, how do migrants' development projects work? In what do they differ from development projects promoted by traditional aid actors? Is there a specific modality of aid that migrants adopt to generate development? This paper discusses migrants' own modalities to promote development through a case-study in Somaliland and advocates for more empirical research on migrants' projects in their origin countries with the view to provide evidence for policy formulation in the migration and development sector.

In describing migrants' contribution to development, this work identifies specific elements that characterise migrants' activism based on

[*] Lecturer in International Cooperation for Development at University of Naples "L'Orientale".

sentiments, a marked organizational capacity and the tendency to build transnational networks to support their actions.

2. *Migrations and Development discourse*

In this account, the term "migrant" is used as a synonym for *diaspora*. It is however important to note that *diaspora* - the segment of migrants this work concerns itself with - indicates those foreigners who are relatively integrated into their settlement societies and, at the same time, manifest a will to contribute to the wellbeing of their origin societies through various forms of capital (mostly social and economic) they can dispose of. This form of social activism is implied in the notion of *diaspora* and describes what this work refers to as "the modality of aid" that migrants use to contribute to the improvement of the leaving conditions of people in the origin countries.

The question of "how much can migration contribute to the development of origin countries" has been debated over the last five or six decades, dividing those scholars who conceived migration as detrimental for origin countries and those who noticed positive effects on the economies of the origin countries by effect of remittances sent by migrants to their extended families.

During the 1970s and 1980s the prevalent school of thoughts considered migration as an effect of poverty and at the same time its consequence: relatively well-off populations migrated in search for better living conditions, leaving the country of origin emptied of its quality workforce and thus generating a negative spiral of further deprivation and poverty in sending countries.[1] This pessimistic view embraced by neo-Marxists and structuralist scholars called upon the role of the State to reverse the negative trend with structural reforms able to activate internal markets and economy and retain the population in country. In this perspective, the relationship between poverty and migration is linear and proportional: more poverty was equal to more migration.

This "pessimistic" view was later challenged by an optimistic perspective on the relationship between migration and development, mostly moved by the phenomenon of the remittances that migrants used to send home, that were able to counter poverty and activate positive develop-

[1] Papademetriou, D. G. (1985).

ment. During the 1980s and 1990s, the extent to which remittances could contribute to the development of migrants' countries of origin became the subject of investigation of many scholars, mostly economists.[2]

This "optimistic" approach, largely embraced by the Neo-liberal school, emphasized the role of the individual migrant – the so-called *agency* – in contributing to activating development processes in multiple places, pointing to the evidence that rich societies tend to be more mobile and that migration stimulates development rather than the opposite.[3] The result of empirical research conducted in Latin America, and the Mediterranean Countries suggested that if a positive impact on migrants' origin countries was attributable to the engagement of migrants in sending remittances back home, this impact was however limited to a local micro-economic level and did not influence the macro-development framework at the national level.[4]

The 2000s marked a surge in the Migration and Development studies, probably triggered by the availability of structured data on remittances provided by the World Bank, and by the shocking figure of 2003 showing the total amount of remittances worldwide surpassing the volume of official development assistance (ODA) to countries benefitting from aid.[5]

An enormous amount of money flowing into the economies of poor countries were seen by many as potentially able to push countries out of the poverty trap and many empirical works of those times were intended to demonstrate these assumptions. The results however were not able to prove the assumption valid as different countries experienced different results. Scholars belonging to the Neo-Marxist school correctly pointed out that poverty depends on structural constraints of states, such as the limited access to welfare, justice, power and markets by the majority of the population of least developed countries; in these circumstances, they affirm, it is naïve and unrealistic to postulate that migrants' remittances may influence such processes. Consensus seems to converge on the idea that remittances, seen as an economic contribution of migrants to their origin families, generally affect the micro, rather than macro level of the receiving countries' economies.

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[2] See for instance Massey Douglas S. et al. (1998), and Agunias, Dovelyn Rannveig (2006).

[3] Skeldon R. (1997).

[4] World Bank (2001).

[5] World Bank (2017).

According to Hein de Haas,[6] who is among the leading scholars working on migration theory, the theoretical framework used to explain migration as a phenomenon is still unsatisfactory. The reason is that both the two dominant approaches, the functionalist and the historical/structural, contain useful elements as well as limits. In 2014, De Haas advanced the idea of framing migrations within the capabilities theory of Amartya Sen, Nobel laureate in economics in 1998, who conceived of poverty and underdevelopment as a "capability gap", occurring when individuals are deprived of their substantive freedoms, such as the ability to live to old age, engage in economic transactions, or participate in political activities. In his notorious work *Development as Freedom*, Amartya Sen proposed a new definition of development as a condition in which individuals are able "to achieve outcomes that they value and have reason to value".[7] In such view, migration is a function of aspirations and capabilities to migrate.

To Sen's perspective, De Haas added the opportunity structure theory that brings the structural element to Sen's theory, i.e. the external opportunities that may facilitate or hinder migration individual choices and aspirations. De Haas, in sum, proposed an aspiration-capabilities theoretical framework to understand human mobility, with the aim of bridging the gap between the divergent theoretical schools on migration and at the same time account for empirical realities of migration narratives.[8]

To date, few empirical studies have explored the potential of the theoretical framework proposed by Hein De Haas in 2014, and there is the need to promote empirical works to support the validity of his theory. This study takes some initial steps in this direction, exploring how migrants' projects operate locally through an ethnography I collected in 2014 between Denmark, Germany and Burao, the second largest city of Somaliland and the capital of the Togdheer region.

3. *How do migrants' projects work? The case-study of Mandhaye hospital in Burao*

This story unfolds in various places, but the epicentre is without

[6] Hein de Haas (2014).

[7] Amartya Sen (2001). p. 291.

[8] Hein de Haas (2014).

question a small city located in the midst of the desert highlands of Somaliland: Burao.[9]

Burao hosts some 350.000 inhabitants, mostly living as nomads. The city is an important commercial centre, and the largest livestock market in the region. Wealth, however, is not apparent: camels and goats are easily found in the dusty streets of the city centre, while the outskirts host lovely villas built by wealthy diaspora individuals who dream of their return home.

Burao is also the place where Dr. Ahmed Haji Hassan Awad, was born and raised back in the 1950s, before migrating to Germany, where he became a medical doctor and a specialist in internal medicine. After his studies, Ahmed Awad established his life and family in Germany, working there as a doctor and marrying a German woman, Brigitte.[10]

In 2005, at a certain point in his life, Dr. Ahmed felt the desire to visit his homeland and see what kind of contribution he could give to its development. Using his professional skills, Dr. Ahmed decided to assess medical facilities in Somaliland.

During his first tour to Somaliland, he found that the condition of health facilities in the country was acceptable compared to the needs of the population, except for one medical sector that was almost abandoned by the Ministry of Health, that was ~~the~~ mental illness.

What drew his attention was the desperate situation of children and youngsters with learning disabilities, who were kept at home, often chained and without any kind of proper medication or stimulation. Some were hospitalized in the psychiatric hospital of Berbera and others were simply left to fend for themselves – as a result becoming homeless. Hargeisa hospital had a department for the mentally ill though it was badly organized, and almost unable to provide effective treatments to patients.

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[9] Some names have been changed in order to protect the identity of those who requested anonymity. This does not apply to public figures in the exercise of their scientific functions, such as University Professors, and to those subjects whose name were already public.

[10] The story of *Mandhaye* hospital relies on different sources. Primary source: Direct interviews to Dr. Ahmed Awad in Burao (June 2014), telephone interview to dr. Amina Ali (July 2014). Secondary sources: narratives from http://fatumaali.dk/mhis/mental%20health%20center.html (lastly accessed 29 November 2018) and the report by Anne Lindhardt and F. Ali (2010) Mental health services in Somaliland Report-Fact finding mission to Somaliland. Mental Health in Somalia (MHIS), January 25th till February 4th 2010.

In 2006, back in Germany, with the help of his wife, Dr. Ahmed started mobilizing friends and colleagues to raise funds for a new mental hospital in Burao, and set up the NGO Medical Care Somalia (MCS) for this purpose.

Dr. Ahmed, knew he lacked a background in psychiatry to address mental health gaps in his Country and decided to create a network of European and Somali psychiatrists in the diaspora, encouraging them to join his project. Using his NGO as a catalyst, Dr. Ahmed started contacting medical doctors who were part of his extended professional network in Europe. This is how Dr. Anne Lindhardt, who was director of mental health services in Copenhagen and Associate Professor at the University of Copenhagen, was sensitized, together with her colleague, Dr. Anders Michelsen.

In Somalia, Dr. Ahmed used his clan-based network and involved the Togdheer Development Committee (TDC), a group of eminent persons at the community level who had been very active in the establishment of the University of Burao in 2004, significantly contributing to the advancement of the education sector in the region and to local development. TDC became involved in Dr. Ahmed's project to establish the mental health hospital in Burao and was key in its implementation, assisting in the restoration of a ward just near the main city Hospital, the start-up of activities, and enabling its operation, including staff wages and availability of drugs. In March 2008, Dr. Ahmed and TDC opened a day hospital for mentally retarded children and youths, and six months later an outpatient unit for psychiatric patients in a facility that they named "*Mandhaye*" hospital.

While the hospital was being set up, Dr. Ahmed began looking for Somali psychiatrists in the diaspora to support the hospital with qualified and skilled personnel. A combination of word of mouth and good luck led him to a Somali psychiatrist, a native of Beletwyene in South Somalia who was living in Denmark, Dr. Amina Ali.

Dr. Amina was an experienced psychiatrist in Denmark. When she was young, she pursued her secondary school in Mogadishu, than she studied medicine in Moscow and later specialized as a psychiatrist in Denmark where she worked on transcultural psychiatry, general psychiatry and community psychiatry. To Ahmed, Dr. Amina seemed to be the perfect resource for the hospital and, in 2007, he convinced her to become fully involved in the project.

Dr. Amina accepted the challenge posed by Dr. Ahmed. She visited Somaliland in 2008 and once back to Denmark established an informal

network of professionals in psychiatry, the Somali Psychiatric Network (SPN), with the aim of providing diaspora expert knowledge to Somalia in the field of mental health. Two important nodes of this network were the Somali psychiatrists, Dr. Yakoub Aw Aden from Sweden and Dr. Jama Yusuf Elmi from Norway.

In January 2009, Dr. Amina Ali established her own Danish-Somali NGO, the Mental Health in Somalia (MHIS) involving Dr. Anne Lindhardt of the University of Copenhagen as vice-chair, with the aim of establishing mental health services in Somalia, treating patients, training health professionals and providing education to relatives and to the public at large on mental health issues.

Under the umbrella of the NGO MHIS, with her colleague Anne, Dr. Amina visited Burao again in 2010 to get a better understanding of the situation in Somaliland, to assess the feasibility of the interventions they had in mind and to establish priorities for upgrading the hospital to European approaches to mental sickness treatment. The following is narrative of the two doctors on their visit in Burao: "During our stay in Burao Mental Health Centre, the rumour that two international doctors were in town, spread in the community in few days. One day, 60 patients showed up, all accompanied by families, so more than 100 people were waiting in the clinic when it opened. They were queuing and when the working hours for the clinic were over, 20 (of them) had to return home. Of course, most severe cases including patients brought to the clinic in chains by family members had priority".[11]

After this visit to Burao, Dr. Amina started working regularly at *Mandhaye*, bringing Danish professionals annually to work at the centre on a voluntary basis and looking for funding opportunities for the hospital through her own NGO MHIS.

The commitment and enthusiasm of Dr. Ahmed attracted other actors. In 2010, Dr. Ahmed enrolled a regional diaspora organization composed of Somalis natives of Burao living in the UK and in Norway, the Togdheer Abroad Foundation (TAF). TAF-UK helped in building an in-patient unit that was later opened in 2011, equipping it with 10 beds for men and 5 beds for women, and paying the salaries of the staff for 2 years. TAF-Norway assumed the responsibility from TAF-UK in 2012 and changed its name to *Mandhaye Norway*.

[11] Testimony drawn from the report by Anne Lindhardt and F. Ali (2010) *Mental health services in Somaliland Report-Fact finding mission to Somaliland*. Mental Health in Somalia (MHIS), January 25th till February 4th 2010. P. 14.

Capitalizing on the participation of a large community of Somali medical doctors in northern Europe, Dr Ahmed created the Somali-Danish NGO *PeaceWare-Somaliland*, composed of a number of Somali organisations. Among these, were the Somali Psychiatric Network (SPN), consisting of psychiatrists in Scandinavia; the German-based Medical Care Somalia (MCS), started by Ahmed and Brigitte Awad; the Danish NGO Mental Health in Somalia (MHIS), founded by Amina Ali; and, most important, the University of Copenhagen.

Peaceware Somaliland participated in a project promoted by Associate Professor Anders Michelsen of the University of Copenhagen's Department of Arts and Cultural Studies. As a technical partner, the University added a key component to Dr. Ahmed's project: the Somaliland Telemedical System for Psychiatry project.

This project built on a research platform called PeaceWare ICT4D that experimented the use of information technologies in medical assistance in developing countries. PeaceWare established tele-psychiatric facilities at the *Mandhaye* hospital in collaboration with the Somali psychiatrists of TAF, Dr. Yakoub and Dr. Jama, the so-called *mirror Doctors*, as the patients used to call the psychiatrists who, since 2012, conduct weekly Skype consultations with the Outpatients at *Mandhaye*.[12]

In 2013, the Ministry of Health of Somaliland recognized the value of the work that was being done at *Mandhaye* hospital and stepped in by putting the staff on the payroll and giving *Mandhaye* the status of ward under the General Hospital of Burao.

Later, in 2014, the Ministry of Health took responsibility of around 30% of the Hospital budget. The local business community also contributed regularly, in particular the money transfer company *Dahabshil* that covered the running costs for the tele-medical system, as did the hotel Cityplaca and other businessmen in Burao.

When I was in Burao in 2014,[13] I had the opportunity to attend a tele-psychiatric session at *Mandhaye* hospital myself. I witnessed how Dr. Jama Elmi from Norway visited a patient through skype. I talked to patients and their parents who were enthusiastic about the opportunity to receive treatments by an international Somali doctor, in line with mod-

[12] For further reference, see also https://globalhealth.ku.dk/news/news_2009-2011/the_mirror_doctors_the_somaliland_telemedical_system_for_psychiatry/ (accessed 29/11/2018).

[13] Fieldwork in Somaliland was funded by the Danish Refugee Council, as part of the Mid-Term Evaluation of the Diaspora Project, May-July 2014.

ern standards on mental diseases. I also talked to people in Burao and I collected various testimonies of appreciation of the *Mandhaye* project by the entire community who contributed to it in various ways: the food for patients was being paid annually by local donors during Ramadan, as a *zakat* contribution; also *sadaqa*[14] was occasionally donated to the hospital through the hospital charity account. The level of knowledge of *Mandhaye* experience in Burao by the community and the high degree of participation to this initiative induced me to consider this diaspora-led project as one of the most participatory and successful social projects promoted by the Somali diaspora I had ever seen.

4. *How do migrants' projects differ from traditional ones? The four distinctive elements*

Not entirely donors and not really beneficiaries, diaspora organizations operate through their own modalities to promote change and largely rely on enriching social capital and networks across territories. Back in Italy, I began reflecting on the elements that brought *Mandhaye* to success and on the characteristics of the diaspora projects I had visited during my fieldwork.

In my view, the success story of *Mandhaye* hospital contains various elements that characterise diaspora associations' modality to promote successful development initiatives.

These elements are, in order of importance, sentimental, social, organizational and transnational.

The sentimental element expresses the passionate commitment and the motivation of Dr. Ahmed, a skilled diaspora member residing in Germany, who was motivated by the willingness to contribute to the development of his origin country, or, in other words, by the dream of a better society in the homeland. Because this willingness is grounded on a sentiment, it is potentially perpetual and not opportunistic. In fact, external opportunities to develop local initiatives – such as availability of funding, or other NGOs – are created by the diaspora to fulfil the "dream", not vice versa. The following extract of the interview with Dr. Ahmed[15] confirms this thesis:

[14] Zakat and Sadaqa are religious forms of charity that individual perform annually (Zakat) or on voluntary basis (Sadaqa) to support the poor and destitute.

[15] Interview with Dr. Ahmed Awad, Hotel City Plaza, Burao, Somaliland, June 2014.

VS: Dr. Ahmed, based on your experience, what is the key for success of a Diaspora initiative?

Dr. Ahmed: Motivation is the key element. You must love your country and be committed to invest your time and your money for the benefit of your people.

The use that Dr. Ahmed made of words pertaining to the sentimental sphere, such as *love*, suggests that the real driver of diaspora engagement in development is emotional rather that rational.

Rationality occurs at a later stage, when Dr. Ahmed, pushed by his motivation, moved to elaborate a strategy to achieve his objective. What kind of capital did Dr. Ahmed need most? The answer is social capital and names, the second element that characterizes diaspora successful modalities to promote development. In fact, in diaspora modes of being development actors is the social, before financial, capital critical to trigger durable change. The resources Dr. Ahmed used to fulfil his objective in Burao encompass all the skills developed in his migration path over various decades. This is confirmed by the explanation Dr. Ahmed gave me during our conversation in Burao:

VS: How did you manage to attract so many actors around your idea?

Dr. Ahmed: When I was a young student at University in Germany, I used to be an activist in youth associations. There, I developed networking skills and I acquired the competences to build a group, motivate people to a common objective. This experience at University encouraged me to think I could mobilize other people to reach other, more important objectives, such as the one of the Mandhaye hospital.

In his early adulthood, Dr. Ahmed understood he had charisma, he could influence the actions and thoughts of others and he built on this innate quality to develop other skills that made him a leader. Leadership and charisma are crucial personal qualities that compose the so-called *social capital* Dr. Ahmed used years later for the *Mandhaye* hospital project.

The third element is organizational. This refers to the way Dr. Ahmed organized himself and his group to pursue his goal. Dr. Ahmed, in fact, set up multiple formal and informal organizations to gather human and financial resources, and he developed a network of all actors and of other potential partners that span over the national boundaries of Germany, across Europe to Norway, UK, Sweden and Somalia. The capaci-

ty to overcome boundaries to expand its network of supporters and to set up organizations for mobilizing a collective action is another important characteristic of diaspora successful strategies to promote development initiatives.

The fourth element is transnational. This refers to the outreach capacity of diaspora leaders or associations to extend their network across boundaries, involving various territories and maximizing the external opportunities they may offer. In the story of *Mandhaye* hospital for instance, the involvement of Dr. Amina in Denmark opens the doors to funding sources offered by the Danish Refugee Council Diaspora Program, funded by Danish International Development Agency (DANIDA). The Diaspora Program was aimed at identifying leading diaspora organizations and individuals to support their transnational activism with training and small grants.[16] On the same note, the University of Copenhagen represented an important external resource to equip *Mandhaye* hospital with innovation technology. Similarly, Sweden and Norway, the UK, all these territories offer their contribution to the project and are a determining factor in its success.

5. *New development practices?*

This paper offers an insight on how diaspora projects work through an ethnography collected in Somaliland. It suggests to consider migrants' contribution to development, such as the case of *Mandhaye* hospital in Somaliland, as a form of transnational activism whose objective is development. This activism needs to be framed on one side as the aspiration of diaspora individuals to transfer competences and channel funds to their origin countries, on the other as the capability to do so, offered by an environment that is not hostile to diaspora engagement. In the case of *Mandhaye* hospital, external opportunities were offered to the ambitious Dr. Ahmed by projects supporting migrants' activism in

[16] Led by Mingo Heiduk, the Diaspora Global Program of the Danish Refugee Council is still operational in Denmark and expanded significantly since 2014. Today, it operates across multiple geographic and thematic areas, such as in the humanitarian support of diaspora organizations to their origin communities, in the capacity enhancement of diaspora organizations, and in projects involving networking and knowledge sharing. For further information, see http://www.drc.ngo/relief-work/diaspora-programme.

development between Denmark and Somalia, and by a general supportive policy of local authorities in Somaliland who acknowledge the role of the Somali diaspora in social and economic development.

In such a situation where individuals like Dr. Ahmed are able to manifest their aspirations and realize them, and external variables do not represent an obstacle but encourage activism, new development practices, such as the case of *Mandhaye* hospital in Somaliland, have the potential to influence local development and enhance the welfare of the local population.

Whether the impact of the *Mandhaye* experience was limited to the local level only, or had snowball effects touching the regional or even the national level, is a question needing more in-depth evaluation and research. In order to be effective, however, evaluation and research probably needs to develop new tools and adapt to new development practices, such as the ones promoted by migrants' activism. This work concludes suggesting the need to invest in empirical research on possible ways to adapt project evaluation tools to the four elements that this paper identifies as characteristics of diaspora transnational projects, accounting for the sentimental element (motivation) as indicator for sustainability, and for the social, organizational and transnational elements in assessing diaspora efforts in aid and development.

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