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**Engaging Diaspora Health Workers
in Humanitarian Action**

Submitted by
Bridgit Raine B. Au-Gener

Supervisor: Dr. Elisabeth Meur

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ABSTRACT

In this global age, humanitarian action is being carried out by different actors, bringing with them diverging sets of principles, norms and practices outside the formal humanitarian system. The diaspora communities, particularly the health workers, are largely involved in bringing humanitarian assistance to origin countries in times of crisis. These new players render their professional medical service by taking advantage of the cultural and linguistic familiarity and political and religious affiliation, among others, to get in touch with the affected population as quickly as they can. However, despite their increasing prominence in the humanitarian field, the formal system does not necessarily view them in an equal footing.

This paper gives an overview of how the traditional humanitarian actors engage the diaspora health community in humanitarian action. In countries with specially high density of health professional out-migration, the risks and vulnerabilities of the population are higher in times of crisis. This literature review provides a brief discussion of the dynamics on the increasing prominence and significance of the diaspora health workers in the field of humanitarian action, running in parallel with the traditional humanitarian actors.

Keywords : diaspora, non-conventional, health, medical, humanitarian action, traditional, formal system, engagement, migration, origin countries, affected population, vulnerability, risk

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation	Description
AMHE	Association of Haitian Physicians Abroad
ECOSOC	Economic and Security Council
ICRC	International Committee of the Red Cross
IOM	International Organization for Migration
MSF	Medecins Sans Frontiers or Doctors without Borders
NNU	National Nurses United
NGO	Non-Governmental Organization
NRNA	Non-Resident Nepali Association
PMAA	Philippine Medical Association of America
PNA	Philippine Nurses Association of America
RNRN	Registered Nurse Response Network
SAMS	Syrian American Medical Society
UDHF	Uganda Diaspora Health Foundation
UHP	Ushahidi Haiti Project
UOSSM	Union des Organisations Syriennes de Secours Medicaux or Union of Syrian Doctors
WBG	World Bank Group
WHO	World Health Organization
WHS	World Humanitarian Summit

I. INTRODUCTION

Today, the international humanitarian response system is faced with new challenges given the scale, magnitude and frequency of crises happening around the world. At the same time, humanitarian needs of the affected population are overstressing the available resources, which includes the humanitarian actors expected to respond in a timely and efficient manner in all types of crises. Bringing in “new” actors, such as the diaspora community (Davey, 2012), and recognizing their distinctive contributions in the humanitarian sector – such as skills, networks and informational advantage on the country of origin affected by a crisis – may improve upon, and contribute to, the overall humanitarian response on the ground.

According to the summary report of International Organization for Migration (IOM) (2015), the diaspora is already an active actor in the level of humanitarian and development efforts, fuelled by their “homeland orientation and boundary maintenance” (Cohen, 2008). In addition, with the fast-growing communication technologies and financial innovations, the modalities of ‘diaspora humanitarianism’ are seen to expand throughout its involvement in response to a number of humanitarian crisis (Sezgin and Dijkzeul, 2016). For instance, sending economic remittances, providing in-kind support, volunteering in social media outlets for crisis mapping, translating messages, creating new software or application for humanitarian purposes, are just among the many other ways the diaspora utilizes (IOM, 2015). On this note, the diaspora aid transcends beyond kinship, reaching the most vulnerable people regardless of race, tribal, political and religious affiliations (Svoboda and Pantuliano, 2015). However, putting them in the mainstream of the formal humanitarian system has not yet been systematically explored (Nagarajan et. al. 2015).

This paper aims to look at the potential contributing role of the diaspora, particularly in the health sector, in humanitarian response. It will also look at how the traditional humanitarian actors can incorporate and build on the opportunities brought about by these new actors to better serve the evolving needs of the affected population (IOM, 2015).

In this respect, this research will explore to what extent does the traditional humanitarian actors engage diaspora health workers in humanitarian action? I will particularly focus on the health sector because provision of quality emergency healthcare (i.e basic, surgical) in times of emergency is a primary need. I will firstly discuss the concept of diaspora to understand their unique characteristics. Secondly, I will provide an overview of the status of health workers migration, particularly from developing countries, which greatly

affects the local health systems in the absence or limited number of health workers in the origin countries. Thirdly, I will start discussing the diaspora's contribution in humanitarian emergencies. Further in this section is the discussion highlighting the diaspora health workers' significant roles in humanitarian response through provision of "culturally competent care" to the affected population of origin/home countries (Nagarajan et. al. 2015). Lastly, I will provide an analysis on the significance of engaging diaspora health workers by humanitarian actors in fostering durable and sustainable solutions, distilling the lessons for successful engagement in emergency response.

II. Definition of Diaspora: Who are they?

The term 'diaspora' has created ambiguities and is often interchanged with the term 'migration' (Safran, 1991, Opiniano, 2002; Gamlen, 2008). Many scholarly works on diaspora studies generally try to explain the transversal 'home' and 'away'. This transnational sentiment implores transcending beyond geographical space, and rooting "the scattered seeds" (Aguinas, 2009) to their place of origin (Safran, 1991; Gamlen, 2008; Cohen, 2008).

Diaspora is an old phenomenon. Like any other concept in international migration, the rebirth of the term is often linked to emerging issues of migration, i.e., development, security, brain circulation etc., which has created new interpretations across space and time (Cohen, 2008 ; DEMAC, 2016).

In its strict historical sense, diaspora characterizes the dispersal of Jews in the form of forced expulsion, signifying "oppression and moral degradation" (Safran, 1991, Cohen, 2008). Over time, the meaning of diaspora has changed, particularly in increasing the use of 'diaspora community' to symbolically categorize people, i.e. 'expatriates, expellees, political refugees, alien residents, immigrants, and ethnic and racial minorities *tout court*' (Safran, 1991).

However, changes in this global age have prompted new waves of diaspora-related concepts. Powerful discourses on deterritorialization of identities and multiculturalism have transcended the dominant tradition of the term. Today, diaspora is constructed and deconstructed, adapting to the situation, which can be "made and unmade" (Van Hear, 1999 cited from Cohen, 2008). Nonetheless, despite the continued shifts in its meaning, diaspora contains three core elements constitutive of its identity. Brubaker identified these elements, namely "dispersion (either traumatically or voluntarily and generally across state borders),

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homeland orientation (whether real or imagined), and boundary maintenance (the process whereby group solidarity is mobilized and retained, even accepting that there are counter processes of boundary erosion” (cited from Cohen, 2008, p.12).

For the purpose of this paper, the term “diaspora” of the 21st century is best defined by Gamlen (2008):

An umbrella term for the many extra-territorial groups that, through process of interacting with a variety of state institutions at, below, and above the nation-state are attributed with various thickness of ‘diasporic membership’ in their home country. These groups include temporary or transnational migrants who spread their time between several places in which they hold some or other status (e.g. citizen, denizen, visitor). They also include longer term but still first generation emigrants settled in another country, and descendants of emigrants who – in certain places at certain times – identify as diasporic or even as members of a fully fledged diaspora ‘community’ (p.267).

The above description captures the current parameters of the concept as it continuously evolves over time. Stephane Dufoix (2008) analyzed the changes of the term, and he saw that technologies nowadays can bring people together, which allows the creation of “nonterritorialized” transnational networks.

III. Health Workers’ Migration

Health is one of the most critical and controversial sectors of international migration. Today, the absence or shortage of health workers represents crisis in countries that suffer low health worker density accompanied by a faltering health-care system (Nagarajan et. al., 2015) As defined by the World Health Organization (2006), health workers are ‘people engaged in actions whose primary intent is to enhance health’. In essence, people are the driving force of the economy, and “having the right staff in the right place” (WHO and WBG, 2014) is a promising global health mantra in achieving greater access to affordable and effective health care for all.

However, both the developed and developing economies have reported that they are gravely affected by the lack of health professionals. Globally, there is a shortage of around 7.2 million health workers (physicians, nurses, midwives) and the WHO (2013) estimated that it would shoot up to 12.9 million by 2035. With at least 83 countries that are still below the basic health threshold, (i.e., 23 skilled health professionals per 10,000 people), the WHO reports alarming implications on the health of billions of people. As Dr. Marie-Paule Kieny,

WHO Assistant Director-General for Health Systems and Innovation, warns: “The foundations for a strong and effective health workforce for the future are being corroded in front of our very eyes by failing to match today’s supply of professionals with the demands of tomorrow’s population” (WHO, 2013).

Moreover, the WHO and the World Bank Group (2014) reported that many of the foreign-trained doctors and nurses are found in major English-speaking countries. The crucial flow will continue to rise, as demand for health services are vital for the aging population in many of the industrialized nations. While WHO enforced the Code of Practice in recruiting health personnel internationally¹, unfortunately migration of health professionals will persist even without the active recruitment on the part of the traditional destination countries (WHO and WBG, 2014).

Hence, the compounding global shortage of health workers will worsen in the years ahead as many developed countries are becoming more reliant on migrants to fill in the health sectors domestically², from expanding demand for home care to specialized hospital aides. An adequate number of skilled health workers in proportion to the needs of the population is required in a functioning national health system to achieve the Universal Health Coverage (UHC)³ goal (WHO, 2014). However, given the current trends on the reported health worker drain in many sending economies, the challenges posed by inequitable distribution of health workers has left the poorest communities underserved (Nagarajan et. al., 2015).

IV. Diaspora in Humanitarian Emergencies

A. Diaspora Aid : A brief overview

With the recent influx of various humanitarian emergencies, the traditional humanitarian actors are looking for new ways to expand their capacity to reach as many affected populations as possible. Tagging the diaspora community as one of the key players in

¹ The WHO Code of Practice on the International Recruitment of Health Personnel is a non-binding instrument, but it identifies ethical norms as well as institutional and legal arrangements to guide international cooperation on the issue of health-worker migration. It also serves as a platform for continuing dialogue (Siyam and Dal Poz, 2014).

² For instance, Switzerland is one of the countries that highly benefit from the trend inflow of health personnel, especially nurses, coming from member countries of the Organisation of Economic Cooperation and Development (OECD) (WHO and WBG, 2014).

³ Universal Health Coverage or UHC is defined by WHO and WBG (2014) as “people receiving the quality services they need without incurring financial hardship, requires a health workforce that can effectively deliver a wide range of promotive, preventive, curative, rehabilitative and palliative services to all people”.

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delivering both development and humanitarian aid is now being explored (Danish Refugee Council, 2015; Bostrom et. al, 2016).

Seemingly, the diaspora community is firstly recognized for its substantial economic contribution, which potentially soars when a crisis happens (King and Grullon, 2013; IOM 2015 ; Bostrom et. al, 2016). This ‘unrequited transfers’ become a tool of economic and social insurance as it provides direct cash support to recipient families (Kapur and McHale, 2005). Remittance is an important source of funding, especially to countries that have a high rate of poverty, poor governance, social fragility, and environmental insecurity (ECOSOC, 2014 ; Danish Refugee Council, 2015).

Currently, countries are exploring a more innovative and flexible financing landscape, as discussed in the 2016 World Humanitarian Summit (WHS). In fact, the 2014 figures in the Global Humanitarian Assistance (2016) report show that the financial inflow constituted by remittances amount to USD 69.3 billion (bn), or 25% of the international resources, five times bigger than the international humanitarian assistance (USD 13.4bn or 4.8%) and twice as much as the overseas development assistance (USD 34.5bn or 12.4%) flowing towards the 20 countries receiving the most humanitarian assistance. Although the government holds the primary responsibility to protect and respond to the people’s need, especially during evolving humanitarian crises and in countries trapped in protracted situations, it cannot always address the full spectrum of needs and vulnerabilities of the population. Hence, remittances, as one of the key financial sources, may serve as a lifeline support to help families and communities find ways to survive and to recover on their own. Moreover, it can also be used to boost humanitarian resource to help cover large-scale, sudden-onset humanitarian emergencies, on top of the money allocated for international humanitarian assistance, a miniscule amount compared to remittances (GHA, 2016).

Furthermore, at the height of humanitarian emergencies, different interests of diaspora organizations, associations, networks, or even individual capacities instantly mobilize to raise funds and other type of resources to help their home countries affected by a crisis (King and Grullon, 2013; Sezgin and Dijkzeul, 2016 ; Bostrom et. al 2016). The ‘diaspora aid’ is defined in a sense of personal responsibility towards their families and communities back home, and this unconditional sentiment makes this kind of home-based orientation unique in the humanitarian world (Sezgin and Dijkzeul, 2016). Mobilization of humanitarian assistance comes out naturally among the diaspora community, utilizing the different skills sets and professional expertise, the technologies available, local knowledge of the context, well-established contacts and material assets they have to save lives. The direct approach of

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delivering aid expands opportunities for the families and communities affected by a crisis to procure things based on evolving needs (King and Grullon, 2013; Sezgin and Dijkzeul, 2016). This also gives the affected individuals a sense of ownership and maintains their dignity.

Also, since diasporas have the capacity to have first-hand information on their countries of origin, they can provide access and respond immediately where the need is. This has led to many diaspora initiatives to voluntarily provide any means they can to save their communities (Danish Refugee Council, 2015; Sezgin and Dijkzeul, 2016). For instance, some diaspora communities are known to establish charitable foundations and even grassroots non-governmental organizations (NGOs) that directly provides humanitarian assistance, in the same manner as the formal humanitarian system, especially in areas where access to international NGOs are limited and/or prevented (King and Grullon, 2013; Sezgin and Dijkzeul, 2016). They send teams of medical personnel, relief volunteers and other professionals to provide humanitarian relief, without taking too much time learning the context of the crisis and establishing connections with the affected population (Sezgin and Dijkzeul, 2016).

The diaspora is also largely taking advantage of the new technologies, which facilitates greater communication and information-gathering when a crisis happens. The use of mobile phones and social media outlets virtually connects the affected population and the diaspora. Using this new modality of engagement enables them to respond immediately such as remitting money, crisis-mapping, and sharing life-saving information, among others (Bostrom et. al, 2016).

Communication is a vital aid in humanitarian response, particularly in bringing about informed decisions by the affected population. Reaching the population in need, knowing their situation, and being able to transmit vital messages (i.e. location of medical assistances and shelters, sources of clean food and water, and even where to find help to trace families) in a language they understand can save lives and prevent further suffering (BBC World Service Trust, 2008 ; Bostrom, 2016). In some cases, the use of social media such as Facebook by Syrian American Medical Society (SAMS) helped them communicate crisis information regularly and posts life-saving information to people they cannot attend to. Also, the Ushahidi Haiti Project (UHP), one of the most successful engagement of Haitian diaspora to the affected population, created a shared platform on needs assessment and location of aid. The project showed that access to reliable and timely information should be a key part in humanitarian response (BBC World Service Trust, 2008 ; Bostrom, 2016).

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This non-conventional ‘diaspora humanitarianism’ provides a new modality of speeding up aid provision to save as many lives as possible (Sezgin and Dijkzeul, 2016). Although the diaspora-led response is unhinged to the traditional humanitarian principles, identifying possible collaboration with the conventional humanitarian system may increase the chances of diversifying the means and methods of mobilizing assistance, given the substantial contribution from the diaspora (i.e. the know-how, cultural proximity and other local elements they know) and the evolving communication and technologies, which can be tapped to map the needs.

B. Health and Emergency : The works of Diaspora Health Workers

As the world humanitarian emergency expands, non-traditional actors appear on the radar of humanitarian space as first aid responders (IOM, 2015 ; Bostrom et.al, 2016). However, their visibility remains nuanced as the formal sector requires more “professionalized” background, or “volunteers affiliated with official agencies” (Whittaker et.al, 2015). However, there is a growing body of knowledge that the invaluable assistance of this emerging sector is being studied in line with the concept of “citizen participation as a key principle of disaster risk reduction and resilience building” (Whittaker et.al, 2015).

Most of the diaspora health communities in general were self-motivated in volunteering through medical missions to their home countries (IOM, 2015 and Nagarajan et.al, 2015). This sustained link makes it more interesting for origin countries to “foster durable relationship(s)” (Nagarajan et. al. 2015). Mobilizing these diaspora health workers can potentially help the damaged healthcare system to recover as soon as possible when an emergency strikes. Human resource is critical at the early phases of disaster. Mobilizing the right people – with appropriate sets of skills, who can speak the language, and understand the culture in providing the basic healthcare and other types of support – can contribute to broader early recovery and build on the affected communities’ resilience.

Recently, diaspora health workers have been increasingly known to respond to humanitarian crises in various natural or complex emergencies, such as during Typhoon Haiyan in the Philippines, earthquakes in Nepal and Haiti, the Ebola outbreak in Africa in 2010, the 2004 Indian Ocean tsunami and earthquake, and the complex crisis in Syria, among others (Migration Information Source, 2010; Nagarajan et. al., 2015).

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The philanthropic initiatives of diaspora communities have been mainly driven by their solidarity sentiment towards their country of origin. Taking the example of the Philippines, a country that has a long history of labor migration of nurses and other medical professionals, the diaspora network has established a strong foothold in the country's long-term development activities and short to medium-term humanitarian initiatives (Garchitorena, 2007). The Filipino diaspora has systemically been building professional associations, such as the Philippine Nurses Association of America (PNAA), the Philippine Medical Association of America (PMAA), and the National Nurses United's (NNU) Registered Nurse Response Network (RNRN), among others all over the world (Garchitorena, 2007; Chen, 2013). This is a testament that the Filipino diaspora is actively supporting the country's medical needs by funding public hospitals through hometown associations, and also providing short to medium term medical trainings to Filipina nurses in some provinces through annual relief missions by some diaspora volunteers (Garchitorena, 2007).

In times of humanitarian crisis, the diaspora medical network plays an active part in the initial medical response phase until the recovery phase as part of the "ethos of mutual aid" (Chen, 2013). The diaspora medical response understands that the context needs more than just short-term relief. In a major humanitarian crisis, meager medical supplies, damaged hospital facilities and community clinics, limited available medical attendants, and inadequate local assistance and media exposure in some areas typically make it very difficult for certain affected communities to recover and build resiliency (Garchitorena, 2007; Chen, 2013; NNU, 2013; Whittall, 2014). For example, some of the first responders in the aftermath of Typhoon Haiyan were diaspora health workers, particularly registered nurses deployed under the RNRN program of National Nurses United. Emergency response came with medium to long-term plans, by aiding the affected healthcare systems in areas devastated by the typhoon, and strengthening the medical human resource by creating educational and training programs, amplifying the medical resource to cover the wide-scale health needs (Migration Information Source, 2010; Chen, 2013; NNU, 2013; Hanley et. al, 2014).

The same happened in Nepal last April 2015 when the strong earthquake devastated the country, resulting to USD 7 billion worth of losses (Shrestha, 2015). The Non-Resident Nepali Association (NRNA) played a key role in the early phase of response and was able to raise USD 3.17 million (Shrestha, 2015). The diaspora was active in providing emergency relief goods, non-food items, and medical supplies. Some volunteers were pivotal as digital humanitarians, which intensified large-scale search and rescue operations and provided timely data for a more efficient humanitarian response (Shrestha, 2015). They even stayed on for a

longer period, assisting in the reconstruction and rehabilitation phases of the communities. Mental recovery was also a crucial process for many people; hence, many of the diaspora health volunteers participated in mental rehabilitation as part of the long-term recovery phase (Nagarajan et. al., 2015).

What happened in Nepal reflects a similar context in the 2010 Haiti earthquake, where large-scale destruction overstressing local capacities was also observed. Many Haitian-American doctors and nurses surged to the country, particularly with the subsequent cholera outbreak that took thousands of lives (Migration Information Source, 2010; Castor, 2010). Although the Haitian medical diaspora has long established connections with the country through medical relief missions such as the Association of Haitian Physicians Abroad (AMHE), the country's physical resiliency from natural disasters is low. Hence, in the wake of disaster, the physicians in the country at that time amplified their emergency primary healthcare and surgical interventions, mostly at their own expense (Castor, 2010). The invaluable contribution of this pool of human resource and their professional expertise did not only respond to the short-term needs of the affected population. They lobbied further in particular to the Haitian medical diaspora professionals because the diaspora could easily establish trust and connection to the affected Haitians. Speaking Creole is a big thrust in the midst of a chaotic and unorganized situation, especially when the surge of foreign aid did not do well in the first phase of response (Castor, 2010).

Moreover, with the protracted crisis situation in Syria, the high-risk situation left the country medically understaffed, due to deliberate targeting of hospitals and other medical facilities, leaving many victims untreated (Weissman, 2013; Whittall, 2014). A British aid and development NGO (Hand in Hand for Syria) and a British Syrian charity (Syria Relief), were formed by the Syrian diaspora to provide medical aid and in other sectors such as water, sanitation, hygiene, food security, livelihood, among others (Ahsan, 2013 ; Svoboda and Pantuliano, 2015). The same goes with the Syrian American Medical Society (SAMS) and the Union of Syrian Doctors (UOSSM) that remained the lifeline of humanitarian relief in the opposition-held areas, where limited INGOs and traditional humanitarian organizations could penetrate (Weissman, 2013; Whittall, 2014; Sezgin and Dijkzeul, 2016, DEMAC, 2016).

In the meantime, there were few traditional humanitarian organizations, such as Medecins Sans Frontieres (MSF), also known as Doctors Without Borders, that closely worked with the affected people on the ground (Weissman, 2013; Whittall, 2014). MSF's operational landscape faced massive difficulties, particularly establishing principled aid response in opposition-held areas. This led MSF to collaborate with several non-traditional

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aid actors, such as the diaspora medical actors from UOSSM and regional NGOs, in order to expand its access and aid delivery to the affected population (Whittall, 2014). However, MSF faced immense criticisms from the local organizations and actors because of its inflexible and hardnosed protocols and approaches that did not work well with the realities on the ground. The dilemma of imposing a principled approach to balance the organization's perception versus the evolving environment on the ground made it difficult for MSF to expand and diversify its network in a highly politicized aid environment (Whittall, 2014).

Whatever interests and reasons the diaspora community has, their humanitarian action is geared towards the principle of humanity. Saving people, responding to their immediate needs to prevent further suffering, and helping the affected population recover and rebuild their lives mirror the same goals that traditional humanitarian and development actors have.

Yet, despite the substantial importance of potentially engaging diaspora health networks, the literature remains a gray area, with discussions remaining on a case-by-case basis. As stated above, the important role of diaspora health workers in their country of origin, particularly in times of emergencies, should not be staged as one-off interaction but rather a sustained, long-term relationship (Sezgin and Dijkzeul, 2016).

Diaspora health workers have unique characteristics in contributing back to their origin country. Engaging them in times of crisis can accelerate the provision of quality healthcare – recognizing that many of them have been exposed to more advanced quality healthcare systems in countries where they migrated. Moreover, some of the them might have had professional training in public hospitals before they migrated, so they can most likely provide “culturally competent care” (Nagarajan et. al. 2015).

For instance, taking the case of the Armenian diaspora during and after the fall of the Soviet Union, its humanitarian efforts were widely recognized in the history of the country as provision of emergency relief up to long-term, sustainable health care services through hospital-to-hospital partnerships, led by the diaspora medical experts themselves (Farmer and Chobanian, 1994).

Another example is the UK-based Uganda Diaspora Health Foundation (UDHF) that contributed in addressing the looming crisis of non-communicable diseases in Uganda. Raising awareness and forging partnerships with schools empowered local communities as well as the committed diaspora health workers, who supported the initiative of sharing their knowledge and expertise (Mulimira et.al, 2015).

The collective action of the diaspora health community enables the provision of ‘culturally competent care’ (Nagarajan et. al. 2015) by bringing with them human, financial,

intellectual, political and cultural capitals that can make significant difference in rationalizing today's interconnected world (Aikins and Russell, 2013). Their professional exposure to diverging skills sets from clinical to surgical expertise has proven successful in either humanitarian or development interventions (Bostrom et. al, 2016; DEMAC, 2016). Besides, their voluntary involvement in humanitarian response presents a more personal action based on their sense of attachment to the affected population (Aikins and Russell, 2013; Nagarajan et. al. 2015; Bostrom et. al, 2016). Hence, fruitful engagement of the diaspora health networks could facilitate speedy assessment based on the evolving needs of the affected population.

V. Analysis on the Opportunities and Challenges in engaging Diaspora Health Workers

The looming humanitarian crises in this generation continue to overstretch the finite resources that traditional humanitarian actors can provide. Even the formal international humanitarian system, which is dominated by United Nation (UN) agencies, the International Committee of the Red Cross (ICRC) and other Westernized non-government organizations, toils with problems on access and protection (Svoboda Pantuliano, 2015 ; Bostrom, 2016). Many of these organizations face operational and organizational dilemmas in responding to the evolving complexity of conflicts and disasters, especially when deliberate killing of aid workers and targeting of neutral facilities are frequently encountered today (Svoboda and Pantuliano, 2015 ; DEMAC, 2016).

Formal aid organizations grapple with challenges such as a bureaucratic system of donor funding conditions and counter-terrorism legislation. This results to reputational risks to aid agencies which affects their access, particularly in a highly politicized humanitarian settings. The absence or limited presence of international humanitarian agencies in many insecure environments has led to the rise of new actors, often diaspora organizations and professional networks of medical groups (Svoboda and Pantuliano, 2015).

Filling in the humanitarian response gap by these new actors was largely criticized by the formal aid system because of their unstructured response. For instance, many of the Syrian diaspora medical professionals who rendered their service were inexperienced in humanitarian work. Hence, going to Syria motivated by either individualized or collective sentiment does not follow the same formal structure as that of the formal aid agencies (Svoboda and Pantuliano, 2015). Moreover, the formal humanitarian sector claims that firstly,

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expertise in providing humanitarian action rests in their domain; and secondly, humanitarian action should remain guided by the core humanitarian principles of humanity, impartiality, neutrality and independence (Whittall, 2015 ; Svoboda and Pantuliano, 2015 ; DEMAC, 2016).

Discussion over the contribution of diaspora communities in humanitarian action is either confined to their specific assistance in a particular crisis, or as a liaison of international aid or non-government agencies (Aikins and Russell, 2013; King and Grullon, 2013 ; Bostrom, 2016 ; DEMAC, 2016). More so, the diaspora, a non-homogenous entity, is presumed to favor a particular affiliation or personal bonds. Hence, access in areas impossible for the formal aid agencies is attributed to community or personal affiliation. On this note, the formal humanitarian agencies struggle to collaborate with them because of perception, neutrality and impartiality issues (Svoboda and Pantuliano, 2015). The underlying personal intentions and agendas complicate genuine partnership, and therefore was confirmed difficult to establish, even if access can be facilitated by local counterparts (Whittall, 2015 ; Svoboda and Pantuliano, 2015 ; DEMAC, 2016).

In spite of this, in the case of Syria, a staff member from MSF itself clearly recognized that at some point, “the only realistic way to increase aid in the rebel zones today is to support Syrian Diaspora networks” (Weissman, 2013). Yet the diaspora organizations are the ones frequently reaching out to the formal aid system instead of vice versa (Svoboda and Pantuliano, 2015; DEMAC 2016) . But some diaspora find it problematic to fit in the formal humanitarian sector, despite efforts of adapting to the stringent rules and regulations, because they are merely seen as “service providers” (Svoboda and Pantuliano, 2015).

Aid agencies’ way of viewing ‘partnership’ is a misnomer for the diaspora organizations (Svoboda and Pantuliano, 2015). Workshops provided for strategic planning, capacity building, crafting needs and feedback assessments, processing monitoring and evaluation results, among others, were often lacking substantial usefulness in an ongoing crisis. Moreover, many of the diaspora actors lack the knowledge of the jargon concepts used in the formal humanitarian system, making it appear exclusive for the actors familiar with the sector. Hence, partnership and collaboration were a problematic task in an unparallel system, making it harder to provide a well-coordinated and systematic response on the ground (Svoboda and Pantuliano, 2015).

On the positive side, even though coordination is as complex as the stretch of conflicts and disasters, giving voice and visibility to the new actors may foster durable solutions (Svoboda and Pantuliano, 2015). Information-sharing is vital in coordination mechanisms.

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The diaspora's unconventional way of working, not having the same standardized principles and norms of Western aid practice, gives them a full spectrum of exploring alternative ways of obtaining information on the real needs of the affected population based on the evolving humanitarian landscape (Svoboda and Pantuliano, 2015). Their proximity to the affected population, regardless of their political or personal agendas, leverages their work in a manner accepted by the people (Whittall, 2015 ; DEMAC, 2016). Moreover, their speedy mobilization of humanitarian aid and formation of networks in complex humanitarian settings enables them to expand the scope of help, especially to countries and areas that are out of the formal humanitarian system's radar (Svoboda and Pantuliano, 2015 ; DEMAC, 2016).

As such, cultivating the value-added opportunities with the diaspora – not just seeing them as an add-on to the formal aid sector – may expand access, aid delivery and protection to a large-scale affected population. In the report of Svoboda and Pantuliano (2015), diaspora organizations in Syria prioritize the provision of medical supplies in hard-to-reach areas and provide healthcare assistance, since conflict is not expected to end anytime soon. Further, the diaspora health community that already established their presence even before any humanitarian emergencies may have the ability to facilitate trust and connection. This may result in a considerable positive perception and acceptance for the partner aid organizations by the affected population (DEMAC, 2016).

The diaspora aid increasingly highlights the potential linking of relief, rehabilitation and development (DEMAC, 2016). Conducting relief and development missions prior to the crisis, unceasing presence during the crisis, and continuously working in the post-crisis presents a long-term, durable humanitarianism. Seemingly, although the diaspora is often unstructured, its potential to serve and respond to the call of humanity based on its capabilities and frailties enables it to identify and weigh the benefits and the costs of working closely with the affected population. Also, the diaspora tries to engage and reach out to the formal humanitarian system, despite being recognized as simply “service providers or sub-contractors” (Svoboda and Pantuliano, 2015). In some cases, NGOs that established connections with the diaspora found to contribute positive results in bridging relief and development activities (Sahloul, 2014).

Having diverging views are normal in any kind of situation, but the parties involved should set a realistic end goal in terms of saving lives, preventing further suffering and protecting human dignity at all times.

VI. Conclusion

Humanitarian action today is no longer confined to the traditional humanitarian aid system. The humanitarian space has currently expanded to various actors with diverging principles, motivations and norms with the end goal of serving humanity. Origin countries took the opportunity to utilize the diaspora capital in both humanitarian and development activities as a way of curbing brain drain, which constraints the available local human resources and leaves the population vulnerable in times of crisis. In particular, access to quality healthcare is one of the pressing needs in any humanitarian emergency. The unprecedented presence of diaspora health workers, operating in parallel with the formal humanitarian agencies or even exceeding their medical relief efforts, are increasingly recognized in the world of humanitarianism.

Diaspora aid is commonly known for its economic contribution to origin countries. Having the sense of homeland orientation puts them in a unique position of accessing the affected population when a crisis happens. Their linguistic and cultural familiarity, ethnic, tribal, political, and religious affiliations enable them to mobilize quickly and get in touch with the communities. Moreover, diasporas are also known as active development agents. Establishing this kind of unbroken connection both to the country and to the families enables them to effectively mobilize assistance quickly by taking advantage of all the available resources they have to save their families, friends and the wider population. Also, communication is a vital tool in humanitarian response. The diaspora largely utilize new technologies, particularly social media outlets, to obtain information and pass life-saving messages.

In a volatile and insecure environment, the formal humanitarian system has increasingly grappled with the necessity to work and to share the same space with the diaspora organizations. In fact, ‘partnerships’ created out of necessity, when the international organizations’ access were reduced and the situation had already metastasized, were viewed merely as a staged collaboration. On this note, the formal aid system continuously casts doubt on the effectiveness and necessity of engaging other actors outside their system.

The increased recognition of engaging the diaspora in humanitarian action has led to a call for more effective partnership, collaboration and coordination. Successful partnership will depend on mutual recognition of their strengths and weaknesses. Exploring the similarities among the divergent, isolationist humanitarian actors may bridge the aid divide in this

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literature gap. However, there is a long way ahead for negotiations on how to effectively and efficiently engage the diaspora communities in any humanitarian response.

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