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**A social change model of health development in the Republic of Georgia**

**Susan Landfield**

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**Introduction**

Georgia, a country twice the size of The Netherlands, has a population of 5.4 million (including the contested areas of Abkhazia and South Ossetia), 25 per cent of whom reside in the capital, Tbilisi (UNDP 1997). As a Soviet Republic, Georgia was one of the more affluent and developed states, but the collapse of the Soviet Union (USSR) thrust it into a cycle of economic decline. The human and material damage caused by the ethnic violence in the breakaway regions of South Ossetia and Abkhazia in
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1992–1993 further weakened the economy. The subsequent internal displacement of some 280,000 people burdened the already floundering political and economic systems. Georgia became dependent on international aid for food and healthcare.

The Georgian health system was based on the Soviet Semashko Model, a totally centralised, command-and-control healthcare system (HCS) with almost 100 per cent state ownership and financing. Under the USSR, central authorities in Moscow controlled planning, organisation, and allocation of almost all resources. Tasks and responsibilities of the Ministry of Health (MoH) at the republic level were minimal (performance evaluation and reporting) (Groenewegan and Marré 1997). Consequently, experience at all levels of the Georgian government in planning, management, and resource allocation is limited.

Reliable and universally accessible healthcare as experienced during the Soviet era was just one more casualty of the deteriorating economic and political systems in Georgia. People’s ability to pay for healthcare plummeted. At the same time, deteriorating facilities and services have contributed to a generalised loss of public confidence and an overall decline in public health.

Healthcare reforms (HCRs) introduced in 1995 aimed to restructure the healthcare system from one that was centralised and top-heavy with personnel and facilities towards one that was decentralised, made rational use of resources, and was responsive to ‘consumer’ need. These reforms were designed and implemented under the Georgia Health Project with technical support and financing from the World Bank. But budget shortfalls have meant that only a small percentage of government monies reach health facilities or the programmes for which the funds are intended. The HCR process thus far has achieved minimal success in meeting the health needs of the population. A wide gap exists between formal legislation and actual implementation, particularly in regions farthest from Tbilisi.

History and justification for MSF-Holland’s intervention

Médecins Sans Frontières-Holland (MSF) is an emergency medical NGO that began running health projects in south-west Georgia in February 1994 in the Republics of Achara, Guria, and Poti City. MSF was concerned that the deteriorating socio-economic situation could swell the numbers of vulnerable people, and felt that this warranted further intervention. Health Access Surveys conducted by MSF in Kobuleti Rayon (district) in the Republic of Achara in September 1995 and February 1996 indicated that 17 per cent of the 100,000 population lacked money to pay for even basic medical care (Aalders 1996).

Parliamentary Resolution 269 of the HCR process, entitled ‘On Additional Measures for Improvement of Health Care System under Market Economy Conditions’ contained innovations for the state provision of medical care. The state was to provide services for people within certain socio-medical categories, such as pregnant women, infants under one year of age, invalids, war veterans, and persons with specific diseases. In addition, the Ministry of Labour and Social Defence was to establish criteria for defining the poverty line, and to identify persons meeting those standards (HealthNet International and UNICEF 1997:23–24). By mid–1996, however, these criteria had yet to be defined.

In reality, budget appropriation and allocation for healthcare had been inadequate to provide even basic health services for any people defined by the state as vulnerable, while MSF perceived that these categories were in any case not comprehensive. In early 1996, MSF employed a sociologist researcher to undertake action-oriented research: to define the criteria for vulnerability, identify those who met these criteria, set up a registration system that would be dynamic, and establish monitoring and evaluation criteria. This research was to be action-oriented because, simultaneously,
MSF was setting up a dispensary to provide basic health services and essential drugs for those identified as vulnerable. This was initially viewed as an open-ended pilot project.

Methodological structure and operation of the dispensary

The sociologist established socio-economic criteria for identifying vulnerability based on data from group discussions and in-depth interviews with people from all social strata. The final screening questionnaire focused on three areas: income, whether the family had something to sell, and food stocks.

MSF invested four months from project initiation to the opening of the dispensary. MSF did not install the dispensary in an existing medical facility, but chose to renovate a separate building. The renovation and hiring of employees for the dispensary proceeded simultaneously with the research. The medical staff consisted of two local therapeutists (the closest Soviet equivalent to a family doctor), one paediatrician, and two nurses. These practitioners were trained by MSF in Western medical standards and used only drugs included in the World Health Organisation essential drugs listing.

Village and street committees (in cities) are local governing bodies familiar with all families within their governance. They provided lists of families whom they believed should be screened for vulnerability according to broad criteria provided by MSF. These committees are appointed by municipal government leaders, who are themselves appointed by the executive branch of the national government. The Social Support Division of the Kobuleti Social Affairs Department (whose tasks include responsibility for unsupported pensioners) screened families from the committee-compiled lists, using the MSF questionnaire. A questionnaire score was obtained for each family. Those scoring above a certain number were classified as vulnerable and eligible for free medical care.

From this original screening, 4,623 people were accepted as eligible for medical care at the MSF dispensary. The Social Affairs Department (SAD) had its own list of 796 elderly pensioners living alone without financial support. MSF decided automatically to accept this group as vulnerable since they had already been ‘screened’ according to SAD’s criteria. Finally, there were 3,431 internally displaced people (IDPs) from the conflict in Abkhazia residing in government-supported refugee centres and with private families. MSF decided to accept this entire group as vulnerable without screening.

In June 1996, MSF opened the Kobuleti dispensary to provide basic medical services and essential medicines for this defined vulnerable population, as a parallel service to the existing Georgian HCS. The number of people accepted as vulnerable after a second screening in September that year represented 9.7 per cent of the population of Kobuleti Rayon.

HealthNet International

In December 1996, MSF began handing over its health projects in Georgia to HealthNet International in preparation for leaving the country. HealthNet is an independent NGO, which was founded with the assistance of MSF and works towards rebuilding health systems in the aftermath of crisis. The emphasis is on using local expertise and resources so that improvements can be sustainable. HealthNet therefore works closely with existing authorities, developing knowledge and skills and reinforcing public sector structures.

MSF approached HealthNet about assuming responsibility for the management and further development of the Kobuleti dispensary and its screening system. HealthNet was initially reticent, given that these existed alongside local health and government structures, something that offered inherent barriers to sustainability and integration. But HealthNet finally agreed after an initial assessment highlighted specific design com-
ponents that looked promising in terms of transforming the dispensary from its status as a parallel structure. Discussions with other international health agencies in Georgia at the time revealed that all were struggling within this interim stage from relief to rehabilitation and recovery. International health agents in former Soviet Union (FSU) nations were finding that field-tested models and development blueprints that are accepted as NGO best practice in the traditional areas of Africa, Asia, and South America, were proving insufficient or inappropriate in FSU nations, given their unique socio-political culture and evolution and current perspective.

Faced with this broad challenge, HealthNet concluded that its first objective was that the dispensary serve as a model for other development organisations working in FSU nations. Assumptions about the continuum from relief to development could be tested. Strategies that proved most effective in facilitating critical linkages tying short-term relief assistance to longer-term development operations could be highlighted. In response to the changing face and timeframes of humanitarian relief operations, conventional separations between relief and development interventions are no longer appropriate. Building the capacity for self-reliant rehabilitation needs to start with the relief operation in an effort to avoid the negative externalities of dependency such as happened in Sudan and Tajikistan (Cohen and Deng 1998:166–168, 182–186). HealthNet’s objective was to identify and further promote those design components of the Kobuleti project which most effectively built on local capacities and institutions, thus promoting sustainability and minimising dependency.

Under the Soviet system, all health facilities were centrally owned and controlled by the state. The HCRs in Georgia had mandated that control and management of health facilities was to be decentralised. Therefore, HealthNet’s second objective entailed the promotion of a community development model that aimed towards integration of the facility and the screening system into the evolving Georgian healthcare system in concert with the HCR process.

The basis for HealthNet’s social change model

In designing an overall strategy and specific interventions, HealthNet drew on institutional experience, informed by current development research which examines under what conditions aid fails or succeeds. A 1991 World Bank study points to several such conditions, three with relevance in this case. Aid fails ‘when recipients allow the availability of external advice to substitute for efforts to develop the internal institutions that are necessary for long-term economic and social development’. In contrast, ‘aid can be quite helpful to a recipient when it invests in long-term projects to develop infrastructure, human capital and other resources ... and when it is accompanied by competent technical advice, be it on agricultural policy or healthcare or environmental protection or the proper functioning of government and legal institutions’ (O’Hanlon and Graham 1997:45–46).

A current development strategy that draws from these lessons is the concept of ‘people-centred, participatory development’. This model links human and social capital as the underlying foundation in the development process, and promotes the emergence of effective societies through capacity-building processes and structures. Aid that makes a positive impact does so through enhancing the functioning of the state, the private sector, and/or civil society.

The backbone of this development paradigm is that of social learning, a concept introduced 50 years ago in the works of Albert Hirschman. The OECD Development Co-operation 1997 Report explains social learning and its relevance to development strategies in this way:

Essentially, social learning occurs when local actors adopt new ways of
proceeding that generate a series of decision requirements, leading to ‘instructive learning’ and an improvement in performance over time. The learning process is essentially undetermined and open-ended, i.e. there is no advance blueprint. There is a premium, however, on the willingness to take decisions in situations of uncertainty and on flexibility and adaptation to local contingencies . . . People and institutions at all levels become more competent and more confident as decision-making and taking initiatives become a familiar practice. (Michel 1997:17–18)

This report points to ‘the importance of strengthening developing country societies’ capacity to manage problems and exploit new opportunities’ in all area of involvement (ibid.)

As an external actor, HealthNet viewed its role in the Kobuleti dispensary project as that of facilitator in a social learning process. Under the management of MSF, the overall purpose of the Kobuleti dispensary was to provide primary healthcare to an underserved population in terms of Western standards of medical practice. HealthNet’s overall purpose encompassed a broader domain in seeking to enhance local capacity and to stimulate positive social change among all internal actors and stakeholders involved with the Kobuleti dispensary.

Project outcome

HealthNet’s first step was to set up an advisory board composed of civil and health officials and business people in a bid to foster local ownership and responsibility for the idea behind the dispensary, that of providing healthcare for vulnerable people. Regular meetings were held, and members were requested to propose, participate in, and be accountable for mechanisms to begin fostering community involvement. HealthNet’s role was limited to that of facilitator.

The original six members of the board were chosen by the Kobuleti Rayon Deputy Governor (who also served on the board) and clearly represented a traditional power base from the Soviet era. HealthNet introduced the idea that representatives from the ‘client’ population be included so that the board could be more broadly representative of the community and as a step away from the top-down approach of the past. This concept generated polite interest but no concrete action by the board during its year of operation.

Over the course of its existence, this board’s overall functional output was minimal. Input from business people was self-serving at best, and obstructionist at worst. The civil and health authorities, although receptive to the concept of a cooperative model of community responsibility, often floundered when faced with its practical application. The board’s finest moment occurred when HealthNet handed over administrative responsibility for the screening system that determined vulnerability to the Kobuleti Social Affairs Department. Implementation required functional and budgetary cooperation from the Governor’s office, which was not forthcoming. This was finally obtained when board members petitioned the Deputy Governor during one of the meetings.

In addition, an interface was set up with doctors from the dispensary and those from government facilities in Kobuleti Raion. Therapeutists and paediatricians were invited to observe medical practice at the dispensary (with its emphasis on rational use of drugs and Western treatment protocols). Open meetings were held with this group to discuss these protocols versus those standards favoured by government facilities.

Initially, community physicians resisted the idea of this forum, as some level of resentment existed from the medical community towards the dispensary. Months of discussions with key community physicians ensued before enough measure of goodwill could be built so that the gap between
community and dispensary medical staff was bridged. Once that was accomplished, this group functioned effectively in its role and collegiate collaboration was high.

HealthNet worked with numerous Rayon and regional government bodies responsible for the civil and medical allocation and administration of healthcare for the identified vulnerable groups. Finding out which agency was responsible for what range of tasks proved difficult, and sometimes impossible. For example, the identification, qualification, and allocation of social or medical support to various categories of vulnerable groups was handled by different national government agencies. Medical support was also available at the municipal level, but levels of reimbursement and the illnesses covered varied from region to region. Municipalities received guidelines from the Ministry of Health (MoH) so they could determine vulnerability, but also exercised varying degrees of local discretion. In addition, departmental functions and responsibilities were in a constant state of flux, as legislated healthcare reforms trickled outwards from centre to periphery.

In promoting integration of the dispensary into the existing health structure, HealthNet honoured the existing governmental separation of powers in all its capacity-building activities. But in the search for rational counterpart responsibility, HealthNet encountered a tangled web of bureaucracy that yielded little in the way of clear direction for integration of this structure. Bureaucratically numbing legacies from the Soviet period, such as top-down control and the absence of horizontal information sharing or cooperation, generated ongoing and formidable obstacles.

HealthNet had early introduced the concept of local government cost sharing. Board members were presented with detailed accounts of monthly operating costs for the dispensary and charged to investigate and secure local capital resources in initiating community cost sharing. HealthNet outlined the limitations of its donor funding, preparing the board and the community for the fact that external funding might be entirely withdrawn with only a few months’ notice. Despite these efforts, ongoing government promises to begin cost sharing did not materialise until the last remaining months of HealthNet’s involvement, and only then in response to HealthNet’s ultimatum to leave sooner unless cost sharing was instituted.

Final outcomes

Receptiveness towards the handover of the MSF-devised screening system to local authorities was feasible for two reasons. First, SAD, the government department most involved, had been given some measure of control over the design and implementation of the system from the beginning. This partial integration into existing government structures had fostered a strong sense of local ownership, laying the groundwork for sustainability. There was also an economic incentive because those identified as vulnerable were given free basic medical services. But when HealthNet withdrew from the Kobuleti project and government backing was not forthcoming, local authorities lost motivation for further involvement with the screening system.

Sufficient local motivation for handing over the dispensary operations to local authorities proved elusive throughout HealthNet’s project period. External donor funds for Kobuleti were terminated 16 months after HealthNet’s takeover of the dispensary. The team devised and implemented a plan for gradual withdrawal of financial and technical support over a four month period, during which time tactics remained couched within the overriding objectives of promoting local responsibility.

During HealthNet’s last remaining weeks, the municipal government offered to pay salaries and operating costs at the dispensary and to allow staff to continue serving the identified vulnerable people if HealthNet would leave the remaining drugs and durable goods. HealthNet agreed, and designated to
which local health facilities the remaining equipment and supplies should be donated when government support was withdrawn. Follow-up with the dispensary staff months later revealed that the government had not honoured any of these financial commitments in support of the dispensary.

Conclusions and recommendations

The outcome of HealthNet’s experience is strong empirical evidence for the effectiveness of utilising a people-centred participatory model of development that encompasses the interlinked functioning of the state and civil society in FSU nations. In forwarding its project objectives, HealthNet experienced its most positive gains in those areas where MSF had tapped into existing government structures and made use of local human and social capital. The most formidable barriers to integration involved design components that were running in parallel with existing structures, or lacked sufficient or appropriate linkages through internal actors.

Cost-sharing strategies necessary to ensure sustainability were difficult to impose mid-project. Cost sharing among the aid agency, beneficiaries, and local authorities should be negotiated from the outset of the project, continued for its duration, and with external sources slowly withdrawn as local stakeholders shoulder increasing responsibility. In this way, aid activities are viewed from the beginning as complementary rather than substitute resources. Local ownership by beneficiaries, the community at large, and government structures is enhanced, raising the likelihood that the activities will be self-sustaining.

The long-term sustainability of this project was crippled by a lack of strategic vision from the outset, which led to the creation of a parallel aid structure. The limited objective of the dispensary, to provide basic healthcare for an identified vulnerable population, further constrained its effectiveness and potential for development. Given the myriad complexities of working within FSU nations, quick-fix solutions risk perpetuating existing and endemic problems – society-wide dependencies, top-down hierarchies, bloated and turf-defensive bureaucracies, and irresponsible government.

A quote from Kevin Watkins, policy advisor with Oxfam GB, a British development NGO, is instructive of the dangers in setting up parallel structures:

There is a dangerous tendency on the part of donors to see NGOs as an alternative to the state . . . In the last analysis, it is up to the governments to provide their citizens with viable health, education and wider social welfare systems – and it is important for governments to invest in enhancing their capacity to do so. Creating parallel NGO structures weakly connected to the state and virtually autonomous in their operation, as has happened in much of Africa, is a prescription for long-term dependency, rather than human development. (Watkins 1996:32)

The risks of inappropriate and ineffective intervention are great. As Larry Minear and Thomas Weiss (1995:217) state: ‘The global humanitarian community should intervene effectively or not at all. The powerful urge to do something or, more likely, to be seen doing something should be resisted – unless the measures taken have a reasonable chance of achieving their objectives.’

References


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Background material


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