DISPLACEMENT, HEALTH, AND HUMANITARIANISM IN POST-SOVIET GEORGIA

An NCEEER Working Paper by

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TITLE VIII PROGRAM

Project Information*

Principal Investigator:	**Erin Koch**
NCEEER Contract Number:	**825-12**
Date:	**January 19, 2012**

* The work leading to this report was supported in part by contract or grant funds provided by the National Council for Eurasian and East European Research, funds which were made available by the U.S. Department of State under Title VIII (The Soviet-East European Research and Training Act of 1983, as amended). The analysis and interpretations contained herein are those of the author.

Executive Summary

Approximately six percent of Georgia's population (4.5 million) is Internally Displaced Persons (IDPs). The majority fled their homes during civil war between Georgia and Abkhazia in 1993 and remains unable to return. Amid privatization and government restructuring IDPs must navigate a confusing maze of policies in order to receive pensions, medical insurance, and other resources. This marginalization is instantiated, for example, in dilapidated living conditions and inadequate information about their rights. This paper provides a preliminary anthropological analysis of the health effects of displacement and of humanitarian aid in Georgia, highlighting changing government strategies for health care and IDP policies. I draw on interviews with IDPs and aid workers and on participant observation in collective centers to explore how IDPs are caught in a tension between social immobility and shifting cycles of bureaucratic upheaval and uncertainty in ways that exclude them from the programs that are designed to assist them.

Introduction

"When the [IDP] problem developed international [organizations] used to say 'let's not give the IDPs a fish, let's give them a fishing stick.' It was strange for us, we wanted food and fish. As I think of it now, they were experienced in…other conflict zones and they were right, we truly needed a fishing stick…[but] the people have become so used to receiving things that they still expect support from others and it is very bad." – Lia, representative of local NGO who works with IDP populations in western Georgia.

"You see, in Georgia people do not go to the doctor until they are very sick…there is no culture of prevention [preventative medicine], probably because it is too expensive. Healthcare is a very big problem. Not because there are not enough doctors or medicines, but because everything is very expensive. There is everything but money… we would have a culture of prevention but money stipulates everything." – Marina, Georgian physician who works with IDP populations in western Georgia.

"Poverty is everywhere [in the Georgian population] but I think the Government forgot about us IDPs. What can I say about a government that only provides me with 22 Lari per month, 88 Lari for my family of 4? We just buy bread flour and that is it. Misha says we should use our hands, but what can we do when there is nothing to do?"[1] – Marika, IDP from Abkhazia, age 30.

The quotes with which I open this paper encapsulate some of the most pressing issues that influence the health of individuals who have been living in protracted displacement in

[1] At the time of the interview, 1 Georgian Lari (GEL) was equivalent to approximately US$ 60 cents. "Misha" refers to Mikheil Saakashvili, the current President of Georgia.

western Georgia since 1993. They also reflect widely shared opinions of displaced people, NGO workers, and medical professionals about the politics of NGO and government assistance in relation to government health care and other social service reforms.[2] In this paper I draw on ethnographic research about the health effects of displacement and humanitarian interventions among internally displaced persons (IDPs) in post-Soviet Georgia.[3] The goal of the paper is to provide preliminary insights about protracted displacement in relation to cycles of upheaval and uncertainty in government and foreign assistance programs that target Internally Displaced Persons (IDPs) in western Georgia. I am interested in how this uncertainty creates a paradoxical situation in which IDPs are simultaneously caught between social immobility and bureaucratic turmoil. [4] These issues are particularly salient in the contemporary arena of global governance for poverty reduction in which target populations become new kinds of subjects and objects of assistance (Mosse 2005).

[2] Here I chose to include observations and data from a select number of interviews with the different constituents who participated in my research. Although they are not representative of the opinions of everyone with whom I worked, and should not be taken as typical of all IDPs, the materials presented here do reflect the majority of perspectives that were shared with me in the research process.

[3] In summer 2010 and summer 2011 I conducted a total of 14 weeks of research in a small city that is the administrative center of the Samegrelo region of Georgia. Ethnographic research consisted of participant observation in collective centers where IDPs reside, 4 IDP clinics, a quality of life and health survey that I distributed to 90 IDPs, and semi-structured interviews with 55 IDPs, 2 government officials 6 health care providers and 15 representatives of NGOs and international humanitarian and development organizations that work with IDPs in western Georgia. My research greatly benefited from the assistance of a social worker, a physician and affiliate of a local NGO who wanted training in qualitative research methods (and also assisted with transportation). I thank the three of them, and all of the members and staff of another local NGO with whom they are all affiliated in different ways, for their generous assistance in conducting this research. For purposes of anonymity, I do not name the NGOs by name here. I also thank Tinatin Meparishvili for assistance with transcribing and translating interviews and Sophia Mikava for tabulating and translating survey results. Finally, I thank the IDPs who shared their life stories, concerns and time with me. All names are pseudonyms except in the case of Government officials or unless otherwise indicated. Preliminary research for this project was supported by the University of Kentucky College of Arts & Sciences, and by the IRES Short-Term Travel Grants Program (STG), with funds provided by the US Department of State Title VIII Program.

[4] The phrase Internally Displaced Person (IDP) refers to someone who has fled his or her home—usually as a result of armed conflict, persecution or natural disaster—but who does not cross a recognized international boundary. The concept of internal displacement is highly nuanced, and is and is a subject of recent policy and scholarly discussion. For an excellent overview of that discussion see Mooney 2005.

Georgia, a small country of 4.5 million people, bears a population of approximately 258,000 Internally Displaced Persons (IDPs) who make up nearly six percent of the total population.[5] The majority of them, approximately 220,000, fled their homes during civil war between Georgia and Abkhazia in 1993 and since then remains unable to safely or legally return to Abkhazia. An additional 127,000 people fled South Ossetia into Georgia in the 2008 Russo-Georgian war. The Government of Georgia estimates that 236,000 of the current population of IDPs have been displaced since the 1990s, indicating that a majority of IDPs displaced in 2008 have returned to South Ossetia (International Displacement Monitoring Center 2011).

Georgia's IDP crisis raises significant issues about social and political status of displaced populations, the health effects of displacement and lived experiences with aid and relief programs on the ground. Displacement results in cultural and political marginalization, exacerbates illness, creates new forms of infirmity, and disrupts social support networks (Doliashvili and Buckley 2008, Mitchneck Mayorova, and Regulska 2009). Their cultural and political marginalization is instantiated in dilapidated living conditions, inadequate information about their rights, and most recently forced evictions of IDPs from government-owned housing.[6]

IDPs in Georgia are not a homogenous population. Many in and around Zugdidi, for example, are hopeful, are employed seasonally or year-round, consider themselves to be integrated and socially mobile, have become owners of and renovated their living spaces and participate in small business and other training programs provided by local NGOs with foreign assistance. And so-called "locals" people who are not IDPs, face some of the same issues: poverty, bad living conditions, unemployment, limited and ineffective government assistance,

[5] The country Georgia is approximately the size of the state of South Carolina in the United States.

[6] Here I refer to evictions that are part of the official action plan for implementing the state strategy for addressing the IDP population, launched in 2009, which I discuss in detail below.

and an incomprehensible, often-shifting bureaucracy that alienates them from the social services designed to assist them.

The people who I discuss in this paper, however, persist in a conundrum: they are all made up as a population. Following Ian Hacking (1999), this "making up" of populations simultaneously casts them as sites of intervention and control and puts them in motion.[7] IDPs are a "moving target" driven by engines of humanitarianism, international development, and government restructuring for health and social services. And, they are caught; simultaneously rendered immobile and in a constant state of upheaval, perpetuated by ongoing changes in assistance programs for which they oscillate between eligible and ineligible.

Historical and Ethnographic Context

Georgian history can be characterized in part by conflict and instability, largely attributed to ethnic diversity throughout the Caucasus and Georgia's geopolitical location, located at a strategic crossroads for empire building and trade (Grant 2009, Grant and Yalçin-Heckman 2007, Suny 1994). Centuries of cosmopolitanism have also made questions of unity and division prevalent in Georgian historical consciousness and shape current conflicts over ethnicity and sovereignty (King 2008).

Georgia's separation from the Soviet Union in 1991 was marked by coups d'état, civil war, drastic poverty, an energy crisis and chronic problems with internally displaced persons (Legvold 2005, Manning 2007, Manning 2008b, Pelkmans 2006). Since the collapse of the Soviet Union, the breakaway provinces of South Ossetia and Abkhazia have had ongoing battles

[7] According to Hacking, as categories of people are designated for assistance or interventions, characteristics are attributed to them. These characteristics shape interactions with them as populations, but the interactions also transform them. Thus aid recipients such as IDPs are always already moving targets, producing what Hacking calls the "looping effect" (1999).

with the Georgian government. The government's ability to resolve these conflicts has been seriously compromised by its turbulent internal politics, including the violent coup d'état that ousted President Zviad Gamsakhurdia and precipitated the Georgian-Abkhaz civil war in the early 1990s.

In 1995, former Soviet foreign minister Eduard Shevardnadze assumed the Georgian presidency and disarmed many of the militias involved with that coup. However, the long conflict caused grim and enduring problems. The country witnessed a dramatic decline of economic output that was close to 78% from 1991-1995, and annual inflation skyrocketed to 8400% by the end of 1993 (Belli et al. 2004: 110). Government expenditures for social services plummeted, and the health care system was particularly damaged. "The economic decline and fiscal collapse produced an immensely negative impact on the health care system of the country. Public expenditure on health was reduced to US$ 0.81 per person per annum in 1994" (Ibid.). Political stability, democratization, and economic growth were hampered by corruption and stagnant institutional mechanisms for social service delivery (Collier and Way 2004).

Shevardnadze was pushed out of the Presidency in November 2003, when a political opposition led by former Minister of Justice Mikheil Saakashvili took over Parliament and was elected to the office of President in 2004. Riding on the wave of hope created by the "Rose Revolution" of 2003 Saakashvili introduced neoliberal reforms with the help of the World Bank, USAID and the EBRD. Saakashvili also promised to change Georgia's endemic corruption and its widespread poverty and to set the stage for the resolution of the IDP problem, and promised to integrate Abkhazia and South Ossetia into the Georgian state.

“Strategic Plans” and Structural Upheaval for IDPs

Poverty is widespread in Georgia, with around 30 percent of the population living below the poverty line and, according to official rates, which are assumed to be lower than actual rates, approximately 17 percent unemployed. However, IDPs are among the poorest of Georgia’s citizens, many of whom face prolonged unemployment. As one representative of the Ministry of Refugees and Accommodation explained to me during an interview, the effects of poverty are often exacerbated for IDPs, whose daily lives are also affected by marginalization, limited awareness of rights and access to information and lack of trust in government and foreign aid programs.

Under the Shevardnadze government’s 1996 strategic plan for IDPs they remained virtually quarantined in dilapidated Soviet-era hotels or abandoned buildings where they experienced overcrowding, malnutrition, and disease (Greene 1998, Weinstock, et al. 2001).

In 2000, the so-called "New Approach" to resolve the IDP problem in Georgia was advanced by the Georgian government in cooperation with international relief agencies such as the UN Development Program, the UN Office for the Coordination of Humanitarian Affairs, the World Bank, USAID and the Swiss Agency for Development and Cooperation. Based on neoliberal principles of individualism, “capacity building," "sustainability," and market-based mechanisms in lieu of the direct provision of aid, the program was supposed to ameliorate IDPs' living conditions and economic prospects (Government of Georgia 2007b, Manning 2008a, UNDP 2008). The New Approach was plagued with implementation delays and bureaucratic red tape, and IDPs often either did not receive or did not know of services available to them (Kharashvili et al. 2003).

The Rose Revolution of 2003 held out new hope for the resolution of the IDP problem. Mikheil Saakashvili promised to eliminate widespread corruption, remove barriers to the effective utilization of international aid, and bring Abkhazia, South Ossetia, and the then semi-autonomous province of Adjara back under the control of the Georgian state. In the process, previous state responsibilities were allocated to local NGOs and international relief organizations. Some reforms were overt conditions of WTO membership or World Bank funding while others were informally required as part of establishing membership in supranational organizations such as the OSCE (WTO 2000). From rebuilding rural infrastructure to health sector restructuring, the Georgian government allocated many previously state responsibilities to international agencies and NGOs, setting the stage for dependency on foreign assistance under the umbrella of neoliberal free market reforms that emphasized privatization, state withdrawal and individualism.

In 2007, the Georgian Ministry for Refugees and Accommodation released a new strategy for the IDPs, who were labeled *devnilebi,* or "persecuted ones," (Government of Georgia 2007a, Lois and Tavartkiladze 2008, Manning 2008a). The Georgian government acknowledged the terrible condition of IDPs' housing and their limited economic prospects, and acknowledged the fact that IDPs' morbidity and mortality rates were significantly higher than the Georgian average (Government of Georgia 2007a: 5). However, despite the planning, little in the way of assistance reached the IDPs (Katsitadze 2004). The ongoing inefficiency of aid even when funding is available is unfortunately common in humanitarian projects (WHO 2005, Halperin and Michel 2000).

The 2007 plan was superseded by the August 2008 war. The government ordered a "joint needs assessment" to study needs generated by the war (United Nations and World Bank 2008).

Concurrently, international aid agencies coordinated relief efforts and issued a flash appeal to foreign donors. Over $109 million was requested in the October Flash Appeal, which sought to fund 105 projects aimed at new IDPs. In October 2008, international donor agencies and foreign governments pledged $4.5 billion or $1.25 billion *more* than the amount requested by the Georgian Government (Transparency International 2008). During interviews with NGO workers and government officials all emphasized that government responses to the "old" and "new" IDP populations stand in stark contrast to one another.[8] The failure of the 2007 IDP plan also sheds light on the ways in which excluded populations such as IDPs are socially and politically positioned in tension between humanitarianism and the global politics of indifference (Helton 2002).

The social status of IDPs—their position and perceived social worth in the broader cultural context—is reflected in ongoing discussions of integration. Integration of IDPs is currently a prominent issue among government officials, policy makers and aid workers, as reflected in the evolution of Government plans to respond to the IDP situation. "Integration" under Saakashvili's administration has been largely characterized by displacing the displaced. As cosmetic changes to buildings in the most affluent areas of the capital and most heavily trafficked streets remain an important symbol of development and westernization, the IDP population was increasingly seen as a blemish in the city's landscape. The laundry that hung from balconies of former Soviet hotels that had been occupied by IDPs since the early 1990s, for example, were seen as a symbol of state failure to recapture control of Abkhazia and South Ossetia from Russian control, and as a sign of failure to successfully transition to a market economy (Manning 2008a).

[8] IDPs displaced in 1993 are referred to in policy and mass media as "old IDPS," contrasting them with people displaced from South Ossetia and Abkhazia in 2008, AKA the "new IDPs."

When I asked one representative of the Ministry of Refugees and Accommodations who is also an IDP to elaborate on official uses of the term "integrated" she explained, "when officials discuss integration they usually are referring to rapid and serious improvements of living conditions, nothing more." However, integration is also a matter of social belonging. Being integrated would mean that IDPs have access to resources and employment opportunities that could allow them to feel like they are part of society: "I think that they are already part of society but they still do not have quality [i.e. of housing] and equity. They maybe have equality before the law but they do not have equal access. I think that in our case, integration should also mean to give them access to social services and employment, to improve their lives."

Housing is another sensitive issue, and many people displaced in 1992-1993 complain that the government cares more about the new IDPs. Efforts are underway to improve conditions for old IDPs through rehabilitations and privatization programs, but progress is slow. In contrast, within three months of that 2008 conflict, a portion of the aid money was allocated to build 36 settlements of small track houses, often referred to as "cottages," for the newly displaced.[9]

Because some of the buildings IDPs were housed in had high market value, Saakashvili attempted to move many IDPs out in order to redevelop the sites as commercial buildings (Fitigu 2005, Manning 2008a). In Tbilisi in 2004, IDPs were evicted from two large derelict hotels where they had lived for over a decade, which were redeveloped into for-profit hotels and a casino (Chaffour 2004, Lois and Tavartkiladze 2008). Other reforms aimed at small traders abolished the outdoor bazaar that many IDPs depended on for employment and income

[9] Settlements are located in both rural and urban areas, with inhabitant sizes ranging from less than 100 to approximately 8,000 at the time of preliminary research in 2009. Although the Government has been locally and internationally praised for the swift housing measures taken to resettle new IDPs, the construction has suffered from bad planning. Housing structures in the settlements that were built immediately following the 2008 war are also not well insulated, have poorly constructed floors that rapidly gave way to flooding (and snake infestations) and there are also longer-term health concerns about allergies and respiratory illnesses that may develop as a result of mold.

(Bezhiashvili and Kavelashvili 2004). At the same time, many IDPs were left in less visible collective centers, often living in cramped quarters without cooking facilities, running water or functioning sewage systems. Other reforms aimed at small traders abolished the outdoor bazaar that many IDPs depended on for employment and income (Bezhiashvili and Kavelashvili 2004). This change in fortune led many IDPs to question the legitimacy of the Saakashvili regime. Both "new" and "old" IDPs face extended unemployment; they are entirely dependent on aid from the government and assistance organizations for even the most basic supplies such as food, clothing, household goods, and so on. Moreover, after months and years of being displaced, many people feel that their lives have become less meaningful.

The 2009 strategy prioritizes improving IDP living conditions, but in practice has involved moving people on short or no notice to locations in the country where they have no social support networks or hope for employment. There have been numerous protests at the IDP and Refugee ministry in Georgia. Protestors have expressed their anger about how they are being treated with acts of self-immolation and people sewing their mouths shut (Brooks 2011, Radio Free Europe 2010).

The so-called "old IDPs", or "Shevardnadze's IDPs" are dispersed throughout the country (but primarily in western Georgia) in collective centers and private accommodations. An estimated 42 percent live in collective centers, which are privately or government owned buildings that were offered to them as emergency, short-term housing when they crossed the border into Georgia. They were never meant to house people long-term. Most of them are former kindergartens, partially or non-functioning hospitals, former factories and other sites of Soviet production that are not equipped with facilities for heating, cooking, or running water. The conditions are dilapidated, unsanitary, and for the most part inhumane. These populations are

also distinguished by the hundreds of millions of dollars in international aid provided to the Government of Georgia to resettle the new IDPs in makeshift settlements, and by the fact that the new IDPs were automatically enrolled in the free health insurance for "the poor" when they register for IDP status, whereas old IDPs were required to go through an official assessment. This situation has exacerbated inequities and animosity between old and new IDPs, because IDPs from the 1993 wars are excluded from, or must petition for allowances under the new action plan, whereas new IDPs are automatically eligible for them.

The government is currently focusing on rehabilitating collective centers that it deems suitable for renovation, and making the residents the legal owners. For IDPs who live in collective centers that are too run down to be renovated, the government is building new apartment buildings and houses and offering them to IDPs.[10] However, many IDPs are not willing to accept these offers because they do not like the new locations; moving away from social networks, employment, and family will only displace them again. Moreover, although the living conditions will be better, many people are resistant to being moved into 30-40 square meter spaces in a new city or village.

Others feel abandoned, such as Nino, a woman in her 60's who expressed confusion over the new relocation plans, and their status within it. Nino lives in a severely dilapidated collective center near the Black Sea, not far from a cluster of new hotels that are being built with government funding to promote tourism in Georgia that some argue is at the expense of helping IDPs (Corso 2011). In Nino's words, "I have been sick for two months and I don't have money to visit a doctor. I receive social support but it is not enough…there is nothing good happening. Nobody tells us if we are going to move out of here or not, or if they will give us new houses or

[10] In summer 2011 the Action Plan was extended for 2012-2014, prolonging renovations, construction and IDP relocations and the uncertainty that surrounds this process.

they will move us into apartments (in Poti). We are very confused. We can't go to the forest to get wood because the police will catch us if they see us. If the wood flows down the water we take it and that is our source of heat. We cannot fish either, that is prohibited...when it rains a lot the water floods the house. We have been in this type of condition for 18 years. Nobody has told us what they plan to do with us."

Nino's confusion and lack of transparent information is widespread among the IDPs in western Georgia. One of my research assistants who was present at this interview, and who is a physician who has helped many IDPs asked Nino if she has relatives who can help. Nino replied, "who can support me? All of them are IDPs themselves." Marina, a Georgian social worker who also assisted me with my research, asked Nino if she was aware of her rights as an IDP. Nino's response again reflected the lived experiences with structured uncertainties and bureaucratic upheaval that affect the lives of so many IDPs in Georgia. When she suggested that she has no rights, Eliso, the doctor who had some familiarity with Nino's medical history, asked her if she had ever attended any community meetings, or if anyone had ever come from the government or an aid organization to explain their rights. Nino said, "No, no one, that is what I am saying! They came only once and took photos where there was flooding. They took pictures of the water and left…they keep telling us they will come and support us, but the only thing they do is take pictures. If we were young we would go and try to find out [about our rights]. Where can we go now? Even if we do nobody will pay attention to us. No one has been here and I am not going to run around and fight in vain. I am tired already. I have not been to Zugdidi in five months. How can I go there? I have no money for transportation."[11]

[11] Zugdidi is the largest city in the region of Georgia where Nino lives. IDPs who want to exercise their rights to new or renovated housing or other social services have to travel there to the regional office of the MRA.

Health Care Reforms and Structured Uncertainties

Health is a particularly sensitive and urgent issue for IDPs, many of whom live in dilapidated collective centers, where conditions are cramped, and lack adequate sanitation.

In Georgia, decentralization, economic collapse, and the protracted civil war left only shattered remnants of the previous health care system. With the dismantling of the centralized Soviet health infrastructure Georgian state institutions inherited, among other things, under-resourced and overburdened medical facilities. Economic and social conditions worsened, and the country was left without a healthcare system until 1995 (Gotsadze, Zoidze and Vazadze 2005). Reforms in the early 1990's supported mainly by international organizations focused on developing a primary health care approach and "rationalizing" a system that was characterized as excessive in terms of the level of specialization, the number of facilities, hospital beds and service providers, and length of in-patient stays (Schecter 2011:16).

Those efforts—designed to privatize the health system and introduce a fee-for-service mechanism—have consistently emphasized "optimization" of the health care system, dictated by the World Bank, now among the largest source of funds for health reforms in the world. In the countries that were formerly regulated by the Soviet Union, so-called free market reforms presuppose a universal subject who will act in its own self-interest (Humphrey and Mandel 2002) through self-education (for example about pregnancy) preventive care, avoiding smoking and alcohol, and eating a healthy diet. Despite ongoing reforms aimed at reducing poverty, health sector privatization and promoting competition of a free market for medical services out-of-pocket payment remains high, deterring patients from seeking care at health facilities (Gotsadze et al. 2005, Karavasilis 2011, Skarbinski et al 2002). These practices cannot be reduced to the limitations patients face in adopting or "resisting" a "new mentality" or adapting to a different

system in which the responsibility of living a "healthy lifestyle" is now wholly placed on consumer patients. Patients who do not seem to act as their own advocates for a healthy lifestyle are often given an additional diagnosis of irresponsible and indifferent (and thus "typically Soviet") in ways that mask the limits of a changing healthcare system (Rivkin-Fish 2005:126-127).

Under the Basic Benefits Package, a series of health care reforms in Georgia launched in 1995 IDPs were supposed to continue receiving free medical care, which they were first entitled to as members of a vulnerable population (Gzirishvili and Mataradze 1998). However, IDPs were rarely informed about services provided through the Ministry of Health; these free services did not include treatments or laboratory tests. These aspects, combined with informal fees demanded at time of service, fear of stigmatization and distrust of the government discouraged people from seeking clinical care. Moreover, the government often defaulted on its responsibility to reimburse practitioners for care provided to IDPs with insurance, which discouraged practitioners from treating IDP patients (Kharashvili et. al.2003, Zoidze and Djibuti 2004). Thus, although IDPs at one time may have been entitled to greater health benefits than the general population on paper, they faced unique social, political and economic factors that increased susceptibility to disease and barriers to care (Buck et al. 2000, Doliashvili and Buckley 2008, Sumbadze and Tarkhan-Mouravi 2003).

Radical privatization was announced in 2007, to make a sharp turn away from the semi-centralized system that had emerged and become stagnant since the first post-Soviet reforms in 1995.[12] "The privatization reforms sent shock waves through a country where much of the

[12] The radical push for privatization in the health care sector also included the "100 New Hospitals" Plan that was designed to build new hospitals on prime real estate, sold by the government at very low rates, primarily in urban areas. The owners would be required to use the spaces for hospitals for seven years, at which time they could use it for whatever they wanted. That plan was cancelled (Transparency International 2010). The government also tried to

population still lives in poverty...and cannot pay even small insurance premiums…hospitals were suddenly faced with the need to enter into a complex system of reimbursement, but the infrastructure did not exist…the motivation for the privatization of healthcare was the same as for all other sectors of the economy. This was not a reform that aimed to improve efficiency, access, or quality in health care – the primary goal was to let market forces take over and relinquish the government's responsibility for the health sector." (Schecter 2011, 18).

Ongoing transitions in Georgia's health care system create additional obstacles to living a healthy life. Health care policies define population categories that determine access to free or low-cost services and state-funded insurance. Amid privatization and restructuring, IDPs and other "vulnerable populations" are no longer guaranteed basic services free of charge. Instead, they must qualify as "poor" under a new set of standards measured by social workers, and navigate a confusing maze of policies (Hou and Chao 2011, Mataradze 2011. See also Bauhoff, Hotchkiss and Smith 2011). In this context, poor health emerges in tension with medical and social service restructuring that is shaped through relationships between the government and international organizations.

In 2007 the Government began its Targeted Assistance Program for socially vulnerable populations (TSA). Since then, the Social Services Agency (SSA) conducts assessments of individuals and households throughout the country that apply for allowances from the state. The assessments involve an invasive scoring process, whereby, for example, the mere fact of employment (irrespective of salary) or possession of a television or refrigerator might increase the points allocated to the household regardless of the actual amount of income. The assessments involve an invasive scoring process whereby, for example, the mere fact of employment

introduce a 5-Lari health insurance plan for individuals who could not afford private insurance, but who also did not qualify for heal insurance under the Targeted Assistance Program. Very few people who qualified pursued that option and it was also abandoned after one year (USAID representative personal communication, summer 2009).

(irrespective of salary) or possession of a television or refrigerator might disqualify an individual or household regardless of the actual amount of income. [13] Many IDPs do not qualify for the state-supported medical insurance, AKA "the policy" and there is confusion, understandably, as to whether *if* they are registered under the poverty line, their allowance would be higher than the IDP allowance and whether they can take both. They cannot.

In summer 2010 I returned to a village close to the Inguri River that separates Georgia from Abkhazia to interview residents of two of the most dilapidated collective centers in the area. The local branch of the MRA and international organizations and NGOs working locally recognize residents of those centers as among the most vulnerable IDPs in that region. One afternoon my research assistants and I spent a couple of hours talking with a woman who I call Dali, a woman in her fifties who has been living as an IDP since 1993. Like the majority of IDPs who I spoke with over the course of my research, Dali was happy to speak with someone who was interested in learning about her life from her point of view.[14]

In response to my question about IDP health Dali replied, "A lot of us devnelebi have damaged health…I was sick before [the war in 1993] but I became five times worse here. Some people who were healthy are sick. We have no support, and we worry a lot. There is only a river dividing…We see our home and we cannot go there…I think that is why we are getting ill…. I want to live in normal conditions. This is what I ask the Minister and the local government but no one is listening. (Referring to the head and local representative of the Ministry of Internally

[13] At the time of research I learned through interviews with NGO workers that the government was planning to shift from an assessment policy that focuses on "assets" to one based solely on revenue. The benefit of the new procedures will be that people who might own a television or refrigerator for example, but who still live under US$2 a day, will not be excluded from receiving TSA benefits because they own a television. At the time of writing, no update is available.

[14] Nearly 75% of the respondents to my written survey included comments of gratitude for my research, emphasizing a general lack of interest in and lack of knowledge about Georgia's IDP situation. Of those 75%, nearly half expressed frustration with government officials, NGOs and international organizations that pay them visits, ask questions, make promises but never return. Similar sentiments were expressed during formal interviews and informal conversations, as well.

Displaced Persons from the Occupied Territories, Accommodation, and Refugees).

In Dali's words, she is "fully disabled" not because of the rheumatoid arthritis she's developed or the physical disability that restricts her movements to a wheelchair. And not because she cannot use the wheelchair to enter her two-room dwelling in which the wooden floors are too disintegrated to support its weight. She is disabled because she is socially immobilized as an IDP. In talking with me about her personal history, everyday life, and state services she used the word *devnelebi*—persecuted ones—to refer to IDPs, rather than *ltovlebi*, refugees. She also wove together her personal traumas, living conditions, and the uncertainty that shape her daily life with the forms of governance that, in her terms, keep her from living a normal life. In our conversations many IDPs draw similar connections between protracted displacement, and ongoing changes in state services for people who do or do not qualify as living under the poverty line. Out-of-pocket payments remain a significant obstacle, even for those who have "the policy."

Humanitarianism in Action?

From the perspective of some international donors and human rights organizations Georgia's substantial protracted IDP population symbolizes the failure of the Government of Georgia to socially and economically integrate them. Under the pressure of international eyes, amplified attention to the old IDPs operates as a form of assistance that Mariella Pandolfi has termed a "'human friendly" form of international politics" (2008: 173). That is, an ethos in which government assistance that is largely dependent on international donors, takes on a gesture of human rights interventions rather than substantial and long-term care for citizens, or would-be citizens. This humanitarian ethos simultaneously targets "vulnerable populations" for assistance

and reproduces hierarchies for recipients of aid, and social hierarchies more generally (Fassin 2007). Humanitarianism takes on a political, rather than apolitical role (Barnett and Snyder 2008, Feldman 2007, Klein 2004, Malkki 1995, 2005, Rubenstein 2008, Stein 2008). And, taking a neoliberal turn, assistance focuses on helping them learn how to help themselves. Health is a primary site for this paradoxical mode of assistance and government restructuring.

For NGO workers assisting IDPs in Zugdidi, this kind of confusion and lack of information is a major obstacle in providing assistance, as I learned from Anika. Anika works for a European NGO that was involved with a long-term project to bring social work and advocacy services to IDPs. "Lack of information is a serious obstacle," she explained during an interview in 2010. "People don't know when their place will be rehabilitated, or if it will… Often the government (local municipality) also does not know." This conundrum is also emblematic of the ways in which old IDPs have been marginalized by the government, and underscores why IDPs do not trust the government. They also do not trust many international organizations because many send a representative who makes a lot of promises that they fail to deliver.

The tension produced by foreign assistance programs and state withdrawal of social services is also a major problem. Anika explained, "When we go to the higher levels of the government they perpetuate the idea that international organizations are primarily responsible for implementing the IDP action plan…They very often ignore us and don't respond to our requests…they feel that we are bothering them although we are basically demanding from them that they fulfill their responsibilities…and very often…government [representatives] try to push their tasks on us. [They tell IDPs] 'Go ask this NGO or that NGO.' It is not our task to provide the community with things that the government is supposed to supply."

Another obstacle to helping IDPs help themselves is what many on the ground (in

Zugdidi) refer to as a passive "IDP mentality." For Anika this is clearly a sensitive issue. Struggling to find her words she said "I don't know lack of…lack of motivation maybe…I have the feeling when I am having an interview or a talk with our beneficiaries and I am trying to show the new ways or how the future could somehow look…I don't really feel that what I say is received on the other side…And I still think that there are not enough efforts made to inform them, especially the rural population. There is no proper language that is being used to contact them. Using this whole NGO vocabulary is really like using a foreign language [even translated into Georgian]…even the word "social worker" is difficult." Perhaps this lack of a common language influences whether some IDPs are seen as having a "passive mentality," a mentality or worldview that I would argue is reinforced by the lack of information they are provided by local and national government officials about accommodations, health insurance and other social services.

During our conversations, most people intertwined a flurry of concerns to reflect on and recount lives caught between a state of abandonment on the one hand, and cycles of bureaucratic upheaval and uncertainty on the other. A lack of trust in the Government, and fears of learning about health conditions that they might not be able to afford treatments for, or that might orphan their children discourage people from seeking medical care. Many are even reluctant to seek services at the IDP clinic in Zugdidi, where officially registered IDPs can receive low-cost medical care even if they do not have insurance.

Although for IDPs living a "healthy life" clearly involves more than the absence of disease, the dilapidated state of most collective centers, protracted traumas and other factors related to poverty clearly contribute to or exacerbate illnesses. The main health problems that afflict IDPs are psychological distress, dermatological conditions (especially lice),

gastrointestinal diseases (resulting from lack of sanitation and clean water, and inadequate nutritional support), goiter, and stress-related conditions such as hypertension. But some conditions they do not necessarily attribute to being displaced. For example, chronic heart disease and high blood pressure are also widespread in the general population.

For the remainder of this paper I concentrate primarily on the narrative someone living with heart pains that I call Tamuna. Tamuna is in her mid-50s. She has warm brown eyes and a cheerful smile when she offers one. But she also exudes a deep sadness with her demeanor. Tamuna fled Abkhazia in 1993 and has been living in the same single room in a collective center with her two children since then. Their room, no bigger than 10 by 15 feet, is on the second floor of a building where a total of thirteen families currently reside.

Their floor does not have running water, and the electricity supply is precarious, at best. Although the residents go to great pains to keep their personal spaces clean, many of the 1-3 room quarters have broken or empty windows, severely cracked and crumbling walls and floors, ceilings that leak when it rains, and mold and dust reside there as permanently as the IDPs.

In describing her everyday life Tamuna said, "My life is hard, it is hard for me to live here. It's the 18th year that I am here and it's very difficult for me. You see the conditions of ours. We sleep in cut beds (cut mattresses) all 3 of us, me and my 2 children. I am sick myself. I have neurosis; I have pain in my heart. I have to have a surgery done [heart surgery] and I don't have enough money to buy medicines. My condition is bad. … I don't have a policy…I applied again, but the man came, one guy and I did not have the IDs of my children. They lost the IDs at school." She went on to discuss the difficulties of getting replacements, which involves costly travel to Tbilisi, the capital city.

As our conversation continued Eliso, familiar with her medical history, suggested to

Tamuna that perhaps she was suffering from long-term anxiety. Tamuna concurred and said, "I am afraid of everything, I worry about everything, I think about the worst all the time." As our conversation proceeded, we inquired as to whether Tamuna had sought psychological services. She told us she had, but that she only received a prescription for an anti-anxiety medication that she said she can neither afford nor live without, and the advice that, "I am the doctor of myself, that I have to be the doctor of myself now. He said I should think of the positive stuff, of my children. So I take the broom and I sweep the house; that calms me down."

As an officially registered IDP Tamuna receives a monthly allowance of 22 Georgian Lari ($12.50 at the time of research) because she lives in a collective center owned by the government. This is less than the allowance she would receive if she qualified as "socially vulnerable" [living under the poverty line]. Tamuna used to have minimal but free health care through a state funded policy specifically for IDPs. But that policy was cancelled after the SSA began its Targeted Assistance Program for socially vulnerable populations in 2007.

Here, Dali's experiences as a disabled person who has been living in among the worst conditions are insightful. The few times that I met her, Dali struck me as a sharp, determined woman with a will to live that defied her living conditions. She tells me that her determination comes from the people around her, and from her faith in God. Dali, who described her health to me as *dazianebuli* (damaged) said "For me personally as a sick person, these conditions are really bad. You have to depend on someone else and wait until they do something for you. I don't have the health problems that will qualify me for the benefits received by people in the first category of 'disabled person.' We don't have a bathroom inside, nothing at all. The floor is totally broken. Snakes and lizards come out of there. The walls are falling apart and the ceiling is too. They say no repair can be done here and we were not for that either. We never wanted to

live here forever," she said, angrily waiving her hand at the building behind her.

As our conversation continued Dali explained that she had been trying to advocate for her rights to better housing, and to better health benefits for years through proper channels, rather than trying to bribe people (her example). But she also spoke with an air of defeat: "I don't sleep well and I have some problems with nerves. There is nothing to hide. Our nerves are as bad as our petrol. I could stand so much before, but everything has to end, this type of life, this illness, everything...I am existing, but not living." At this point Marina, who introduced me to Dali, chimed in and asked her if she had contacted the local government lately. "Do you know what your rights are?" I asked.

Dali replied, "I don't know, they don't do anything we ask for. So I don't know what the rights are, I think they took all the rights away from us." Marina, ever the optimist, said, "No, you truly have the right to ask an apartment in the social houses that are being built." But Dali's experience as someone whose health is damaged, to use her word, but perhaps not quite damaged enough, trumped everything else: "Yes [I went to the government office] and I said that [I am sick and I have a right to better housing]. That man shouted at me saying that he had an IDP sicker than me and gave an apartment to him."

Dali and Tamuna suggest that the health effects of displacement are not purely biological effects of living in squalor. Nor are they merely biological outcomes of social factors, such as what some might call a "passive mentality," lack of information about and access to their rights, or a shifting political terrain of human friendly national politics that minimizes state services for vulnerable populations. Instead, I argue from an anthropological standpoint that the meanings IDPs give to poor health are co-produced with embodied effects of medical and social service restructuring in contemporary Georgia. Caught in between immobility and upheaval, afflictions

related to protracted displacement are reinforced by state policies that determine access to habitable housing, medical services, and pensions.

In this shifting terrain, how is vulnerability being redefined? And how do important and much needed interventions not only respond to but also reconstitute meanings of health, illness and living a "normal life?" Caught in a tension between social immobility and shifting cycles of bureaucratic upheaval and uncertainty, IDPs reconstitute meanings of living a healthy life in ways that suggest that assistance might be keeping them alive, but they are hardly living.

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