DISSERTATIONS IN
SOCIAL SCIENCES
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STUDIES

Marja Tuomi

Diffusion of Social Innovations Across the Borders

Social Sector Cooperation with the Republic of Karelia

Publications of the University of Eastern Finland
Dissertations in Social Sciences and Business Studies No 33

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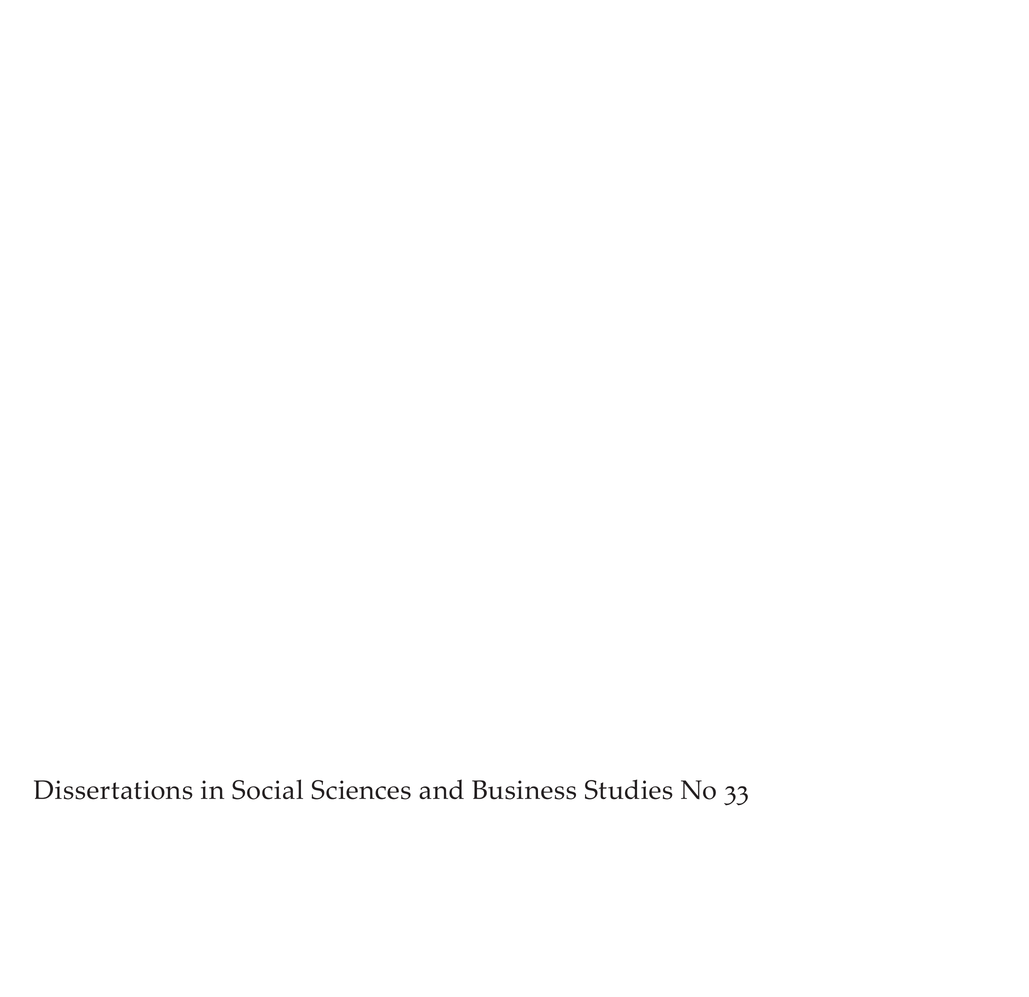

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Itä-Suomen yliopisto
Yhteiskuntatieteiden ja kauppatieteiden tiedekunta
Kuopio
2012

Kopijyvä Oy
Joensuu, 2012
Editor: Eija Fabritius
Sales: University of Eastern Finland Library

ISBN (nid): 978-952-61-0637-3
ISSN (nid): 1798-5749
ISSN-L: 1798-5749
ISBN (PDF): 978-952-61-0638-0
ISSN (PDF): 1798-5757

Tuomi, Marja
Diffusion of Social Innovations Across the Borders. Social Sector Cooperation with the Republic of Karelia 243 p.
University of Eastern Finland
Faculty of Social Sciences and Business Studies, 2012
Publications of the University of Eastern Finland,
Dissertations in Social Sciences and Business Studies, no 33
ISBN (print): 978-952-61-0637-3
ISSN (print.): 1798-5749
ISSN-L: 1798-5749
ISBN (PDF): 978-952-61-0638-0
ISSN (PDF): 1798-5757
Dissertation

ABSTRACT

The disintegration of the socialist system resulted in flow of external support for a variety of sectors in the former socialist countries. This study concerns social sector cooperation financed by the Government of Finland, other Finnish actors and the European Union with the Republic of Karelia, Russian Federation. The external support was planned to be temporary and lead to sustainable changes. The aim of the study was to examine how widely the social innovations introduced in the frames of the joint projects diffused and adopted in the Republic of Karelia, and which factors influenced these processes. The study covers the period 1992-2008.

The theoretical frame integrated Everett M. Rogers' diffusion theory with institutional change theories. Rogers' variables influencing adoption and diffusion were modified for the purpose of this study and diffusion was divided into two stages: external and internal. Diffusion and adoption were examined through five case studies, which were selected on the basis of eight criteria. Data on the adoption and diffusion was collected mainly by qualitative methods.

The results of this study show that all the three categories of variables considered: attributes of the innovations, communication and the institutional framework influenced both stages of diffusion as well as the adoption of innovations, but differently at each phase.

Among the factors most conducive to adoption and diffusion were relative advantage, commitment of the local actors and decision-makers to the cooperation and dissemination of information about the innovations. Among the factors delaying the adoption and diffusion were incompatibility of the innovation with the existing operating environment, inadequate financial resources and an absence of a clear and consistent reform policy. The fact that Karelia is part of the Russian Federation clearly influenced the adoption and diffusion of certain innovations.

Key words: diffusion, diffusion of innovations, social innovation, Republic of Karelia, transition countries

Tuomi, Marja
Sosiaalisten innovaatioiden leviäminen yli rajojen. Sosiaalisektorin yhteistyö Karjalan tasavallan kanssa 243 s.
Itä-Suomen yliopisto
Yhteiskuntatieteiden ja kauppatieteiden tiedekunta, 2012
Publications of the University of Eastern Finland,
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ISBN (nid): 978-952-61-0637-3
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ISSN (PDF): 1798-5757
Väitöskirja

ABSTRAKTI

Sosialistisen järjestelmän hajoaminen johti ulkoisen tuen virtaan entisten sosialististen maiden eri sektoreille. Tämä tutkimus koskee Suomen hallituksen, muiden suomalaisten toimijoiden sekä Euroopan unionin tukemaa sosiaalisektorin yhteistyötä Karjalan tasavallan, Venäjän federaatio, kanssa. Ulkoinen tuki oli suunniteltu tilapäiseksi ja johtavan kestäviin muutoksiin. Tässä tutkimuksessa tarkasteltiin kuinka laajasti yhteishankkeiden puitteissa esitetyt sosiaaliset innovaatiot levisivät ja juurtuivat Karjalan tasavallassa ja mitkä tekijät vaikuttivat näihin prosesseihin. Tutkimus kattaa vuodet 1992 - 2008.

Teoreettisessa viitekehyksessä yhdistyivät Everett M. Rogersin diffuusioteoria ja institutionaalisen muutoksen teoria. Rogersin innovaatioiden omaksumiseen (adoption) ja diffuusioon vaikuttavia tekijöitä (variables) modifioitiin tätä tutkimusta varten ja diffuusio jaettiin kahteen vaiheeseen: ulkoiseen ja sisäiseen. Diffuusiota ja omaksumista tarkasteltiin viiden hankkeen kautta, jotka valittiin kahdeksan kriteerin perusteella. Aineistoa innovaatioiden omaksumisesta ja diffuusiosta kerättiin pääosin laadullisin menetelmin.

Tutkimuksen tulokset osoittavat että kaikki kolme muuttujakategoriaa: innovaatioiden ominaisuudet, kommunikaatio ja institutionaalinen viitekehys vaikuttivat sekä diffuusion molempiin vaiheisiin että innovaatioiden omaksumiseen kuitenkin eri tavoin kussakin vaiheessa.

Innovaation suhteellinen hyöty, paikallisten toimijoiden ja päätöksentekijöiden sitoutuminen yhteistyöhön ja tiedon levittäminen edistivät innovaatioiden omaksumista ja diffuusiota, kun taas innovaation vähäinen yhteensopivuus toimintaympäristön kanssa, riittämättömät taloudelliset resurssit sekä selkeän ja johdonmukaisen uudistuspolitiikan puuttuminen olivat hidastavia tekijöitä. Karjalan tasavallan kuuluminen Venäjän federaatioon vaikutti selvästi tiettyjen innovaatioiden omaksumiseen ja diffuusioon.

Asiasanat: sosiaalinen innovaatio, innovaatioiden diffuusio, innovaatioiden omaksuminen, Karjalan tasavalta

Forewords

My roots are in Russian Karelia. Ever since childhood I have heard my father talking about Karelia but it became real for me only when I began my work as a project secretary for the STAKES Karelia project in 1995. Over the years and as new projects started up I began to feel concerned about how much real effect our projects had on the developments of Karelia. Did we indeed achieve the changes which our projects were intended to achieve – did the seed of change take root?

The decision to embark on this study was an easy one, getting started and realising the extent of it were at times decidedly painful, making progress – at least in my own estimation – was slow and completion a day of great joy. First I wish to express my heartfelt thanks to Professor Markku Kivinen and Docent Timo Piirainen for so kindly agreeing to be the pre-examiners and also to extend my gratitude in advance to Professor Kivinen for consenting to be the opponent at the public defence.

The idea to do a doctoral dissertation came after the turn of the millennium and in 2004 I began my studies as a postgraduate in the then department of Political Science at the University of Tampere. Without the encouragement of Professor Emeritus Jyrki Käkönen in July 2004 this work would probably never have come to fruition. Thank you, Jyrki. Although in view of my educational background (a master's degree in international relations) the University of Tampere appeared the obvious place at which to continue, progress only began in earnest three years later in late summer 2007, when I decided to change the approach and emphasis of the study and transferred to what is today the Faculty of Social Sciences and Business Studies at the University of Eastern Finland (formerly the University of Kuopio), becoming the supervisee of Professor Juho Saari. I cannot find words to thank Juho. He immediately perceived why the work was not progressing and helped me to see how to extricate myself from that predicament. Juho is a wonderful supervisor: he listens, he comments, he offers ideas, is there when needed, offers kind words when the going is rough – encourages, encourages and encourages some more. Thank you, Juho.

Except for a few brief periods my dissertation was accomplished alongside my professional work. I gratefully acknowledge my employers, the National Institute for Health and Welfare, the Helsinki Deaconess Institute and the Finnish Institute of Occupational Health and my line managers Ali Arsalo, Jutta Immanen-Pöyry, Ulla Parviainen, Jarmo Kökkö, Birgitta Rantakari, Antti Elenius and Suvi Lehtinen for being so positive about my research work and for allowing me leave whenever needed. Thanks also to my colleagues who in many and various ways supported or showed interest in my research, especially Regina Montell, Simo Mannila, Satu Leinonen, Dmitry Titkov, Sirje Vaittinen, Satu Zukale, Minna Nummi, Christina Nyback and Salla Mäkelä.

A big thank you also to Tiina Laatikainen, Tiina Vlasoff, Kristiina Salovaara, Mikko Vauhkonen, Marja-Leena Kärkkäinen, Tytti Tuulos, Tapio Saavalainen, Aulikki Kananoja, Martti Kemppainen, Minni Hyrkkänen, Anita Koivuselkä, Paula Laamanen, Maria Waltari and Olli Kuukasjärvi.

I also owe a debt of gratitude to two splendid women, Docents Pauliina Aarva and Anneli Milén. We started together in the Karelia project in mid 1990s and fortunately they continue to be a part of my life even though our paths took different directions. To Pauliina my thanks for the good discussions over phone, your comments on my work at various stages and for being the sparring partner of my mock defence. Anneli: a friend in need is truly a friend in deed. You came to my aid in the final stages and read my text with a critical eye. Hugs to both of you!

I express my gratitude to my Karelian colleagues and friends for their support and for opening doors which would otherwise have been closed to me.

This was a rewarding but heavy road. In the course of it I lost both my parents and a very dear friend. Mother and Father, you looked forward to seeing your second daughter complete her doctorate, but such was not to be. My mother's last words to me – when I was again compelled to cancel a visit were "Never mind, Marry, finish your work and then come when you have the time. Look after yourself, get some fresh air, remember to get a bite to eat and keep your feet warm then we'll get to celebrate". I have tried to act on this advice and even though you are gone from me, yet you are both with me as I go along my road. Thank you for your support at all stages of my life.

My dear friend Rossy, Anne Vienonen, died prematurely only a few months ago. Thank you, Rossy, for you concern for me when your own strength was ebbing. Today I raise my glass to you and to our friendship, which gave me such strength.

Thanks to my friend Ulla Idänpään-Heikkilä for reminding me that life goes on outside doctoral research work and for tempting me out now and then for a bit of cultural enjoyment. Thanks to Hilkka and Hannu there in Turku for pleasant times on the golf course and in the evenings.

Thanks to my "own family", my beloved siblings, Pirkko, Päivi, Riitta, Erkki, Taina, Ulla, Terhi, and Kari and your families for your support and presence in my life. Special thanks to Taina and Kari for doing what you promised when we celebrated Taina's doctorate and for being there when I needed support, advice or a willing listener. Thanks to Pirkko for early morning calls, to Terhi for angel therapy, and to my niece Marja for relaxing discussions and winter swimming expeditions.

Heta, Tage, Bastian, Akseli and Joonas – thank you for your interest in my research and for diverting my attention from it on your visits. Thanks also to my parents-in-law Helle and Paavo Välimäki. When working on a doctorate everything else seems secondary. Almost three years ago the wonderful Bastian entered our lives, periodically calling a halt and putting "work" in its proper place. As I wrote and a tiny hand touched my knee a round-eyed small boy asked "Marja, can we please listen to some Moomin songs?" or "Let's have a game of billiards" that was that. What could possibly be more important than Moomin songs?

And finally my dear husband Kari, who supported me in all possibly ways over these years. Read, commented and took care of the household. Many things enabled me to cope; you are the most important among them. Without you this work would never have been completed. When I cast about for a reason to pack up, you got me back on my feet and in front of the computer. Thank you for slowing me up when I was going too fast, for being my drag anchor. A couple of days after I had submitted the manuscript for pre-examination and had apparently calmed down somewhat, you said "Marja, welcome back home." Now I have time for you again.

Thanks to the University of Eastern Finland for assistance with practical arrangements to Annikki Honkanen, Sirkku Nuolemo, Eija Fabritius and for the layout to Erja Hirvonen, to Eoin Corcoran for checking the English and especially to Virginia Mattila to whom it owes its final form.

This research was supported by the Ministry for Foreign Affairs of Finland, Finnish Church Aid, University of Kuopio and Karjalan Sivistysseura.

I dedicate this dissertation to my beloved parents, Liisa and Paavo Tuomi.

At home in Korso, on a beautiful day in November 2011.

Marja Tuomi

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KEY ACRONYMS

BI	Business Innovation
CA	Change Agent/cy
CPSU	Communist Party of the Soviet Union
GP	General Practitioner
EC	European Commission
EU	European Union
FILHA	Finnish Lung Health Association
FSC	Former Socialist Countries
FSU	Former Soviet Union
HIT	Health care systems in transition
IDP	Innovation Development Process
IMF	International Monetary Fund
KMC	Karelian Medical Conference
LFA	Logical Framework Approach
LP	Local Partner
MFA	Ministry for Foreign Affairs of Finland
MHSD	Ministry of Health and Social Development of the Republic of Karelia
MOE	Ministry of Education and Youth, Ministry of Education of the Republic of Karelia
MOH	Ministry of Public Health, Ministry of Health of the Republic of Karelia
MSAH	Ministry of Social Affairs and Health of Finland
MSP	Ministry of Social Protection, Ministry of Social Wellbeing of the Republic of Karelia
NGO	Non-governmental Organization
NPHI	National Public Health Institute (since 1.1.2009 National Institute for Health and Welfare)
OL	Opinion Leader
PCA	Partnership and Cooperation Agreement
PHARE	Pologne-Hongrie: assistance á la restructuration des économies
PHC	Primary Health Care
PSU	Petrozavodsk State University
RK	Republic of Karelia
RF	Russian Federation
RSFSR	Russian Soviet Federative Socialist Republic
SI	Social Innovation
STAKES	National Research and Development Centre for Welfare and Health (since 1.1.2009 National Institute for Health and Welfare)
SU	Soviet Union
TACIS	Technical Assistance to the Commonwealth of Independent States
USSR	Union of Soviet Socialist Republics
WB	World Bank
WHO	World Health Organization

1 Introduction

> "Projects are temporary, they come and go. If the project manages to foster partners' confidence in their own capacity to carry on the process, it has accomplished the most important task" (Kananoja 1999a, 3-4).

The collapse of the Soviet Union (SU) in 1991 was an event of considerable magnitude. Signs of existing problems had been observed long before, but still the sudden dissolution of the entire socialist system was unexpected. The Soviet regime had managed to maintain its basic functions until the mid-1980s. The new era, initiated by Mikhail Gorbachev, with a strong policy of reforming and restructuring the Soviet system finally led to the breakdown of the Soviet state (e.g. Sakwa 2008, 9-15). In December 1991 the Union of Soviet Socialist Republics (USSR) dissolved into 15 independent post-socialist countries.

The newly independent states (NIS) started to develop in diverse ways but most of them aimed at establishing a market economy. The situation was difficult and challenging, as the desire to abolish all the Soviet structures as quickly as possible and move to a free market economy was strong among the decision-makers. The overall socio-economic crisis pervaded the entire society: all fields and levels. This study focuses on issues related to people's wellbeing and developments in the social sector.

In the Soviet Union, the provision of most welfare services and benefits was organised through state owned enterprises. The dismantling of the Soviet structures also demolished this basis. Closure and privatisation of the state enterprises contributed to the emergence of serious socio-economic problems, including unemployment, increase of poverty, deterioration of health of the population, decrease of the birth rate and an increase in mortality. The former social protection system was developed for different conditions and had limited possibilities to help people in need. The new situation required the development of new benefits and services (Kay 2011, 151). The need for reform of the existing social protection system was obvious.

Russia's road towards market economy and democracy has not been easy and errors have not been avoided. The transition from a centrally planned economy to a market economy has continued for over 20 years – much longer than many originally anticipated. The emerging Russian market economy does not resemble any of the western democratic market economies. In 2009, the Russian political system was characterised as "a hybrid of mass democracy[1] and authoritarian political culture" (Kivinen 2009, 118).

[1] Mass democracy refers to a system where all social classes are weakly organised and represented in the political system (Kivinen 2009, 116).

Under conditions of general socio-economic turmoil in Russia, the international community offered its support in tackling the multitude of problems and finding a way out of the crisis. Finland was among the first countries to start to provide Russia – and in particular the regions close to Finland's borders – with multilevel support in many forms. Finland's interest in supporting stability in Russia was understandable – the countries have a common border of 1 340 km.

This study originates from personal observations from over ten years of working experience on development projects[2] in Karelia. The external support was planned to be temporary and thus it was expected to lead to sustainable changes in Karelian society. However, it appeared to the author that only minor changes had taken place. Regular visits to Karelia and observation of rather slow pace of change raised the question whether and to what extent the external support had contributed to the development of the service provision system and to an improvement in the wellbeing of the Karelian population. In order to answer this question it was decided to take a closer look at the issue and through selected projects to examine what kind of changes occurred. This dissertation is the result of that examination. This study covers the years 1992-2008.

1.1 RESEARCH QUESTIONS AND HYPOTHESES

The main research question of this study is:

How widely were the social innovations introduced and/or supported by the international social sector[3] *projects adopted and diffused in the Republic of Karelia, and which factors influenced these processes?*

The question was further divided into three parts, which were considered separately:

1. How widely were the social innovations introduced *adopted* in Karelia?
2. How widely were the social innovations introduced *diffused* in Karelia?
3. Which factors influence diffusion and adoption of innovations in general terms and in particular with regard to the selected cases?

Qualitative research is described as a process of learning and obtaining new information, within which new questions arise during the process. It is seldom about the testing of hypotheses but these may emerge and be formulated during the research process. (Alasuutari 1994, 189, 240.) This study started with the "guiding

[2] In this study development cooperation refers both to the cooperation with the developing countries of Asia, Africa and South America and to that with the FSC.

[3] In this study social sector is understood widely and includes the health care sector and education sector (as it relates to child welfare). In the Russian literature health care and social protection are considered as a part of the *social sphere* (sotsial'naia sfera), which in addition to health care includes and social protection also education, culture, art and sport (Kurilo et al. 2007, 249).

hypothesis"[4] that information about the innovations introduced was not efficiently disseminated to districts and institutions beyond the pilot areas. However, as the research proceeded the guiding hypothesis proved insufficient and another hypothesis was formulated. Consequently, in addition to the research questions the following two hypotheses were formulated:

1. Only the pilot districts benefitted from the cooperation and the introduced social innovations
2. No significant institutional changes resulted from the projects

If the research questions answer the questions concerning the continuation of the processes started in the framework of the projects, these two hypotheses shed light on the consequences of the cooperation.

1.2 RESEARCH CONTEXT, THEORETICAL APPROACH AND METHODOLOGY

The specific geographical target area of this study is the Republic of Karelia[5] (RK), the most north-western part of the Russian Federation. Despite formal independence, Karelia is not a sovereign state but part of the Russian Federation and subordinate to it.

Contextualisation of the research is a central characteristic of qualitative research. Context refers to historical, social and political issues (Creswell 1998, 250; Stake 1995, 16; Merriam 2002, 4) and describes the specific circumstances and other factors under which the phenomenon researched take place. Knowledge of the context helps to understand, analyse and explain the results. In this case it was necessary to consider

1. The relationship between the districts and the centre in the Republic of Karelia and the position of Karelia in the Russian Federation
2. The impact of the federal reforms on Karelia
3. The socio-economic situation in the Russian Federation as reflected in Karelia and its districts
4. The communication channels
5. The role of informal institutions
6. The influence of the external factors.

[4] Marshall (1995, 37) notes that a guiding hypotheses "illustrates for the reader some possible directions the researcher may follow". The guiding hypothesis was strengthened when I was planning the field trip in Karelia. During the planning a Karelian colleague said that there was no sense in visiting the most remote districts as "some of them are so far away and the roads are in a poor condition" and that anyway "they do not know anything about these projects".

[5] Hereafter, Karelia refers only to the Republic of Karelia (cf. Oksa 1999, 285-289). Karelia on the Finnish side of the border is referred to as Finnish North Karelia.

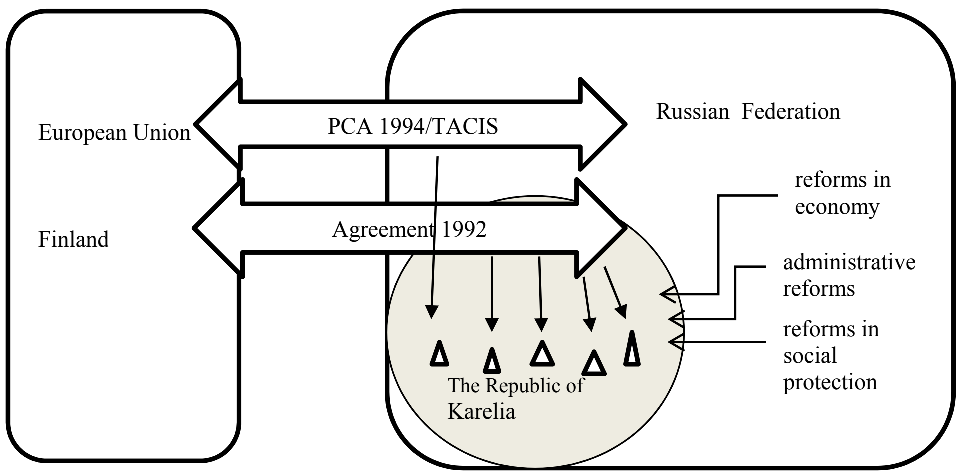

Figure 1: Context of the study

Figure 1 illustrates the context and relations which influenced the cooperation with the Republic of Karelia. The frames and objectives for the cooperation were set in the international agreements between the EU and Russia and between Finland and Russia. The five case projects considered in this study were supported by the European Commission, the Government of Finland and other Finnish actors.

Finland and Finns were among the first to start to re-establish contacts with their eastern neighbours and especially with Russian Karelia. An agreement on cooperation in the common border regions was signed between Finland and the Russian Federation (RF) in 1992[6]. Finland's strategy for cooperation with its neighbouring areas was formulated in strategy documents approved by the Government of Finland. The aim of Finland's bilateral neighbouring area cooperation was to support the process of creating the prerequisites for economic and industrial cooperation, to promote regional stability and balanced economic and social development and to prevent the spread of adverse phenomena to Finland. (Ulkoasiainministeriö 1993, Ulkoasiainministeriö 1996, Ulkoasiainministeriö 2004). With Finland's accession to the European Union in 1995, the Finnish-Karelian border became the first common border between the EU and Russia.

The European Union (EU) and the Russian Federation signed the Partnership and Cooperation Agreement (PCA) in 1994[7]. Previously, in 1989 the EU had launched

---

[6] Suomen tasavallan hallituksen ja Venäjän Federaation hallituksen välinen sopimus yhteistyöstä Murmanskin alueella, Karjalan tasavallassa, Pietarissa ja Leningradin alueella. FINLEX, Valtiosopimukset: 62/1992. http://www.finlex.fi/fi/sopimukset/sopsteksti/1992/19920062/19920062_2 read 21.3.2009.

[7] The PCA came into force only in 1997, but joint projects were started before that. In 1996, the EC together with the Russian federal authorities decided on a large health care and social sector project in the Republic of Karelia.

the PHARE[8] and in 1991 TACIS (Technical Assistance to the Commonwealth of Independent States) programmes. These programmes aimed to support the former socialist countries (FSC) during the transition period. The fields of cooperation and target areas of the TACIS programme were determined by the indicative and action programmes, which were drawn up with the partners[9]. One of the fields of cooperation was in assistance addressing the social consequences of transition. All the five case projects selected were implemented at local level under pressures resulting from changes at the district, republic and federal levels.

The Karelian leadership recognised the advantage that cooperation would provide in combatting the problems and challenges in Karelia and has afterwards assessed international cooperation as one of the most important instruments of social and economic development in the Republic[10].

Everett M. Rogers' (2003) diffusion theory forms the theoretical basis for this study. Rogers' theory has been widely used in different disciplines when researching e.g. innovativeness, the rate of adoption[11] or the role of individuals in the diffusion processes[12]. Compared to other aspects of diffusion research, there have been relatively few studies on the effects of social and communication structures on diffusion and adoption (Rogers 2003, 25). In this study, both are considered.

This study examines which factors influenced the adoption and diffusion of the innovations presented by the case projects. The diffusion process is divided into two stages, external and internal, which are considered separately. Consequently, the influence of the three groups of variables on three different processes, external diffusion, adoption and internal diffusion, is examined.

For this study, Rogers' concepts of innovation, innovation development, diffusion, and of the variables influencing adoption and diffusion were of most interest. Innovations can be of diverse character but they are often understood as something technical and related to business. The distinctive feature of the innovations examined in this study is that they are characterised as *social. Social innovations* refer to measures carried out in the frames of the case projects and which, either directly or indirectly, aimed to improve the wellbeing of the Karelian people.

As noted above, the context and its impact on the phenomenon studied should be carefully considered. In this study, the institutional framework is characterised by the features of an economy in transition[13]. Despite the fact that Rogers mentions

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[8] Originally created in 1989 to assist Poland and Hungary, later the programme covered also the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia, as well as Bulgaria and Romania. Until 2000 the countries of the Western Balkans (Albania, Bosnia-Herzegovina and the former Yugoslav Republic of Macedonia) were also beneficiaries of Phare. However, as of 2001 the CARDS programme (Community Assistance for Reconstruction, Development and Stability in the Balkans) has provided financial assistance to these countries.

[9] For more e.g.TACIS 2000, x-xi

[10] www.Karelia.gov.ru visited 29.3.2010

[11] the relative speed with which an innovation is adopted by members of a social system (Rogers 2003, 23)

[12] See Rogers (2003) The Rise of Diffusion Research Traditions (43-93) and A Typology of Diffusion Research (94-101).

[13] Here economy in transition refers to transition, or transformation, of the socialist planned economy to a market economy. During this period there are simultaneously two economic systems: the receding socialist and emerging capitalist. (cf. Valtonen and Noro 2004, 36-39.)

social system as one of the variables that influence diffusion, due to the context, his approach was extended with some central concepts of the theory of institutional change, which are introduced in order to clarify the role of institutions on the diffusion and adoption processes.

This study applies mainly qualitative research methods. Qualitative methodology calls for interpretation, observations and analyses: "... the qualitative researcher tries to preserve the multiple realities, the different and even contradictory views of what is happening" (Stake 1995, 12). This approach is well suited to this study as it allows in-depth consideration of complexities and processes, to explore where and why the policy and local knowledge and practice are at odds, to study informal and unstructured linkages and processes. (Stake 1995, 41 and Merriam 2002, 3-5.)

The main sources of information for the empirical part of the study were the project documents, publications, newspaper articles, interviews, survey and information received through personal contacts. This study uses literature published in Finnish, English and Russian. As the diffusion and adoption of innovations is examined through several case projects this is a multi-site collective case study. The case projects are in an instrumental role i.e. the projects themselves are not studied or evaluated but a certain phenomenon is examined through them (see 4.2). The selection criteria for the cases are introduced in Section 4.2 and the case projects in Chapter 5.

1.3 ADDED VALUE OF THE STUDY

Social sector cooperation with Karelia and projects implemented in its frames has rarely been evaluated. Although, for instance, the TACIS project considered in this study was monitored regularly during its life, the results and/or consequences were not assessed afterwards. In 1997 and 1998 the Ministry for Foreign Affairs of Finland produced two annual reports about the cooperation in Finland's neighbouring areas, which included a brief general description of health and social sector cooperation (MFA 1997b, MFA 1998). The sustainability or consequences of the cooperation were not the subject of assessment until 2010, when the MFA decided to carry out a wide evaluation of cooperation with the neighbouring areas (Aarva 2011[14]). The evaluation brought successes and failures to light and proposed recommendations for their adjustment.

Why is the study of the diffusion of innovations in Karelia necessary? Is it not sufficient to look at the Russian Federation and the general development trajectories and policies? In the author's opinion, in regard to the issues discussed in this study, it is not. Firstly, the Russian Federation is an enormous country with notable differences between its regions. Development processes in peripheral regions, such as Karelia, seldom receive attention or attract researchers (Laine 2003,

[14] In total 55 projects in diverse fields implemented 2004-2009 were evaluated; 12 of them concerned health care and social protection.

31). This study focuses on Karelia as one of the subjects of the Russian Federation[15] and explores how and to what extent this relationship influences regional developments. The results and experiences are useful for planning future cooperation not only with Russia but also with other countries in corresponding conditions of social change. Secondly, since the beginning of the 1990's, the European Union – including Finland[16] – has invested millions of Euros in supporting social sector reform in Karelia. However, as noted above, the donors have not – until the MFA in 2010 – examined what and how sustainable results have been achieved[17]. Thirdly, although this study focuses on social sector projects, its connections with other sectors and its location among them should be taken into account. The social sector cannot be developed in isolation from other sectors. This study aims to discuss some of these connections and their influence on developments in the social sector. Finally, although business and social innovations are of diverse character, they also have similarities and aim at improving the existing situation. In the author's opinion, the business innovation development process includes viewpoints which could also be used in the development of social innovations and which would promote their sustainability.

Despite the fact that EU and Finnish funding for the social sector cooperation with Karelia is clearly on the decrease, in all probability it will continue in some forms into the future. For this reason, it is important to consider how to make the best use of the financial inputs for the benefit of both parties. This study aims to contribute to the development of social sector cooperation first by identifying factors that need special attention in planning of joint cooperation, and second by examining the role of different actors in the diffusion and adoption processes.

1.4 LITERATURE REVIEW

There is an abundance of literature on the Soviet Union and the reasons for its dissolution. However, for this study information dealing with developments during the past twenty years in Russia and in particular in Karelia was of greater interest. This section first presents publications on Karelia relevant for the study at hand. Next the motives and nature of the western aid to the former socialist countries is briefly reviewed, and finally the wider context of the study – comparable social reforms in other former socialist countries, are reviewed. Literature on social innovations is presented as part of Chapter 2.

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[15] For more see Chapter 3.1
[16] In the period of 1990 – 2007 Finland's grant money to the Republic of Karelia totalled 37 million Euros. The amount covers all sectors (Salo 2007). The exact amount of the social sector support granted to Karelia was not available in the Ministry of Social Affairs and Health of Finland (MSAH) or in the Ministry for Foreign Affairs of Finland (MFA).
[17] Aarva's evaluation report (2011) noted that, in several instances, there is no information available about whether the results of the projects were in use or if processes continued after the project.

1.4.1 Publications on Karelia

The geographical location of Karelia close to Finland has meant that Russian Karelia is a relatively well-known and studied area in Finland. Due to this, most of the literature concerning Karelia has been published in Finnish. The literature on Karelia mostly concerns economic development and business, history, the forest industry, culture and the environment. Instead, there is a dearth of studies in the area of health care and social protection. Nevertheless, there are some publications, which proved very valuable for this study especially when describing the institutional context (Chapter 3).

Although *"Russian Karelia in Search of a New Role"* was already published in 1994 (Eds. Eskelinen, Oksa and Austin) its content, on the history of Finnish-Karelian relations and the socio-economic situation in Karelia at the beginning of the 1990s includes a lot of information relevant to this research.[18] Changes in the wellbeing of the population are mentioned in different contexts but the issue is directly addressed in Marina Popova's (1994) article *"Social Welfare during the Economic Transition in Russian Karelia".*

The history and changes that Karelia went through in the late 20th century are comprehensively described in *"Rise and Fall of Soviet Karelia"* (Eds. Laine and Ylikangas 2001). This book mainly deals with the development of Soviet Karelia and the birth of Russian Karelia in the 1990s. *"Social Structure, Public Space and Civil Society in Karelia"* (Ed. Melin 2005) examines diverse phenomena of transitional Karelia, and contains among others valuable articles by Jukka Pietiläinen *"Media in the Life of Russians"* about the role of and changes in the use of diverse media in Russia, and by Arseniy Svynarenko *"Growing to Be a Citizen: Civil Society and Youth Policies in Russian Karelia"* about the development of civil society in Karelia.

Regis Rouge-Oikarinen's doctoral thesis *"Cross-border cooperation in a changing Europe: the case of the European Union Tacis Programme (1996-2004) as a tool for cross-border cooperation in neighbouring areas of Finland"* provides useful information about Finnish-Karelian cross-border cooperation. The thesis is based on a wide field study and covers 115 TACIS projects, 43 of which were implemented in Karelia. Five of these are related to health and social protection.

In addition to the above there are at least three reports worth mentioning. The first is the first – and so far the only – report on *"Poverty in the Republic of Karelia"* written by Timo Piirainen in 1997. Ali Arsalo and Sanna Vesikansa's report *"Experiences of Finnish cooperation in the health and social sectors in the Republic of Karelia, North-western Russian Federation"* (2000) describes and assesses the first years of the cooperation. The report by Hannu Ijäs *on "Kunnan sosiaalitoimen asiantuntemus lähialueyhteistyössä Karjalan tasavallan sosiaalihuollon reformin kuvaus kuntatoimijan näkökulmasta"*[19] (1999), is based on his personal experiences and includes an assessment of the changing character of social sector cooperation and the roles of the actors involved in it.

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[18] As Jari Metsämuuronen notes (2005, 37) an old source does not mean that the information is outdated.
[19] Expertise of municipal level social work in neighbouring area cooperation Description of the social sector reform in the Republic of Karelia from the point of view of a municipal actor.

The only publication which covered almost the whole research period *"Sotsial'no-ekonomicheskie preobrazovaniia v Respublike Karelia (1990-2005 gg)"*[20] is in Russian and written by the Karelian authors Anna Kurilo, Evgeniĭ Nemkovich and Evgeniĭ Seniushkin (2005). The book describes the socio-economic situation in Karelia during the last years of the SU, changes that got under way in the mid 1980s' and the challenges faced by the Republic at the turn of the millennium. The book includes valuable information and statistics on Karelia.

In 2010 a collection of articles *"Witnessing Change in Contemporary Russia"* was published. The article by Elina Hemminki, Meri Larivaara, Tatiana Dubikaytis, Mika Gissler, Anna Rotkirch and Olga Kuznetsova *"Pecularities in Doing Public Health Research in Russia"* describes very realistically – and as the title suggests – the peculiarities of research work in Russia. The observations in many respects coincide with those of this study, made during the fieldwork in Karelia in 2008. It confirms the crucial meaning of informal networks for people in their everyday lives. Kaarle Nordenstreng's and Jukka Pietiläinen's *"Media as a Mirror of Change"* provides valuable information on how the collapse of the socialist system affected media and media consumption in Russia. In the same collection, Markku Kivinen's *"The Political System in Contemporary Russia"* discusses the issues directly related to this study, namely the challenges facing Russia in the near future and the development of the Russian political system and welfare regime.

Another collection of articles *"Perestroika" Process and Consequences* (Eds. Markku Kangaspuro, Jouko Nikula and Ivor Stodolsky) was also published in 2010. The book includes 15 articles related to perestroika: what it was and what happened during and after it. For this study the most valuable article is Jukka Pietiläinen's *"Perestroika and Changes Reporting of Social Problems in Newspapers"* that describes how writing on social problems changed in Karelian newspapers between the years 1985 and 1991.

In 2011, just before finalising this manuscript two publications of interest and relevant to this study appeared. In January *"Gazing at Welfare, Gender and Agency in Post-socialist Countries"* (Eds. Maija Jäppinen, Mari Kulmala and Aino Saarinen) was published. This contained Linda Cook's *"Russia's Welfare Regime: The shift Toward Statism"*, which discusses the change and character of the current Russian welfare policies after 2005 when the turn from a liberal to a statist welfare model took place. The same publication included Meri Kulmala's article *"Rethinking State-Society Boundaries in a Small-Town Context of Russian Karelia"*, which describes how public structures and civil society organisations in the framework of the Social Service Centre are tackling social problems in Sortavala, Karelia.

Linda Cook's "*Post communist Welfare States Reform Politics in Russia and Eastern Europe"* (2007) does not discuss Karelia but provides an interesting account of the development of welfare policies in Russia from 1990 until 2004. References are made to corresponding changes in Poland, Hungary, Kazakhstan and Belarus. Cook through specific examples illustrates the reasons for the inconsistent development of welfare policies in Russia.

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[20] Original in Russian Социально-экономические преобразования в Республике Карелия (1990-2005 гг.) in English "Socio-economic Changes in the Republic of Karelia in 1990-2005"

1.4.2 Motives and nature of the western assistance for the former socialist countries

Though the motives, interests and hidden agendas of the donors are connected to the theme of this study, the issue is beyond its main focus and is touched only briefly below. Janine Wedel (1998) interestingly describes in her book, "Collision and Collusion: the strange case of western aid to Eastern Europe 1989-1998", the motives and nature of the western (mainly American) aid to Eastern European countries during the first years after the collapse of the socialist system. At the turn of the 1980s, the U.S.A. and the western European countries started to develop special aid programmes, including the new Marshall Plan[21] in order to carry out the task of returning the former socialist countries "to the western home harbour"[22] .

She argues (17-22, 29) that the western donors, organisations and other actors had already before the collapse of the Soviet Union in 1991, "at their fingertips new agencies, procedures, and mechanisms to facilitate aid efforts in the Second World "[23]. Their motives were much the same with regard to the developing countries: "to hold communism at bay, to ensure economic and political stability, and to create markets for the West". However, an essential difference between the two groups of countries was that in the case of the former socialist countries "it was about exorcising the legacies of communism itself" requiring "more dramatic and wide-ranging change".

Expectations on both sides were high: "the West would help the East, and the East would show its gratitude through loyalty and quick reform" (ibid. 22). In addition to financial help and political models, the West would provide the East with economic strategies and cultural identity. The reality did not fully correspond to the expectations of the former socialist countries who, instead of loans, debt relief and technical assistance, expected to receive the aid mainly in the form of grants.

The western donors were very optimistic about the duration of the transition to a market economy: the Americans estimated that it would take five years while the Europeans made a more cautious estimate of a decade or more. Wedel notes that despite the failures and mistakes on both sides in the preparation and implementation of the aid programmes, good results were achieved especially in the frames of long-term, targeted assistance. Establishment of "normal" relationships between West and East and the interchange of people and ideas are mentioned as examples of good results.

An Estonian scholar Tiina Randma, in her article, "Pitfalls of Foreign Aid: Lessons learnt from Estonia" (2002), considers the western aid, its impacts and results from the point of view of a recipient country. Based on the experiences in

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[21] On the original Marshall Plan see Secretary of State of the U.S.A George C. Marshall, Commencement address at Harvard University Cambridge, Massachusetts June 5, 1947. http://www.usaid.gov/multimedia/video/marshall/marshallspeech.html_visited 17.7.2010

[22] "In practical terms, this meant joining the European Union, NATO, OECD, GATT/WTO and the rest of the Euro-Atlantic alphabet soup, whose membership in effect define what is to be a European state" (Sutela 2003, 73-74).

[23] By "Second World" Wedel (1998, 11) refers to the nations of the former Eastern Bloc and the former Soviet Union, by "First World" to the western countries and by "Third World" to developing countries.

Estonia, she mentions the lack of policy planning and strategic management in the recipient country as one of the main problems with regard to the evaluation of the impacts of foreign aid. She notes that foreign aid evaluations tend to focus more on outputs than on effects and that "There is little donors can do if recipients do not have clear policies and strategic management in place". She emphasises that in order to achieve sustainable end results, the external aid should support the recipient country's own development plans.

Randma mentions donors' poor knowledge of a recipient country and organisations, lack of links to power and insufficient sharing of information as factors which influence the results. Insufficient sharing of information is a problem on both sides: the donors and change agencies do not exchange real and specific information with each other, at least in part, because they may be competitors and information is shared only in cases when they are directly collaborating in frames of some project. In a way a parallel situation exists inside the recipient countries: the bodies and organisations compete for international projects and often do not want to share "their" foreign partner with anyone else.

One issue slowing down utilisation of the results is that the aid providers promote what they know best, i.e. their own country's policy approach, which may lead to the transplanting of their models to the recipient countries. Randma also notes that promoters of democracy have often oriented their work to strengthen NGOs and local governments thereby counterbalancing the dominant power of the central government, while senior central government officials and politicians might be as important target group. She concludes that the donors and their local partners should identify all those key persons in the society "who are likely to be of help in implementing plans or policies developed with the assistance of foreign aid". (cf. Wedel 1998, 6-7, 34-38, 183-190.)

1.4.3 Social sector reforms in the other former socialist countries

In order to assess the value of this study it is necessary to consider its results in a wider context. For this purpose, the literature addressing similar processes – reforms of health and social sectors and diffusion and adoption of corresponding social innovations – was examined. Studies on the diffusion of social innovations are still rare. Instead there are studies on the experiences of the transition countries in the adoption of new models and methods. Some of these reports were reviewed for this study.

The most relevant publications proved to be the country reviews published, since 1996, by the European Observatory on Health Systems and Policies[24]. The series of publications, "The Health Care Systems in Transition (HIT)" or "Health Systems in Transition" (since 2006) provide analytical descriptions of the health care systems in different countries and their reform processes. The structure of the publications is uniform. They were published between the years 1996 and 2011.

[24] The observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden, and the Veneto Region of Italy, UNCAM (French National Union of Health Insurance Funds), the LSE (London School of Economics and Political Science, and the LSHTM (the London School of Hygiene & Tropical Medicine).

The depth of analysis varies but each of them includes the required and comparable information. Even though several of them were published about ten years ago and many changes may have taken place since then, their use was considered justified as they illustrate the process of transformation with different perspectives, complexities and challenges as well as successes. Below, for reasons of clarity, the respective countries are referred to rather than the editors of the reviews[25].

From the point of view of this study, the shortage of information in the country reviews about the social protection reforms is a difficulty. Only some of them include brief descriptions of the development of social protection. On the other hand emphasis on international social sector cooperation with Karelia is explicitly on health issues. In order to illustrate the change processes with regard to social protection Appendix 1 presents information gathered about the new legislation adopted in the European transition countries since the beginning of the 1990s. The information was collected from the web pages of the International Social Security Association (ISSA) and includes the information that the member states have delivered[26].

Health sector reforms of 18 European and 9 Asian transition countries were studied and information on selected issues gathered in table 1. Information concerning Kosovo[27] is based on articles about reforms and concerning Bosnia and Herzegovina[28] supplemented with articles.

The countries differ from each other to a great extent by: 1) territory from about 11 000 km^2 of Kosovo to 2 727 300 km^2 of Kazakhstan, 2) population: 1.34 million of Estonia to 45.7 million of Ukraine, and 3) a population density of 1.7 / km^2 in Mongolia and 130/km^2 in the Czech Republic. All these factors are meaningful in reforming the health and social service systems. Russia is not included in this review as it is discussed in Chapter 3.

In most of the countries reviewed the *general transformation* process of society including reform of the health and social sectors started during the first half of the 1990s. The routes and rates varied greatly by country. Ten[29] of the European FSCs joined the European Union after the millennium and seven of them (Croatia, the former Yugoslav Republic of Macedonia, Albania, Bosnia and Herzegovina, Montenegro, Serbia, Kosovo) have applied for membership. In order to gain to the

[25] Authors' names are given in the last page of Literature used.
[26] http://www.issa.int/Observatory/Country-Profiles visited 6.6.2011
[27] "Rebuilding a health care system: war, reconstruction and health care reforms in Kosovo" (European Journal of Public Health, 2006, Vol. 17, No. 2, 226-230) by Dragudi Buwa and Hannu Vuori. "A case study of health sector reform in Kosovo" by Valerie Percival and Egbert Sondorp in Conflict and Health 2010:4:7. National Background Report on Health Research for Kosovo (under UNSCR 1244) by Lul Raka and Dukagjin Pupovci.
[28] "Diffusion of complex health innovations - implementation of primary health care reforms in Bosnia and Herzegovina" by Rifat A Atun, Ioannis Kyratsis, Gordan Jelic, Drazenka Rados-Malicbegovic and Ipek Gurol-Urganci in Health Policy and Planning 2007:22:28-39.
[29] In 2004: Czech Republic, Estonia, Latvia, Lithuania, Hungary, Poland, Slovakia and Slovenia and in 2007: Romania and Bulgaria.

EU the countries need to meet the requirements[30] set by the European Council. The pre-accession process is strongly supported by the EU and, for instance, the legislation is developed to correspond to the EU requirements[31]. For instance, Croatia between the years 2007- 2012 will receive on an annual basis about 150 million Euros and the Former Yugoslavia Republic of Macedonia about 85 million Euros[32].

After independence at the beginning of the 1990s, *decentralization* of power was started in all the countries examined except Azerbaijan, Tajikistan, Turkmenistan and Belorus. Specific circumstances affected the progress of decentralization. For instance, even though in Albania decentralization was started and independent local governments were established, the authority long remained concentrated in the central government[33]. It was characteristic of many countries that some parts of the old structures and institutions were retained in parallel with the new ones (e.g. Albania 2002, 22-23).

The pressure for *health care reform* was recognized and supported by the decision-makers in all countries. Kurt Weyland (2006, 142-143) describes health care reform as a never-ending process, which rarely constitutes a bold, comprehensive transformation "Instead, governments change one component of the multidimensional health system at a time. Health reform is a drawn-out, gradual process not a drastic break point like social security privatization". Reform of the health care system is a complex process that concerns and involves different sectors and aspects of operations at the same time, in an environment that is in permanent change (e.g. Atun et al. 2007; Weyland 2006, 182-183).

Improvement of the primary health care (PHC) system was central in most countries, but the introduction of new models of PHC was challenging due to difficult socio-economic conditions (Atun et al. 2007, 39-30). For instance in Tajikistan

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[30] Any European country that respects the principles of liberty, democracy, respect for human rights and fundamental freedoms, and the rule of law may apply to become a member of the Union. The Treaty on the European Union sets out the conditions (article 6, article 49). The speed with which each country advances depends solely on its own progress towards our common goals. The applicant country must meet a core of criteria before negotiations start. The so-called "Copenhagen criteria ", set out in December 1993 by the European Council, require a candidate country to have: stable institutions that guarantee democracy, the rule of law, human rights and respect for and protection of minorities; a functioning market economy, as well as the ability to cope with the pressure of competition and the market forces at work inside the Union; the ability to assume the obligations of membership, in particular adherence to the objectives of political, economic and monetary union. In 1995 the Madrid European Council further clarified that a candidate country must also be able to put the EU rules and procedures into effect. Accession also requires the candidate country to have created the conditions for its integration by adapting its administrative structures. While it is important for EU legislation to be transposed into national legislation, it is even more important for the legislation to be implemented and enforced effectively through the appropriate administrative and judicial structures. In addition, the EU must be able to integrate new members: it needs to ensure that its institutions and decision-making processes remain effective and accountable; it needs to be in a position, as it enlarges, to continue developing and implementing common policies in all areas; and it needs to be in a position to continue financing its policies in a sustainable manner. http: //ec.europa.eu/enlargement/the-policy/conditions-for-enlargement/index_en.htm

[31] See Appendix 1 that aptly illustrates adaption of new legislation.

[32] Croatia: Annual support varying from 141 million in 2007 to 160 million in 2012. http: //ec.europa.eu/enlargement/candidate-countries/croatia/financial-assistance/index_en.htm. Macedonia: The amount has increased annually being in 2007 58.5 million euro and in 2012 already over 105 million euro. http: //ec.europa.eu/enlargement/candidate-countries/the_former_yugoslav_republic_of_macedonia/financial-assistance/index_en.htm.

[33]http//albania.usaid.gov/?fq=brenda&m=shfaqart&aid=57&kid=52&tit=Local_Government_and_Decentralization_in_Albania_%28LGDA%29 visited 7.7.2010

(2000, 16) and Azerbaijan (2004, 31-32), the Soviet model of provision of health services was still intact after the millennium i.e. enterprises provided health care and social services for employees. Despite the general drive to break with the socialist past[34] some features of the Semashko health care model, mainly the widespread service provision network, were found to be worth retaining e.g. in Albania, Azerbaijan, Belorus, Georgia, Kazakhstan, Kyrgystan, Moldova, Mongolia, Slovakia, Tajikistan, Ukraine, Uzbekistan and Turkmenistan. In Belorus[35] the health system reform did not begin until 2003 (2008, 97-99).

Despite the relatively weak position of the respective ministries of health in several countries, e.g. Albania (2002, 16-18, 22-24), Kazakhstan (2007, XV-VXII, 25-26,138-139), Ukraine (2004, 17, 109-110, 121-122) and Macedonia (2006, 17, 20, 85-87), they had a central role in the reform process.

Due to the *complexity* of the system reforms several factors slowed down the pace of reform, including political instability, continuous changes in the leadership, resistance to change, the deeply embedded culture of administration, the lack of resources and a long-term development programme, the lack of management skills, financial restrictions, the continuation of the old working practices and the low priority of health issues on the policy agenda. (Azerbaijan 2004, 58; Albania 2004, 76-79; Kazakhstan 2007, 109, 138; Latvia 2001, 50; Macedonia 2006, 78; Moldova 2008, 95-96, 117; Mongolia 2007, 121; Romania 2000, 14; Slovakia 2004,92, 104-106, Tajikistan 2000, 65-66; Turkmenistan 2000,15-16, 69; Ukraine 2004, 103-122.) Decentralization also resulted in new challenges within the health care system due to simultaneously undermining the relations between actors inside the sector, the lack of a quality control mechanisms and the diminishing regulatory capacity of the MOH (e.g. Armenia 2006, 133).

Numerous *new laws* related to health and social care were adopted in transition countries in the 1990s. New laws were often considered as solutions to problems and not as tools for the design and implementation of socioeconomic policy (Channel 2005, 8; Nystén-Haarala 2001, 2; WB 2006, ix, 17-18). Despite the considerable amount of new legislation, the basic structural problems facing the system led to situations where the laws adopted did not have the desired effect (e.g. Azerbaijan 2004, 58, 2010, 94; Turkmenistan 2000, 36; Ukraine 2004, 121). Enforcement of new laws was also delayed due to economic inadequacies (Azerbaijan 2004, 58; Bulgaria 2007, 78), vested interests (Ukraine 2004, 35-39, 100), changing political, social and economic contexts (Romania 2000, 73), non-applicability in the existing circumstances (Channel 2006, 5), and due to a lack of implementation and enforcement capacities. New laws were often drafted in very limited timeframes, which was reflected in the end result; sometimes they were so complex that they required immediate changes and amendments (e.g. Romania 2000, 72, 75).

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[34] According to the report "the general public was suspicious of even the use of the term "planning" as it seemed to be a relic of the Soviet system (Lithuania 2000, 18; also Latvia 2001, 264)).

[35] Belorus is characterised as a titular democracy headed by a President with very strong executive powers and with a limited separation of executive, legislative and judiciary branches. Officially Belorus is a socially oriented market economy in which many features of the Soviet administrative-command economy are retained. The pace of economic reform has been evolutionary and moderate. (Belorus 2008, 3-5.)

Wade Channel (2005) notes, that the "hasty transplant syndrome" was one of the critical problems in legal reform assistance. Foreign laws were used as models for new countries without sufficient translation and adaptation into the local legal culture. In some cases the laws were simply translated from one language to another. Channel states that the time limits given for law drafting in project frames are too short (from 1 to 5 years) when compared, for example, with the American system, where the process from inception to law can take from five to ten years.

All the countries examined received support from *international donors* in their reform processes. The majority of the FSCs suffered from severe financial crises and the assistance provided by the western actors was not only warmly welcomed and necessary but also expected (Wedel 1998, 27-29; Shekter 2003, Lagus 2003, Lopez-Claros 2003). However, the impact and consequences were not solely positive (e.g. Wedel 1998, 183-197). Wedel states (1998, 6-7) that the western actors were too well prepared for their rescue operation – they were ready to show what and how to make the changes even before the beneficiaries had managed to define what needed to be changed.

International actors influenced developments in the transition countries in diverse ways. In Romania, international organizations affected the contents of the health reform by raising the issue of the orphanages, thereby forcing the government to take urgent action (Romania 2000, 72). Also, the influence of the consultants' native health systems, in some cases, became obvious. In Romania the introduction of a capitation payment and contracting is influenced by U.K. experiences while the health insurance system draws on the German example (2000, 72-73; cf. Mongolia 2007, 140).

Changes in leadership, administration and health care structures led to the delay of reforms in several countries e.g. Romania (2000, 72-75), Kazakhstan (2007, 109-110) and Mongolia (2007, 130). In some countries changes of the key persons in the country's administration prevented continuity of the reforms. For instance in Romania, between 1996 and 1998, the Minister of Health changed six times and there were eight different Secretaries of State. In Mongolia, the situation was to some extent even worse; here the top civil servants, who play a key role in setting agendas and the design and implementation of health policies, come and go with ministers. From 1990 to 2007 the Mongolian Government changed eight times and the Minister of Health seven times. Consequently, the Government and the MOH lacked the institutional memory and there was not sufficient continuity to coordinate the reform process.

Absence of a clear development policy and a strategic framework may be reflected in poor coordination of international assistance (e.g. Armenia 2006, 147, Azerbaijan: 2010, 94). In Kazakhstan, a lack of coordination of the cooperation led to the implementation of pilot projects that ran far ahead of the policy agenda (2007, 138). In Kyrgyzstan (2005, 94) and Uzbekistan (2007, 155-190), the establishment of special coordination units for health care reforms avoided this problem. The lack of a national policy on health care reform as well as the commitment of the government to its implementation hindered the reform process in several countries

e.g. Azerbaijan (2004, 58-59; 2010), Armenia (2006, 112-114), Kazakhstan (2007, 110), Mongolia (2007, 119-130, 138-140), Romania (2000, 67-76) and Ukraine (2004, 103-121).

The role of external donors and agencies increased in several countries due to an absence of local leadership resulting in fragmented reform (Albania, Azerbaijan, Bulgaria, Georgia, Kyrgyzstan, Moldova, Romania, Kazakhstan, Tajikistan). In Mongolia, the donors "not only provided critically needed assistance for the social sector, but also influenced certain policies and programmes, which have shaped the health policy agenda" (2007, 26-27). Good results were achieved with external support in PHC and child health, for example, but due to the considerable amount of financial support (as of 2005 13% of health expenditure) "the continued influence of international donors on existing health policies and programmes since the mid-1990s have undermined the Government's leadership role, resulting in donors driving current health care reforms".

Even though health issues were included in national policy agendas in several countries the results were rather modest. In the case of the Ukraine, the main legislative act "Principles of Legislation on Health Care in Ukraine" was adopted as early as 1992. However, an absence of clearly defined priorities and plan of implementation resulted in inconsistent and often contradictory policies. In the HIT Ukraine (of 2004), it states that Ukraine still lacks an integral long-term programme for reforming the national health care system. The report also notes that the reasons for postponing radical health care reforms in the Ukraine are mainly of a political nature, as reform implementation will require the government to confront its inability to meet its commitments to free health care with existing funds. (Ukraine 2004, 103-121.)

The Ukrainian case raises questions about the aims and motives of the external actors. If the general political situation remained unstable, the role of the MOH weak and the innovations tested[36] in the frames of joint projects were not adopted and diffused, what caused the donors to grant more funds to the country? At what point should the recipient country show their commitment to the cooperation and start to allocate their own additional finances in the health sector? Answering these questions is beyond the scope of this study but is of crucial importance when planning future cooperation.

Despite the challenges described above, there are several good examples of testing, adoption and diffusion of innovations in the frames of international cooperation and with external support (e.g. Azerbaijan 2004, 58-59, Armenia 2006, 112-114, 137, Croatia 2006, 97-98; Kazakhstan 2007, 110, Bosnia and Herzegovina, Kyrgystan 2005, 53-55, 107-108, Georgia 2002, 37-38; Uzbekistan 2007, 155-160,160-162, 190 and Mongolia 2007, 119-138, Atun et al. 2007, 36).

[36] The common practice in development projects is to test the innovations in certain agreed areas or institutions. This practice concerns not only European projects but is universal (see Weyland 2006, 57).

The conclusions based on this review are the following:

1. International support was of crucial importance for the transition countries suffering from insufficient finances
2. International support promoted the start of health care reforms
3. An important prerequisite for the successful implementation of complex health system reforms is a holistic long-term development programme or a strategy that the decision-makers are committed to
4. The structures supporting the change should be developed simultaneously with the reform process
5. In order to yield optimal benefit, the international support should be coordinated by the beneficiary and integrated with the local resources.

1.5 STRUCTURE OF THE STUDY

This introductory chapter briefly describes the research context, methodology and theoretical approach, and concludes with a literature review. The second chapter presents the central concepts and theoretical framework applied. The third chapter describes the socio-economic context of the study, the Republic of Karelia. The fourth chapter introduces the methodology and methods used. The fifth and sixth chapters report the empirical part of the study. First the five case projects are outlined, after which the findings of the study are summarised and discussed. The last chapter includes general considerations regarding the issue examined and suggestions for further research.

1.6 REMARKS FOR THE READER

In this study is used the Library of Congress transliteration system without diacritics, except for cases when convention has decreed otherwise. For instance, Pitkyaranta not Pitkiaranta and Danishevski - not Danishevskiĭ. The soft sign is omitted from the end of the words and names.

Table 1: Review of the health care systems in transition

	Albania, 2002	Armenia, 2006	Azerbaijan, 2004, 2010	Belarus, 2008	Bosnia and Herzegovina 2002[37]	Bulgaria, 2007	Croatia, 2006	Czech Republic, 2009	Estonia, 2008	Georgia, 2009	Hungary,2004
Decentralisation/ health sector	+	+	-	+	+~	+	+	+	+	+	+~
Pace of change in policy	-	-	-	-	-	~	+	+	+	+	+
New institutions established	+	+	~	+	~	+	+	+	+	+	+
Old institutions functioning	+	+	+	+	~	+	~	+	~	~	n/a
MOH (role in reforming)[39]	+	+	+	+	~	+	+	+	+	-	~+
Health care reform	-93	-96/ -01	-99/ -08	03	97/- 00	98	-93- -01	-95/ -01	-91	-95/ -06	-87[40] /-94
Political commitment of the HC authorities	+	~	~	+	~	+	+	+	+	+	+
Political will of the decision-makers towards change	+	~	~	+	~	+	+	+	+	+	+
New legislation supporting the change process	+	~	+	~	+	+	+	+	+	+	+
Enforcement of the laws	-	-	-	~	~	~	+	+	n/a	+	+
Public satisfaction with services	~		-	-	-	-	-	+~	~+	-	-
Under table payments	+	+	+	~	+	+	+	-	~	+	+
Reform of H/c financing system	+/~	+	+/~	~	~	+	+[42]	+	+	+	+
Semashko model or some parts of it in use	+	~	+	+	-	-	-	-	-	-	-
Parallel h/c systems	-	~	+	+	-	n/a	n/a	-	-	-	n/a

Marks: + yes, - no, ~ some actions taken, changing, weak
* Based on information taken from the country profile pages of ISSA (International Social Security Association) on 15.5.2011 Appendix 1.

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[37] As a consequence of the Dayton Agreement of 1995 two distinct health care systems are operating in the country. International technical cooperation and support for development has been very considerable financially, but has suffered from a lack of interagency coordination at the system level. (http://www.ohr.int/dpa/default.asp?content_id=380)

[38] Macedonia represents a case study of a system moving from highly decentralized to more centralized structures. However, at present the political aim is to move back to a decentralized system. As stated above, the system in place in the Socialist Federal Republic of Macedonia (pre-1991) was highly autonomous and decentralized, with health service provision and financing controlled and managed at municipal level (15). With the transition to an independent country, there was a need for central health planning and for this purpose the Ministry of Health was established in 1991. The Law on Health Care was passed in the same year setting out a process to centralize the financing and stewardship functions, at the same time aiming to preserve some autonomy for the provider structures at local level. Against a background of limited resources, the need for an effective central planning infrastructure took precedence over the development of a management role at regional level. The establishment of the Health Insurance Fund contributed to the further strengthening of the central strategic and operational planning.

Latvia, 2001, 2008	Lithuania, 2000	Kazakhstan, 2007, 2011	Kyrgyzstan, 2005, 2011	Kosovo, 2006	Macedonia, 2006	Moldova, 2002, 2008	Mongolia, 2007	Poland,1999, 2005	Romania, 2000, 2008	Slovakia, 2004	Slovenia, 2002, 2009	Tajikistan, 2000, 2010	Ukraine, 2004, 2010	Uzbekistan, 2007	Turkmenistan, 2000
+	+	-	+	n/a	~[38]	+	+	+	+	+	~	~	+	~	~
+	+	-	~	n/a	~	-	~	+	-	~	+	~	-	~	~
+	+	+	+	+	+	+	~	+	~	+	+	~	~+	+	~
-	~	+	+	+	+	+	+	~	+	+	n/a	+	+	+	+
+	+	n/a	+	+	~	+	+	+	+	+	+	~	+	+	+
-96	91	89/ 92	-96/ -06	n/a	91	-98/ -07	-94	-89/ -99	-93/ -06	-90/ -02	-92 -08	-93/ -02	-92/ -07[41]	96	-95
+	+	-	+	+	+	+	~	+	+~	~	+	-	~	+	+
+	+	+	~	+	+	+	~	+	+~	~	+	-	~	+	~
+	+	+	+	+	+	+	~	+	+	+	+	~	~	~	~
n/a	n/a	-	~	n/a	~	~	n/a	~?	-	~	~	~	-~	~	~
-	+	n/a	-	n/a	-	-	-	-	-	-	+		-	-	-
+	+	+	+	n/a	~	+	+	+	+	+	~	+	+	+	+
+	+	~	+	+	+	+	+~	+	+	+	+	+	~-	~	-
-	n/a	~	+	n/a	-	+	~	-	n/a	~	-	~	+	+~	+
+	+	n/a	n/a	n/a	n/a	+	n/a	-	+	-	+	+	+	+	+

[39] Despite the fact that the MoH had a central role in health care reform in several countries they often were quite weak and had only limited power over the finances.
[40] Health care reform was already started in the 1980s but due to a lack of consensus on the modernization its implementation has been slow.
[41] The review states that no large-scale reform has been undertaken and that it is hard to call the changes in Ukrainian health care reforms (2010, 172).
[42] Health financing was centralized.

	Albania, 2002	Armenia, 2006	Azerbaijan, 2004, 2010	Belarus, 2008	Bosnia and Herzegovina 2002[37]	Bulgaria, 2007	Croatia, 2006	Czech Republic, 2009	Estonia, 2008	Georgia, 2009	Hungary,2004
H/c Professionals											
- status	-	n/a	-	-	+	-	+	~	+	+	n/a
- salary[43]	-	-	-	~	-	-	+	~	+	n/a	-
- satisfaction	-	-	-	n/a	-	-	~	~	~	n/a	-
- incentive system	-	-	-	~	-	~			~	+	-
GP training /health care professionals	-	+	-	+	+	+	+	+	n/a	-	+
Sufficiency of the health care professionals[44]	-	-	-	+	~	+	-	+	-~	+	+
Service provision											
- public	+	+	+	+	+	+	+	+	+	+	+
- private[45]	+	+	+	~	~	+	+	+	+	+	+
Quality of services[46]	-	~	-	-	~	~	+	+~	n/a	-	~
Attitudes towards family medicine	+	+	+	+	+	+	+	+	+	+	+
Health insurance[47]	-95	n/a	-08	-	-97/ -99	-98	-93	-91	-91	[48] v?	-89
Role of external funding in reform process	+	+	+	-	+	+	+	na	-	+	+
WB	+	+	+	n/a	+	+	+		+	+	+
USAID	+	+	+	n/a	n/a	+	n/a	n/a	n/a	n/a	+
EU	+	+	n/a	n/a	+	+	n/a	n/a	+	+	+
WHO	+	+	+	+	+	+	+	n/a	n/a	+	n/a
Other	+	+	+	+	+	+	+	n/a	+	+	+
Dependence on external funding	+	na	+	na	na	na	na	na	na	na	na
Equality of the districts	-	-	-	-	-	-	-	-	~	-	-
NGOs in health care service provision	+	+	+	-	n/a	+	+	na	+	~	+
New legislation in regard to social protection*	96-06/5	98-05/3	05-10/6	98-05/12	n/a	98-06/7	97-00/8	98-10/32	95-10/22	05/1	96-09/25

Marks: + yes, - no, ~ some actions taken, changing, weak
* Based on information taken from the country profile pages of ISSA
(International Social Security Association) on 15.5.2011 Appendix 1./number of acts

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[43] Here is referred to salaries in public sector.
[44] Here – indicates that the number of educated health professionals was not sufficient; + that there was a sufficient number of professionals, but in many cases not of the correct specialisation. Due to historical background there was a superfluity of specialists doctors and shortage of GPs and nurses.
[45] In many countries were restricted to dental care, pharmaceutical disciplines and diagnostic services.
[46] Improvement of quality of services has been recognised in many countries but they lack effective mechanisms for assuring and monitoring the quality (e.g. Czech Republic, Hungary, Ukraine).
[47] This refers to the year when the first law on health insurance of any type (mandatory, voluntary, private) was adopted or when a plan in health insurance was first approved (e.g. Tajikistan, Uzbekistan). The second year mentioned refers to a new law that changed the earlier practice.

Latvia, 2001, 2008	Lithuania, 2000	Kazakhstan, 2007, 2011	Kyrgyzstan, 2005, 2011	Kosovo, 2006	Macedonia, 2006	Moldova, 2002, 2008	Mongolia, 2007	Poland,1999, 2005	Romania, 2000, 2008	Slovakia, 2004	Slovenia, 2002, 2009	Tajikistan, 2000, 2010	Ukraine, 2004, 2010	Uzbekistan, 2007	Turkmenistan, 2000
-	-	-	-	-	~	-	-	~	-	-	n/a	-	-	-	-
~	-	-	-	-	~	-	-	-	-	-	~	-	-	-	-
~	n/a	n/a	n/a	-	~	-	-	~	-	-	n/a	-	-	~	-
+	~	~	-	-	-	-	~		-	-	~		-	-	~
+	+	+	-	+	+	+	+	+	-	-	+	-	+	+	-+
-	+	-	+	n/a	+	+	+	~	-	+	-	-	-	~	+~
+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
+	~	~	+	+	+	~	~	+	+	+	+	~	~	~+	~
~	n/a	-	-	n/a	-	-	-	-	-	-	+	-	-~	-	~+
+	+	+	+	+	n/a	+	+	+	+	~	+	+	-	-	+
-98[49]	-91	-	-97	+	-91/ -91 -00	-98/ -04	-94/- 02	-99 -03	-97	-94/ -02	-92	-05[50]	-96[51]	-04	-96
+	n/a	+	+	n/a	-	+	+	n/a	+	~	n/a	+	-	+	~+
+	+	+	+	+	+	+	+	[52]	+	+	+	+	+	+	+
n/a	n/a	+	+	n/a	n/a	+	n/a	n/a	+	+	n/a	+	+	+	n/a
+	+	n/a	n/a	n/a	n/a	+	n/a	n/a	+	+	+	+	+	n/a	n/a
+	+	+	+	n/a	+	n/a	+	n/a	+	+	+	+	+	n/a	+
+	+	+	+	+	+	+	+	n/a	+	+	+	+	+	+	+
na	na	na	na	na	na	na	+	na	+	na	na	+	na	na	na
-	-	-	-	n/a	-	-	-	-	-	+	+	-	-	-	-
+	~	+	+	+	~	+	~	+	+	~	~	~+	~	-~	~
96-09 /20	95- 10/17	95-05 /7	98- 05/3	n/a	00- 09/4	99/1	96- 01/4	96- 09/21	96- 10/23	96- 09/26	96- 04/10	983/	99- 05/8	05- 09/2	05/1

[48] Only private health insurance.
[49] In Latvia is a tax based insurance system.
[50] A plan was introduced in 2005.
[51] Legally possible but in practice plays a very minor role in Ukraine except for railway workers, who are all insured (2010, 147-148).
[52] Not mentioned in the review, however e.g. WB and EU have widely supported health reform in Poland.

2 Theoretical framework

In order to be able to examine diffusion of innovations it was necessary to determine a solid theoretical basis for it. Diffusion theory offered a suitable approach for studying innovations but in this case – due to the institutional context – it was necessary to widen the approach and supplement the theory with another (Figure 2).

Concept	→	Theory	→	Scope	→	Chapters
Innovation	→	Diffusion	→	Innovation development process	→	2, 5, 6
Institution	→	Institutional change	→	Emergence, development and change	→	2, 3, 5, 6

Figure 2: Key concepts and theories applied

The diffusion theory suggests that certain variables influence the rate of adoption and diffusion of innovations. One of these is the social system. However, as the institutions are in a central position in the study it was considered necessary to take a close look at institutions. Consequently, in the study two theories are applied: diffusion theory and theory on institutional change.

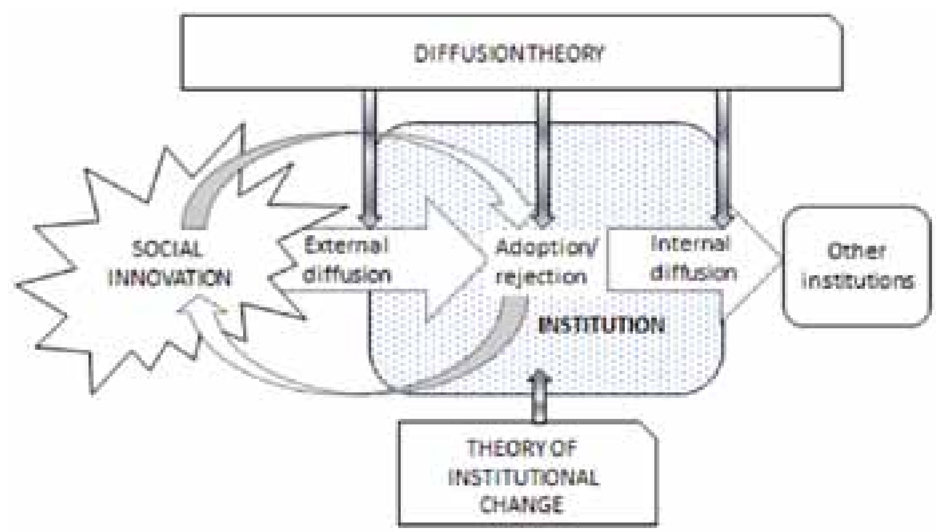

Figure 3: Theoretical framework of the study

As will be described in subchapter 2.2 below, in this study diffusion is divided into two stages: external and internal. For both of these, as well as for adoption, the influence of three different groups of variables is considered separately. Innovations are considered as models which can and should be modified to suit the local conditions and which may, even after a prior rejection, be subsequently reconsidered, modified, and adopted. Adoption is not considered as a precondition for internal diffusion but may serve to promote it. (Figure 3.)

This chapter first describes the concepts of institution and institutional change, their emergency and change. Subsequently are presented the key concepts of the diffusion theory and variables modified for this study.

2.1 THEORY OF INSTITUTIONAL CHANGE

The innovations introduced and supported by joint international projects are central to this study. However, innovations do not emerge, develop or diffuse in a vacuum but in a certain institutional environment. The aim of the innovations introduced was to facilitate the development and change of Karelian institutions of various types.

Institutional change refers to institutional formation, development, elaboration, or change within an institutional form, deinstitutionalisation and re-institutionalisation (Jepperson 1991, 152). Lindner (2003, 913-916) characterises institutional change as the introduction of new rules or interpretations of rules that supplement or replace the existing ones. Institutional changes are characterised as costly and difficult, consequently they are neither frequent nor routine (Powell 1991, 197).

Institutions take shape and change due to a contradiction between the institutions and their environment or with other institutions, from external shocks, internal crises, or innovations. Other drivers of change are formal laws and informal norms and practices due to human actions. (Ebbinghaus 2005; Friedland and Alford 1991, 249-251; Heiskala 2003, 24; Jepperson 1991, 43-149, 152; North 1990, 3-6; Roland 2004, 11-16; Scott 1995, 33, 52-61; Van de Ven et al. 2008, 90, 151-152.)

In the case of this study the entire institutional framework – the socialist system – was in the throes of changes which pervaded all levels and fields of the societies. As Figure 1 (Chapter 1 p. 18) illustrates pressures from the internal Russian reforming processes as well as outside occasioned changes.

The literature presents different definitions for institution. On the basis of a review of definitions on institutions, Jűtting (2003, 11-15) classifies institutions according to the degree of formality, different levels of hierarchy and the area of analysis. Innovations are divided into formal and informal, into hierarchical levels and into economic, political, legal and social. Jepperson (1991, 43) considers institutions as important determinants of the quality of governance of a society which can "simultaneously empower and control". They give both frames and a basis for our everyday lives. Douglass C. North (1990, 3-6) defines institutions as "humanly

devised constraints that shape human interaction" which reduce uncertainty by providing a structure for everyday life. North (1990, 3-6, 36-54) divides institutions into *formal* and *informal,* which underlie and supplement the formal rules. *Formal* institutions refer to "the rules of the game" laws, constitutions, political, judicial and economic rules, and *informal* to codes of conduct, traditions, practices and norms of behaviour. North's definition of institutions is applied in this study with the exception that organisations are considered as formal institutions[53].

Gerald Roland (2004, 11-16) writes about *fast-* and *slow-moving institutions.* In fact, the *formal* and the *fast-moving* and the *informal* and the *slow-moving* institutions resemble each other not only in content but also in the way of change. Both *formal* and *fast-moving* institutions can change rapidly and by authoritative decisions, while *informal* and *slow-moving* institutions require slower change and cannot be changed by authoritative decisions[54]. *Informal* institutions do not react immediately to changes in *formal* institutions (North, 1990, 45). Changes can be both *continuous* and *discontinuous*. Some institutions may go through smaller changes over a longer period of time, and then change very abruptly, while others tend to change continuously, albeit slowly.

Institutions are generally resistant to change: in the case of *formal* institutions changes may threaten the position of those in power (North 1990, 83; Martin 2006) and in the case of *informal* institutions they may threaten traditional and/or deeply rooted practices and modes of action. The balance of power between the parties determines the dynamics of change of *formal* institutions. (e.g. Deacon 1992, 43-44; Roland 2004, 14-20.)

Different kinds of institutions appear in diverse forms and stages in this study. Firstly, the agreements on cooperation created the basis and framework for the cooperation. Secondly, the social innovations aimed to produce changes in both *formal* and *informal* institutions. Thirdly, the institutions acted both as subjects and as objects in the cooperation and at three levels: federal, regional and local. They were also in key positions in deciding on the adoption or rejection and diffusion of the innovations. Finally, the people who were either involved in the implementation of the projects or whom the changes concerned had different backgrounds (cultural, professional etc.), which likewise affected the processes discussed.

Institutionalisation refers to the process of embedding of a custom or norm within an institution or society. It proceeds by steps, and is a transformation process during which a new practice or mode of action gradually replaces the old one. Institutionalisation is not simply present or absent, but often *in process.* Institutionalisation may occur accidentally as a by-product in creating other structures, whereas deinstitutionalization is seldom accidental. Transmission, maintenance (either voluntarily or by sanctions) and resistance to change influence

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[53] North (1990,7) distinguishes between organisations and institutions: institutions determine the opportunities in a society and organisations are created to take advantage of them, as the organisations evolve, they alter the institutions.
[54] Alanen (2003, 229), referring to Dahrendorf, notes that it is possible to establish political institutions in six years but the formation of cognitive patterns of everyday life and adequate lifestyles may take as long as 60 years.

the speed of institutionalisation. Continuity increases the process of acceptance and institutionalisation. New practices, which are not internalised and followed voluntarily, can be maintained by sanctions. (Jepperson 1991, 151-152; Powell 1991, 195; Roland 2004, 12-16; Zucker 1991, 83-105.)

Institutionalisation is not always successful. It is called "incomplete" when the influence of external pressures is partial, inconsistent or short-lived and the results are only weakly institutionalised (Powell 1991, 199-200). This also concerns cases when, for example, the authorities encourage the adoption of new practices but lack the power to mandate them, or when government legislates certain policies but leaves the actual implementation of the policy unspecified.

Transplanting refers to a direct transition or copying of an institutional model to another environment. Transplanting may seem tempting but includes risks. Roland (2004, 17-27) notes that institutional transplanting of *fast-moving* institutions is likely to be unsuccessful due to the differing cultural system and backgrounds, including the autonomous *slow-moving* institutions. Transplanting is more likely to work when, in addition to the institutions, the technology, knowledge and culture are transplanted. This is also emphasised by North (1993), who argues that if the formal rules of one economy are adopted in another environment the performance characteristics may appear very different due the different informal norms and enforcement.

Powell et al. call failures in transplanting "*unsuccessful imitations*", which may lead to unintended changes[55], especially if the routines or forms are transplanted across socio-political contexts (1991, 199-200). This kind of imitation may create local modifications and lead to the occurrence of new hybrid arrangements.

Recombination happens when practices are borrowed from dissimilar sources. This can result in an unstable situation, if the borrowed practices are contradictory to each other (Powell 1991, 199-200). Roland (2004, 8-9) notes that institutional systems are not modular constructions where one module can replace another.

In the frames of international development cooperation different approaches and methods are used to achieve the set goals. Their selection is influenced by the motives of the actors involved, professional skills, available resources, and operational environment among others. Even with a good approach and intentions the outcome may sometimes – due to unexpected impacts from the environment – turn to undesired or unanticipated.

2.2 THEORY OF DIFFUSION OF INNOVATIONS

Theory of diffusion of innovations dates back to the beginnings of research in the social sciences, particularly in the field of sociology. Although the concept was originally introduced in the early 1900s by Gabriel Tarde, Georg Simmel and

[55] Rogers (2003, 30-31) mentions three kind of consequences that may result as a result of adoption or rejection of an innovation: desirable versus undesirable; direct versus indirect and anticipated versus unanticipated.

the German-Austrian and British diffusionists, it was Everett Rogers who in 1962 published the modern theory. Research on the diffusion of innovations model began with the Bryce Ryan and Neal C. Gross investigation (1943) of the diffusion of hybrid seed corn among Iowa farmers. However, the influence of their study reached far beyond the study of agricultural innovations and outside the rural sociology tradition of diffusion research that they represented. Since the 1960s the diffusion model has been applied in a wide variety of disciplines, including public health, education, communication, marketing, geography, psychology, sociology, and economics. From the diffusion studies in various disciplines there emerged a series of generalizations about the process of innovation diffusion.[56]

Rogers defines *diffusion* as the process in which an innovation is communicated through certain channels over time among the members of a social system. This is the general definition for diffusion applied in this study. The main elements of diffusion are innovation, communication channels, time and social system (Rogers 2003, 5-35).

Rogers (2003, 221-222) proposes five groups of variables that affect the rate of adoption: 1) the five perceived attributes of innovations: relative advantage, compatibility, complexity, trialability and observability, 2) communication channels, 3) the type of innovation decision, 4) the nature of the social system, and 5) the extent of change agency[57]'s (CA) promotion efforts. Due to the scope and context of this study these five groups of variables were modified and re-grouped. The re-grouped variables are introduced later in this chapter (Section 2.2.3). The first section introduces the concept of innovation and social innovation (Section 2.2.1). Subsequently it describes how diffusion and adoption are understood and defined in this study (Section 2.2.2).

2.2.1 Innovation and social innovation

Innovations are often viewed as positive as they are supposed to be useful, profitable, constructive and able to solve problems. They emerge from the recognition of a problem or need, which stimulates the creation of an innovation to solve the problem. Innovations may also originate from a shock[58], which, according to Van de Ven, Polley, Garud and Venkataraman (2008, 28-29), need not always be negative as it may trigger innovations and lead to cooperation among several actors to pursue the same goal.

[56] For more on the history of diffusion research Rogers 2003, 39-101.
[57] Here: The foreign intermediary actor between the donor and the local partner of the beneficiary country, who in practice implements the project with the LP and reports to the donor.
[58] Examples of such shocks include new leadership, product failure, a budget crisis, loss of market share.

Although innovations[59] are frequently perceived as technological, they may be of very diverse *character* e.g. medical, preventive[60], incremental, technical, administrative, business and social. Unlike technological innovations, which often aim to advance scientific knowledge and not necessarily apply that knowledge to practical problems (Rogers 2003, 137-138), social innovations endeavour to *solve problems and improve the existing practices*. (e.g. Hämäläinen and Heiskala 2004, 45-48; Hämäläinen 2005, 197-204; Hämäläinen 2008, 100; Pol and Ville 2009; Rogers 2003, 156-157, 234-244; Schienstock and Hämäläinen 2001, 55-59; Van de Ven et al. 2008, 9-11, 28-30.)

The concept of social innovations[61] is relatively new and there is no established definition of the term[62]. The concept is applied in different situations and there is no consensus regarding its relevance or specific meaning, "It is a term that almost everyone likes, but nobody is quite sure what it means" (Pol and Ville 2009).[63] Pol and Ville state that although business innovations[64] (BI) are pervasive generators of human wellbeing, there are other innovations that have significant impact on social performance and which are in the nature of a public good. These innovations are called social innovations. They emphasise that business and social innovations are different, yet overlapping concepts. The intersection of the two sets of innovations is called the set of bifocal innovations (ibid., Figure 1 p. 884).

Scholars consider social innovations as reforms related to the regulation, politics and organizational structures and model of operations which improve the performance of a society (Hämäläinen and Heiskala 2008, 10-11), as one of the means of social reform (Saari 2008, 18) or as "new ways of reaching specific goals" (Schienstock and Hämäläinen 2001, 55-59). Hämäläinen and Heiskala (2004, 46) note that in a way all innovations are social in the sense that they change the prevailing practices (also Heiskala 2003, 25-26). Pol and Ville (2009, 879) see them as prime movers of institutional change.

Taipale and Hämäläinen (2007, 16-17) divide social innovations of the health and social field into *systemic* and *practical* depending on their aims and Nikula et al. (2011, 18-19) talk about micro and macro level phenomena depending on what

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[59] Innovation and invention are sometimes confused but they are different things. *Invention* is always something new, an opening, while *innovation* presents something *new for the adopters*. (Van de Ven et al. 2008, 9) Conger introduced in 1974 a term of "social invention" which is defined as "a new law, organisation or procedure that changes the ways in which people relate to themselves or to each other, either individually or collectively" (Conger 2009).

[60] Preventive refers to an innovation that aims to avoid some unwanted event in the future. Accordingly, the desired result or consequence can only be observed after some time. In contrast, an incremental – that is, non-preventive – innovation provides a desired outcome in the near future. (Rogers 2003, 176, 233-236.)

[61] Pol and Ville (2009, 883) introduce a concept of a *pure* social innovation that refers to social innovations addressing needs that are not satisfied through the market mechanism.

[62] The background and use of the concept both generally but especially in the Finnish context are briefly described in Saari 2008 (18-29).

[63] An example of the use of the term can be found in the publication "100 Innovations from Finland" (Taipale 2007). The book introduces 108 Finnish social innovations from eight fields of life from a schizophrenia project to eroticism in everyday life.

[64] Hereafter in this study, for the sake of simplicity, innovations are divided into business (BI) and social (SI) innovations. Business innovations refer to innovations developed primarily for profit seeking and social to innovations that aim to improve the wellbeing of the population.

level the social innovation takes place. The system changing character of social innovations is also emphasised by the Social Innovation Centre[65] that states "A true social innovation is systems changing – it permanently alters the perceptions, behaviours and structures that previously gave rise to these challenges."

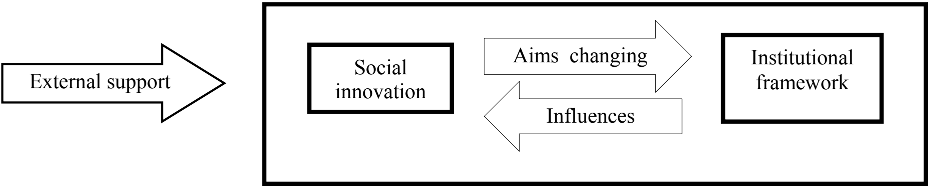
Pol and Ville (2009, 878-885) reviewed definitions given for SIs and discovered that they "revolve around new ideas conducive to human welfare enhancement". Based on the review they proposed the following definition: "an innovation is termed a *social innovation* if the implied new idea has the potential to improve either the quality or the quantity of life" (2009, 881).

As the foregoing illustrates, the concept of social innovation is still taking shape and although Pol and Ville's definition is close to the author's understanding of social innovation, it was defined more concretely for the purposes of this study.

Social innovations in this study

Rogers' (2003, 12-17) definition of innovation as "an idea, practice or object that is perceived as new by an individual or other unit of adoption" is widely cited and forms the basis for the definition of social innovation in this study. Therefore, the *newness* for the adopters is the decisive aspect. (cf. Nikula et al. 2011, 17-18.)

In this study social innovation is defined as "an action or measure, perceived as new by the local partners, which aims to improve the wellbeing of the population and is introduced and/or supported by international projects supporting social sector reform in the Republic of Karelia".



Modified from Nikula et al. 2011, 29.

Figure 4: Interaction between social innovation and institutional framework and the role of external support

As noted in Section 2.1., institutions play a key role in this study. The social innovations developed in the frames of the projects aimed at changes in the existing structures, institutions and practices. However, the institutions simultaneously influenced the innovation development process, embedding and diffusion. This relationship is examined through the case studies introduced in Chapter 5.

[65] http://socialinnovation.ca/about/social-innovation, visited 19 June 2010

2.2.2 Diffusion and adoption

In project planning and implementation, project cycle management (PCM)[66] based on the logical framework approach (LFA) are widely used tools. PCM is a term used to describe the management activities and decision-making procedures used during the life-cycle of a project. It helps to ensure that projects are supportive of the overall policy objectives of development partners, relevant to an agreed strategy and to the real problems of target groups/beneficiaries, feasible, meaning that objectives can be realistically achieved within the constraints of the operating environment and capabilities of the implementing agencies and benefits generated by projects are likely to be sustainable (European Commission 2004, 17). The project cycle (PC) consists of identification, planning, implementation, monitoring and evaluation phases (MFA 1997, 9-10)[67].

The five phases mainly coincide with Rogers' innovation development process (IDP) which includes "all the decisions, activities, and their impacts that occur from recognition of a need or a problem, through research, development, and commercialization of an innovation, through diffusion and adoption of the innovation by users, to its consequences" (2003, 137-138)[68]. Besides their similarities, PC and IDP have clear differences.

Although both social and business innovations emerge from needs and external pressures, there are some obvious - and from the point of view of this study significant - differences. The main difference concerns diffusion. Rogers' IDP includes the phase of the *commercialisation* i.e. production, manufacturing, packaging, marketing and distribution of the innovation. A corresponding phase is not present in PC. Nowadays a dissemination plan is often included in the project plan, but the dissemination of information and the diffusion of an innovation are different things. Diffusion calls for decisions and often requires concrete changes in institutions and the operating environment. Commercialisation as a word does not fit well with development work, but with the idea behind it – to ensure that the innovation is adopted and diffused – is also appropriate for development cooperation. In the project context commercialisation could be considered as "preparation of diffusible products". BIs are developed taking into account the factors that *promote* their diffusion and adoption. This part, which could remarkably improve the sustainability[69] of the project results, could more also be taken into account in project planning. Project plans rarely include a diffusion plan, even though diffusion may be the *desired* end result.

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[66] In 1992 the European Commission adopted "Project Cycle Management" as its primary set of project design and management tools based on LFA. The first manual was produced in 1993 and the most recent update is from 2004. The LFA is a methodology for planning, managing and evaluation programmes. Both tools are widely used also by other actors.

[67] There are variations on the standard model but the main idea is the same. For instance, in the model presented by Van de Ven et al. (2008, 16, 23, 26) there are only three main stages: initiation, development and implementation/termination. EC PCM guidelines (2004, 16) gives five phases: programming, identification, implementation, formulation, evaluation&audit.

[68] Rogers discusses innovation process in an organization separately (2003, 417-435).

[69] In this study sustainability refers to the degree to which an innovation is continued over time after the external project funding ends. (cf. Rogers 2003, 476.)

Rogers (2003, 5-6) defines diffusion as a process in which an innovation is communicated through certain channels over time among the members of a social system. In this study diffusion is considered as a *two-stage process* consisting of *external* and *internal* diffusion (Figure 5).

Stage	Stage I - External diffusion	Stage II - Internal diffusion
Diffusion	From outside the borders of Karelia ⟶ Diffusion and piloting (adoption/ rejection)	Inside Karelia, across the district borders - - - - - - - - ⟶ (Adoption and) Diffusion
Actors	Joint efforts in the framework of projects	Local actors alone or supported by regional, federal or external CAs

Figure 5: Two-stage diffusion of innovations

External diffusion is characterised as a period and process of *joint planning and detailed introduction* of the proposed social innovation to the local partners (LP), "an uncertainty reduction process" (Rogers 2003, 232-233). Provision of detailed information about the SI at this stage is especially important in cases where the innovation introduced differs essentially from the existing practices and when strong resistance to the innovation can be expected. Failure to transmit all necessary information can result in diffusion failure (Rogers et al. 2005, 11). (cf. Marquand 2009, 150.)

The local partners may adopt or reject an innovation at any phase of the cooperation. Rogers (2003, 177) defines adoption as "a decision to make full use of an innovation as the best course of action available". This definition is applied in this study. Rejection[70] is a decision not to adopt an innovation and may be taken even after a prior adoption decision. Rejection may be either active or passive. Active rejection means that the decision on adoption was considered but then rejected whereas passive rejection means that the adoption was never really considered (ibid. 177-178).

Due to the nature of the social innovations of this study, their adoption in most cases required decisions from the local, regional or federal authorities[71]. *Adopters* of the SIs are defined as *the Karelian social sector authorities at different levels, institutions providing health and social services and professionals working in them.* (cf. Atun 2007, 32). Hereafter, the adopters and local actors are referred to as Local Partners (LP).

During the second diffusion stage, the same SI *or its modified* version is replicated beyond the pilot areas/institutions and is termed *internal diffusion*. Replication of innovations can take place in diverse ways: in the framework of new joint projects (Figure 6) or by local efforts (Figure 7). The pilot areas and institutions can be considered as a kind of "home nests" of the SIs.

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[70] Rejection is not necessarily absolute and final but the innovation may be re-invented later (Rogers 2003, 186-188) or "sent to the shelf" for along time (Van de Ven et al. 2008, 35).

[71] SIs may *embed in* working practices without any formal decisions about their adoption.

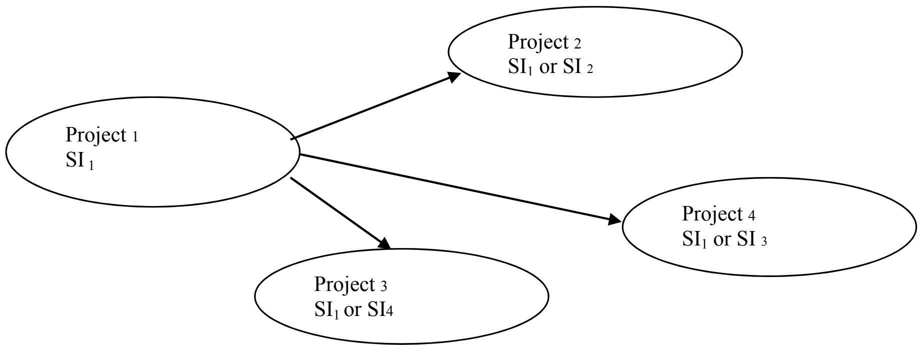

Figure 6: Diffusion by replication of the project

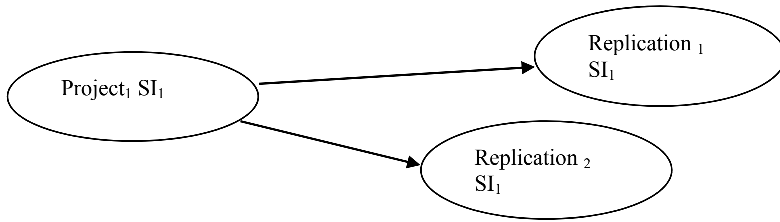

Figure 7: Replication of a tested social innovation by local actors

According to Rogers (2003, 395-402), in reality an actual diffusion system is a hybrid combination of certain elements of a centralized and a decentralized system. In a decentralized system innovations spread relatively spontaneously through networks, are re-invented by the adopters and meet the needs of the users more than in a centralized system.

Full adoption of an innovation requires the firm commitment of the local, and in some cases of the republic and federal, decision-makers. Therefore, consideration of the entire institutional framework and its influence on adoption of the SI is of crucial importance. (Popova 1994, 120-133; Nemkovič et al. 1994, 78-86.)

2.2.3 Variables influencing adoption and diffusion

An integral part of project planning and IDP is situation analysis, which includes an assessment of risks and assumptions. Political, economic, environmental, social and cultural conditions as well as institutional capacity, socio-cultural and gender equality aspects are suggested factors to be considered (e.g. Ulkoasiainministeriö 1997, 34; Ulkoasiainministeriö 2000). Such an assessment was carried out in all the case projects of this study (see Chapter 5). However, good background work and successful project implementation does not necessarily lead to adoption and diffusion of the innovation.

In light of the results of earlier diffusion research, Rogers (2003, Figure 6-1 p. 222) presents five groups of variables influencing the rate of adoption: perceived attributes of innovations, type of innovation decision, communication channels, the nature of the social system and extent of CAs promotion efforts in diffusing the innovation.[72] Due to the scope and context of this study the variables were re-grouped. The only group that remained the same as in Rogers' model is the perceived attributes of the innovations. Re-grouping and re-definition were considered necessary for the following reasons. Firstly, as described above the research context was complex and a detailed examination of the social system and its institutions, and both the formal and informal structures was required. Therefore, all the variables relating to the social system, including decision-making, were combined. The new variable is called *institutional framework* (Chapter 3). Secondly, in Rogers' model the role of CAs is notable. In this context, although the role of the external CAs is important, in particularly at the beginning, it is closely related to conveying information, consequently the CAs' role is discussed under *Communication*. Communication refers to communication channels and structures as well as communication between the project parties, with other actors and towards the general public. Accordingly, the variables were re-grouped as follows (Figure 8):

Rogers' categories of variables		**Categories modified for this study**
Attributes of the innovations	→	Attributes of the social innovations
Communication channels	}	Communication
Extent of change agents' promotion efforts		
Type of innovation-decision	}	Institutional framework
Nature of the social system		

Figure 8: Modified categories of variables

Each of the categories is described separately below.

Attributes of Social Innovations

Despite the fact that the five perceived attributes of innovations proposed by Rogers (2003, 219-266) proved relevant for this study, the number and character of the attributes may vary greatly. (cf. Van de Ven et al. 2008, 59-62.)

Relative advantage describes the superiority of the proposed innovation compared to the one it supersedes. The nature of the innovation determines the type

[72] There are also other kinds of classifications. E.g. Wejnert (2002) mentions three components influencing diffusion: characteristics of the innovations, (benefits and consequences); characteristics of innovators or actors (people, organisations, states etc. and their position in social networks), and characteristics of the environmental context (geographical setting, societal culture, political conditions, global uniformity).

of relative advantage e.g. economic, social, technological or other. Relative advantage denotes a promise of change for the better. The economic cost of an innovation may affect its rate of adoption[73]. Experience has shown that the sooner the advantage and results become visible the more easily the innovation is adopted. Consequently, in regard to *preventive* innovations the task is more challenging as the results can only be observed after some time or not at all. Relative advantage may also be connected to gaining higher status. (Rogers 2003, 229-240.) Based on her experiences for Swedish-Russian cooperation, Maria Lagus (2003, 296) notes that it seemed that the Russian organisations wanted to participate in international cooperation most of all because it increased their status and gave them more authority in their contacts with the Russian officials.

Incentives can be used in order to speed up the rate of adoption, to increase the relative advantage or to ensure the adoption. Incentives can be either direct or indirect payments in cash or in kind. They can be given to both potential adopters and diffusers as well as to individuals and systems, at the time of adoption or afterward (Rogers 2003, 236-238). Provision of incentives is quite common in project cooperation; however, there are big differences in their use[74]. In addition to payments in cash and in kind, the selection of a district or an institution for piloting can also be considered as an incentive. Although the pilot institution is expected to deliver specific inputs in project implementation, it often receives training, equipment and other benefits from the project.

Offering incentives is one diffusion strategy but it may endanger the continuity of the processes initiated[75]. For instance, payment of different kinds of compensation to local experts and partners or use and maintenance of the office and other equipment[76] may impair the sustainability of the development processes. Rogers points out (2003, 238-239) that where an innovation is adopted partly because of an incentive,"there is relatively less motivation to continue using the innovation … and so the innovation's sustainability may be lessened".

Compatibility is the degree to which an innovation is perceived as consistent with the existing socio-cultural values, past experiences, beliefs, previously introduced ideas and needs of the adopters. Compatibility positively affects adoption and is a confirming factor which reduces risks and makes the innovation more meaningful. Incompatibility with cultural values can block the adoption of innovations. (Rogers 2003, 240-241, 243-246; Rogers 1971, 145.) In addition to the above-

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[73] Rogers (2003, 233) also defines relative advantage also as a ratio of the expected benefits and the costs of adoption of an innovation.
[74] Examples are given in the case descriptions in Chapter 5.
[75] Marquand states in light of experiences of projects implemented in Siberia that "once the carrot of the study visit to Europe was no longer there, recruitment became very difficult indeed" (2009, 128).
[76] In the 1990s problems emerged due to the fact that most of the equipment purchased in the frames of the EU financed projects was of western origin. At that time, the western equipment was of better quality and the Russian partners often preferred it, however, problems occurred with the maintenance and procurement of spare parts for the equipment. Fortunately, the situation changed quite quickly when the quality of the Russian equipment started to improve and the western equipment became available in the FSU. In 2005, a representative of the Russian Ministry of Justice noted that they (= the ministry) prefer Russian equipment, because then they could be sure that no problems would arise with the service and spare parts. The same person said that their stores are full of unused western high-tech equipment (Notes Tuomi, June 2005).

mentioned aspects it is – in this context – also crucial that the innovations are congruent with the development policy or strategies of donors and beneficiaries.

A firm belief in the relative advantage of an innovation and ignorance of indigenous knowledge by the CA may lead to the introduction of an incompatible innovation (Rogers 2003, 254-257). Non-understanding or disregard for deeply engrained traditions and cultural values may lead to rejection or delay of adoption of an innovation. (cf. Järvinen 2007, 264-266.) However, the reason may also be simply insufficient situation assessment or misunderstanding. In the 1990s the Government of Finland supported building a centre for elderly Ingrians in Karelia and aimed to offer a modern model for service provision. As is well known, issues and practices related to health and social care are closely related to culture, tradition and attitudes. Although the project was successful, it encountered problems due to insufficient feasibility and background studies. The project assessment carried out by the University of Joensuu states that although the expertise of the Finnish trainers was of a high level, difficulties emerged in transferring the know-how in a situation where the problems related to services provided to old people differed greatly in quantity and quality from those in Finland. (Jämsen et al., 1998, 21-22.)

Innovation development also produces a contradiction: the more compatible an innovation is, the less change it represents. An idea that is completely congruent with the existing practice is not an innovation. Complex innovations can be introduced in packages or clusters of interrelated innovations, in which the adoption of one facilitates the adoption of the others. One should begin the introduction where the relative advantage is high and build from there. (Rogers 2003, 245-250; Dearing 2009, 510-511.)

Complexity is the degree to which an innovation is perceived to be difficult or easy to understand and use. It correlates directly with the adoption rate and may be a barrier to adoption (Rogers, 2003, 257-258). The social innovations examined in this study are complex, as they all assumed changes in both formal and informal institutions. Technically their implementation required changes in the legislation, the development of structures, in the provision of additional financial resources and also changing people's attitudes and ways of action.

The complexity of an innovation can be mitigated by a "step by step" approach, setting understandable, simple and realistic[77] milestones and building "on what is working while also focusing on what is not" (Shaw 2005). Vladimir Mikhalev (1996, 21) suggested that Russia should follow "a cautious gradualist approach" in the reform of the social security system as "radical restructuring may destroy the old system much faster than a new one can be created". If innovations are too complex or differ too much from existing practices they may meet strong opposition. Van de Ven et al. (2008, 54-55) suggests so-called "home-grown" changes,

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[77] Van de Ven et al. (2008, 31) based on their research and findings of 14 innovation development processes, state that the competition for financing for innovation development "created unattainable performance expectations for most innovation projects studied by Minnesota Innovation Research Program, MIPR. The initial project plans and budgets, coloured as they were with optimism, were used more as a vehicle to obtain resource commitments from investors or corporate sponsors than they were to develop realistic alternative scenarios of business creation".

which link and integrate the "new" with the "old", as opposed to substituting, transforming, or replacing the old with the new[78]. The complexity of an innovation is an aspect that should be thoroughly considered from different viewpoints including the socio-cultural aspects and traditions during the innovation development process.

Trialability refers to the degree to which an innovation may be experimented with on a limited basis. The importance of trialability – or piloting[79] – has been understood in the realm of development cooperation for a long time. It has become common practice to test and demonstrate new innovations in selected pilot districts and/or institutions during a project. However, experience has shown that the selection of the pilot area/s or institution/s is not easy. It may lead to situations whereby the same areas are selected again and again in the frames of different projects, while others are never chosen. This can lead to an increase in inequality between districts.

The last of the five attributes is *observability,* which describes the visibility of an innovation to others and relates positively to the rate of adoption. The more visible the results are, the more likely the innovation is to be adopted (Rogers 1971, 23; 2003, 258). The observability of an innovation depends on its character: the advantages of some innovations can be seen relatively soon, whereas with others only after some time or possibly not at all. Visibility can be improved through the distribution of information about the innovation and its consequences (see Communication below).

Communication

The question of *communication* is of utmost importance for diffusion. In this study communication is understood broadly to include the transfer of information, communication channels and structures as well as relations between different actors in frames or in relation to the cooperation. *Communication channels* are all the means by which information is conveyed from one individual to another. Communication is a process of transferring, creating, sharing and exchanging information (Rogers 2003, 18). In a way, in this study, the projects themselves serve as the main communication channels during the first stage of diffusion.

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[78] Kosonen (2004) studied in the small city of Vyborg in North-West Russia how the enterprises established in Soviet times, their successors and the new enterprises got over the change of the economic system in 1995-2002. She came to the conclusion that the socialist traditions cannot be interpreted only as impeding the development as they have helped some enterprises over the most difficult times and also the entire socio-economic community of Vyborg over the worst crisis. Temmes (2002, 7) also states that "One of the core questions in transitions is how to save the good achievements of the Communist era and the linkages with common European tradition in basic and higher education, in infrastructure, communication systems, and (….) in domestic and export industries". In regard to the last mentioned he emphasises that it is important to bear in mind that "it is also a question of the institutions of welfare state, which in Soviet system was inbuilt in the industrial organisations".

[79] Brian Martin (2006, 39-42) refers to testing social alternatives as "social testing", referring to the introduction of major social alternatives for the purposes of research, demonstration and social learning. He also states that social innovations are held in a straitjacket, as the powerful groups do not want results showing the value of an innovation they oppose. See also James W. Dearing (2009, 511) about experimental demonstration and exemplary demonstration.

In international cooperation, communication occurs in diverse forms and between different actors involved in the cooperation and concerned by it. In order to achieve sustainable results and guarantee utilisation of the achieved results, it is important that communication between different levels functions; that information flows from the top to bottom and vice versa and also horizontally between the actors.

Interpersonal contacts are considered the most effective communication channel, despite the fact that through the mass media it is possible to reach a large audience rapidly, disseminate information and change weakly held attitudes. Interpersonal contacts provide a two-way channel for the exchange of information and can persuade people to form or change a strongly held attitude. (Rogers 2003, 18-20, 204-205.)

Since the collapse of the Soviet system the number of newspapers, television channels, and media outlets has increased significantly in Petrozavodsk (Pietiläinen 2005, 99). According to a survey carried out in Karelia, the main source of information in terms of national and international issues was the television and for local issues newspapers (Pietiläinen 2005, 100-101, 115; Ministry of Defence 2008, 23). In the frames of project cooperation, information is often shared in seminars and training events, which, according to Peltola and Vuorento (2007, 55-56), are an effective form of information dissemination but not sufficient for the embedment of results. The reason for this is that often the same civil servants and decision-makers who already support the ideas presented attend the events.

In the diffusion of innovations, the existing *communication structures* and knowledge of the opportunities they afford are important. Communication structure is "the differentiated elements that can be recognized in the patterned communication flows in a system" and consists of different cliques, groups and the interconnections between them (Rogers 2003, 24). Network analysis[80] provides tools for the examination of communication structures, relationships within networks and between them. Both the communication structure and *communication networks* are multilevel and the location of an individual in these structures and networks has great meaning with regard to the receipt and sharing of information. (Rogers 2003, 24-27, 127, 337, 363.) Functioning administrative structures provide good channels for distributing and sharing information. Although communication structures and networks are not studied here in detail, the flow of information in these structures was examined in the survey (more in Chapters 5 and 6).

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[80] According to Johanson et al. (1995, 1) network analysis is not a single research method but a number of research techniques developed for the research of network materials or a number of techniques by means of which it is possible to collect and outline diversity of the social structures and observe the interdependence of social phenomena with each other. Richard Scott (1991, 3) sees network analysis as a "set of methods for the analysis of social structures, methods which are specifically geared towards an investigation of *relational* aspects of these structures". Granovetter (1973, 1360) argues that "the analysis of interpersonal networks provides the most fruitful micro-macro bridge". Some researchers take the view that network analysis also includes an idea of both informal and formal ways of examinating phenomena i.e. a chance to study the information flow, which cannot be otherwise directly observed (Lehtinen and Palonen 1999, 182). Also Knoke 1990, 8-9, 235 and Marsden in Carrington et al. 2005, 9.

Networks are good platforms for the exchange of information. They are usually characterised as voluntary, flexible, equal, reliable, reciprocal and temporary. However, they can also be used for exercising power, in that information may be targeted at only certain members of the network. In form, networks may be centralised or decentralised, and formal or informal. Centralised networks are thought to be more effective in the diffusion of innovations than decentralised networks (Valente 1999, 53). Decentralised networks are client controlled with a wide sharing of power and control by the members of the network (Rogers 2003, 394-401)[81].

Strong ties are considered to be efficient channels of sharing information however, not only strong ties are important. Granovetter (1973, 1364) argues that the weak ties[82] can sometimes be even more important for the distribution of information. The main significance of the weak ties is in the *bridges* which they can form between different groups. A bridge is "a line in a network which provides the *only* path between two points" (ibid. 1973, 1364). Through weak ties and bridges the information spreads beyond the frame of the networks and can reach large numbers of people from other networks. (Granovetter 1973, 1983.)

The importance of involving people in central positions in the administration and networks cannot be underestimated[83]. These people, called variously, *opinion leaders (OL), influential persons or champions*[84], possess a unique position at the centre of the system's communication structure and interpersonal communication networks. (Rogers 2003, 26-28, 414-415; also Van de Ven et al., 2008, 98-102, 113; cf. Martin 2006).

Change Agency

The funds granted for the case projects of this study were not given directly to Karelian beneficiaries. Instead, they were channelled through and administered by a third party, organization or agency that in practice carried out the project with the local partner. In this study this intermediary actor is called the c*hange agency/agent* (CA). The CA's role is that of a reliable partner, developer, innovator, and supporter and also of a communication link between the donor and the beneficiary. Unlike the case with BIs, the main aim is not to make the local partners adopt the innovation but to support them in finding the model that best suits their purposes.[85]

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[81] For more on the nature of networks see e.g. Johansson et al. (1995, 9-20), Mattila and Uusikylä (1999, 103), Barabási (2002).

[82] Granovetter (1973, 1361) defines weak ties as acquaintances and strong ties as friends (1983, 201).

[83] At the beginning of the 1990s some Finnish high-level politicians and influential persons considered Karelian relations important and kept the issue of cooperation on the agenda. These contacts created the basis for Finnish-Karelian cooperation. Among the first was Professor Pekka Puska (Director General of the National Institute of Health and Welfare under the MSAH of Finland since 1.1.2009), the director of the North Karelia project, who visited Karelia at the turn of the 1990s and started negotiations on cooperation in the border region. Also, during the visit of the Minister of Social Affairs and Health, Mr Jorma Huuhtanen to Karelia in September 1993, the protocol of intentions on health and social sector cooperation between the MSAH of Finland and the MOH and MSP of Karelia, and between the two Karelian ministries and the Provincial Administrative Board of the North Karelia of Finland (Pohjois-Karjalan lääninhallitus) were signed (Sosiaali- ja terveysministeriö 1993).

[84] Hereafter opinion leaders, influential persons and champions are referred to as opinion leader (OL).

[85] Overadoption implies that one role of the change agent is to prevent "too much" adoption of an innovation, as well as to try to speed up the diffusion process (Rogers 2003, 232).

The CA's role in the cooperation changes by stages. In an ideal case the CA makes itself unnecessary as the project draws to a close. Rogers notes (2003, 391) that the CA should aim to increase the client's self-reliance to such an extent that it would lead to the termination of dependence upon the CA. The very same approach is stated in the Finnish Government action plans (Ulkoasiainministeriö 1993, 1996, 2000, 2004), which stress that cooperation with the neighbouring area is of a temporary nature and should avoid the creation of dependency relations.

Emma Crewe and Elizabeth Harrison (1998, 69-90) have taken up a fundamental issue regarding the use of the terms partnership and partner. They state that the ideal of partnership[86] may be laudable but "whatever is said, there are structural inequalities" and a certain hierarchy related in the financial issues. Relations between the donors, CAs and LPs may appear differently. The rights and obligations of the CAs with regard to the use of funds vary depending on the donors' instructions: in some cases the CAs are allowed to use project funds to cover their own costs related to the project implementation (e.g. salaries, rents, travel) while in others some CAs are expected, in addition to the funds granted, to contribute to the project funding by paying so-called self-financing shares. However, in any case the CA *controls* the use of project funds and is responsible for reporting it to the donor.

Institutional framework

The last of the three groups of factors affecting adoption and diffusion is the institutional framework i.e. external factors. This refers to factors that either directly or indirectly have an influence on the adoption and diffusion of innovations. Wejnert (2002, 310-311) referring to Ormrod (1990) notes that "a fundamental element in adoption theory is the recognition that innovations are not independent of their environmental context but that they rather evolve in a specific ecological and cultural context and that their successful transfer depends on their suitability to the new environments they enter during diffusion". The institutional framework of the study, the Republic of Karelia, is described in the following chapter.

2.3 SHORTCOMINGS AND BIASES OF DIFFUSION RESEARCH

Diffusion research has been criticised for being pro-innovation biased, individual-blame biased, recalling problems and for increasing inequality and the socio-economic gap between the higher and lower socio-economic status segments (Rogers 2003, 105-136).

Rogers mentions pro-innovation bias as one of the most serious shortcomings of diffusion research. Pro-innovations bias is the implication in diffusion research that an innovation should be diffused and adopted by all members of a social

[86] Shekter (2003, 281) states that partnership works most effectively when its principles are clearly defined at the very beginning.

system, that it should be diffused more rapidly, and that the innovation should be neither re-invented nor rejected. Pro-innovation bias may result from the source of financing when the funder is expecting certain kinds of results or focusing only on the research of successful or relatively rapidly diffusing innovations. It may lead to rejected, discontinued and re-invented innovations being ignored. Due to pro-innovation bias success stories are known much better than innovation failures. How the pro-innovation bias was overcome in this study: first, the cases and accordingly the innovations were selected on the basis of set criteria but not on their successfulness. The idea behind the selection of several different kinds of projects and innovations was to examine which factors promoted and which impeded adoption and diffusion. In order to overcome this bias Rogers suggests investigating "the broader context in which an innovation diffuses" and that researchers could "see an innovation through the eyes of their respondents, including why the innovation was adopted or rejected". Both these approaches were applied in the study. (2003, 112-116.)

The recall problem i.e. dependence on the respondents' self-reported recall data regarding the time of the adoption of an innovation. In this study this problem was only marginal, as information was also collected by other means and from different sources. On the other hand, individuals were not defined as primary adopters of the innovations. In almost all cases the adoption of innovations required a prior decision by the authorities (121-122, 126-128).

One of the shortcomings of diffusion research is mentioned as the fact that researchers have not paid much attention to the consequences of innovations. It has been shown that diffusion of innovations widens the socioeconomic gap between the higher and lower socioeconomic segments in the system (2003, 130). Due to the nature of the innovations studied here, they do not widen the gap but rather aim to narrow it. Instead, in this context, another kind of problem, which may lead to greater inequality between the geographical areas, may emerge if the same areas are selected as pilot areas time after time. This can – at least to some extent - be overcome by effective dissemination to other areas of information about the achievements gained. (see Rogers 2003, 133-134.)

3 The Republic of Karelia

In the author's experience, except for the basic knowledge on Karelia, little is known about the developments in the Republic during the last few decades. As the institutional framework influences the diffusion and adoption of innovations the aim of this chapter is to provide the reader with information about the socio-economic development in Karelia and also about the development of civil society during the period under consideration.

The chapter begins with general information on Karelia and follows with a description of the administration, economy and social protection systems. Due to the scope of this study, the emphasis is on the latter. The chapter includes a brief description of the emergence of the Russian welfare model and concludes with a brief account of the international social sector cooperation and of the two main donors funding the case projects; the Government of Finland and the European Union.

3.1 GENERAL INFORMATION

The Republic of Karelia is located in the North Western Federal District of the Russian Federation[87] (Figure 9). To the west, Karelia has a 790 km long border with Finland and with the European Union.

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[87] According to the presidential edict No. 849 of 13 May 2000, the Russian Federation is administratively divided into seven federal districts, with a presidential representative appointed in each one. On January 19, 2010, a presidential edict No. 83 established the North Caucasus Federal District, which is a portion of the former larger Southern Federal District. Thus, the Russian Federation has eight federal districts: Central Federal District, North-Western Federal District, Southern Federal District, North Caucasus Federal District, Volga Federal District, Urals Federal District, Siberian Federal District, Far Eastern Federal District.

Source www.gov.karelia.ru

Figure 9: Geographical location of the Republic of Karelia

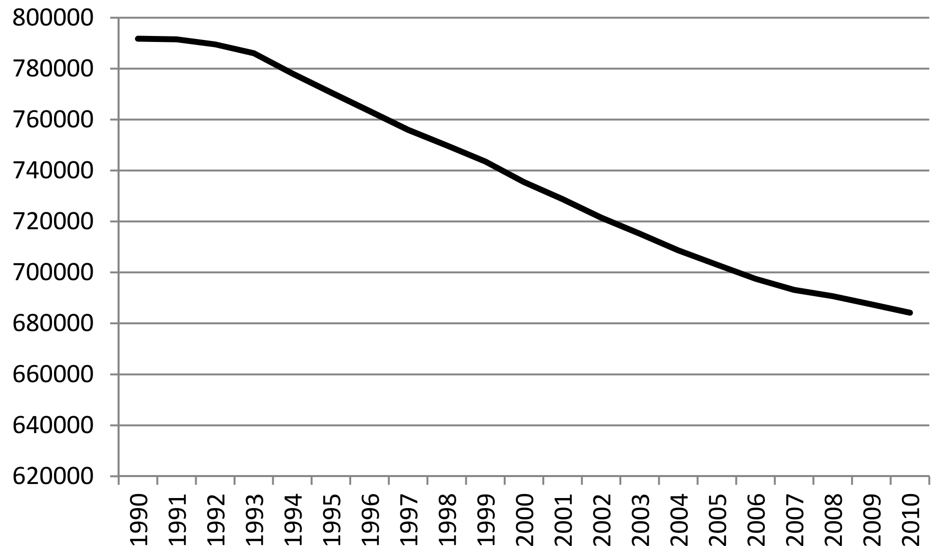
The Finnish-Russian border has changed several times since the Notenberg peace of 1323 (see Sarhimaa 1998, 27; also Paasi 1994, 26-40)[88]. Soviet power was established in Karelia in 1917-1918, and in 1920 it was named the Karelian Labour Commune (KLC). Five years later, in 1923, the name was changed to the Karelian Autonomous Soviet Socialist Republic (KASSR). Following the Winter War between Finland and the Soviet Union 1939-1940, Karelia was renamed the Karelian-Finnish Socialist Soviet Republic. In 1956, Karelia became an autonomous republic within the RSFSR. On 9 August 1990 the Supreme Soviet of the KASSR adopted the declaration on state sovereignty and on 13 November 1991 it was renamed the Republic of Karelia[89].

The territory of Karelia is 180,500 km^2 with a population of 684,200. According to the All-Russian population census of 2002 the population by nationality are: 76.6% Russian, 9% Karelian, 5.3% Belorussian, 2.7% Ukrainian, 2% Finns and 0.7%

[88] More e.g. Eskelinen, Oksa and Austin (1994), Kirkinen, Nevalainen and Sihvo (1994); Liikanen, Zimin, Ruusuvuori and Eskelinen (2007, 26-30); Oksa and Varis (1994).

[89] According to Larisa Boïchenko (2005, 236) in 1991, when the Republic of Karelia was established, its separation from Russia was discussed in the Supreme Soviet of Russia. However, the city council of Petrozavodsk turned to the residents of Petrozavodsk and to the Supreme Soviet with an appeal that Karelia should remain a part of Russia. The justification was that Karelia would not have preconditions for separation and the establishment of an independent state. At the same time the city council approved general outlines for the division of powers between Russia and Karelia as well as for the economic autonomy of Karelia.

Veps[90]. The territory is approximately 0.01% (of 17 million km^2) and the population approximately 0.5% (of 142 million) that of the Russian Federation. The capital of Karelia is Petrozavodsk, which is home to over 250,000 inhabitants. Karelia's population has decreased significantly during the last two decades; from 806,400 at the beginning of the 1990s, under 690, 000 in 2009 (Figure 10). About 75% of the total population lives in the cities, about one third of them in Petrozavodsk. The population decline can be explained by three simultaneous phenomena: an increase in mortality, a decrease in births and emigration.



Source: Karelstat 2008, 2011

Figure 10: Population in Karelia in 1990-2010

The legislative power in Karelia is vested in the unicameral Legislative Assembly, a permanent supreme representative and the only legislative body of the Republic of Karelia. It comprises 50 deputies, elected by a direct secret ballot vote for a term of five years[91]. The executive body of Karelia consists of the Head of the Republic, the Government, the administration of the Head of the Republic, ministries, committees, departments, and inspectorates. The Head of the Republic appoints the ministers, heads of the state committees, heads of departments, and other chief executive officers[92]. The Federal Government has several bodies in Karelia, for instance, the federal security service, defence, foreign affairs, border

[90] www.gov.kar.ru/Gov/Different/karelia3_e.html visited 9.4.2011 also Oksa and Varis 1994, 41-69.
[91] http://gov.karelia.ru/gov/LA/common_e.html.
[92] The executive powers of the subjects of the RF may be 1) bodies of general competence (governments, administrations of territories) and 2) bodies subordinated to the governments or regional administrations (ministries, committees, and other departments, which directly administer socio-cultural, political, economic and policy issues) (Salicheva 2000, 89-90).

guard, taxation, customs, state property, drug circulation control, Pension Fund and Employment Fund.[93] The judicial authority in Karelia is held by the federal courts, the Constitutional Court of the Republic of Karelia and the magistracy of the Republic.[94] Karelia has its own Constitution (adopted in 1993 and 2001).

Karelia as a part of the Russian Federation

Karelia joined the Russian Federation in 1992 after the collapse of the Soviet Union. Karelia's position in the RF and its autonomous rights were defined in the Federal treaty signed by the Republic in 1992[95], and by the Federal Constitution of 1993[96]. Article 77 of the Constitution confirmed the right of each federal subject to decide on its public administration system, as long as it complied with the Federal laws. Despite formal independence as a subject of the RF, Karelia is not a sovereign state. In Russia there is a particular system of "combination of two sovereignties within one state", where the sovereignty of the federal state is above that of the federal republics (Tolonen and Toporin 2000, 72-73; Kurilo et al. 2007, 7).

Karelia is one of 21 republics among 83 formally equal subjects[97] of the Russian Federation. In practice, the economic status and potential of each subject affects its political influence and role in the Federation. (Helanterä and Tynkkynen 2002, 45-52; Valtionvarainministerö 1997, 6; Topornin 2000, 74; Zimin 2004b, 7.) Compared with the other regions of the RF, after the breakdown of the SU, Karelia had some obvious advantages. Until 2004 it was the only region that had common border with the European Union (Karjalan Sanomat 26 January 2002), it is located near to industrially developed central Russian regions of Moscow and St. Petersburg, and it is a transport junction in the border region and between Murmansk in the North and St. Petersburg in the South. In addition, it possesses significant natural resources and has good relations with Moscow[98]. Eskelinen and Zimin (2003, 4, 9) note that although Karelia's position among the other regions has to some extent declined, its position as a politico-institutional unit has strengthened since the collapse of the SU. However, in many respects Karelia remains on the Russian periphery (Melin and Nikula 2005, 145).

Democratic transformation began in Karelia at the end of the 1980s, but the development has been slow. During the period covered by this study there were two heads of the republic[99]: the former first secretary of the regional CPSU,

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[93] http:_//gov.karelia.ru/gov/Power/struct_e.html. visisted 2.10.2010

[94] http:_//gov.karelia.ru/gov/Law/index_e.html visisted 2.10.2010

[95] The Treaty was valid only until 1994 (Ruutu and Johansson 1998:5, 27). In 1998 president Putin put an end to signing any more Federal Treaties (Ministry of Defence 2008, 46).

[96] Articles 3-5, 72 and 77.

[97] There are 46 oblasts (regions), 21 republics, 4 autonomous okrugs (territories), 9 krais, 2 federal cities (Moscow and St. Petersburg), and 1 autonomous oblast.

[98] In 2002 during the inauguration of the Head of the Government of Karelia, Sergei Katanandov, President Vladimir Putin gave him watches as a present. Giving the present President Putin expressed the wish that Mr Katanandov would "synchronize time with the Kremlin". Afterwards when Mr Katanandov was asked whether Karelia would follow the Moscow course he answered positively. (Kolesova 2008, 36.) On 21 July 2010 at the inauguration of the new Head of the Republic, Andrei Nelidov, Katanandov presented Nelidov with the same watches (http:// www.gov.karelia.ru/gov/News/2010/07/0721_e.html).

[99] See Tsygankov (2001, 264-267) on the transfer of power from CPSU in Karelia.

Viktor Stepanov 1990-1999, and then the former mayor of Petrozavodsk, Sergei Katanandov, in 1999-2010[100]. Dusseault (2010, 113) notes that at the beginning of the 1990s in Karelia, a "seamless transfer of political power" from the Communist party to the institutions of the new Republic took place. Tsygankov describes Stepanov's years in power – despite the general turmoil in society – as a time when social, political and economic life developed without serious trouble; Karelia proclaimed its sovereignty, the Supreme Soviet was replaced by a two-chamber parliament[101], the post of Chairman of the Government of Karelia was created and the privatisation of state property was carried out. In the 1990s all the institutions of the democratic power strengthened. The change of the Head of the Republic in 1999 did not alter the ruling elite; instead it resulted in a change of personnel in the republic's administration. (Tsygankov 2001, 266.)

Katanandov's election as Head of the Republic marked a change. Dusseault (2010, 115, 124) calls him as "a Karelian version of a federal technocrat", completely loyal to Moscow. Katanandov openly supported the lead role of Moscow[102]. He maintained close relations with the major enterprises in the Republic and seemed to have a 'social contract' with big business (Zimin 2004a, 4), which in turn supported Katanandov. Many of the enterprises were granted tax concessions. Katanandov monopolized all the mass media during his first years in power and the state's grip on the development of civil society strengthened. The political parties do not play a major role in the region's political life (Dusseault 2010, 111,133; Tsygankov 2001; Zimin 2004a, 9). Karelia's dependence on the RF increased further during Katanandov's years in power.

3.2 INSTITUTIONAL CHANGES IN KARELIA

The socio-economic situation in the area of the former Soviet Union had started to deteriorate long before its dissolution, which further accelerated the process. The institutional changes and reforms initiated in the Russian Federation at the beginning of the 1990s were directly reflected in the regions. This part briefly describes reforms in administration, economy and social protection as they relate to this study.

3.2.1 Decentralisation of powers

The last president of the Soviet Union, Mikhail Gorbachev, began administrative reforms in the mid 1980s. The idea of local self-government was revived,

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[100] In July 2010 the then Head of the Republic of Karelia, Sergei Katanandov, after 12 years in office, requested the early termination of his powers from the President of the RF. On 19 July, 2010 President Medvedev appointed Andrei Nelidov as the new Head of Karelia. (http://www.gov.karelia.ru/gov/News/2010/07/0719_03_e.html visited 21.8.2010)

[101] The two chambers were united in 2003 into one unicameral parliament. http://www.karelia-zs.ru/history.html

[102] According to Alexseev (2000) in 2000, when Putin started the recentralisation of powers, most governors of ethnic regions of Russia became antifederalists. However, there were some exceptions including Sergei Katanandov, who suggested not only strengthening vertical subordination, but also extending the term of the Russian president "for life, if he has the support of the people".

and Gorbachev underlined the active role of the local soviets in decision-making. However, the aim was not to disturb the political ideology or the role of the communist party in the system but to develop socialist democracy within it. Several administrative reforms were outlined in Russia in the 1990's. The task was challenging, as during the Soviet era the central government exercised powers practically from top to bottom throughout the country. (Heusala 2005, 181-305, 350-351; Salicheva 2000, 85-94)

Two major federal administrative reforms took place during the period under examination. The first law on local government was adopted in 1995 and the second in 2003[103]. The law (No. 154- FZ) of 1995 divided the structure of government into public authority and local government. The public authority consisted of the federal and regional levels and local government was excluded from it (Article 12). Local government referred to a voluntary union of people for the solution of common problems. The law decentralised decision-making powers and distributed responsibilities between three levels: federal, republic and district. The federal was responsible for the army, control of taxation, security, the judicial system and the prosecutor system; the republic authorities were responsible for making laws and amendments to them, regional arrangements, the protection of nature and security; and the local authorities were responsible for social-economic development, local financing and taxes, municipal property, education, general maintenance of order, housing and health care (Ulkoasiainministeriö 1997, 23).

Administratively Karelia consisted of 18 districts (*rayons*) [104] (Figure 11). The law of 1995 gave the districts with the right to respond autonomously to local problems provided that they respected the federal legislation (Salicheva 2000, 93-94). Despite the increased independence at local level, enforcement of the law resulted in difficulties, as the responsibilities and funding were not balanced and funding for the federal mandate was largely inadequate (Liborakina and Rotkirch 1999, 27-28; Mannila et al. 2000, 27-28). Leo Granberg and Larissa Riabova (1998, 187-188) state that the local authorities were "totally unprepared for adopting such a duty" without financial resources and with a lack of political legitimacy[105]. Insufficient financial resources and managerial capacities, as well as the "unrealistic level of state commitments to the benefits package" (Tragakes 2003, 190-191) were a common problem in the Federation during the 1990s.

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[103] The local government system in Karelia is based on laws "On the Reform of the Local Government" (adopted in 1993), "The Law on Local Government in the Republic of Karelia" (adopted in 1994), the federal Law "On the General Principles of the Organization of the Local Self-government in the Russian Federation" (came into force in 1995), "The Law on Local Self-Government" (No. 131 of 2003), and the "Law on the Financial Basis of Self-Governance" (1997). The first local government elections took place in Karelia in 1994.

[104] Petrozavodsk was a town of republican significance and Kostomuksha and Sortavala of district significance. Seven of the 13 Karelian towns were directly subordinated to the governmental administration (Petrozavodsk, Segezha, Kondopoga, Kostomuksha, Sortavala, Kem and Pitkyaranta) and six (Medvezhegorsk, Belomorsk, Suoiarvi, Pudozh, Lahdenpohia and Olonets) to the district administration. In addition to the towns, there were 44 urban centres, 101 village council-areas and 668 villages.

[105] Melin and Nikula (2005, 54) note that the main flaw of the law was the paradox that the local government had wide latitude but very small financial resources.

Figure 11: Territorial-administrative structures of Karelia

Table 2: Basic information about the municipal districts of the Republic of Karelia

District	Population/ (% living in district centre or cities) 1990	2008	Territory km²	Population density	Industry structure
Republic of Karelia	**791 800**	**690 700**	**180 520**[106]	**3,8**	
Petrozavodsk	272 900	268 800	113	2378.6	pulp and paper machinery, forest, shipbuilding
Kostomuksha	32 100	30 400 (98%)	4 046	7.5	iron ore
Belomorsk	30 300	21 700 (55%)	12 797	1.7	shipbuilding, food, quarrying
Kalevala	11 800	9 700 (55%)	13 260	0.7	forest
Kem	26 400	19 200 (70%)	8 029	2.4	forest
Kondopoga	48 100	42 700 (79%)	5 951	7.2	pulp and paper, quarrying, mining
Lahdenpohia	19 000	15 700 (53%)	2 210	7.0	plywood
Loukhi	24 800	17 600 (64%)	22 552	0.8	forest, quarrying, fishing
Medvezhegorsk	47 200	35 100 (66%)	13 695	2.6	forest, shipbuilding, quarrying, resin extraction
Muezerskyi	20 300	15 000 (26%)	17 660	0.8	forest
Olonets	30 500	25 300 (37%)	3 988	6.4	agriculture
Pitkyaranta	27 700	22 300 (57%)	2 255	9.9	pulp and paper, quarrying
Prionezhkyi	25 300	23 100 (-)	4 475	5.2	forest, agriculture
Priazha	23 100	17 000 (24%)	6 395	2.0	agriculture, forest
Pudozh	31 500	25 200 (39%)	12 745	2.0	mining, food, forest
Segezha	56 300	47 000 (91%)	10 723	4.4	pulp and paper, aluminium
Sortavala	38 100	33 300 (77%)	2 190	15.2	forest, clothing, food
Suoiarvi	26 400	21 600 (51%)	13 739	1.6	cardboard, quarrying

Source: Demograficheskiĭ ezhegodnik Respubliki Kareliia 2008, 8

[106] Includes territorial waters 23 697km²

The law also resulted in weakened communication between regional organs of government and the local level. In the *"Kontseptsiia razvitiia zdravoohraneniia v Respublike Kareliia na 1999-2003 gody"* [107] (1999, 7) it is noted that as a consequence of the decentralisation the republic organs of government did not get enough reliable information from the local level and partially lost control over the general situation including processes in the health care system.

The aim of the new law on self government (No.131) of 2003 was to bring the decision-making closer to the population and to streamline the local government structures of the subjects of the Federation. The law confirmed a two-level system of local government consisting of municipal rural settlements (selskie poseleniia) and of municipal urban settlements (gorodskie poseleniia) at the lower level and of municipal districts (munitsipal'nye raĭony) at the upper level[108]. In Karelia 127 municipal units were created, including 87 municipal rural settlements, 22 municipal urban settlements, 16 municipal districts and two town districts (Petrozavodsk and Kostomuksha). The territorial-administrative structure did not change significantly: the number of districts remained the same, 18[109]. In total, 80% of the local management was changed. The law came into effect on 1 January 2006 in Russia, but due to several problems in its enforcement[110], the federal authorities prolonged the transition period until the end of 2008. In Karelia, the law came into full effect on 1 January 2007.

Responsibilities for organising financing and delivery of services to the population, were delegated from the centre to the regions and local levels without corresponding finances. Initially, the subnational governments favoured decentralisation and autonomy. They assumed that they would get increased tax allocations or control over other resources with revenue-raising potential. However, the result was that the share of the regional and local level spending for education and social protection increased and federal spending decreased. Decentralisation increased the role of the local authorities but did not resolve the problems; instead it contributed to growing regional disparities in social expenditures and service provision. In addition to financial inadequacy, problems emerged with regard to a lack of preparedness and skills to manage financial issues at a local level. (Danishevski et al. 2005, 154-155; Cook 2007, 66-71, Lagus 2003, 293.)

As Table 2 (page 61) shows, Karelian districts differ greatly from each other both in area (from Sortavala 2,190 km^2 to Loukhi 22 552 km^2) and in population density (from 15.2 in Sortavala to 0.7 in Kalevala), while the industry structure is mainly the same throughout the country: forest, pulp and paper industry, metallurgy and mining.

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[107] Original in Russian Концепция развития здравоохранения в Республике Карелия на 1999-2003 годы. In English Concept of Development of Health Care in the Republic of Karelia. The Concept (#163) was approved by the Head of the Government on 1 April 1999.

[108] For more e.g. Wollman and Gritsenko 2009.

[109] The Veppsian *volost* was included in the Petrozavodsk municipal district. See footnote 239.

[110] According to Aleksandrova (2005, 16) several issues were not legally regulated e.g. people did not yet see the local government as their own power but somebody else's; the power had not come closer to the population; the resources provided did not correspond to the tasks transferred to local authorities.

Differences between the Karelian districts also became more apparent. The so-called "border-factor" started to influence people's living since mid 1990s. Communication and cooperation with Finns became easier for those living in the districts located close to the Finnish border in particular, Sortavala and Kostomuksha, which have border crossing points in their territories. [111] Finnish "day-shoppers" became an everyday phenomenon in the border region cities of Sortavala, Lahdenpohia, Pitkyaranta and Kostomuksha. Zimin (2004a, 13) predicted that their "socio-cultural influence" would be felt also in Petrozavodsk.

The privatisation of state companies and property benefited the districts to varying extents. In Soviet times the big paper and pulp enterprises (e.g. in Kondopoga, Kostomuksha, Segezha, Petrozavodsk and Pitkyaranta) offered the population not just employment but also welfare services[112].

During the field visit to Muezerskyi in February 2008, representatives of the district administration related that the situation in Muezerskyi had become intolerable. The district's main settlement is in the middle of a large forest area but the inhabitants lacked firewood as the forests were rented to outside companies who were not concerned with the situation in the district. The income from tax revenue and share of profits promised to the administration had proved minimal.

However, there are also positive examples. In Kondopoga district, the pulp and paper mill supported the development of the city and district. It built a modern ice-rink, an imposing concert hall and other facilities for the city. The wages are about twice the average income in Karelia and always paid on time (Melin 2005, 74)[113].

In conclusion, as a result of the administrative reforms the decision-making powers were delegated to lower levels of administration without the provision of corresponding financial resources, which led to further deterioration of services and differentiation of the Karelian districts.

3.2.2 Economic situation

Karelia played an important role in the Soviet system of division of labour and production. This role has not changed despite the crisis years: it produces 10% of the iron ore, 23% of the paper, 9% of the cellulose, 7% of the industrial wood, 4% of the saw-timber, and about 60% of the paper sacks in Russia[114].

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[111] In 2009 there were 17 crossing points in total on the Finnish-Russian border, only three of which (Niirala/Wärtsilä, Vartius and Kuusamo) were for passanger traffic. The rest were in occasional use, mainly for the transportation of wood. (Helsingin Sanomat 21 July 2009.)

[112] According to Oksa and Saastamoinen (1995, 101), the role of the forest enterprises has been very important in the rural areas of Karelia. They note that "there is a need to reorganise the provision of rural services, because the forest companies, as was common practice in socialistic countries, have maintained local infrastructure and service institutions as a function of their leading role in the village. The budgets of the enterprises provided… for the "social sphere", including housing, communal infrastructure, kindergartens, music schools, club houses, library, health clinic, and sports facilities… In urban areas many social functions were organised by the municipalities or state authorities but are in rural areas usually established and maintained by enterprises."

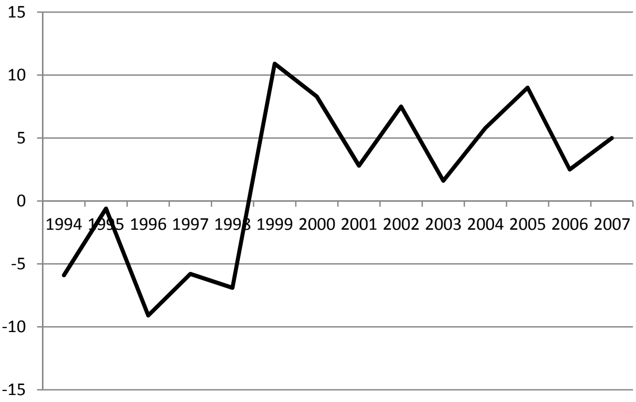
[113] For critical opinions on the "Kondopoga phenomenon" initiated by the General Director of the Kondopoga paper mill Vitaly Federmesser see e.g. Tsyganov (2004), Rautio (2004).

[114] www.gov.karelia.ru/gov/Different/karelia3_e.html. See also Kurilo et al. 2007, 7; Eskelinen and Zimin (2003) in a nutshell a description of the Karelian economy after the dissolution of the FSU and Dusseault's (2010, 110-133) description of political and economic developments.

The Karelian economy has been based on a strong industry complex, gradually strengthening transport and service sectors and weak agriculture. The industry complex consists of forest, wood-processing, pulp and paper, ferrous metallurgy and construction material industries. Agriculture plays a minor role in the Karelian economy and, despite large and fertile cultivatable areas, Karelia is not self-sufficient in staple foods. Forests cover about half of Karelia's territory, which makes the forest industry dominant. Karelia is an export-oriented region specialising in the production of paper, board, timber products and ferrous metals. This specialisation makes the Karelian economy both vulnerable to, and dependent on international prices and markets. (Eskelinen and Zimin 2003, 6; Karjalan Sanomat 20.3.2002; Kolesova 2008, 11-21; Tilastokeskus 4/1997, 23-24; Melin and Nikula 2005, 145.)

Kurilo et al. (2007, 15-16) note that the most important result of the twelfth five-year plan (1985-1990) was the break-up of the entire administrative-command system and its structures in the economy. At the same time the lack of a clear, considered, and adopted concept for the reorganisation of the economic mechanism at central and republic levels aggravated the development of crisis phenomena, which delayed the formation of a market infrastructure. For ordinary Russians, the 1990s was "a decade of stumbling from one economic crisis to another" (Salmi 2006, 17).

Towards the end of the 1980s the rate of growth of industrial production decelerated and the socio-economic crisis developed rapidly. The gross regional product (GRP) (Figure 12) decreased throughout the 1990's. As a result of the crisis of the 90's the republic was on the verge of financial-economic collapse (Kolesova 2008, 17).



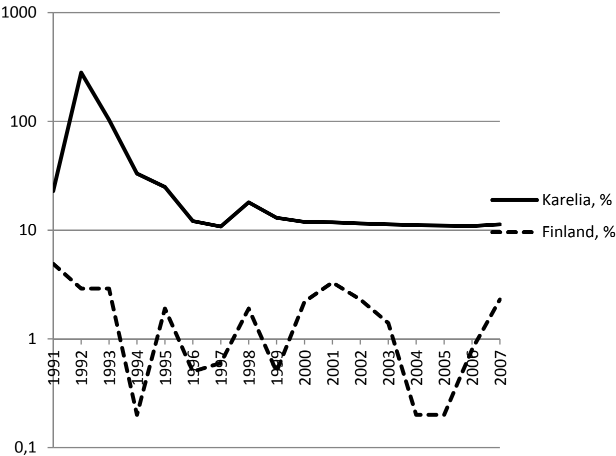
Source: University of Joensuu 2000, 2002, 2007

Figure 12: Annual change (%) of GRP per capita in Karelia in 1994- 2007

In the Soviet era the general level of prices was low and prices for the basic necessities and food were state subsidised. Following the economic collapse and reforms prices for all goods and services – except for the sources of energy – were released in January 1992. The prices rose 33-fold but the wages only 8.4, resulting

in a decrease of the real incomes of the population by more than half (Kurilo et al. 2007, 56-57). From 1991-99, the real incomes of the population decreased by almost 65%. A corresponding phenomenon was observed throughout Russia (ibid. 13).

Inflation was a new phenomenon for Russia and since the beginning of 1990s it remained high. Compared with Finland where the inflation rate varied from 2.9% in 1993 to 3.3% in 2001, the corresponding figures were in Karelia 103.2% and 11.8%.

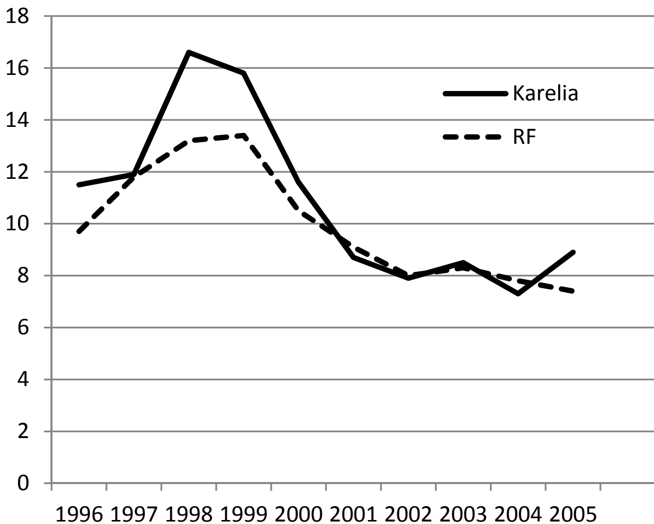


Source: Karelia: Karelkomstat and Kurilo et al. (2007, 57) years 1992-1999, University of Joensuu, years 2000-2007; Finland: Statistics Finland

Figure 13: Annual inflation (%) in Karelia and Finland in 1991- 2007 (logarithmic scale)

At the same time "the cornerstone of the social policy" in the Soviet Union, namely the full employment, disappeared and unemployment started to increase (Figure 14). From 1990-98 about 25% of the jobs in Karelia disappeared (the corresponding figure in Russia was 15.5%, University of Joensuu 2000, 6)[115]. Since 2000, the unemployment level in Karelia has been close to the Russian average.

[115] For more on the emergence of unemployment in Karelia see Morozova (1994, 109-119).



Source: Statisticheskiĭ biulleten Upravlenie federal'noĭ sluzhby zaniatosti naseleniia po Respublike Karelia 2006.

Figure 14: Unemployment (%) in Karelia and Russian Federation in 1996-2005

There were significant differences between the Karelian districts with regard to unemployment. According to the Karelian branch of the Federal Service on Employment and Labour[116] (2006, 30) during the period from 1992 to 2007 the lowest unemployment rates were in the city of Petrozavodsk and the districts of Sortavala, Lahdenpohia and Kostomuksha, and the highest in Kalevala, Pudozh and Belomorsk. On 1 January, 2007 they were 11.9 % in Kalevala, 10.5% in Pudozh and 9.1% in Belomorsk[117].

In the mid 1990s, the shadow sector in the economy of Karelia had an approximately 20% share of total industrial production. According to the Karelian employment service (2006, 5) towards 2000 about 32,000 citizens were working in the informal sector, equivalent to a 9% of the share of active population of Karelia.

[116] Despite the name of the publication "Labour market in the Republic of Karelia in 1991-2005", Statistic bulletin of the Karelian department of the Federal Service on Employment and Labour (FSEL) it also includes figures for 2006. In addition, when the publication was given to the author in the branch of the FSEL in Petrozavodsk, the figures for 2007 were added to it by the officials. Original in Russian Рынок труда Республики Карелия в 1991-2005 года статистический бюллетень.
[117] According to the Annual Report of the Head of the Republic (2009, 80) on 1 January 2009 the highest unemployment rates were in Kalevala 8.1%, Belomorsk 7.3%, Loukhi 6.1%, Pudozh 5.0%, Kem 6.3% and Muezerskyi 5.9% and the lowest in Petrozavodsk 0.8%, Kostomuksha 2.2% and Sortavala 1.6%.

Reforms in economy

Economic reform[118] had already started in Russia during the second half of the 1980s. *Perestroika* began under the last president of the SU, Mikhail Gorbachev (1985-1991), and was an attempt to respond to the economic challenges and problems emerging in the Soviet economy. The aim was "to rejuvenate Soviet socialism" not to replace it (Sutela 2003, 45-47), and "to direct the country smoothly towards a market economy in the guidance of the Communist Party" (Nystin-Haarala 2001, 137-139). Instead of resolving the problems the *perestroika* process led to the emergence of new ones and finally to the breakdown of the Soviet state. Sutela (2003, 120) states that without the mistaken economic policies of the *perestroika*, Soviet socialism might have survived for many more years.

Economic reform was an essential part of transition, and a precondition for it. The absence of clear economic reform models and processes was apparent (Blaho 1994, 5). Due to the difficult financial situation, Russia – like most of the transition countries – needed external funding in to order relieve the consequences of the dissolution of the SU and to advance transition.

The International Monetary Fund (IMF) offered technical assistance to transitional economies during the transition period. The IMF had little previous knowledge of the socialist countries. In June 1990 the IMF, the World Bank (WB), the Organisation of Economic Co-operation and Development (OECD) and the European Bank for Reconstruction and Development (EBRD) were tasked to study the Soviet economy "proposing ways of reforming it and recommending means by which the international community could assist in such efforts" (Sutela 2003, 67.) The package of recommendations, the so-called Washington Consensus, was originally designed for the developing countries, descended into financial crisis in 1980s. The Consensus required that the client state should commit itself to recommended policies against the loan. At that time the details of the IMF credit agreements were kept secret, which created "a picture of the Fund secretly dictating unpopular and possibly harmful policies" (Sutela 2003, 77). According to Sutela (2003, 75-80), Russia was not treated in a similar way to some other clients and that the financial institution was used for political purposes. Russia was considered "too important to be strictly handled", which resulted in a situation where policies and reforms were agreed but not fully implemented. (Rautava and Sutela 2000, 77-122; Sutela 2003, 128-132.)

The Russian leadership aimed at radical changes as it was believed that the window of opportunity would soon close. Sutela (2003, 72-73) states that the idea of window of opportunity was understandable but "perhaps the major mistake in transition thinking" as support to the old system hardly existed and many former communists had transformed themselves into entrepreneurs. (also Rautava and Sutela 2000, 80.) The Consensus did not restrict the transition to economic reforms but also emphasised institutional change and suggested sequencing over a period

[118] The first outlines of economic reform were prepared in June 1987 but in total, and depending on the way of counting, from 11 to 40 programme drafts for economic reforming were considered during the *perestroika* (Sutela 2003, 47-52).

of ten years (Sutela 2003, 81). The reform package negotiated between the RF and the IMF consisted of four main elements: liberalisation, stabilisation, privatisation and structural changes (Table 3).

Table 3: Main elements of the transition policy and their impact on Karelia

Element	**Consequences (positive and negative)**
Liberalisation (of prices, entrepreneurship, foreign trade)	Increase in prices (inflation), loss of jobs, loss of social and health care services and benefits earlier provided by the employers. Emergence of new working places and opportunities.
Stabilisation of the economy (monetary policy and creation of a basis for sustainable economic growth)	Cuts in government expenditure, loss of jobs. Emergence of new job creation. Creation of the basis for long term development planning, new opportunities for development of social protection.
Privatisation	Unemployment, declining wages, closure of the state enterprises. Emergence of new types of enterprises and new kinds of employment relations, weakening the role of the Soviet type health care and social service provision.
Structural changes	Dissolution of the Soviet institutions and structures, establishment of new ones. Decentralisation of powers. Increase of local independence.

Each of the elements affected the wellbeing of the population and had both positive and negative consequences. Rautava and Sutela (2000, 294) note that it seems that in order to achieve a virtuous circle in which different changes strengthen and reinforce each other it is necessary to proceed in a determined way in all policy subsectors simultaneously. They also state that the Washington consensus was not a one-size-fits-all "straitjacket", but was flexible for different kinds of solutions. (2000, 77-122.)

The role of the western advisors in the selection of 'shock therapy' in Russia has been widely criticised. Shekter names shock therapy as the best known, sad example of the unsuccessful recommendations of the economically prosperous countries (2003, 278)[119] . Gerner and Hedlund (1994, 25) write "it has been stunning to see Western advisors suggest policies for Russia that they would never even dare to contemplate for their own societies." (See also e.g. Cook 2007, 46: Melin and Nikula 2003, 258)

Consequently, the foundations of the socialist system were destroyed but the end result was not exactly as anticipated. Augusto Lopez-Claros (2003, 314-318) notes that the specific objectives and the methods for their attainment were approximately the same as in tens of other analogous programmes: liberalisation of markets, the elaboration of financial policy aimed at stabilisation of the macroeconomic system, integration with the world economy, and the improvement of

[119] Original in Russian "самым печально известным примером неудачных "рекомендаций экономически благополучной страны".

the legal and organisational basis of economic reform. He argues (2003, 317-321, 334-335) that the results of the efficacy of the reform proved rather limited due to a number of serious omissions and the fact that the loans of the IMF were not used for the agreed purposes. The Russian government used the IMF loans as a substitute for tax revenues, and absorbed them directly into the federal budget. (cf. Kurilo et al. 2007, 54-56, 71-72, 87-88, 117.)

Kolodko (1999, 14, 24-25) argues that one of the reasons for failures in the implementation of policies based on the Washington consensus was the confusion of the means of the policies with their ends. Privatisation and liberalisation were only instruments of economic policy, while sustained growth and a healthier standard of living were the desired ends. He emphasises the importance of the institutional changes as "the most important factor for the progress toward durable growth" and that institution building should be a gradual process[120]. If institutional building is missing, he continues, there is a place for the emergence of informal institutionalisation that can fill the systemic vacuum.

The lack of the virtuous circle led to a situation where the changes did not support each other. The importance of the development of the legislation in the change process is stressed by Nystén-Haarala (2001, 3), who argues that the inherited Soviet laws could even constitute a block to transition. The same was emphasised by Kolodko (1999, 24-25) who notes that the establishment and development of new laws should be addressed before privatisation of state assets and liberalisation, since only if the former is secured can the latter contribute to sound growth.

Due to inconsistent policies, in Russia emerged an economic system unable to fulfil its basic functions in different sectors. Instead of a functioning market system there appeared a system with a wide grey sector, a poor taxation system, and increasing disparities between the regions and peoples. (Rautava and Sutela 2000, 303.)

Reflections of the federal reforms on Karelia

The main purpose of privatisation was to break the dependence of enterprises on the state budget and was as much a political as an economic act. As is well known, the end result of privatisation in Russia was not as hoped. (e.g. Sakwa 2008, 295-304.)

In Karelia privatisation was carried out in set time frames 1992-1997[121] and resulted in the emergence of a non-state sector of the economy with prevailing private ownership and diverse organisational-legal forms. According to Kurilo et al. (2007, 58-59) the scheme of mass-forced privatisation managed to destroy the previous economic system but did not function in its "creative role" i.e. in the creation of an institute of efficient proprietors interested in the development of production that would serve as a basis for a future socially oriented market economy. (cf. Cerami 2009, 108-109 on privatisation of housing.)

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[120] In the WB Report Transition Ten First Years (xxx, xxi-xxii) the East Germany case is presented as an example of a not very successful implementation of quick institutional changes. It was stressed that "while institutional change is important, so, too, is policy reform, and it is essential that they proceed hand in hand".

[121] See Dusseault 2010 (121-122) on the reluctance of the companies with privatisation.

In the beginning of the 1990s President Yeltsin granted Karelia several privileges "in change for the republic's political support of the president during the conflict with the Duma" (Dusseault 2010, 118-119). Karelia was allowed (as of 1991) to retain 90-100%[122] of the taxes collected in Karelia for regional development. Previously 60% of all taxes collected had gone to the Federation. According to the Presidential Decree No. 318 of 26 December 1991 "On conditions for an experiment for establishment of a special way of investments in the Republic of Karelia"[123] a fund for the reconstruction and development of the national economy of Karelia was established in December 1991. The privileges also concerned exports: products produced in Karelia were exempted from export duties. According to Kurilo et al. (2007, 56) these privileges were abolished prematurely and the originally planned duration of eight years was shortened to 2.5 year, which further aggravated the economic crisis. (Also University of Joensuu 2000.) Kurilo et al. (2007, 56, 71-72, 87-88,117) state that the additional tax revenues were not used efficiently: the government subsidised the old enterprises more than investing in new[124], competitive companies and in practice the fund became an appendage of the budget. The fact that some privatised enterprises were given tax relief or exemption further impaired the economic situation[125].

Moscow started to tighten the 'financial belt' in particular in relation to the regions (Kolesova 2008, 22-24; also Cook 2007, 70). Toward the end of the 1990s the Russian Federal Government changed the tax-sharing arrangements between federal and regional levels, thus directly reducing future revenues of the regions (University of Joensuu 2000, 6). The turnover tax for enterprises was cancelled, which markedly decreased the income of the Republic's budget. At the same time the turnover tax started to go in full to the federal budget (Karjalan Sanomat 3 June 2001) and prospects for the future became more uncertain (Karjalan Sanomat 21 February 2001). In August 2002, the Karelian Government noted that the hopes for federal help had not materialised and that the promises of the Federal Government did not convince it any more (Karjalan Sanomat 31 August 2002).

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[122] There are different figures in the literature: Nemkovič et al. (1994, 80) give 90% while Kurilo et al. (2007, 55-56) note 100% for 1992-1995 and on loan conditions at interst of 3% in 1994-1998.

[123] In Russian Распоряжение О создании условий для ускоренного развития Карельской АССР и расширении ее экономической самистоятельности, май 1991; Об условиях экономического эксперимента по созданию особого порядка инвестирования на территории РК.

[124] In regard to Ukraine Piirainen (1995, 27) notes that "For social reasons, continuous financial support for unproductive enterprises has been necessary in the short run because of the lack of adequate alternative sources of social support; in the long run, however, the continuation of social policy of this type creates serious obstacles to the attainment of the goals of economic policy".

[125] For example in 1996, the taxes collected from the forestry companies formed only 20% of all the budget revenues at the same time when its production formed almost half of the total production of the Republic (Ruutu and Johansson 1998, 31). Lopez-Carlos (2003, 320, 335) state the tax privileges granted to enterprises restricted the possibilities of the state to meet the acute social needs of the population. The federal tax code was adopted only in the late 1990s and merely regulated general principles of taxation and was very complex in nature (Nystén-Haarala 2004, 90). In order to avoid taxation the private enterprises often left the registration undone and many of those which were registered partly continued their unofficial activities and kept double book keeping (ibid. 136). The taxation system did not work properly, which resulted in financial problems at local level and in non-delivery of services for the population. (also Dusseault 2010, 120-122; Kolesova 2008, 29; Nystén-Haarala 2001, 107-111 about the income basis of the municipalities and challenges in it.)

The change in relations between the Federation and the regions were also reflected in relations between the region and the districts. Most of the taxes and fees collected at local level were earmarked for use by the regional government. As a result, the districts became even more dependent on the provision of financial resources from regional and federal levels (Salicheva 2000, 49-51; University of Joensuu 2002, 5).

3.2.3 Social protection

The shortcomings of the Soviet system – not only with regard to the social sector but more generally – became obvious in the mid 1980's (e.g. Ryan and Stephen, 1996). Nelson and Kuzes (1998, 487) note that in 1986 "ideological fragmentation among the USSR's decision-makers and planners had reached a critical point, and traditional orthodoxies could no longer be sustained among a large number of them". The inefficiency of the centralised system and the poor level of services were conceded; signs of the serious problems of the Soviet welfare system were apparent before the disintegration of the Soviet state (e.g. Tragakes and Lessof 2003, 7-10). However, the system still functioned and was able to provide the population with the basic services.

The political ideology of Soviet society denied the existence of social problems, and considered them as phenomena characteristic of the capitalist system (e.g. Mannila et al. 2000, 27). Nevertheless, social problems existed but public discussion of them was restricted[126]. (e.g. Braithwaite 1997, 30-49; Piirainen 1997, 224-226; Simpura 1995; Turuntsev and Simpura 1998).

Organisation of social protection in the Soviet Union

Braithwaite (1997, 30) characterised the Soviet system of social support "as a universal job guarantee combined with low controlled prices and a state-run retirement and social insurance system". The state provided its citizens with the basic necessities and prices, e.g. for electricity, housing, transport, and basic food supplies, were subsidised. The citizens had a constitutional right to work. Health care and education were available for all and free of charge[127]. The Soviet Semashko type health care system (e.g. Pidde 2003, 82-83; Tragakes and Lessof 2003, 22-25) was centrally planned and managed in a highly hierarchical way. In addition to the official system there existed parallel systems for serving the employees (in some cases also their families) of some ministries, industries and the government (e.g. Tragakes and Lessof 2003, 36-37; Rese et al. 2005, 205). Health care services

[126] Piirainen (1993, 84) notes that, for example, publication of the results of research on e.g. nutrition, poverty and infant mortality was not allowed. Brian Harvey (1995, 8) states that the possibility of poverty was denied in the communist system and that poverty was a hidden problem but never discussed in such terms.

[127] As to the free health care Tragakes and Lessof (2003, 68) notes that "free health care was in fact an illusion, as patients frequently had to make payments to doctors and nurses in order to receive care." Pidde et al. (2003, 83) argue that the mechanism by which the model functioned was coercive in that the Minister of Health was personally responsible for the state of affairs in every health care establishment.

were provided in in the rural areas by feldsher stations[128], rural health centres (hospital or ambulatory) and district hospital. In the urban areas the hierarchy of clinics and hospitals was the same but markedly more special health care services could be provided (for more Tragakes and Lessof 2003, 118-142). Health care personnel were well trained but their salaries were relatively low. Partially as a result of this, and the fact that especially in the 1990s payments were often delayed, informal payments became common (e.g. Aarva et al 2009).

The right to work is mentioned as the cornerstone of Soviet social security. Social protection was closely related to work and consequently divided into two parts, for the working population and the non-working (Mannila et al. 2000, 27). The function of working places was not only to offer work but also to provide social and health services. The state enterprises, for example, organised child day care, offered sports and cultural facilities, holiday resorts, as well as housing, social assistance, and training. Due to this, unemployment meant not only the loss of a job but also dropping out of the networks that provided social services and benefits. (Kivinen 2002, 106; Foley and Klugman 1997, 196-198; Manning 1993, 50; Piirainen 1997, 141-142, 226.)

Granberg and Riabova (1998, 174-176) state that social policy in the Soviet Union was organised to a high degree on the same premises as the western institutional model: the main concept was distribution and redistribution of the income. However, the essence was different "the Soviet system was not built to complement the market economy, but to replace it". Nick Manning (1992, 31) divides the development of social policy of the Soviet Union into five periods[129]. Common to all of them was that although some problems were recognised by the leadership, they were not discussed openly but instead denied. Piirainen (1997, 225-226) claims that there was no need for any "secondary" redistributive social policy because "the centrally planned allocation of resources and life chances was already social policy in itself".

The socialist countries provided state-funded health care and social services, which were "nearly universally available although comparatively of low quality" (Cook 2007, 1). Bob Deacon (1993, 6-8) has characterised the Soviet system as "a particular type of welfare state", a workers' state and a system of full employment, hidden privileges, free medical care, (but poor service, lack of equipment, and increasing mortality rates), guaranteed child day care, cheap housing (but small and modest), good social security (but work-related), and a low retirement age. He characterises the Soviet Union as an underdeveloped and inefficient economy,

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[128] Feldsher stations (фельшерско амбулаторный пункт). Feldsher is a specialist nurse-midwife providing primary health care and referring patients to policlinics or hospitals.

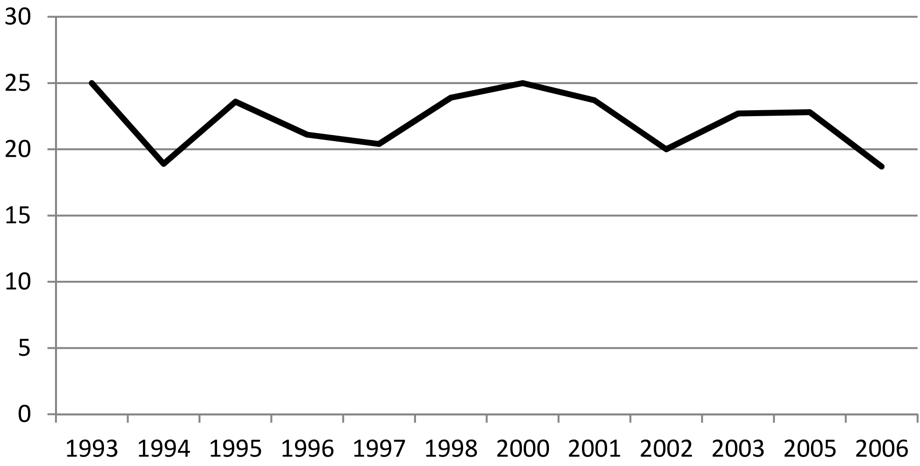
[129] Periods of Soviet social policy: 1) utopian model (1917-21) problems were seen as results of social disorganisation brought by war and capitalism 2) urban (1921-29) more debate about the nature and existence of social issues; sectional interests; 3) industrial (1929-57) social issues analysed and dealt with – rising housing problems with industrialisation 4) Khruschev: education reform, housing problem, time of politicisation of social problems but the reforms failed because power remained behind industrial managers , 5) 1964-1984 period of stability more than change. Instead of identification of problems and problem groups they were rooted out. "In a sense there were no social problems in the 1970's" given "unreal assurances of business as usual" (35-36).

which had attained some progressive achievements that, however, benefitted only the privileged party-state apparatus.

Deacon's account aptly describes the Soviet reality. However, the opinions of Piirainen (1997, 53, 224-245) that the quality of the services varied but covered the whole population and Boris Topornin (2000, 58-59), who states that even though the social protection was low, it was real and systemic are more in line with the author's personal observations[130].

Impact of the dissolution of the Soviet social protection system in Karelia

The Soviet social protection system was developed for more stable conditions and could not meet the needs of the new ones. The share of people living under the minimum subsistence level started to grow and varied between the years 1993 and 2006 from 18.9% to 25% (Figure 15). The corresponding figures in Russia in 1993-1999 varied in the range of 20.8 to 35.3% (Tilastokeskus 1999, 72).



Source: Statistics Finland 1999, Kurilo et al. 2007, University of Joensuu 2007

Figure 15: Share of population (%) living under the subsistence minimum level in Karelia in 1993-2006

The income inequality continued to expand and the growing gap between rich and poor started to widen further towards the end of 1990s'. In 1993 the income of the wealthiest 10% of the population was almost ten times that of the poorest 10%. As the Figures 16 and 17 show, the differentiation of the population continued throughout the period examined. (cf. Karjalan Sanomat 19 January 2000.)

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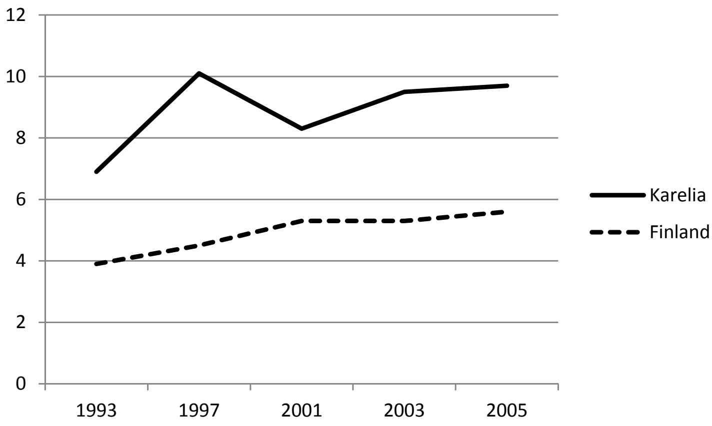
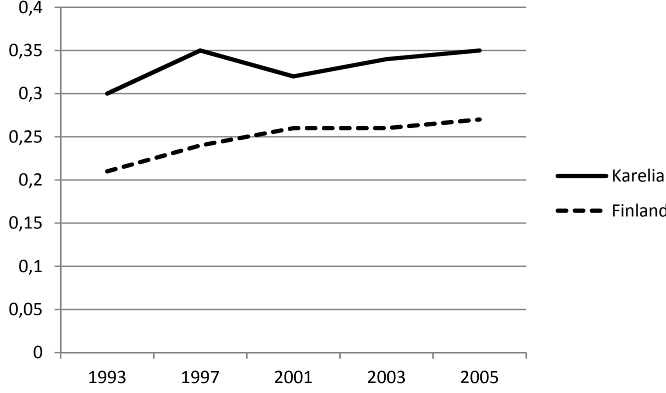
[130] The author lived in the Soviet Union, in Ukraine for six years 1979-1985.



Source: Kareliastat, Statistics Finland

Figure 16: Ratio of total personal incomes of the richest 10% of the population to the total personal incomes of the poorest 10% of the poorest in Karelia and Finland in 1993-2005



Source: Kareliastat, Statistics Finland

Figure 17: Development of the Gini[131] coefficients in Karelia and Finland in 1993-2005

Despite Katanandov's assurances that the government was striving to resolve the social problems and strengthen the economy in order to improve the social wellbeing of the population the share of the population living in poverty remained high (Karjalan Sanomat 25 March 2000, Karjalan Sanomat 20 March 2002).

The health and living standards of the population deteriorated and at the same time the birth-rate decreased and the mortality and morbidity rates increased (Figures 18 and 19). During the period 1998-2007 morbidity increased in all population groups.

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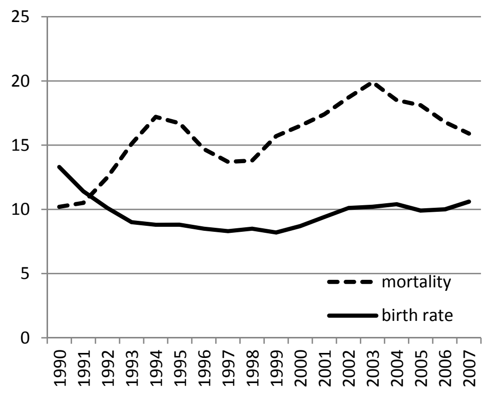
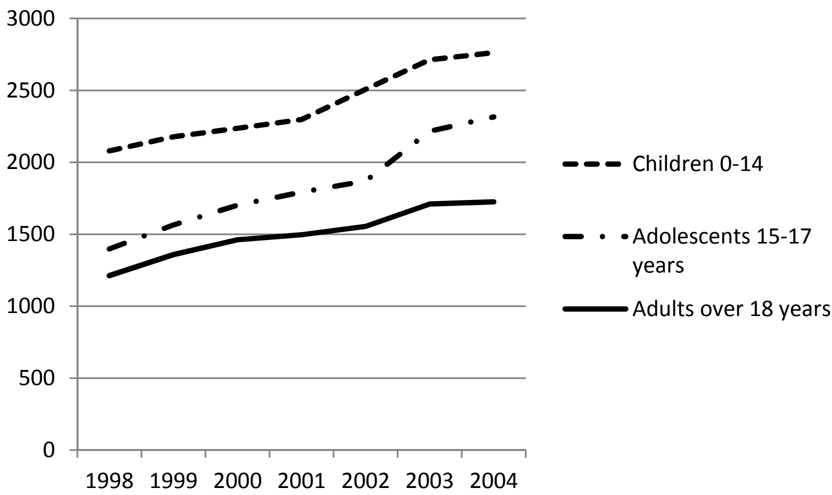
[131] The Gini coefficient varies from zero to one. Zero means full equality, while one means complete inequality.



Source: Demograficheskiĭ ezhegodnik Respubliki Kareliia 2008

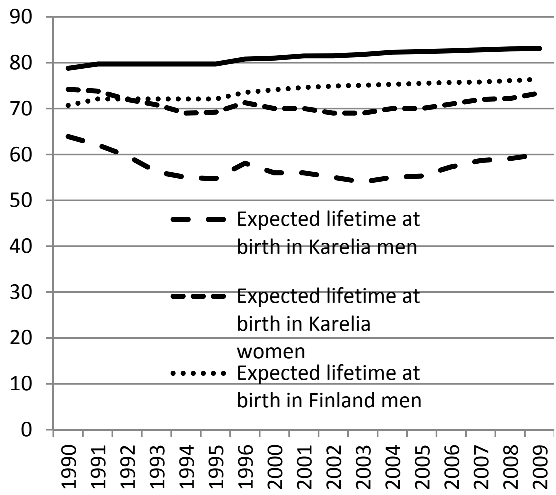
Figure 18: Birth and mortality rates (o/oo) in Karelia in 1990-2007



Source: Ministry of Health of the Republic of Karelia 2004

Figure 19: Morbidity rates (incidence) in Karelia in 1998-2004

Between 1998 and 2004 life expectancy at birth fell drastically, especially among men in Karelia (Figure 20). This trend is the opposite to that of western countries, where the life expectancy is increasing. For instance, the gap between the life expectancy of men at birth in Karelia and Finland increased from seven years in 1990 to almost 20 years in 2004. The corresponding differences for women are four years in 1990 and 12 years in 2004.



Source: Karelia: years 1990-2000 MOH of Karelia, years 2000-2006 Demograficheskiĭ ezhegodnik Respubliki Kareliia 2008, years 2007-2009 Karelstat, Finland: Statistics Finland

Figure 20: Expected lifetime (years) at birth in Karelia and Finland in 1990-2009

Unemployment, poverty and alcohol abuse[132] led to an increase in the number of families at risk[133]. Children were one of the groups seriously affected by the social transition[134] (e.g. Cerami 2006, 6; Gekkin 1995, 12-13; Grinblat 1997, 40-1; Paulovica 1995, 76-88). In the Soviet era children were considered to be one of the privileged groups of the population (Markov 1998, 69-70). During the years of *perestroika* the number of social orphans[135] increased four-fold in Karelia (Grigor'eva 2003). The Karelian Government mentioned the problems related to child protection and its development amongst the most burning issues in Karelia (Gekkin 1995, 12). Karelia adopted its own regional law on child protection in December 1995.

[132] In 1998 there were 2.5 million people registered as alcoholics at medical establishments. Alcoholism was the most common cause of death in Russia in 1996.

[133] Rimashevskaia (2003, 104-111) notes that in conditions of transition to a market economy the lives of families with children became hard when the state support for families decreased. The changed housing policy, privatisation of state dwellings, unemployment and a catastrophic fall in living standards caused the families to start to develop new survival strategies. See Förster and Tóth (2001) on corresponding phenomenon in Czech Republic, Hungary and Poland.

[134] Institutions for infants and women were linked to the health care system, while institutions for children over 3 years of age were included in the educational system (Leppik 1995, 25).

[135] Social orphans are children whose parents have either lost their parental right (lishenie roditelskyh prav) or who have abandoned their parental functions due to material reasons (neblagopoluchia) (Rimashevskaia 2003, 114). Lyudmila Shipitsyna (2007, 6-8) distinguishes social orphans of three categories: 1. children having no parents, as well as those children with parents whose parental rights have been taken away, whose parents are incarcerated or incapable of performing their parental duties due to their personal, social and moral characteristics, 2) orphan children and children deprived of parental care that have physical and psychological disabilities, 3) orphan children and children deprived of parental care with behaviour problems leading to susceptibility to criminal environmnents and lack of self-protection.

Several simultaneous processes resulted in difficulties in maintaining social and health care services. Privatisation and closure of the state enterprises led to unemployment and subsidised prices and the enterprise-based social benefits started to disappear. At the same time, state funding for health care, education and the social sector decreased. (Cook 2007, 62-70; Deacon 1993, 8-10; Granberg and Riabova 1998, 176-178, 191; Manning 1993, 46-59.)

Table 4 illustrates the scale of the problems and the complexity of the situation faced by Karelian society in the 1990s and the responses of the regional and federal authorities to them.

Table 4: Challenges and responses to them in social field in Karelia

	Situation in 1990s	**Measures taken**	**Situation in 2008**
Economy	Overall economic crisis - decrease of industrial production	Law on Joint Ventures 1988 Laws on privatization 1991 Free foreign trade Privileges granted to Karelia by the RF Fund of development and reconstruction	Stabilised: the economy remains one-sided based on forest industry and mining industry
	Unemployment	Law on employment (1991) Establishment of employment service offices in all the districts Ministry of Labour and Employment established 2004	Situation stabilised Low level of unemployment benefits The real unemployment level remains unclear, a lot of hidden unemployment[136]
	High inflation	Devaluation in 1998	Slowed down and stabilised at 10% level but still on high level
Administration	Dissolution of the Soviet administrative structures	Constitution of the RF 1993 Constitution of the RK 1993, 2001 Law on Local Self Government in 1994 (Karelia) Federal Laws on Local Government in 1995 (#122) and on Local Self-government (#131) in 2003	New Federal structures New laws adopted, failures in enforcement Insufficient funding for realisation of the obligations at different levels Unclearly defined responsibilities Differentiation between districts

[136] Hidden unemployment refers to cases when workers formally have employment, but there is neither work nor salary. People cling to their old "work collectives" even though the enterprises have ceased to produce anything. In some cases the crises-ridden enterprises were still able to provide the employees some basic necessities and they continued their existence for social reasons. (Piirainen 1995, 21-22.)

	Situation in 1990s	Measures taken	Situation in 2008
Wellbeing of population	Deterioration of the living standards	Establishment of the Ministry of Social Protection in 1994 Law on minimum subsistence 1996 Establishment of the Social Support Fund in 1992	The overall situation improved to some extent About 20% of the population live under the minimum subsistence level
	Weakening position of families with children Increase in social orphans Increase of families in risk	Decree "On imperative acts for protection of abandoned children and orphans" in 1993 Establishment of the Committee on Families, youth and childhood in 1994 Republic programme Deti Karelii 1995-1997 (Children of Karelia)	Centers for social services and rehabilitation established The process of integration of disabled children into society started and continues Lack of funds
	Weak position of disabled Lack of professionals (social workers)	The decree of the President of the Russian Federation on Measures of State Support for the Activity of all-Russian Associations of Persons with disabilities #254 of 22 December 1993 The Federal Law on Social Protection for Persons with Disabilities in the Russian Federation # 181 of 24 November 1995 Federal guidelines for the social protection of disabled (1995, 1996) Karelia: Legislation on social protection of the disabled (1993) Establishment of rehabilitation centres since 1992	Improved to some extent Insufficient funding: part of rehabilitation centres/departments have been closed Training of the social workers started
	Homelessness	Shelters in Petrozavodsk in 1996 (40 places)	Problem still acute
	Alcohol abuse[137]	Federal and Republic programmes on Healthy Life Style 2000-2011	Problem still topical High morbidity rates are related to life style including abuse of alcohol

[137] Before 1997 no official statistics on the use of alcohol were kept. According to the statistics after 1997 abuse increased steadily: 1997 – 6.18; 1999 – 6.85; 2001 – 7.94; 2003 – 8.8; 2005 – 9.6 litres of absolute alcohol /person (Karelstat 2008).

	Situation in 1990s	Measures taken	Situation in 2008
	Insufficient social services	Federal Law on Social Services to the Population (1995) Federal Law to the Elderly and Handicapped (1995)	Social service centres established Different forms of non-institutional care developed Inadequate or incompetent personnel in the institutions
	Deterioration of the health situation - increasing morbidity and mortality rates - decreasing birth rates - financial system - spread of tuberculosis	Law on Health Care 1993 Education of general practitioners started (Law on GPs' in 2001 – cancelled in 2006) Law on health insurance # 340 of 3.11.1994 National Priority Project 2006-2008 "Urgent measures for TB control in Russia for 1998-2004" (Decree of RF#582 of 11.6.1995) "On the prophylaxis and decreasing of TB incidence in the Republic of Karelia in 1998-2000" Concept of development of health care in the Republic of Karelia in 1999-2003 (#163 of 1.4.1999) Decree of the MOH RF #324 of 24.11.1995 "On improving TB control of the population in the Russian Federation" Decree of the MOH of the RK #59/23 of 14.2.1995 "On organising differential fluorographic examinations of the population of the Republic of Karelia" Decree of the MOH of the RK #290/34 of 28.12.1998 "On specific prophylaxis of TB in the Republic of Karelia	Emergence of new diseases (HIV) and re-emergence of some old (TB) Insufficient funding Insufficient health care services (especially in rural areas) Unclear financial rules, "informal payments". Serious environmental problems in some districts Inadequate health promotion Hazardous drinking and eating habits
	Inadequacy or outdated equipment	Support from foreign actors, projects National Priority Project	Improved Differentiation between districts and cities and rural areas continues
	Lack of medicine	Federal support Foreign support Law on medicine	Improved provision and selection of pharmaceuticals but increase in prices Differences between districts, cities and rural areas

The pressures for a reform of social protection were obvious. The reform strategy was not clearly articulated but topics were mentioned in several documents (Ministerstvo zdravoohraneniia 1995a; Ministerstvo sotsial'nogo obespecheniia 1994; Ministerstvo obrazovaniia Karelii 1993; Ministerstvo zdravoohraneniia 1994; Protokol…1995b) and the Karelian ministries clearly expressed their interest in European views and experiences of reform.

The Karelian administration initiated the identification of a comprehensive long-term development programme for social and health sectors in 1994 and "a new concept" for reforming of the social protection system was drafted[138] in 1990s. In the terms of reference for the Karelian health and social sector TACIS project it was noted that the absence of a republican and federal framework policy (including legislation), the lack of understanding and knowledge of the needs of the population, and a deficiency in financial resources, was an obstacle to tackling the most urgent issues. (European Commission 1996, 6.) The reforming process was linked to Russia's development strategies[139].

3.3 THE EMERGING RUSSIAN WELFARE MODEL

The period of *perestroika* 1985-1991 along with *glasnost* and new freedoms raised the hopes and expectations of the people towards the government and authorities. However, the expectation of a fast transition to a market economy was unrealistic (Blaho 1994, 44) and in many cases turned into disappointment (Nystén-Haarala 2001, 22) and nostalgia (Topornin 2000, 58)[140]. The reforms did not bring wealth as quickly as anticipated and the civil activity that arose during the first years of perestroika already started to decline by the mid 1990s (e.g. Malinova 2010, 182-183). It is claimed that "the reform measures came too late for real results and their conceptual unclarity, coupled with the retarded and watered down implementation, were doomed to fail at the conception" (Blaho 1994, 6-8). Granberg and Riabova characterised the social policy of the 1990s in Russia as "harmful and dangerous because it was not capable of coping with the alarming differentiation and disintegration of Russian society, processes are regionally uneven, leaving

[138] Comments on the draft were requested from Finnish experts.

[139] The Minister of Social Protection of Karelia, Valery Semenev, noted in the joint Finnish-Karelian seminar in Helsinki in May 1995 that the main strategic principles corresponded to those defined in Russia (Protokol 22.-24 May 1995).

[140] Attitudes towards changes varied. Simpura et al. (1999, 55) referring to Pakkasvirta (1999) on the basis of the results of a survey carried out in St Petersburg in 1993-1994 distinguishes four main attitudes towards the change of life: 1) the beginning of a new positive era; 2) the changes were necessary, but poorly implemented; 3) embarrasment and disorder and 4) difficulties and collapse. According to Mošes (Helsingin Sanomat 8 July 2009) due to control of media and communication, the population of Russia is not aware of the real situation in the country. A great part of people of Moscow still seemed to believe that Soviet Union collapsed due to the reforms initiated and in particular because the opposition was allowed to get stronger and criticize the authorities.

less-favoured regions in a very different position (1998, 171-172)".[141]

Institutional changes influencing social protection

As described above, social protection was organised in the FSU in a special way: the state owned enterprises organised and provided social and health care services. Dissolution of the state and privatisation led to changes in the service provision policies, which for its part resulted in deteriorating health of the population and the emergence of new problems. The Soviet welfare system started to collapse. The old allocation norms for the revenues for social expenditure were abandoned in 1991. The starting point for the solution of the problems was quite weak, as the existing social security system did not function well enough to cope with new social problems (Hanhinen 2001, 9).

The decisions on institutional and structural changes made by the federal authorities were reflected in developments in Karelia. In the political field the treaty between Karelia and the Russian Federation (1992) and the new federal Constitution (1993) confirmed the position, rights and obligations of Karelia in the Federation and defined the main political institutions of Karelian society: the Constitution, the Government and the Parliament. In the economy privatisation was started in Karelia in 1992 and completed by 1997. Private property became equal to state, municipal and other forms of ownership. Private entrepreneurship and the markets (labour, goods) started to form and direct foreign trade was permitted for companies. In the field of administration the decision-making powers were decentralised (1995) and the responsibilities were divided between three levels of administration: federal, republic and local level. In the legislation numerous new decrees and laws were adopted. In accordance with the Constitution of the RF, Karelia (like all federal subjects) had the right to enact its own legislation to be enforced in its territory[142]. How did all these changes influence the development of social protection?

Social policy, its development and implementation depend on the economic resources of a society, on its will and ability to invest in social policy (Niemelä et al. 1996, 104). Piirainen and Turuntsev (1998, 153-154) stress that reform of the social protection system "must be an integral part of the overall development of economy and society, and social policy must contribute to the attainment of the major goals set for economic policy...".

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[141] Understanding the new phenomena that appeared with the emerging market economy was difficult for a notable part of the population in the 1990s (e.g. Kurilo et al. 2007, 32; Tragakes and Lessof 2003, 192-193; Mikhalev 1996, 6-7) and people still believed in the state and saw it as their major hope for improvement (Granberg and Riabova 1998, 176-178, 191; Melin and Nikula 2005, 21-22). However, the results of a survey carried out in St Petersburg in 1998-2000 (Mannila et al. 2000, 37) concluded that the interviewed people did not expect much from their public services. Rose reports (2003, 124) about the results of the survey carried out by the All-Russian Center for Public Opinion Research in 2000 (in the frame of the New Russian Barometer project) which show that over three quarters are adapting to the new conditions: 42% has already adapted, 30% strive to adapt and 8% answered that they live as before without noticing changes and 20% (mainly of age over 60 years) that they are not able to adapt to post-soviet changes.

[142] Karelia passed, for example, laws "On patients rights", "On primary medical care" and on "General practice", which did not have parallels at federal level (Tragakes and Lessof 2003, 188; also Topornin 2000, 25-51).

Throughout the 1990s the situation with the financing of social protection and health care expenditure was complicated as the republic and district levels were dependent on the federal budget. The local budgets consisted of local taxes and fees, financial support and subsidies from the state and bonds. However, the tax revenues that should have formed the basis for the budget remained modest, partly due to a widespread "grey economy"[143]. Sutela notes that although Russia has had the image of a country that cannot collect tax revenues, the share of tax revenue was never very low. The real problem was on the expenditure side and the inherited excessive welfare obligations and a very heavy military burden. On the other hand he argues that the Russian state helped to form a culture of non-payment: "if the state did not care about its commitments, why should companies pay taxes, wages or for purchases from other companies". (2003, 158-165.)

New enterprises were not obliged to continue the Soviet practice of the provision of welfare services (Kananoja 1997, 17; Kosonen, 2004, 19; World Bank 2002, xvi-xvii) but in many cases it continued (e.g. Liborakina and Rotkirch 1999, 28; Kortelainen 2004; Sutela 2003, 163-164). According to a survey carried out in Russia, the social benefits as an element of salary have gradually started to lose their meaning, as they are not as "qualitative" as before (Vinogradova 2003, 58).

In health care the problems were also related to previous health care structures and the traditions of institutional care, which remained almost unchanged (Tragakes and Lessof 2003). Most of the health care premises belonged to the state and the health care institutions were directly subordinate to the Ministry of Health. Insufficient funding of new technologies, equipment and medical supplies led, on the one hand, to declining morale among health care professionals and a lack of incentives to improve the quality of care, and on the other, to diminishing trust among the population in the system. (Rowland and Telyakov 1991.)

Financing of social protection

One striking feature of the post-Soviet system of social protection was the fragmentation of funding sources and responsibilities. During the period under examination social protection and health care were financed by the state, regional and district budgets and by special funds. The general financing principles were that:

- All the acts defined by the federal laws and adopted at federal level were to be financed from the federal budget.
- The republic budget was to cover the costs for additional regional measures defined by the republic laws, decrees and other regional target programmes adopted at republic level.
- The district budgets were to finance the measures approved at local, city and district levels.

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[143] For more about the "grey" or "shadow" economy, see for example, Sutela 1993, 88-90. Ruutu and Johansson (1998, 31) state that the most powerful monopoly companies in Russia, in the electricity and gas industries and in railway transports, did not pay taxes to the state, which limited the state's capacity for investments.

Since the beginning of the 1990s, four federal funds[144], ministries and local governments contributed to the financing of health care and social protection. The laws on funds were interpreted and followed differently in the Russian regions[145] and their enforcement remained incomplete. The funds did not function properly and the expected result was not achieved. According to Axelsson (2002, 146-153) the structure itself was problematic; it was perceived as being too fragmented and divided, since the different social funds functioned quite independently and with very little coordination or cooperation between them. Federal laws governed the tasks and responsibilities of the Pension, Health Insurance and Employment Funds, while the Social Insurance Fund was regulated by government decrees (ibid. 13). Rates of contributions were decided by the Federal Government and the State Duma, all social funds "belonged to the state" and were mainly paid for by employers.

The director of the Health Insurance Company Petromed (Karelia) stated in December 1997 that services for the population had not improved and remained insufficient because, in practice, none of the most important economic mechanisms on which the insurance system was based functioned (Severnyi Kur'ier 15.12.1997). Almost ten years later, in November 2006, the then deputy prime minister of Karelia stated that the main goal of the (health insurance) law was still unattained and that the insurance principles had not become common in the country (Karjalan Sanomat 16.11.2006; also Kontseptsiia…1999, 4).

Russian welfare model

When the developments in Russia are examined it is obvious that there have been serious attempts to improve the wellbeing of the population since the beginning of the 1990s. The main problem may be that the social policy has not been actively developed but the changes occurred as side effects of economic reforms. The reforming and restructuring of Russian society began with crucial institutional changes aiming at a transition to a market economy within a few years. The emphasis was on economic reforms, while health care, education and social protection remained secondary priorities. Priority was given to issues that were considered to relieve pressures on the state budget (Cook 2007, 185). Liberalisation, privatisation and decentralisation, all aimed to restrict the state's role in the welfare structures.

Linda Cook's (2011, 15 also Cook 2007, 135-136) description of the development of the Russian welfare model illustrates how changes in the social field took place. She divides the development into three periods: initial liberalisation (1991-1993), deadlock or the period of incipient democratisation (1994-1999) and then

[144] Pension Fund (established in 1990), Employment Fund (established in 1991), Health Insurance Fund of compulsory medical insurance (established in 1991), and Social Insurcance Fund (established in 1991). See more e.g. Danishevski 2005, Axelsson 2002,142-154; Nemtsov 2003, 368-373, www.pfrf.ru/for_employers/ (17 February 2011)

[145] In the Ulyanovsk *oblast* the local authorities decided to ignore the Russian system of compulsory medical insurance 1992-1996 and continue funding health care institutions of the region mainly in the same way as before 1992 (Konitser-Smirnov 2003, 245). Marquand argues that laws in Russia were made separately by the regional and federal duma and by presidential decree. "Often they were contradictory, or at best obscure. There were no clear rules for federal subsidies to the regions. So the regions did as best they could, taking notice of federal law only when it suited them" (2009, 38-41).

breakthrough, which was followed by democratic decay and a reversion to statism (since 1999). The liberalisation started with radical changes that were often poorly developed and implemented. Privatisation of state property led to a change in the role and functions of the former state enterprises, which could no longer act as key institutions for social services (Kivinen 2010, 19).

Several welfare reforms have been initiated and carried out but due to political opposition and "statist-bureaucratic welfare stakeholders, particularly from social sector ministries that had a vested interest in the inherited system" (Cook 2011, 17), the reform process took some steps back instead of a step forward. The reform proceeded "haltingly and inconsistently". Putin's election to the office of President and the simultaneous gradual economic recovery marked a change in the reform process but the direction continued towards the liberal welfare model[146]. First, Gref's welfare reform was introduced in spring 2000, which emphasised the major role of markets and the private actors as producers and providers of services (Cook 2007 153-157 table 4.3.; 2011, 17-21). The second crucial step away from the Soviet welfare model was the adoption by the federal Duma in 2005 of federal law #122 that aimed to replace some of the benefits in-kind from Soviet times with a simpler and more modern system of cash payments. The changes were necessary as the existing system did not correspond to contemporary needs and did not include, for example, unemployment benefits. The "monetisation reform" was hastily prepared and proved controversial. The law provoked nationwide protests against Putin's administration and forced the government to make several concessions, which undermined the basic rationalising thrust of monetisation. (Cook 2007, 179-182; cf. Rasell and Wengle 2008; Cook 2011, 20; Kivinen 2009, 128-132.)

Later, in 2005, Putin turned the direction "back toward statist welfare policies" with the introduction of Priority National Projects (PNP) in health, education and housing and new demographic policies (Cook 2 011, 14). The PNPs were generated in a 'Soviet way', within the state institutions without independent specialists. The PNPs revived a view of the state as a strong actor in social policy that forms and shapes the society, takes responsibility and acts on it (Cook 2011)[147].

Decentralisation was a part of the liberalisation project. The aim was to delegate rights and powers from the higher hierarchical structures to lower levels. Both de-

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[146] Liberal welfare model is one of the three models distinguished by Esping-Andersen in his famous publication The Three Worlds of Welfare Capitalism (1990). The two others are conservative-corporatist and social-democratic. For the liberal model characteristic is: restricted role of the state and public health insurance, public support targeted mainly for specific groups, income security based on private insurances, strong private sector provides most of the health care and social services as well as education, differences in incomes wider than in the other systems. The conservative-corporatist model is characterised by a moderate level of decommodifcation, the direct influence of the state is restricted to the provision of income maintenance benefits, insurance based system, NGOs supported by the state organise especially child care and home help services, most health care services provided by the private sector through insurance schemes. The social-democratic model the level of decommodification is hight, there is universal social security, health care and education system, based on taxes and other contributions, strong public sector, private sector, NGOs and church also service providers, small differences in incomes.

[147] Cook (2011, 31-32) argues that the PNPs did not respond to societal need and "their goal is not mainly social justice and distributive rationality, but economic and military power, the strengthening of human capital and military preparedness".

centralisation laws (1995 and 2003) aimed to strengthen the role of the municipalities and delegate them wider responsibilities for service provision. The laws had the same shortcomings: the obligations delegated to the municipalities did not correspond to the financial resources allocated for these purposes. At the same time the public pressure to improve the health care system was weakened by intensive networking, institutionalisation of informal structures and continued use of the Soviet model of service provision. (Salmi 2006, 93; World Bank 2011, 29-31; Rassell 2008, 9; Sutela 2003, 163-165 .) The deep rooted attitudes and expectations of the employees and local authorities sometimes do not enable enterprises to alter the previous practices as a "refusal to provide traditional services would create a hostile environment that would be risky for his business" (World Bank 2011, 30)[148].

Decentralization started to turn into recentralization at the turn of the millennium. Putin established the seven federal districts, or so-called super regions[149], which functioned under the presidential administration. In 2002, the regional governors were excluded from the Federal Council and in 2004 the direct elections of governors were cancelled and the power for their appointment vested in the Federal President. The executive power was made into a completely vertical structure. (Gel'man 2009; also Heusala 2005, 234-270.)

Consequently, although liberalisation was started in all fields it was not carried through. The insufficient institution building and retention of important Soviet institutions led to the incomplete support and development of markets and civil society. The Putin era policy did not encourage the population to be active and discuss political issues. On the contrary, they were encouraged to obey the Kremlin (Melin and Nikula 2005, 150). The role of civil society organisations was restricted and some of the earlier established national and governmental committees were abolished (Cook 2011, 31; cf. Dzihbladze 2005, 182-187; Kivinen 2002, 80; Kivinen 2008; Tragakes and Lessof 2003, 43). The role of organisations of social classes and NGOs remained modest in the formulation of social policies when compared to western countries and the role of the key players was occupied by specialised elites and professional organisations. (Kivinen 2010, 19; also Nikula et al. 2005, 31.)

The inconsistency in policies and decision-making was reflected in slow institution building, which according to Kolodko (1999, 17-18) formed an integral part of transition and a precondition for successful transformation. Many of the new institutions were built by people who had previously worked in the Soviet institutions, which led to a transfer of the "old ways of doing things" (Iivonen 1993, 47; Piirainen 1993; Rautava and Sutela 2000, 123-150). Kivinen (2010, 15) notes that a characteristic of the existing Russian system is "weak institutions of everyday security and welfare". (also Ministry of Defence 2008, 30-31.)

The Russian welfare state has only marginally succeeded in reducing poverty among people in need (Cerami 2006, 12-13, 16-18). It is estimated that it will take many years to create the preconditions for welfare in Russia and that the key challenge is to establish new social policy structures: both resources and rules of the game (Kivinen 2009, 135; 2010, 19).

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[148] See also an example provided by Nikula et al. (2005, 35-59) from the district of Priazha in Karelia.
[149] see footnote 87.

3.4 CIVIL SOCIETY DEVELOPMENT IN RUSSIA AND KARELIA

The existence or non-existence of a civil society[150] in the Soviet Union is an issue discussed by several scholars. Many of them are of opinion that it existed formally but was very weak and did not fully correspond to the western understanding of a civil society. (Shlapentokh, 1989; Shlapentokh 2001, 116-117; Kivinen 2002, 43-44; Melin 134-137; Granberg and Riabova 1998, 194-176, 183.)

In the Soviet era "the voluntary social organisations" were controlled and managed by the party organs and their task was to support official policy. Jelena Zdravomyslova (2005, 206) divides the history of social movements and NGOs during the perestroika in Russia into three phases: 1) Pre-political phase before 1988, when the struggle for civil rights was semi-official, half legal and only a little political; 2) Political phase from 1988 to 1991, when the struggle for civil rights and the free functioning of NGO's became a part of the general movement for the subversion of the Soviet system; and 3) the legal phase after 1991, when the NGO's became actors of the developing but weak civil society in Russia. (also Dzhibladze 2005, 176-180.)

As a result of the difficult economic situation and deterioration of the social situation of the population, some of the NGOs strove for cooperation or "social partnership" with the state powers in order to be able to participate in resolving some social problems. The aim of the NGOs was to provide support and services to such groups of the population that received inadequately or no support from society. Suvi Salmenniemi (2005, 197) states that due to the withdrawal of the state from its social obligations the wellbeing of citizens became, to a larger extent, a responsibility of the families and non-governmental organisations[151]. (cf. Kay 2011, 75.)

During the first years of *perestroika* civil activity rose sharply and thousands of NGOs, as well as tens of political parties, societies and associations emerged all over the country. In the 1990s the speed slowed and during Putin's administration the function of the non-governmental organisations met several restrictions and difficulties (Dzhibladze 2005, 184). Averin and Praždnov (1995, 56) state that the sharp decrease in civil activities after the elections of 1990 may have resulted from the failures of the administration to realise given promises, dire deterioration of the economic situation and the standard of living, and the fact that the market economy did not bring the promised welfare to the population but instead inflation and unemployment.

Why has the development of civil society and civil movements remained so modest in Russia? Granberg and Riabova (1998, 184-185) state that the actions of civil society and civil movements may cause a counter-reaction to Communism

[150] Civil society has been defined "as the political space between the individual and the government, expressed by membership in NGOs, social groups, associations and other organisations that may, among other things, advocate political positions on behalf of their members". Civil society can also be seen as a "third sector", distinct from government and business, which refers to "intermediary institutions", such as professional associations, religious groups, labour unions, citizen advocacy organisations, giving voice to various sectors of society and enriching public participation in democracies. (OECD 2005.)

[151] Sari Hanhinen notes that one of the functions of civil society and the third sector is to undertake some functions of the state in the social sector and that the Russian non-governmental organisations have not been able to do this (2001, 12).

in the mentality of the population thereby negatively affecting their willingness to participate, especially in cases where the aim is to cooperate with the state or public organisations. The ordinary citizens do not appreciate NGOs and participation in them due to their past experiences; in Soviet times, the leaders often took advantage of their positions in organisations. The people have lost their trust in participation in organisations and have a distorted picture of it. Despite unwillingness to participate in organisations, people are willing, and even expect, to receive aid from them when needed. (also Zdravomyslova 2005, 209.)

The lack of a charity work tradition[152] and the absence of functioning infrastructure, have also influenced the weak development of civil society. The strong tradition of dictate policy in the Soviet era and the passive role into which the citizens were forced still affects the behaviour of the people. The historical, political and cultural starting points for the development of civil society in Russia have been weak. (Boĭchenko 2005, 242; Dzhibladze 2005, 171-172; Kivinen 2002, 210-211; Skvortsova 2005, 38.)

At the beginning of the 21st century a new phase started in the relations between the state and NGOs through the coinciding emergence of new forms of cooperation and the increase of state regulations and control over the organisations (Salmenniemi 2005, 191). President Putin's administration took a bipartite stand toward NGOs: on the one hand, it recognised the existence of civil society and the social partnership between the state and NGOs in official speeches but on the other hand, it attempted to create a system of selective corporatism. Selective corporatism is used here to refer to a system that supports organisations that are expected to support and promote the official policy of the state. Several new laws restricting the functions of NGOs were adopted after the millennium. (Zdravomyslova 2005, 212; Dzinbladze 2005, 185-187; Chirikova 2007, 43.) Though the voluntary, non-governmental sector remains weak and underdeveloped in Russia it does exist. At least in part because civil society is still very fragile and not firmly settled the restrictive laws of the past few years have seriously undermined it.

Salmenniemi (Helsingin Sanomat 21 August 2009) states that civil society in Russia seems to be divided more clearly into two camps. The first works in close cooperation with the authorities e.g. youth organisations, social and health sector actors who often provide services that the state cannot provide and are therefore useful to the authorities and supported by them; their actions do not present any threat to the political system. The second group includes human rights and environmental organisations and organisations studying corruption that are on a permanent collision course with the political and financial interest groups. She also notes that in the current situation public criticism towards those in power demands exceptional courage in Russia.

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[152] Skvortsova noted in her presentation in the seminar Division of Labour between State, Private Sector and Third Sector in Helsinki 2007 that actually charity work has deep roots in Russia. She noted that mutual help and philanthropy was a part of Russian history that was liquidated after 1917 and re-emerged in the mid 1980s.

Karelian civil society development

Active citizenship[153] is required for the formation of a civil society and a functioning democracy. Since the beginning of the 1990s several political parties, NGOs and other organisations[154] and associations have emerged in Karelia (Liikanen 2001). A Karelian scholar, Larissa Boĭchenko, (2005, 241) states that in her opinion in addition to active citizens many civil servants and politicians in Karelia have also come to better understand the meaning of civil society and the constitutional state due to the geographical location of Karelia in the border regions with the Nordic welfare states.

In 2003, there were about 1,000 registered non-governmental and non-commercial organisations in Karelia[155]. Most of the organisations (256) acted in the social field and of those 75% were in Petrozavodsk. About 50 of them were involved with the problems of families and children. According to another source, (Seniukova 2005, 75) in 2005, 16% of all registered NGOs in Karelia's public sector were in the social field (183) and 17% of them dealt with issues related to women, 16% to children, 67% to war veterans, the elderly and the disabled. Many of the NGOs often received financial support from local and foreign sponsors[156] (ibid.; also Boĭchenko 2005, 241; Mikkola 2008, 337.) and according to Melin and Nikula (2005, 147) only very few of the associations and societies were well organised and hold regular meetings.

Arsenyi Svynarenko (2005, 84-88) suggests that two factors are characteristic of civil society in Karelia: first, people's low trust in the institutions of civil society, and second, there is a clear gap between the private and public spheres, a gap between "we" family, friends, the President, the church and "the Other" – the government, parties, the police, and the army. As a result of the lack of trust in existing institutions people are not interested in participation in parties and organisations, which would be essential for the development of civil society and democracy[157]. (also Lagus 2003, 304.)

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[153] Arseniy Svynarenko (2005,84) refers to Bendix (1977) and divides citizenship into 1) active based on the achievement of rights through social struggle and to 2) passive handed down from above by the state.
[154] According to a survey conducted in 2002 in which 1000 respondents participated in Petrozavodsk, Priazha and Kondopoga 52% of 18-22 year olds take part in the activities of public organisations. However, it is necessary to note that about half of them are members of the trade unions and "can hardly be associated with active participation" (Melin 2005, 85).
[155] For the sake of comparison: in 2006 in Finland there were 70,000-80,000 associations to which belong over 4/5 of the population (Taipale 2007, 64). According to Konitser-Smirnov (2003, 256) in Samara *oblast*, in Russia 3,292 NGOs were functioning in 2000, a large share of which provided social services.
[156] According to Boĭchenko there is no coordination of actions and nobody knows how much funds flows to Karelia through these channels or their share of the total budget of Karelia (2005, 241). The same problem exists in the social sphere: there are no records of the international social and health care projects funded by foreign actors in Karelia.
[157] During the international summer school in Petrozavodsk in 2006 in one session was discussed issues related to the third sector. The students were asked if the foreign financial assistance had hastened the process of transition in Russia and the building of an independent and influential third sector, and what kind of difficulties exists in this regard. The following kind of comments were noted: "…there is no independent and influential third sector in Russia, independent newspapers come again under the control of the authorities","People do not trust organizations", "People have also other, more urgent difficulties to solve than deal with a third sector, they want solutions for their own problems", "Older people still have "Soviet" attitudes, thus a change will take a generation" (for more Demidov and Heininen, 2006).

The initiatives of NGOs are highly appreciated in some districts of Karelia. In Segezha district, the local administration cooperates closely with the local NGOs, for instance, in the development of child protection services (Grinblat 1997, 126-128).

3.5 INTERNATIONAL SOCIAL SECTOR COOPERATION

Finnish-Karelian cooperation[158] started immediately after the borders "opened" at the turn of the 1990s[159]. The cooperation spread to different levels and was implemented by diverse actors. The first steps of cross border cooperation with Karelian were taken by Finnish non-governmental organizations and municipalities from the border regions (Eskelinen, Haapanen and Druzhinin 1999, 333; Karjalan Maa 2.11.1995). Why were Finns so eager to support Karelia? The cooperation was wide not only because of the geographical proximity and the common history of the two countries (e.g. Kirkinen et al. 1994) but can be explained also by certain other factors. For Finns, Karelia is an undefined concept that refers to diverse issues and areas: to geographical areas populated by Karelians, to areas ceded as a result of the Winter War; or to so-called East-Karelia i.e. Karelia on the Russian side of the border (Kangaspuro 2003, 1-2). Kangaspuro suggests that the picture of Karelia is more often based on images or mental pictures than on personal experiences. Oksa (1999, 286-293) writes about social images or mental constructions, "mixtures of facts, emotions, and narratives of the common past and desired future which are shared and produced socially" in regard to Karelia.

In addition to the geographical proximity and history there are similarities between the regions on both sides of the border in their peripheral location from the state centres, rich forest reserves, and sparse population (Eskelinen 1995, 88). Ijäs (1999, 12) has defined eight motives for cooperation: a purely altruistic wish to help, fear, pity, commercial interests, regional interests, export of values, cultural factors and others. In the case of Karelia there were also critical and negative attitudes among Finns towards helping (e.g. Leppänen 2005, 154; Rouge-Oikarinen 2009, 84-85).

Initially, the prevailing form of cooperation was at local level and relatively small in scale. The second half of the 1990s was the golden age of cooperation: humanitarian aid continued, several new long-term (three-year) projects and the only EU financed TACIS project were implemented. Since the end of the 1990s the role of the multilateral programme type cooperation within the EU's Northern Dimension policy gained strength.

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[158] In addition to Finland, other Northern European countries have also cooperated with the Republic of Karelia since the beginning of 1990s. However, in this case the focus is on Finland's and EU's support to Karelia.

[159] There are several registers, reports and reviews on the Finnish actors who implemented projects in Karelia in 1990s. e.g. Joensuun yliopisto (1993) Karjalan tasavaltaa, Pietaria, Leningradin aluetta ja Baltian maita koskevat hankkeet vuonna 1993; STAKES Kartoitus suomalaisten sosiaali- ja terveysalan yhteistyöhankkeista Baltiassa sekä Pietarissa ja Leningradin alueella (24/1996); Itä-Suomen lääninhallitus (1997) Sosiaali- ja terveydenhuollon lähialueyhteistyö Joensuun palveluyksikön alueella Lähialueyhteistyörekisteri; Itä-Suomen lääninhallitus (1998) Sosiaali- ja terveydenhuollon lähialueyhteistyö Pohjois-Karjalassa Lähialueyhteistyörekisteri; Stakes, (1994) Kuvaus suomalaisista sosiaali- ja terveydenhuoltoalan yhteistyö- ja avustushankkeista Karjalan Tasavallassa 1992-1994.

Form/Time	1990	1995	2000	2005
Humanitarian				
Bilateral non-commercial/ governmental and non-governmental cooperation				
Multilateral commercial				
Multilateral non-commercial				

The darker and stronger the line, the bigger the role of the cooperation

Figure 21: Social sector cooperation with the Republic of Karelia in 1990-2008

The official neighbouring area cooperation between Finland and the Russian Federation is based on an agreement on cooperation signed in January 1992. It aimed to facilitate and encourage regional and local authorities on both sides of the border to cooperate directly and thus support the development of the cross-border cooperation. The objectives of Finland's neighbouring area cooperation were defined in five strategy documents[160] approved by the Finnish Government. The first strategic plan for cooperation with the neighbouring areas[161] was adopted in 1993. The aim was to promote good relations between the parties and alleviate and prevent the spread of phenomena with predicted adverse effects[162] on Finland. The difference in the level of socio-economic development in the Finnish-Russian border region was at that time – and still is – the biggest in the world (Eskelinen 1995, 88). The assistance was supposed to be temporary and dependency relations were to be avoided. The present neighbouring area cooperation is based on the strategy approved by the Government of Finland in April 2004, it emphasises the commitment of the partners to cooperation, as well as its productivity, durability, sustainability and effectiveness beyond the scope of the project activities (MFA 2004).

Humanitarian aid carried out by NGOs, municipalities, institutions as well as private persons had already started during the second half of the 1980s. In 1992, the Government of Finland granted its neighbouring areas about 5 million euros (30 million FIM[163]) for humanitarian aid in the form of food products for children and medicine. Most of it, over 4 million Euros (25 million FIM), was used for

[160] Keski- ja Itä-Euroopan toimintaohjelma Suomen toimintastrategia, 1993; Keski- ja Itä-Euroopan toimintaohjelma Suomen lähialueyhteistyön toimintastrategia, 1996; Suomen lähialueyhteistyön toimintastrategia Tarkistus, 1999; Finland's strategy for Cooperation in the Neighbouring Areas, 2000; From Support to Partnership – Finland's strategy for cooperation in its neighgouring areas 2004.

[161] Covered Murmansk, the Republic of Karelia, St. Petersburg, and Leningradskaya *oblast*. In the Action Plan of 1996 the Baltic countries (Estonia, Latvia and Lithuania) were also included in the group. They were excluded in 2005 after their accession to the EU.

[162] See Pursiainen (2001) on so called soft security threats.

[163] Prior to Euro Finland's national currency was Finnish Mark (FIM).

the purchase of food, transportation and administration and the remainder for medicine.[164]

The Finnish-Karelian bilateral non-commercial, governmental and non-governmental cooperation financed by the Government of Finland, regional authorities and various organisations continued actively through the 1990s. The priority areas in the social sector have mainly remained the same (primary health care, HIV/AIDS, tuberculosis, health promotion). The financial volumes varied between 2.5-3 million Euro / year[165] until 2007.

Not only the form and nature, but also the actors and content of the cooperation have varied. Among the first Finnish actors were municipalities and district authorities from the border regions. Hannu Ijäs (1999, 50-55), who studied social sector cooperation from the point of view of a municipal actor, discovered that in the 1990s the emphasis shifted from the local level professional contacts conducted in the frames of the twin-city cooperation to district level cooperation, first, with a view to greater involvement of governmental actors and subsequently to increasing the role of multinational actors. The Karelian partner divides the cooperation into the following four periods[166]: 1) before 1994, a number of small, short-term projects of a humanitarian character. The first period helped to illustrate that firm cooperation requires a common idea; 2) the period from 1994 until 1996 was "very significant" for the Republic of Karelia. The emphasis was on specific longer term projects concerning the development of maternity welfare, disabled and primary health care services; 3) from 1997 until 1999 the TACIS project was implemented simultaneously with over a hundred other development projects. For the first time, health care system was approached from a social problem perspective and 4) the period from 2000 onwards, characterised by a focus on primary health care and general practice as defined in the law on public health of 2000, contagious diseases, support for a healthy life style, and child protection and youth policy.

Since the mid 1990s the tendency has changed from small local level projects to larger multinational, international cooperation efforts. The multilateral non-commercial cooperation in the framework of the Northern Dimension and other international formations and organisations is characteristic of the cooperation since the turn of the millennium.

The Partnership and Cooperation Agreement between the European Union and the Russian Federation forms the legal basis for EU - Russia relations. The agreement was signed in 1994 and came into force in 1997. The agreement covers a wide range of policy areas, sets the principal common objectives, establishes the institutional framework for bilateral contacts, and calls for activities and dialogue.

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[164] Additionally the MFA granted about 83 000 Euros (FIM 500 000) for delivery of hospital equipment no longer in use in Finnish hospitals to the neighbouring areas in Russian Federation (Sosiaali- ja terveysministeriö, 1993a). Also Finnish Red Cross (1992).

[165] Exact information about the total amounts was not available. According to the information received from the MFA (Ulkoasiainministeriö 2008) in 1990-2001 the Finnish support was 19.8 million Euros, in 2002 - 1.1 million Euros between years 2003 – 2007 from 2.4 to 3.1 million Euros per year. In addition to that 3.8 million Euros was granted through NGOs in 2000-2007. N.B. these amounts cover all neighbouring areas.

[166]http://www. kareliainfo.org/page.do?id=98 (visited on 6.2.2008).

The European Union has supported Russia during the transition period through different programmes (Rouge-Oikarinen 2009). TACIS (Technical Assistance to the Commonwealth of Independent States) was launched by the European Commission in 1991. TACIS provided grant-financed technical assistance to 13 countries of Eastern Europe and Central Asia (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Mongolia (until 2003), Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan). The aim was to support them in their transition to market economies and democratic societies. The European Neighbourhood and Partnership Instrument (ENPI) replaced the TACIS programme from 2007 on.

The TACIS indicative and action programmes were drawn up between the partners and assistance in addressing the social consequences of transition (reform of the health, pension, social protection and insurance systems, assistance for social reconstruction and retraining, etc.) was one of the main fields of cooperation.

4 Methodology and methods

This chapter introduces the methodology, data collection approach and the main research method. Chapter 2 introduced the two theories which also affected selection of the suitable research methods and also suggested what kind of data is needed. One of the data collection methods used was a survey conducted in Karelia; its preparation process is described below. Before considering reliability, validity, generalisibility and the ethical issues related to research, the main research method - case study - and the selection criteria for the case projects of this study are described.

4.1 METHODOLOGY

For this study qualitative methods were considered to be the most appropriate[167]. They allow going deep into complexities and processes and consider informal and unstructured linkages and processes. Qualitative methodology calls for interpretations and observations and a consideration of phenomena in wide contexts (Stake 1995, 41-43). It includes several different research methods and strategies including experiments, surveys, archival analyses, histories, field studies, ethnographies, in-depth interview studies and case studies (e.g. Creswell 1998, 186; Marshall and Rossman 1995, 40; Merriam 2002, 6-10; Yin 1993, 13-20; Yin 2003, 23).

Purpose (exploratory, explanatory, descriptive or predictive) and research questions indicate the most suitable research strategy (Marshall and Rossman 1995, 40-43), which is defined as a road map, "an overall plan for undertaking a systematic exploration of the phenomenon of interest; the methods are the specific tools for conducting that exploration" (cf. Yin 2003, 2, 14-15). Based on the earlier knowledge on the extent of the cooperation, the case study approach seemed the most suitable option. Case study is appropriate when "investigators desire to a) define topics broadly and not narrowly, b) cover contextual conditions and not just the phenomenon of study, and c) rely on multiple and not singular sources of evidence" (Yin 1993, xi, 31).

[167] The differences between qualitative and quantitative research methodologies are discussed e.g. in Alasuutari 1994, 25-29, Creswell 1998, 15-16, Yin 1993, 57, Stake 1995, 34-51, Aldridge and Lewin 2001, 5-15.

4.2 DATA COLLECTION AND ANALYSIS

It is characteristic of qualitative research to review and collect different kinds of data, enabling diverse considerations to be based on it and to include evidence on other possible influences on the examined phenomenon. Creswell (2003, 16) emphasises the use of concurrent procedures of qualitative and quantitative data to provide a comprehensive analysis of the research problem (also Alasuutari 1994, 74; Yin 2003, 8; Stake 1995, 12).

The aim of the study was to examine adoption and diffusion of social innovations and factors influenced these processes. Consequently, information was to be collected concerning the innovations, communication and institutional framework i.e. the socio-economic situation in Russia and Karelia during the period under examination.

The materials are divided into hard (statistics, experiments, standardised interviews, and other data suitable for statistical analysis) and soft (un-standardised observations, unstructured interviews, qualitative data from written sources as well as introspection). Both kinds of data were used in this study. Literature in three languages Finnish, English and Russian was examined. This study includes previously unused documents concerning the cooperation and joint projects[168]. Data was collected by diverse methods and from different sources (Table 5). (Creswell 1994, 78-85; 1998, 120; Marshall and Rossman 1995, 78-85; Yin 2003, 93; and Merriam 2002, 12-14.) The information gathered was analysed and based on this project descriptions (Chapter 5) and a description of the research context (chapter 3) were produced.

Project documents are one of the main sources of information. Use of project reports includes a certain problem as they are usually prepared for the donors and do not necessarily describe the real situation but aim to show that the set objectives were achieved in order to secure further funding. Moreover, project documents mainly concern the planning and implementation of the projects, while this study was more interested in what happened after the project. Therefore additional complementary information was gathered from other sources. In the TB project information was obtained from the evaluation reports and in the Segezha case from publications. The Kostomuksha cooperation continues and the reports of the "newer" projects also include information and results of the previous. In the Pitkyaranta case numerous articles were published on the results of the project. The TACIS project was, in this respect, most challenging as no evaluations took place, but fortunately some information was received through personal contacts and publications. The validity of the information was verified by triangulation of data.[169]

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[168] Creswell (1998, 129) encourages to pursue information from sources generally unfamiliar to the reader.

[169] Yin (2003, 97-100) refers to four types of triangulation: data, investigator, theory and methodological triangulation.

Table 5: Data collection and analysis methods

Issue	Data collection method and source of data	Analysis
Social innovations and their attributes	Review of project documents, newspapers, and journals, Interviews Survey, standardised and open-ended questions Field notes Observations Publications Statistics	Classification Content analysis Systematisation of materials combined with observations Direct interpretation
Cooperation	Agreements, minutes Survey Review of newspapers Interviews of both local and European actors Publications Field notes	Classification Content analysis
Diffusion and Adoption	Project documents Publications Survey	Classification systematization of results
Communication and networks	Survey Field notes Review of project documents, newspapers Interviews	Classification systematization Network analysis, matrices
Institutional framework: socio-economic situation in Russia and Karelia	Review of project documents, newspapers Publications Field notes Interviews Statistics	Context analysis, categorisation Systematisation

Examination of diffusion posed another kind of challenge: the project documents concern the implementation period i.e. *external diffusion*, while internal diffusion often takes place only after this. Only one of the case projects was evaluated by external evaluators after each phase of the project (TB project, more in 5.3). (cf. Marquand 2009, 19.) Evaluations conducted by *external* experts give valuable and more objective information than the project reports. In order to examine knowledge on international social sector cooperation at local level and the diffusion of chosen innovations a survey was carried out in 2008. The preparation process is described below and the results in chapters 5 and 6. Conduct of the survey also provided an opportunity to make observations on site (more in 6.1).

As to the external factors that influenced adoption and diffusion, the socio-economic situation in Karelia, including administration, economic situation, developments in social protection of the population, and of the civil society was examined. The situation analysis is presented in Chapter 3.

As Russia scholars well know, much more information and data is now available than in Soviet times. However, even now it is sometimes quite challenging to actually get the information in writing. The culture and traditions change slowly.

Some of the documents used in this study were obtained unofficially ("under the table") through Karelian colleagues and some with special permission.

Survey as a method of data collection in this study

Despite certain limitations[170] of the survey, it proved to be a valuable source of information. The survey covered the entire Republic and provided new information which was not available in any other sources.

The aim of the survey was to ascertain

- How well the social sector professionals in districts knew about the cooperation
- Through which communication channels the respondents received information about international cooperation
- How well the case projects were recognised
- How well the social innovations introduced by the projects were known
- How widely the social innovations were adopted or embedded in the pilot districts
- Whether diffusion had taken place.

Advantages and Disadvantages of Questionnaires

A questionnaire is a suitable tool when there is a need "to obtain information about events that have occurred previously and the information on which now exist primarily in the memories of those to be studied" (Chadwick et al. 1984, 101-102). The problem with questionnaires is often a low response rate; organising special survey meetings in each district mitigated this. This arrangement also provided the opportunity for on the spot observations. Implementation of the survey in this way also turned some factors, which usually are considered disadvantages into advantages and vice versa (Table 6).

[170] The role of the survey and the information gathered diminished as the research proceeded. On the one hand the survey was carried out too early but on the other, due to changes in the Karelian administration, it might not have been possible organise it any later.

Table 6: Advantages and disadvantages of using questionnaires in data collection

Criteria usually considered as an advantage	**In this study**
1. Often the best method of data collection.	In this study not only the best but in fact the only available method for collecting data from all the districts.
2. Collection of information from a large number of respondents.	Information was collected from a relatively small group of respondents but from large geographical area.
3. Obtaining information about past events.	Obtaining information not only about events occurred earlier, but also on the present situation and processes.
4. Can be distributed over a wide geographical area.	Covered the whole republic.
5. Economy	Turned into disadvantage: the two weeks field visit proved (travelling of about 4000 km) quite expensive.
6. Generally easy to get people to participate.	The respondents were selected by the local authorities according to the requirements sent to them beforehand.
7. Anonymity of the respondents is guaranteed.	The local authorities know who participated in the survey and in a couple of districts they were introduced to the author. However, no names were recorded.
8. Generalisation of the findings to the population.	This study did not aim to generalise the results to the whole population. The aim was to find out how much the people working in the key positions (from the point of view of the study) in different parts of the republic knew about the social sector cooperation and social innovations, and how they received the information.
9. The respondent may consult with others, review records and check facts.	The respondents were asked to answer alone. However, in practice in two districts the respondents started to "remember together". The respondents did not have an opportunity to check any details.
10. Easy to administer and manage.	The events were arranged by the local authorities according to an agreed timetable.
11. Useful method for sensitive topics.	It seemed that not all respondents were familiar with this method, or ready to express their opinions openly.
12. Not as time consuming as interviews.	In total analysing the results took about 1.5 months.
13. The researcher's personality does not influence the responses.	The author attended all the events, however, the representatives were not told about my background, as it might have affected the results in some way. The author is fluent in Russian and was able to explain the aim of the survey and answer the questions without an interpreter.
14. The researcher has no control over the person filling in the questionnaire.	No time frame for filling in the questionnaire was set, but the respondents were asked to fill in the questionnaire in the meeting room booked for that purpose.

Criteria usually considered as disadvantages:	
1. Low response rate.	A high response rate was guaranteed by collecting the questionnaires at the events. In one district the respondent had not time to fill in the questionnaire during the meeting but returned it a month later after reminders. In another place, one respondent did not attend the agreed meeting. The questionnaire was forwarded to her but it was never returned.
2. Depth of information not as good as for example in observation or in interviews.	Relevant, but on the other hand enabled making observations (see Appendix 3). As it was decided to carry out the survey in all districts, interviews, which would have taken much more time, was not even an option for this study.
3. Does not allow making observations about the situation.	Observations were made at all the events.
4. Must be relatively brief.	The questionnaire consisted of 31 questions (four of them open-ended) and it seemed to be too long.
5. The risk exists that someone else will complete the questionnaire	The setting and author's attendance prevented this.
6. Only a few open-ended questions.	Open-ended questions would have given more depth but on the other hand, and considering the aim of this survey, the information received from the four open questions proved sufficient for this study.
7. No introduction of the aims and no opportunity for questions.	The author opened all the events, explained aims of the survey and how to fill in the questionnaire. The respondents were encouraged to ask if questions arose.
8. Little value for examining complex social relationships.	The questionnaire included questions about relations and networks.

Source: collected from various sources including Chadwick et al. (1984, 101-102, 137-140); Marshall (1995, 96); Aldridge et al. (2001, 51-52).

Organising a survey proved to be the correct decision for this kind of study, where the target group was small, and it was important to keep the response rate high.

Respondents

Selection of the correct group of respondents is critical for any survey. For this study it was important to reach key persons who were *assumed to have received information* about the projects and social innovations and know about them *due to their working position or duties.* In the survey the three sectors, namely health care, social protection and education, which all participated in the cooperation and were responsible for organising services, were considered separately. The respondents – one from each sector – had to meet at least one of the following requirements:

- *Be responsible for or involved in the development, organisation, or implementation* of 1) health care services; 2) services for disabled children, or 3) child protection
- *Have personal experience* of international social sector cooperation.

Selection of only one respondent per sector from each district included the risk of not reaching the relevant persons. On the other hand, if the respondent met one of the criteria and did not know about the joint projects it would reveal something about the practices of sharing experiences and distribution of information in Karelia.

This was a comprehensive study and despite the relatively small size of the group it was considered comprehensive enough to acquire a general picture of the situation in the republic[171].

Preparation of the questionnaire and pre-testing

The questionnaire (Appendix 2) consisted of 22 questions[172]: three closed, four open and fifteen structural alternative questions[173]. The alternative scales included the option to answer "don't know" or "not at all"[174]. The questionnaire was commented on and revised on the basis of recommendations by Finnish and Russian experts[175].

In order to guarantee the anonymity of the respondents a coding system was developed. Each document was marked with two capital letters: one referring to the district and the other to the sector (H referring to health, S to social protection and E to education). Each respondent received a "personal" number that was added to the questionnaire when it was returned.

Conduct of the survey

In order to be able to conduct a republic wide survey support was requested from the MOHSD and the MOE of Karelia[176]. Both ministries took a positive stance towards the research and were ready to provide a letter of recommendation; the letter was provided by the MOHSD. A local assistant contacted the heads or deputy heads of the districts responsible for social affairs and agreed on the times for the survey. Information on the aim of the survey and the criteria set for the selection of the respondents were forwarded to the local authorities, which recruited the respondents. Although in each session the respondents were reminded that their participation was voluntary, it is possible that the situation and nomination by the head or deputy head of the district administration, did not allow them either

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[171] In 1996 Salmi conducted a questionnaire with 20 participants and in 1999-2000 interviewed eight doctors (2006, 76-78). The study Lonkila and Salmi in 2000 included 50 respondents (Salmi 2006, 168-169).

[172] In addition the questionnaire included nine questions concerning attitudes towards NGOs and religious organisations as providers of health care and social services. This information was not used in this study.

[173] Closed question: answer is either yes/no/don't know; in structural alternative questions a five-step rating scale was used; open questions; in numerical rating questions the rate scale was from 1 to 4.

[174] Jyrinki (1976, 73-74) emphasises that it is important to locate the neutral alternative in the correct place in order to get the correct distribution of opinions of the whole group of respondents. The neutral alternative is recommended to be placed either in the middle or as the last choice. The latter option was used in this survey.

[175] Eight people with different backgrounds commented on the questionnaire. One of the Russian pre-testers checked the correctness of the language and terms (the questionnaire was in Russian). The comments received concerned the formulation, location and meaning of some questions. Two of the commentators advised considering interviews instead of a questionnaire.

[176] I use this occasion to express my gratitude to the Karelian Ministry of Health and Social Development and the Karelian district authorities for their support and assistance in organising these events.

to refuse to participate or to leave questions unanswered[177]. The field visit was originally to be carried out in March-April 2008 but was rescheduled at the request of the Karelian authorities[178]. The change of the time led to another potential problem: the first months of the year are usually a busy reporting and planning period in Russian institutions at all levels. In the end, only in one district did one of the respondents not attend in the agreed place. The inquiry was carried out in all 18 district centres between 11 and 22 February 2008.

The conduct of all the events was similar: the respondents were gathered in one room, and briefed on the research and the role of this inquiry in it. The questionnaires were distributed and the structure and key terms were introduced. It was emphasised that all the information given in the questionnaire by the respondents would be confidential and that their anonymity would be ensured. The respondents were encouraged to ask any questions that arose and to answer all the questions but also advised that they had the right not to answer if they chose. The author's contact information was given on the last page of the questionnaire. The results of the survey are presented in Chapter 6.

4.3 CASE STUDY AS THE MAIN RESEARCH METHOD

The main research method was case study, which allowed the use of a mix of quantitative and qualitative evidence (Yin 2003, 15) and concentration on one or more specific cases. Case studies may be *single* or *collective*. Single cases are defined as *intrinsic* and *instrumental* by the object of research. *Intrinsic* case studies focus on a case because of intrinsic or unusual interest or because the aim is to better understand a particular case (Stake 1994, 237). *Instrumental* case studies focus on a specific issue rather than on the case itself; "The case then becomes a vehicle to better understand the issue" (Creswell 1998, 250) or provides insight into an issue, refinement of a theory or general understanding of it. (Stake 1994, 237; Stake 1995, 3-4, 16.)

A *collective case study* consists of multiple cases, examined in the same study (Creswell 1998, 250) and focusing not on one particular case but on the *phenomenon*. It is "not a study of collective but instrumental study extended to several cases" (Stake 1994, 237). Each case is instrumental for learning about the main issue and the cases are united by common topics under examination (Stake 1995, 3-4, 25; also Yin 1993, 5-8; Yin 2003, 46-53.) Case studies may be within-site or multisite studies, depending on their geographical locations (Creswell 1998, 61-65, 251).

The following options were taken into account while considering the approach for examination:

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[177] Salmi (2006, 86) had a corresponding experience: "In practice, however, there were at least some cases where supervisors clearly pushed, or at least "encouraged", some respondents …. to participate, although they had been instructed that participation was to be completely voluntary".

[178] The author was informed that the presidential elections on 3 March might influence the respondents' chances to participate in the inquiry.

1. To choose one special innovation from different projects and examine its diffusion
2. To choose one district and one social innovation and examine its diffusion
3. To choose one district and examine diffusion of different social innovations introduced there
4. To examine different social innovations introduced by different projects and districts and examine their adoption and diffusion.

The last option was chosen as it enabled consideration of several diverse issues at the same time including the impact and role of the change agent, local actor, implementation time and different kinds of innovations. To summarise, this is a multi-sited collective case study, in which the cases are in an instrumental role i.e. the cases themselves are not the subject but rather the social innovations which they supported, and their diffusion and adoption.

Selection of cases

The character of the research influences case *selection*. There are different methods[179] that can be used in the selection process. The cases may be either pre-specified and given or selected[180] on the basis of defined criteria. Marshall and Rossman (1995, 51) characterise an ideal site of research as one with a possibility to enter, where a mix of the processes, people, programmes, interaction, and structures of interest are present, the researcher is able to build up relations of trust with the participants of the study and the data quality and credibility are reasonably assured.

Uniqueness, a typical or representative example, an information–rich case, "a sample from which the most can be learned"[181], a critical case, a similar or dissimilar case can equally well be considered as selection criteria. Creswell prefers the selection of unusual cases and the employment of "maximum variation" as a strategy to represent diverse cases and to fully display multiple perspectives of the cases (1998, 120). According to Yin "the simplest design would be the selection of two or more cases that are believed to be literal replications[182]" (2003, 52), however, this would have required prior knowledge of the outcomes. (Creswell 1998, 61; Stake 1994, 243-244; Yin 1993, 35; Yin 2003, 39-46.)

When the multiple case study method is chosen, it is important to make a proper selection of cases. These may be cases which "seem to offer an opportunity to learn" and which are believed to lead to better understanding "about a still larger collection of cases" (Stake 1994, 237, 243). However, even a proper selection of cases is unlikely to be a strong representation of others. Case study research is

[179] Replication method, sampling method, cross-case replication. According to Yin the replication method should be used in multiple case studies. (Yin 1993, 34, 79; Yin 2003, 37).
[180] In intrinsic case studies the cases are "given" and not chosen, while in instrumental and collective studies the researcher chooses them (Stake 1994, 243).
[181] Called a purposive or a purposeful sample (Merriam 2002, 12).
[182] Literal replication predicts similar results of the cases while theoretical replication predicts contrasting results but for predictable reasons.

not sampling research, a case is not studied in order to understand other cases but to understand "this one case" (Stake 1995, 4).

There is no limit to how many cases can be included in a multiple case study, or definition of an ideal or maximum number of cases for one study[183]. Creswell (1998, 63-64) notes that "the study of more than one case dilutes the overall analysis; the more the cases … the greater the lack of depth in any single case". In this case the number of the cases was not determined beforehand but they were selected from among those projects implemented in the framework of social sector cooperation with Karelia. The selection was made on the basis of the eight criteria presented in Table 7.

Table 7: Selection criteria for the case studies

	Criteria	**Justification**
1	At least the first phase of the project was over.	The adoption and diffusion of an innovation often takes place only after the project has ended.
2	The project either introduced or supported a social innovation as defined in this study.	Both local innovations and those introduced by external change agencies were considered. Humanitarian aid was not considered a social innovation.
3	The projects were to cover different geographical areas of the Republic of Karelia.	In order to examine a) if differences between the districts affect adoption and diffusion and b) information flows.
4	The projects were to be carried out both at republic and district levels.	To be able to consider if this fact influenced adoption and diffusion.
5	The supported innovations were to differ from each other.	To consider how the character of an innovation influenced adoption and diffusion.
6	The European change agency was to be different in each case.	To explore the role of the CA.
7	The projects were to differ from each other by duration and funds available.	To consider how duration and available funds affected adoption and diffusion.
8	The projects were to be implemented at different times.	To study if the institutional changes that had taken place in Karelia had influenced adoption and diffusion processes.

The cases (Table 8) can be criticised for being too similar (long term projects/cooperation) and not including any small scale, grassroots level, short-term projects. This option was considered in the planning phase, but rejected. The decision was based on the assumption that if the innovations of the case projects, which can be considered as "big" projects, with external financial and professional assistance, had not diffused, it seemed unlikely that the social innovations developed in the frames of smaller projects at grassroots would have done so. The chosen combination of cases highlighted differences between the projects and their implementation. The geographical location of the case projects is presented in Figure 22.

[183] ".. typically the researcher chooses no more than four cases" (Creswell 1998,63); "the number of cases depends on the certainty you want to have about the results", up to 10 cases (Yin 2003,51) .

Table 8: The selected cases[184]

Duration[185] (criteria 1,7,8)	Social innovation[186] (criteria 2, 5)	Geographical districts (criteria 3)	Level of implementation/LP (criteria 4)	European actor/s (criteria 6)	Financing and financial resources[187] (criteria 7)	The name of the project
1992-2008	Promotion of healthy life-style Establishment of health monitoring system Investigation of the risk factors of chronic diseases	Pitkyaranta	District level[188]/ Pitkyaranta central district hospital, district authorities, the Ministry of Health	National Public Health Institute (Finland)	NPHI, MFA	Investigation of the risk factors and behavioural characteristic in Pitkyaranta (1992-1994)
1997-1999	Introductions of the GP model Training of GPs Training of social workers	Kondopoga Sortavala Petrozavodsk Olonets	Republic District / Administration of the Head of the Republic	Consortium: STAKES (Finland) Netherlands School of Public and Occupational Health National Health Overseas Services NHS (U.K.)	European Commission, 2.7 mil. Euro	Support to the Implementation of Social and Health Care Reforms in the Republic of Karelia
1999-2008	Prevention of the spread of tuberculosis new approach and method of cure	Medvezhegorsk Petrozavodsk	District level / Ministry of Health	FILHA Finnish Lung Health Association	MFA FILHA	Fighting Tuberculosis in Karelia 2000-2004
1997-1999	Improvement of child welfare system new approach to development of preventive services and open care	Segezha	District authorities, Ministry of Education	LSKL Central Union for Child Welfar)	MFA , LSKL	The development of the child welfare system in the district of Segezha 1997-1999
1992-2008	Improvement of position of disabled children New approach towards disabled, development of services for disabled children	Kostomuksha	District authorities, Ministry of Health, Ministry of Education	The Province of Oulu[189], Finland	MFA The Province of Oulu, Finland	Support to the Rehabilitation centre for disabled children in Kostomuksha

[184] Originally six cases were selected. In spring 2008 one of them, the first long-term social sector project carried out in Karelia "Support to the implementation of the social and health care reforms in the Republic of Karelia in 1995-2000" was excluded. The project was financed by the MFA of Finland, and implemented by the National Research and Development Centre for Welfare and Health, STAKES. The project met the criteria and its duration, 5 years, was exceptionally long. However, due to the facts that 1) STAKES was also the lead agent of the selected TACIS project, 2) the social innovations (disabled children and child welfare) were partly covered by another case, and 3) the pilot areas coincided with some others (Medvezhegorsk and Petrozavodsk), the case was excluded.
[185] All cases did not start as projects i.e. did not have exact frames (Pitkyaranta and Kostomuksha). In those cases the author set the frames and refers to the first joint project. (for more 5.1 and 5.5)
[186] The SI is defined for the purposes of this study by the author. The projects might have defined the SI differently.
[187] This column refers to the main donor/s. In addition to these several organisations and institutions may have supported these projects.
[188] District level – the project was implemented mainly at district level; Republic level – the project was implemented in several districts and planned to cover the whole republic.
[189] Province of Oulu was located in the northern part of Finland and had a common border with the Republic of Karelia. The system of the Finnish regional state administration was reorganized in the beginning of 2010 and since then Province of Oulu is part of the Regional State Administrative Agency of Northern Finland.

Figure 22: Location of the case studies in Karelia

As the figure illustrates, the five case studies were implemented in the territory of seven Karelian districts. Two of the projects (TACIS and tuberculosis) were piloted in more than one district.

4.4 RELIABILITY, VALIDITY AND GENERALISATION

Qualitative research calls for interpretations and is thus subjective[190]. Creswell (2003, 182) states that the researcher cannot escape the personal interpretation when doing qualitative research. Merriam (2002, 19-21) notes that researchers should articulate and clarify their assumptions, experiences, and values, which might occur at any stage of the study. The author of this study has been well aware

[190] Scholars consider the role of the researcher in the research process differently. See e.g. Creswell 1998, 75, Marshall 1995, 59, Stake 1995, 92-99.

of the risks of studying "your own backyard"[191] and strove to follow Merriam's (2002, 5) advice: "Rather than trying to eliminate these biases or "subjectivities", it is important to identify them and monitor them as to how they may be shaping the data collection and interpretation". In order to ensure the objectivity of the research, different kinds of sources and methods were used in data collection. The author also submitted the manuscript and/or parts of it for comments to colleague researchers and to people involved in the research process.

The value of a scientific work is assessed by reliability and validity. Reliability is defined as the extent to which the findings can be replicated, or reproduced by other researchers or by the same researcher on different occasions (e.g. Chadwick et al 1984, 46-47; Silverman 2000, 91; Yin 2003, 37, 40). Merriam (2002, 27) states that "Replication of a qualitative study will not yield the same results, but this does not discredit the results of any particular study; there can be numerous interpretations of the same data". In her opinion it is more important whether the results are consistent with the data collected and dependable. In this study the reliability was sought by collecting data from different sources.

Silverman (2000, 175-176) considers validity[192] as another word for truth. Merriam (2002, 28) equates external validity with generalisability. Internal validity refers to the ability of the research to achieve the set goal. The validity of qualitative research has been criticised for the low coverage of the cases, i.e. only a few exemplary cases are included in studies, the fact that researchers seldom provide the selection criteria or grounds for including certain instances and not others and that the original materials are often lost, i.e. the original materials are not available (Silverman 2000, 176; also Yin 2003, 37). In this study, the selection criteria for the case projects are presented (4.3) and Appendix 5 includes an assessment of how successful the selection appeared. All unpublished project documents referred to as well as the original materials (e.g. questionnaires and field notes) are available.

Statistical generalisation is a standard goal in quantitative research aiming at generalisation of the results to the whole population while qualitative research aims more at understanding and explaining the researched phenomena. This study examined the sustainability[193] of the achieved project results in certain socio-economic conditions.

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[191] Creswell refers to Glesne and Pehskin, who question research that examines "your own backyard – within our own institution or agency or among friends or colleagues". They note that this kind of study may seem attractive and provide easy access to informants and getting information at minimal cost, but the negatives outweigh the positives (Glesne and Pehskin 1992, in Creswell 1998, 21). Creswell (1998, 114-115) is also critical in this connection: "Unless a compelling argument can be made for studying the "backyard", I would advise against it".

[192] Creswell (1998, 194, 201 Table 10.1 p. 200) reviewed different definitions and understandings of the term. He proposes (1998, 215) the term verification instead of validity and correspondingly internal and external verification. "Verification… can be both part of the process of research and a standard or criterion for judging the quality of a study". (Cf. Yin 1998, 39-40; 2003, 33-36.)

[193] As Marquand (2009, 19) notes "Sustainability is not a straightforward concept. What is it to be sustained? The precise application of new methods to produce new outputs, changed attitudes or increased capability to apply new ways of thinking to wider fields and teach them to others? Donors pay lip service to this, but do little to investigate what has happened later, provided they are satisfied that their money has been spent according to their rules. They do not really enquire into the nature of the sustainability which they say they seek".

4.5 ETHICAL ISSUES

Ethical issues should be considered carefully in the research process. The chosen strategy should not violate the participants' privacy or "unduly disrupt their everyday worlds, put them in danger or at risk or violate their human rights" (Marshall and Rossman 1995, 42). The protection of anonymity may be a concern with regard to the cases and the participants/respondents, and there are different ways to ensure anonymity. In some cases the researcher can determine whether it is possible to guarantee the anonymity of the individuals and define only the cases. Yin (2003, 158) suggests doing it by naming "the individuals but to avoid attributing any particular point of view or comment to a single individual, again allowing the case itself to be identified accurately". As the most desirable option Yin considers disclosure of the identities of both the case and the individuals.[194] (Marshall and Rossman 1995, 59-62; also Chadwick et al 1984, 212; Creswell 1998, 132-133; Merriam 2002, 29-30; Silverman 2000, 201.)

In this study it was decided not to name any Karelian respondents or interviewees[195] but only the cases. The protection of anonymity extended not only to the respondents and interviewees but also to other local informants, who assisted in the acquisition of information and data. Due to the professional background of the author,[196] quite a large amount of information was received through personal contacts and communication.

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[194] Quite an opposite approach is also applied when both the names, cases and sites are mentioned (see Marquand 2009).

[195] One of the Karelian interviewees did not permit recording of the interview.

[196] From 1995 until 2009 the author worked as a project manager in STAKES International Development Collaboration and participated in the planning and implementation of several projects in Karelia.

5 The case studies

The five case studies were selected on the basis of the criteria introduced in Chapter 4. The case projects, the social innovations introduced and supported by them and the outcomes with regard to their adoption and diffusion are described in this chapter.

At the beginning of each section basic information is presented about the project and a brief description of the case and the social innovation/s to be introduced. In general terms the cases are described in the same way. However, there are clear differences between them due to notable differences in the duration and content of the projects as well as the availability and quantity of the project documents. In three cases the exact amount of external funding is presented while in two cases (Pitkyaranta and Kostomuksha), due to the character of the cooperation, the exact amounts were not available.

On the Karelian side in the implementation of the projects mainly three ministries were involved: the Ministry of Health, the Ministry of Social Protection and the Ministry of Education. For clarification, the table below shows which ministries participated in which projects.

Table 9: Participation of the Karelian ministries in the case projects

Project	MOH	MOSP	MOE
Pitkyaranta project	x	-	-
TACIS project	x	x	x
Tuberculosis project	x	-	-
Segezha project	-	-	x
Kostomuksha project	-	x	x

Due to several administrative reforms carried out in Russia, and accordingly in Karelia, during the period 1992 - 2008, the names of the ministries changed several times as well as their tasks and sometimes also the civil servants. For instance the Ministry of Social Protection was established in Russia in 1991 and in Karelia in 1994 (Decree No. 196 of 19 August 1994). In 2002 this Ministry was merged with the Ministry of Labour and the name of the new ministry was the Ministry of Labour and Social Development in 2002-2004 (Decree No. 77 of 31 July 2002). In 2004 the Ministry was restructured and social issues were transferred to the Ministry of Health (Decree No. 100 of 23 April 2004). In 2006 the Ministry was dissolved and the name changed to the Ministry of Health and Social Development (Decree No. 85 of 5 June 2006). The name of the Ministry of Education was changed (Decree No. 715 of 20 October 1998) to the Ministry of Education and Affairs of Youth. In

2006 (Decree No. 124 of 21 August 2006) the former name was returned to the Ministry.

The key characteristics of all pilot areas are presented in Figure 11 and Table 2 on pp. 60-61.

5.1 THE PITKYARANTA PROJECT

Name of the project	Investigation of the risk factors and behavioural characteristics in Pitkyaranta
Background	General deterioration of the health of the population
Objective	Reduction of premature mortality of major non-communicable diseases, especially in regard to cardiovascular diseases and promotion of health.
Specific objectives	Improve health monitoring system in the area concerning especially non-communicable diseases and their risk factors To promote a lifestyle that decreases the risk factor level of the main non-communicable diseases in the whole population. To raise awareness of the population on healthy lifestyle[197] and encourage substance free lifestyle. To develop and test effective programmes for integrated prevention and control of major non-communicable diseases (NCD),
Duration	1992-2008
Financing	National Public Health Institute, NPHI[198], North Karelia Province, Finland MFA:[199] approximately €16 700 in 1994 Central Hospital of Pitkyaranta
Change agency	National Public Health Institute North Karelia Centre for Public Health (earlier North Karelia project)
Local partner	Central Hospital of Pitkyaranta Pitkyaranta district authorities Ministry of Health of the Republic of Karelia, The Institute of Preventive Medicine (IPM) in Moscow (Russian Federation)
Pilot area	Pitkyaranta district
Target group	Population of Pitkyaranta district
SOCIAL INNOVATION	Establishment of health monitoring system Promotion of healthy lifestyle Investigation of the risk factors of chronic diseases

Overview

As described in Chapter 3, the general health situation started to deteriorate rapidly in Karelia towards the end of the 1980s. The increasing mortality rates and the role of non-communicable diseases (NCD) and especially cardiovascular diseases (CVD) worried the Karelian health care authorities (e.g. McAlister et al. 2000).

[197] See Palosuo (2000, 46-47) on the emergence of the concept of healthy way of life in the FSU.
[198] The National Public Health Institute (1982-2008) was a governmental organisation under the Ministry for Social Affairs and Health, Finland. The Institute provided decision-makers with information about health related issues. One of the central fields of research was chronic and contagious diseases. Since 1 January 2009 NPHI and STAKES (National Research and Development Centre for Welfare and Health) were merged into a new organization under the MSAH National Institute for Health and Welfare. Professor Puska was selected as the first director general of the new organisation.
[199] Ulkoasiainministeriö 11 August 1994.

Having learned of the good results of the North Karelia project[200] in Finland, the Karelian Government contacted the Finnish NPHI who had carried out the project, and proposed cooperation[201] (e.g. Puska 1997, 342). The MOH of Karelia had carried out some health promotion activities but the political changes and economic problems had significantly influenced the efforts of launching large-scale action programmes in the whole Republic (NPHI 1994b, 5).

Pitkyaranta district was selected to serve as a demonstration area for the other districts of the Republic[202]. Pitkyaranta is located close to the Finnish border[203] and was considered a relatively typical area in the Republic (Laatikainen 2000, 47; Pohjois-Karjala projekti 1996, 2). It was planned to use the results and experiences gained for Karelian national planning, demonstration and training purposes and the project was "to test what useful can be achieved in the rather difficult conditions" (NPHI 1994b, 2, 5, 7). The aim was to promote collaborative efforts for the long-term prevention of major NCDs in order to create a health monitoring system for the Republic (Laatikainen et al. 2006, 4). In the federal context, it was planned for Karelia to become a model region in health policy reform (Pohjois-Karjala projekti 1994?, 1; NPHI 2002, 2.2.2; Puska et al. 1994, 42).

Cooperation between the NPHI, the North Karelia Project, central hospital of Pitkyaranta, Pitkyaranta district authorities and the MOH of Karelia started in 1991. On the Russian side the Institute of Preventive Medicine in Moscow also participated in the project. The first joint project survey was started in 1992[204]. The project administration was integrated into the existing service structures and implemented through strengthened community resources. (NPHI 1994b, 2-10; NPHI 1994a, 2.)

Even though the "Pitkyaranta project" has become a well-known example of Finnish-Karelian health sector cooperation, it was started not as a project[205] but as cooperation across the border, in which diverse actors[206] and networks from both

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[200] e.g. Puska et al. 1994; NPHI 1996, 2; Laatikainen 2002, 231. The North Karelia project studied the risk factors of the chronic diseases. More e.g. http://www.thl.fi/thl-client/pdfs/731beafd-b544-2b-42b2-b853-baa87db6a046

[201] According to Klara Shevchenko, the initiator of the cooperation was Prof. Pekka Puska.

[202] Mentioned in several documents (e.g. NPHI 1994a, NPHI 1994b, 5, Puska et al. 1994, 42; Puska 1997, 350; Laatikainen 2000, 231). The author was not able to find the document in which this was officially noted. In October 2011, Prof. Pekka Puska clarified the issue and noted that Pitkyaranta was selected as a demonstration area by and in the frames of the WHO CINDI programme. (see Pohjois-Karjala projektin tuki ry 1997?, 2-3.)

[203] In an article about the Pitkyaranta cooperation in The New York Times on 3 December 2000 says that "The true distance from Pitkyaranta to Finland is measured in years, not hours".

[204] The continuation followed in 1997, 2002 and 2007. A detailed description of the first survey can be found in Laatikainen, 2000.

[205] Project is ususally defined as a temporary endeavor with a defined beginning and end.

[206] Cooperation participants on the Finnish side e.g. The Martha organization of Northern Karelia (a Finnish home economics organization founded in 1899 to promote the quality and standard of life in the home), University of Kuopio, Joensuun koti- ja laitostalousoppilaitos, Finnish Diabetes Association, Mannerheim League for Child Welfare, Nurses association in Northern Karelia (Pohjois-Karjalan sairaanhoitajayhdistys), the Province of Eastern Finland. These "subprojects" applied funding for their activities themselves. For instance in 1994 they received from the MFA in total about 12,000 euro (72,000 FIM). Due to this there are no reports covering all opearations conducted in Pitkyaranta, but the results were reported in separate project documents, publications and articles (Laatikainen 2009a, Pohjois-Karjala projekti 1994a, 2-3).

sides of the border participated. "The aim was to take advantage of the synergy of the actors and use the scarce resources in the best possible way" (Laatikainen, 2009a). In the project documents it was characterised as a community based demonstration project for the integrated prevention of major NCDs and the promotion of health (NHPI 1994b, 3; NPHI 1994a, 1), a neighbouring area project on health promotion (Pohjois-Karjala projekti 1996), a holistic prevention programme for chronic diseases (Laatikainen 2000, 233) and a cardiovascular disease prevention programme (Laatikainen et al. 2002, 37-38).

The cooperation rapidly extended to cover diverse issues related to health promotion and a healthy life style[207]. The activities were jointly coordinated by the NPHI and the Central Hospital of Pitkyaranta (Pitkyaranta 1994b, 4). In this study the Pitkyaranta project refers to the cooperation between the NPHI and Pitkyaranta district hospital, which aimed at health promotion and the establishment of a model health monitoring system in the Republic.

The project documents do not clearly describe the role of the district or city administration in the project. City authorities are mentioned as a partner in the project plan (Pitkyaranta1994b, 10-11) but in most of the available documents only the Pitkyaranta central district hospital is mentioned as a partner (e.g. NPHI 2002, 3; Agreements on cooperation of 1996, 1998-1999, 2000-2001, 2002-2004, 2003-2006) and coordinator of project activities (NPHI 1994b, 3). However, the positive impact of local influential persons was noted by the Finnish actors "(S)ome politicians have also participated the training sessions and this has been useful for resource allocation and development of health services. Involving politicians can help make the first steps towards healthy public policy" (Laatikainen et al. 2003?, 9; also Puska et al. 2009, 292). The innovations of this project were defined as the establishment of a health monitoring system, the promotion of a healthy lifestyle and an investigation of the risk factors of chronic diseases. The innovations were clearly preventive in nature and the relative advantage of the SIs was obvious: promotion of living habits that would decrease the level of risk factors of the main NCD's in the whole population and the establishment of a health monitoring system. The strategy was to carry out a well-conceived comprehensive programme through existing or strengthened community resources (Pitkyaranta 1994b, 10). The project strove to involve health care personnel in the project but also local mass media, formal decision-makers, informal networks, professionals from the social and education sectors as well as voluntary organisations (NPHI 1994b, 10-1). No financial incentives except for study visits and seminars in other parts of Russia and abroad were provided to LPs. (Pohjois-Karjala projekti 1996b; Laatikainen et al. 2003?, 5-6; Pohjois-Karjalan tuki ry 1996, no page.)

The jointly developed health promotion activities and health monitoring system could first, in the long-term, lead to a decrease in the risk factor levels and, second, provide information and a basis for the planning of disease prevention

[207] For instance: health behaviour, school children's health, smoking among pupils, and working conditions in the hospital. Health behaviour surveys were carried out in the district, in cooperation with the MOH, in 1994, 1996, 1998, 2000, 2004. (e.g. Karjalan Sanomat 11 October 1994, 13 October 1994.)

and health promotion programmes (Laatikainen et al. 2002, 42). The project was compatible with the general Russian Programme "Healthy Russia" and with the WHO global strategy Health for All by the Year 2000 (NPHI 1994b, 3-5: also NPHI 1996, 2).

The operations were planned with the local partners based on Finnish experiences. The Pitkyaranta project was in a way a local parallel to the Finnish North Karelia project (Laatikainen 2010a; Vlasoff et. al 2008). The project conducted training for health care personnel to improve their skills in preventive health care, implementation of experiments and execution of epidemiological research. "During the first years of the project, emphasis was placed on the general education of health personnel and the population" (Laatikainen et al. 2002, 41). Research, training, health education, consultation and campaigns were considered as the main forms of cooperation (Kansanterveyslaitos 1994a, 1-2). NPHI was responsible for the research component (Pohjois-Karjala projekti 1996) but the surveys were carried out by a specially trained local survey team[208] (Vlasoff et al. 2008; Laatikainen et al. 2000, 38).

The project setting was complex as it questioned both the formal health care system and policy and the informal side – attitudes, traditions and cultural issues (e.g. NPHI 1994a, 1; 1994b, 4-5). Although social and cultural discrepancies were continuously taken into consideration they inevitably influenced the implementation of the project, particularly at the beginning (Kansanterveyslaitos 2002, Karjalainen 14 December 1996). The inherited Soviet specialist oriented health care system and the health care strategy focused more on medical care than prevention or health promotion (Laatikainen et al. 2002, 42; Karjalan Maa 14 October 1994). Consequently, there were not many resources or structures in the existing system that could have been utilised when building up health promotion activities (Laatikainen et al., unpublished, 10; NPHI 2002, 4). Despite this the MOH of Karelia considered it necessary to start preventive work and reconsider the health policy (Puska 1997, 350).

The Finnish CA stressed from the beginning that there are no shortcuts to the prevention of non-communicable diseases and health promotion and that the risk factors are closely connected with lifestyle (Pohjois-Karjala projekti 1994?, 1). The whole approach, stressing the individual's personal responsibility for her/his own health was new for the Karelia (cf. Karjalainen 13 August 2007 and Palosuo 2000, 47). Special attention was paid to risk factors such as diet, dental hygiene, environmental health and deeply embedded habits and social norms of society such as smoking and excessive alcohol consumption. (Pitkyaranta 2002, Laatikainen et al. 2003?, 10; Karjalainen 7 August 2006; Karjalainen 27 April 2005.)

[208] Puska (1997, 343) states that "the Finnish team, assisted by local personnel" carried out a survey in Pitkyaranta.

The Pitkyaranta project has been criticised for being introverted[209] in nature. However, the project documents indicate that it communicated about the progress both within the district and beyond its borders. The results and achievements were introduced both in republican (e.g. Pokusaeva, 1999) and federal[210] seminars. Representatives of other districts, e.g. of Suoiarvi, Olonets, Medvezhegorsk and Segezha, were invited to the CINDI seminars organised annually since 2000 (Laatikainen 2009b), and to a varying extent to the Finnish-Karelian Medical Conferences[211] (Pitkyaranta 2002, no page). Several articles[212] about the achievements have been published in international journals.

The project environment was challenging due to the unstable political and economic situation (Puska et al. 1994, 41; Laatikainen et al. 2002, 41-42) and it was also difficult to motivate people to change their lifestyles in the presence of so many stress factors in everyday life (Laatikainen 2000, 237), depression (Oganov 2007) and "when they have to struggle to survive a normal life" (The New York Times 3.12.2000). The Karelian partners predicted that as soon as there was a reduction in social problems the results of preventive work could be better realised (Sydän 2001, 34).

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[209] In interviews two Karelian experts (SS and HH), who had both been involved in the international social sector cooperation from the beginning, stated that Pitkyaranta experiences are not known in the other parts of Karelia partly because Pitkyaranta has not shared information and their experiences with the other districts and that even in Pitkyaranta only a minor part of the health care professionals were involved in the cooperation. They both considered the results of Pitkyaranta cooperation valuable and worth diffusing to other districts in frames of new project (Interviews in 4 August 2009.) According to Laatikainen (2010a) this is a very peculiar feature as the whole project was initiated by the MOH and its representatives took part in all KMC and several other seminars and meetings since 1993. She argues that this is not about cliquism in the Pitkyaranta area but more as a common problem.

[210] The chief physician of the Pitkyaranta central hospital who had participated in the cooperation from the very beginning was often invited to lecture on the Pitkyaranta experience in Moscow and other cities (Laatikainen 2009b).

[211] According to the lists of participants provided to the author by the Pohjois-Karjalan kansanterveyden tuki ry to the author (in June 2010) participators of the Karelian Medical Conference included in 1993 about 150 participants from Finland, 20 from Petrozavodsk, 15 from Pitkyaranta; in 1995 89 from Finland, 20 from both Petrozavodsk and Pitkyaranta; in 1998 52 from Finland and participants also from Petrozavodsk, Pitkyaranta, Kondopoga (Suna) and Sortavala (Haapalampi); in 2000 in total 35 persons from Petrozavodsk, Prionezhkyi, Segezha, Kostomuksha, Kem, Suoiarvi, St Petersburg, Moscow, Sortavala and 15 from Pitkyaranta, the number of Finnish representatives is not mentioned. (Also NPHI 2002.) Based on these documents it seems that the number of representatives from the other districts has increased with time.

[212] e.g. Matilainen Tiina, Vartiainen Erkki, Puska Pekka, Alfthan Georg, Pokusajeva Svetlana, Moisejeva Nina, Uhanov Mihail (2006) *Plasma Ascorbic Acid Concentrations in the Republic of Karelia, Russia and in North Karelia, Finland*; Laatikainen Tiina, Delong Laura, Pokusajeva Svetlana, Uhanov Mihail, Vartiainen Erkki, Puska Pekka *Changes in cardiovascular risk factors and health behaviours from 1992 to 1997 in the Republic of Karelia, Russia (2002);* Puska, Pekka, Matilainen, Tiina, Jousilahti, Pekka, Korhonen, Heikki, Vartiainen, Erkki, Pokusajeva, Svetlana, Moisejeva, Nina, Uhanov, Mihail, Kallio, Irena, Artemjev Anatoli (1993) *Cardiovascular Risk Factors in the Republic of Karelia, Russia and in North Karelia, Finland*; Vlasoff, Tiina, Laatikainen, Tiina, Korpelainen, Vesa, Uhanov, Mihail, Pokusajeva, Svetlana, Rogacheva, Anastasiya, Tossavainen, Kerttu, Vartiainen, Erkki, Puska, Pekka (2008) *Ten Year Trends in Chronic Disease Risk Factors in the Republic of Karelia, Russia;* The Wall Street Journal *Finns find a Fix for Heart Disease: Vast Group Effort* (2003); The New York Times (2000) *An Ailing Russia Lives a Tough Life That's Getting Shorter*; McAlister, Alfred L. Gumina, Tamara; Urjanheimo, Eeva-Liisa; Laatikainen, Tiina; Uhanov, Mihail; Oganov, Rafael; Puska, Pekka *Promoting smoking cessation in Russian Karelia: a 1-year community-based program with quasi-experimental evaluation* in Health Promotion International, Volume 15, Number 2, June 2000

The project was mainly financed by the NPHI and the central hospital of Pitkyaranta (Laatikainen 2009a; Laatikainen 2000, 233). Since 1994 the project received financial support, for example, from the Province of North Karelia, MSAF and the MFA, but the implementation of the project was not dependent on external funding. The main principle, which was confirmed in annual agreements between the parties, was that both parties would cover their own general expenses. This principle also worked in practice[213]. The economic situation in Karelia created some practical obstacles to project implementation (McAlister et al. 2000) and showed, for instance, in the cancellation of the Karelian Medical Conference in 1996 (North Karelia… 1996). The strong commitment of the LP and some key persons as well as the voluntary work of the hospital staff (Laatikainen 2000, 233) were of crucial importance in achieving good results (ibid.).

Adoption and diffusion

Although the importance of health promotion work was already recognised in Karelia at the beginning of the 1990s (Ministerstvo zdravoohraneniia, 1995) and good progress was achieved in Pitkyaranta district in creating the health monitoring system, from the point of view of the whole Republic the results have so far remained modest (NPHI 2002). Instead, several new health promotion related activities, first introduced in Pitkyaranta, have rooted so well in Karelian working practices that nobody even thinks about where they came from. Laatikanen (2009b) correctly notes that although it is not always perceived, many of the practices initiated in the frame of the Pitkyaranta cooperation have spread quite widely in Karelia and to other parts of Russia[214]. Practices, such as "health days" and "health fairs"[215], "Quit and Win"[216] contests, which are currently in use in all parts of Karelia, as well as the Karelian Medical Conference[217] were started in the frame of the Pitkyaranta project.

In 1994, the parties agreed that the Republican health authorities, in close cooperation with the project team, would be in charge of the distribution of the Pitkyaranta experiences and their utilisation for national planning, demonstration and training purposes (NPHI 1994b, 2, 7; NPHI 2002, 4). The Finnish CA noted that the difficult financial situation in Karelia may have influenced the "annoyingly slow spread of these innovations", as well as to some extent the "clammy"

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[213] According to Laatikainen (2009b) the CA would not have been able to do anything if the personnel of the district had not been so interested in the issue and dedicated to the cooperation. The LP paid the salaries of the personnel that participated e.g. in the research work but there was no "floating money".
[214] Thomas Valente (1999, 12-19) talks about *contagion and geographical factors* as means of transfer of good experiences. By contagion he refers "to how individuals monitor other and imitate their behaviour to adopt or not adopt an innovation". The process it is not guided by anybody, not purpose or result-oriented but more spontaneous in character.
[215] First organised in Pitkyaranta with the support and participation of students from Finnish medical schools in May 1998. Information was given e.g. on diabetes, alcohol and drugs, hypertension and risk factors, smoking and its consequences and dental health – information, literature, advice.
[216] "The most effective and mass technique of stopping smoking" (Pokusaeva, 1999) was organised for the first time in Karelia in Pitkyaranta in 1994 and already in 1996 in Suoiarvi district. The first international Quit and Win smoking cessation was carried out in Pitkyaranta in 1996 (McAlister et al. 2000, 111). The idea of the method is to invite smokers to participate in a contest requiring one month of confirmed abstinence from tobacco (ibid.). Incentives were used in this connection: the first prize was a trip to Finland (Karjalainen 14 December1996).
[217] Organised since 1993. The 10th Karelian Medical Conference took place in October 2008.

willingness of universities and other districts to be involved in the joint actions (Laatikainen 2009b). Both the Finnish CA and the main LP noted (Laatikainen et al. 2003?; Laatikainen 2009b) that after ten years of cooperation the experiences had only been adopted to some extent in Karelia and a kind of rigidity in the system delayed the diffusion of tested innovations (Laatikainen 2009b). They also expressed the wish that the experiences, utilisation of data and knowledge and model of action should be taken into wider use in the other parts of the Republic.

Health promotion became one of the priorities in the Karelian health sector after the turn of the millennium and this has been supported by several international projects[218]. In December 2001, the Republican Centre of Medical Preventive Maintenance, therapeutic physical training and sports medicine (RCMPM) was established in Karelia[219]. The RCMPM developed the "Healthy way of life" programme that was approved by the Government of Karelia on 22 February 2002. Originally the programme covered the period 2002 - 2006 but in June 2005 was extended until 2010 by Decree (No. 159р-П) of the Head of the Republic. The aims of the programme coincided with the aims of the Pitkyaranta project: increase awareness of the population and professionals about a healthy way of living and the influence of smoking, abuse of alcohol and drugs on health. The project documents (from 1994 until 2004) and articles confirm that the health promotion activities continued in the district and the health monitoring system was established.

At the turn of the millennium similar activities were carried out in other districts of Karelia e.g. Petrozavodsk (NPHI 2002), Suoiarvi (McAlister et al. 2000, 110) and Olonets (Karjalainen 27 April 2005; cf. Agreement on cooperation for 2002-2004; Vlasoff et al. 2008). In spite of the fact that in the Concept of Development of Health Care in the Republic of Karelia in 1999-2003[220], the establishment of the health monitoring system was set as one of the objectives (1999, 24), no specific actions for the replication of the Pitkyaranta model in other parts of Karelia had taken place by August 2009 (interview of HH 4 August 2009).

The Pitkyaranta project was the first health promotion project in Karelia. Although the original aim of diffusion of the health monitoring model to the rest of Karelia has not been achieved, the project undoubtedly accelerated health promotion work in Karelia by introducing a new approach to personal health and new ways for the work to be done. The achievements of the project were taken into account in the formulation of the Concept of Development of Health Care in the Republic of Karelia in 1999-2003.

Pitkyaranta remains one of the few districts in Russia where relevant longitudinal monitoring data, for example on the risk factors of heart disease, is available. The data gathered on risk factors and health behaviour is unique in Russia (NPHI 2002). Pitkyaranta district was the first WHO/CINDI network demonstration area

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[218] For instance "Health Promotion and Disease Prevention in the Framework of Primary Health Care (PHC) in the Republic of Karelia, 2004–2006" and "Promotion of Healthy Lifestyle and Social Wellbeing of Young People in the Republic of Karelia, 2004–2006" both implemented by STAKES.
[219] Its primary goal is to coordinate, facilitate and integrate health promotion and disease prevention work across Karelia.
[220] Kontseptsiia razvitiia zdravoohraneniia v Respublike Karelia na 1999-2003 gody.

in Karelia and the WHO/CINDI Health monitoring surveys carried out in other parts of Russia were based on the experiences of Pitkyaranta (first in 1994). Other Karelian districts, such as Segezha, subsequently joined the CINDI network. (Laatikainen 2009b; Laatikainen 2009c.)

The need for the diffusion of the Pitkyaranta experiences has been acknowledged in Karelia. In August 2007 the Minister of Health, Valery Boinich, stated that the time of cooperation between separate cities was over – now the work needed to be spread beyond the borders of Pitkyaranta and the whole Republic needed to be joined to the WHO/CINDI programme (Karjalainen 13 August 2007).

The results of over ten years of research of chronic disease risk factors show "how big the challenge is to change lifestyles deep in culture - and in the situation where preventive work and policies do still not receive strong support" (Vlasoff et al. 2008, 666).

5.2 THE TACIS PROJECT

Name of the project	**Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia, Russia**
Background	The collapse of the Soviet Union and the ensuing increase of social and health care problems resulting in need to reform the social and health care system.
Objective	To enhance the wellbeing of Karelian people by supporting to the reforms of social and health care. The reforms were expected to lead to the development of efficient, effective, flexible and high-quality consumer oriented social and health services.
Specific objectives	To support the Karelian Government in developing: Social protection and health policies A legislative and regulative basis for the reforms at different tiers of administration Organisational structures and enhanced management and financing at all tiers of administration A masterplan for a health and social welfare information system Quality of social and health services through restructuring and human resources development Information about the reforms to the Karelian population
Duration	1997 – 1999
Financing	European Union 2.7 million Euro
Change agency	Finnish-British-Dutch Consortium National Research and Development Centre for Welfare and Health, STAKES (lead organisation); National Health Service Overseas (NHS) ; Netherlands School of Public and Occupational Health (NSPOH)
Local Partner	Administration of Chair of the Government Ministry of Health Ministry of Social Welfare Ministry of Education Ministry of Foreign Affairs Ministry of Economics
Pilot area/s	Three pilot districts and two pilot institutions in Petrozavodsk.
Target group	The population of Karelia
SOCIAL INNOVATION	Introduction of the model of general practice Training of GPs Training of social workers

Overview

The initiation and planning of this project differed from the others discussed in this study in an essential way. The overall objective of the project and expected outcomes were defined in the Terms of Reference prepared for the project by a consultant hired by the European Commission (EC 1996)[221]. The application for financing of the Karelian TACIS project in question was signed by the Government of Karelia and the Ministries of Health, Social Protection, Education, Foreign Affairs, and Finance. The change agency's task was to demonstrate how best to achieve the set objectives. In a Europe-wide open tender process, a Finnish-British-Dutch consortium, led by a Finnish organisation STAKES and its unit for international development collaboration, was selected to implement the project, "Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia".

The commitment of the Karelian decision-makers was considered a key to sustainability. The extensive representation of the Republic's administration in the project made the project, in practice, a forum of intersectoral collaboration and gave it the function of coordinating body in the reform process (Kananoja 1999b). Restructuring of social and health care service provision and organisations was considered an essential part of the reform. Due to the economic situation, the health and social sectors were insufficiently funded, which forced a search for new solutions and approaches.

The two-year work plan for the project included eight components: policy design, legislation, management and finance, information systems, human resource development, promotion of PHC and social reform, experiments in pilot regions and secondary measures (STAKES 1996, 41). The consultant[222] was expected "to gain in depth understanding of the current social and health care system in Karelia and of the constraints put by the Federal level" (EC, 1996, 10).

The complexity of the project – and its limitations – already became obvious during the inception period[223]. One of the experts reported that "...it is easy to foresee that the present legislation creates an obstacle to the development of needed restructuring of care organizations and restructuring of consequent financial streams" (Kananoja[224] 1997b). It was also noted that changes with regard to financing and responsibilities of the federal, republican and local governments required the decisions of Republican and Federal institutions and were issues beyond the mandate of the project (Kananoja 1997a).

According to the ToR the new approaches and methods were to be tested in three pilot districts. The pilot districts were chosen according to the jointly (EU experts and local partner) approved selection criteria (Hämäläinen 1997). The districts of Kondopoga, Olonets and Sortavala and two pilot institutions from Petrozavodsk (the Republic Diagnostic Centre and the Republic Centre of Social

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[221] TACIS programme procedures generally as well as TACIS project as a tool of Finland's neighbouring area cooperation are well described in Rouge-Oikarinen 2009.
[222] Term used by the EC, hereafter consortium.
[223] The period of the first three months of the project was called the "inception period" during which the plan of actions given in the project proposal and the set goals were to be adjusted.
[224] Aulikki Kananoja was first one of the project experts and from May 1998 to Feb 1999 its team leader.

Assistance to the Family and Children) were chosen[225]. In the pilot experiments it was decided to focus on the development of primary health care and non-institutional social services, and on strengthening the collaboration of the social and health care sectors (Kananoja 1999a). One of the ToR's requirements was dissemination of the experiences gained to the entire Republic (EC 1996; STAKES 1998).

The project was expected to produce a detailed masterplan for the reform of the social and health care system, including a blueprint for the new social and health care system, implementation measures and activities, transitional measures and time schedules (EC, 1996, 18). The project had a broad scope and introduced several innovations. Two of these were chosen for this study. The first is the training of general practitioner[226]s and the establishment of the model of general practice (GP) and the second is the training of social workers. Both were assessed by the Karelian authorities among the main results of the project (TACIS 1999c).

The project was started at the Republic and district levels separately but gradually communication intensified and a fruitful and regular sharing of information and testing of new options developed between them. Due to the relatively slow pace of policy design at Republic level and active and highly motivated people in the pilots, the role of the pilots was strengthened and their needs and experiences were used as a basis for policy initiatives at Republic level (Kananoja 1999). The Karelian interviewees noted that the excellence of the project was in its holistic, comprehensive and intersectoral approach to reform and its implementation at both district and republic levels. It was also said that it "changed the ideology of primary health care", was "a revolution in primary health care" and "introduced new forms of services such as non-institutional care" (interview with HH and SS on 4 August 2009; also e.g. Moiseev 2001).

Social innovation 1: Training of general practitioners and establishing the GP model

The model of general practice was new for Karelia but not for Russia[227]. Development of the model started as early as the 1980s with pilot projects in St. Petersburg, Kemerovo, and Samara (e.g. Rese, Balabanova, Danishevski, McKee, Sheaff 2005, 331). The first postgraduate training for GPs started in Leningrad[228] in January 1989 (Ryan and Stephen, 1996, 487). According to the educational struc-

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[225] The Ministerstvo sotsial'noi zashshity (1997) proposed Petrozavodsk and Olonets districts; the Ministerstvo zdravoohraneniia (1997?) proposed Pitkyaranta, Segezha and Sortavala and the perinatal centre, dental polyclinic (outpatient unit) and childrens' polyclinic in Petrozavodsk. The long term expert on health care Dr. T Hämäläinen suggested for primary health care Haapalampi in Sortavala district and the diagonostic centre in Petrozavodsk and for social services the districts of Olonets and Kondopoga. The final decision about the pilots was taken by the project steering committee consisting of Karelian and European members.

[226] The Russian interpretation: general practitioner is a specialist in curative medicine providing initial multi-profile medical care at a pre-hospital stage to adult patients. A family doctor provides the same care, only to child patients as well, and moreover is concerned with medico-social problems of families. (Meditsinskaia gazeta 1992; 60, 5)

[227] Prof. Lapotnikov (Tacis information bulletin 1998/3-4) notes that in fact general practice (общеврачебная практика) is like the Russian traditional health care in the countryside (семская медицина). (Also in Tacis Information bulletin 1999/5, p. 13-14 *How was it About the history of Karelian medicine*).

[228] now St. Petersburg

ture in Russia, specialist training falls under the regulatory responsibilities of the federal authorities. Accordingly, the training curriculum was developed at federal level but it allowed for regional variations. Especially at the beginning, the training centres were often established with the assistance of international donors. (Rese et al. 2005, 331.)

In 1992, the federal MOH enacted an Order (# 237, 26 August 1992) "On the phased transition to primary health care based on the work of the general practitioner or family physician" (Tragakes and Lessof 2003,173), which formed a basis for reform (Rese et al. 2005, 331). The order set out plans to extend primary care units, increase the number of primary care nurses and give them greater responsibility, and to provide special training for GPs. The concept was developed further by Order #463 (30 December 1999) "Ministerial programme on general (family) practice" that specified the legal, organisational, information and financial mechanisms necessary for the development of family practice (Tragakes and Lessof 2003, 173, 184).

The Karelian training programme for GPs was based on the federal Guidelines for Drafting Programmes for Postgraduate Training developed in 1995. Country specific conditions, such as low population density, high morbidity rate especially in rural areas, high proportion of people receiving primary health care services at feldsher stations[229], medical *ambulatories* and district hospitals, and the increasing number of old people, were taken into account (Dorshakova 1999). In 1997, the Karelian MOH considered the need to increase the numbers of general practitioners from 60 to 80 in Karelia (Murray 1997).

In October 1996, the first twelve doctors (therapists or paediatric specialists) from rural ambulatories were selected for the two-year GP training programme in Petrozavodsk State University (PSU). The training consisted of six 4-week blocks of theoretical teaching (Murray 1997). The following spring supplementary training was started for the nurses working in the same polyclinics as the doctors (Dorshakova 1999; STAKES 1996, 4).

At the beginning the training programmes were not sufficiently developed, the teachers were not capable of teaching several disciplines and there was practically no training literature (Dorshakova 1999). The project recommended strengthening the curriculum for GP training with the necessary knowledge, skills and attitudes to deal independently with common acute and chronic problems of all family members, health promotion, prevention of disease, and working as a team with nurses. The curriculum was developed further in the frame of the project (TACIS, 1999, 21) and the training continued in the PSU.

In this case the TACIS project supported a *local* social innovation in the sense that the training of general practitioners had already started in Karelia before the project, whereas the model of GP practice for Karelia was developed in the frame of the project. The relative advantage of the GP model over the existing system was in the introduction of a model through which high health care costs could be reduced (van Andel 1997). The new model was expected to improve both the provision and

[229] see footnote 128

range of health care services, particularly in the rural areas. Five different GP models[230] were modified to meet the local needs and were tested in selected districts. The results of the pilot experiments were promising: from the new GP ambulatories the referral rates to hospitals fell by between 30% and 50% in a monitored period during the winter of 1998/99 (STAKES 1999, 24; Tacis Moscow 1997,1998).

The TACIS project differed from the other cases with regard to the use of incentives. The budget was generous compared to the others and it was allowed (EC instructions) to use the project funds to cover different kinds of costs related to project activities. For instance, local office staff and experts were paid salaries and fees in accordance with the donor's instructions. The project organised 13 study tours and visits abroad in order to familiarise the Karelian side with the utilisation of the SIs in Europe, and in all 91 decision-makers and local experts took part in them (STAKES 1999, 32).

The social innovation was clearly not compatible with the existing system but challenged it and suggested fundamental changes. "Marketing" the new model was not an easy task. The existing specialist doctor centric health care system left little space for the GPs and led to their low prestige. The project stressed that the role of GPs should be clearly defined and their position would need to be accepted by the decision-makers, health care professionals and local administrative bodies as their commitment was needed to make the changes work. It was also noted that the non-acceptance of the role of the GPs in the health care system by specialists, politicians, legislators, financial managers and the public could cause a major constraint on the process. (Murray 1997; cf. Danishevski 2005.) The new approach required changes in the incentive and salary system: doctors were not willing to work more without remuneration. The establishment of a GP practice required not only training of doctors, but also commitment and investments from the district health authorities[231]. A part of the project funds was used to purchase medical equipment for the polyclinics and hospitals in Karelia[232].

During the project information about project progress was disseminated in seminars and training workshops and an information bulletin was published on a quarterly basis. The last major activity of the project was to disseminate information about the project achievements to all other districts of Karelia (STAKES 1998).

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[230] GP and social work in Suna/Kondopoga and Mikhailovskyi/Olonets, GP and nursing home in Girvas/Kondopoga, GP and health promotion programme in Haapalampi/Sortavala and GP in an urban environment in Drevlianka area in Petrozavodsk (Tacis 1999a, 29). Based on local assessment (Personal correspondence from 2008 '*STAKES projects*') "the project developed two functioning models of GP practice: in Haapalampi, Sortavala and in Suna, Kondopoga".

[231] The health authorities choose the doctor, nurse and feldsher for the training, apply for a licence for the practice from the MoH of RK and establish the premises for the team. The licence had to be renewed every 5 years. Requirements, including the equipment, are stipulated in Polozhenie ob organizatsii deiatel'nosti VOP (semeĭnogo vracha) #350 of the MoH of 20 November 2002. Original in Russian Положение об организации деятельности ВОП (семейного врача), in English Regulation on organisation of the work of general practice (family medicine).

[232] In total 375 000 Euros (at that time ECU) were used for equipment purchase. In addition to medical equipment other devices (e.g. computers) were also bought.

Adoption and Diffusion – General Practice model

After the project the training of GPs continued and a chair of family medicine (general medical practice) was established in the Petrozavodsk State University. In autumn 1999, the medical faculty of the PSU established a permanent post-graduate course in general practice (STAKES 1999, 6). Since 2000-2001 the course in general practice has been obligatory for all medical students in Russia during the last year of their studies (Danishevski 2005).

The law on general practice (family medicine) in the Republic of Karelia, drafted during the project[233] was adopted by the Karelian Government in July 2000[234], the first in the Russian Federation to do so. Since 1999, when the project ended, about 45[235] Karelian doctors have been granted the certificate of general practitioner. The original aim to improve service provision in the rural areas has not been substantially achieved. In 2008 the GP practices were concentrated in a few cities and districts: 15 of the GPs worked in Petrozavodsk and six in Prionezhkyi district located in the Petrozavodsk district. Interestingly, although the results of testing the model in the pilot areas of Kondopoga and Sortavala were positive, the model – according to the information received – was not adopted in either area. With regard to Sortavala it is known that the GP who worked in the Haapalampi pilot ambulatory moved to Finland soon after the project.

Several difficulties related to legislation, the undefined position of GPs in the health care system, and the training of GPs accompanied the shift to the new model. The cancellation of the Karelian law on general practice at the request of the federal authorities on Nov. 24, 2006, was an obvious setback for developments in Karelia (HH 4 August 2009, personal correspondence Sept. 2009).

In 2008, 19 of the 40 GPs were working in the rural areas. Eight of them worked in the "remote" districts of Loukhi, Kem, Pudozh, Belomorsk and Muezerskyi. It seems that over the years, the situation in the rural areas has not changed much: the number of vacancies in the municipal and state institutions has not decreased and the deficit of health care professionals in the districts remains unchanged (MHSD 2009, 58). For instance, of the 41 graduates from the PSU medical faculty new doctors who entered the health care system of Karelia in July 2008, 17 found work in governmental health care organisations, 13 in municipal institutions of the city of Petrozavodsk and only 11 in other municipal districts (MHSD 2009, 57)[236]. The most difficult situation has traditionally been in the districts of Segezha, Muezerskyi, Luokhi[237], Olonets and some others (MHSD 2009, 58-59). In the first three mentioned only about 50% of the vacancies were filled in the district hospi-

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[233] The draft law was presented to the MOH in October 1998 (STAKES 1999, 23).
[234] Decree 24-П of 14 February 2001, Law No. 425-3PK was approved by the Parliament on 13 July 2000.
[235] The exact number of GPs who graduated was not available in the MoH and the figures received from other sources differ from each other. According to one source (personal correspondence 4 December 2008), in total 44 GPs had graduated and 30 of them worked as GPs at that time.
[236] The situation was to some extent better with regard to other medical personnel with secondary education and the needs of the municipal districts were met (MHSD 2009, 58).
[237] "One of the biggest problems in the district is the lack of medical doctors and nurses... it is difficult to find a flat here. According to the district authorities only 60% of the need in doctors and nurses is met." (Karjalan Sanomat 11 July 2007, The health programme in the district of Loukhi proceeds gradually)

tals (ibid.). Hiring of qualified health care professionals was not only a problem of the remote rural *polyclinics* but also of the district hospitals (STAKES, 2005, 5)[238]. From the second group of graduates from the PSU in February 2002, 16 doctors started their work in Vepsian *volost*[239], Belomorsk, Priazha, Loukhi, Suoiarvi, Medvezhegorsk, Kem, Prionezhkyi, Pitkyaranta, Muezerskyi and four doctors in Petrozavodsk. (Karjalan Sanomat 27 February 2002.)

Cancellation of the Soviet era system of obligatory assignment for the graduates (распределение) forced the authorities to search for new ways to attract employees to remote areas (MHSD 2009, 56-58). However, not even the improved remuneration system has improved the situation. Well-educated medical doctors are welcomed beyond the Russian borders: three of the eleven GPs who were trained in the frame of the TACIS project moved to Finland after the project. The lack of proper working and living conditions, better salaries (e.g. Arsalo and Vesikansa 2000, 18; Karjalan Sanomat 5 July 2000), unreasonable responsibilities and workload, social security and insufficient housing conditions in rural areas have not only made the GPs but also the newly qualified medical personnel leave for the big cities, other parts of the Russian Federation or Finland[240] (Anttila et al. 2005, 5).

The reform of the remuneration system and its principles were widely discussed but "nobody had the courage to do it thus far… the attitudes towards reforming have been sceptical because it was suspected that it may lead to conflicts between doctors (GPs and medical specialist)" (Minister V Boinich, Karjalan Sanomat 16 November 2006)[241]. A drastic deficit of young graduates in PHC "due to non-attractive work in polyclinic conditions" (Danishevski 2005) is not exclusively a Russian problem. Due to the difficulties in recruiting GPs for health centres in Northern and Eastern areas of Finland, Karelian doctors have been directly persuaded to move to work in Finland (e.g. Helsingin Sanomat[242] 3 July 2008;

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[238] There are also positive examples. At the turn of the millenium in Janishpole *ambulatory* (Kondopoga) problems emerged as the work of the GP increased but the salaray remained unchanged. This was said to be a consequence of the inadequate legislation (Karjalan Sanomat 5 July 2000.) The local authorities decided to try to attract health care personnel by offering incentives: an increase in salary of 50% was suggested for doctors and other personnel of 25% (BSTF 2005, 10-11). According to the then first deputy minister of health, Klara Schevtsenko, best results in utilisation of the family doctor model were achieved in Janishpole. These experiences were important not only for Karelia but for the whole Northwest of Russia. (Karjalan Sanomat 27 February 2002.)

[239] The *Vepsian Volost* was a municipal autonomy of Prionezhkyi District. The autonomy was established on 20 January 1994 (resolution No. XP 23/625 of the Supreme Soviet of Karelia) and it was discontinued in 2004. It consisted of 14 villages and its population was 3,166 (2002 Census), with Veps population of 1,202. http:// www.cemes.org/current/LGI/158-eng.htm, http://gov.karelia. ru

[240] The same phenomenon also existed in other fields. Svetlana Pasti (2005,120) writes that Karjalan Sanomat as well as the section of the Finnish broadcasting of the GTRK Karelia (the state owned tele-radio company) faced a difficult situation in 1990s due to the immigration of tens of experienced journalists to Finland.

[241] In the Petrozavodsk University the students (not only medical) were asked what issues most influenced their decisions when looking for a job. In the first place was prospects for professional development (including post-graduate education), modern equipment, access to sources of information and, only then were material aspects mentioned (MHSD 2009, 59).

[242] Helsingin Sanomat is the largest subscription newspaper in Finland and the Nordic countries, owned by Sanoma. It is published daily and in 2008 its daily circulation was 412,421 on weekdays and 468,505. Its name derives from that of the Finnish capital, Helsinki, where it is published.

Helsingin Sanomat 29 November 2010). This raises the question as to the idea of the support if the following day we try to persuade them to leave Karelia.

In light of the information received from Karelia, the GP model was not embedded in the two main pilot districts (Sortavala and Kondopoga) but by 2009 it had been tested to some extent in 16 of the 18 districts of Karelia. The only two districts where it had not been tested and where no GPs were working in 1996-2008 were Lahdenpohia and Kostomuksha. However, it can be said that in Petrozavodsk and in the districts of Medvezhegorsk, Belomorsk, Suoiarvi and Prionezhkyi the model was adopted[243] and institutionalised after the adoption of the law on General Practice in Karelia in 2001 (Personal correspondence 30 July 2009). The result proves that first, the information about the model spread, and second, that trialability positively affected internal diffusion. Despite the fact that the GP model has not been fully established in Karelia, it can be argued that the model was adopted. As Figure 24 below shows, the situation has changed a lot during the years and appears quite unstable. The practices emerge and disappear with the implication that the model has not firmly institutionalised in the health care system, but it has not been rejected either.

[243] In Prionezhkyi district there have been at least two GPs continuously since 1999; in Suoiarvi three since 2004; in Belomorsk two since 2004; in Medvezhegorsk four since 2005. Petrozavodsk has its own story: the first six GPs started in 2004 and in 2008 there were already 15 GPs working. In the districts of Pudozh, Kem, and Pitkyaranta instead of two in 2007 only one was working in 2008. The information was also requested from the MoH and Karelstat but was not available (February 2008, August 2009).

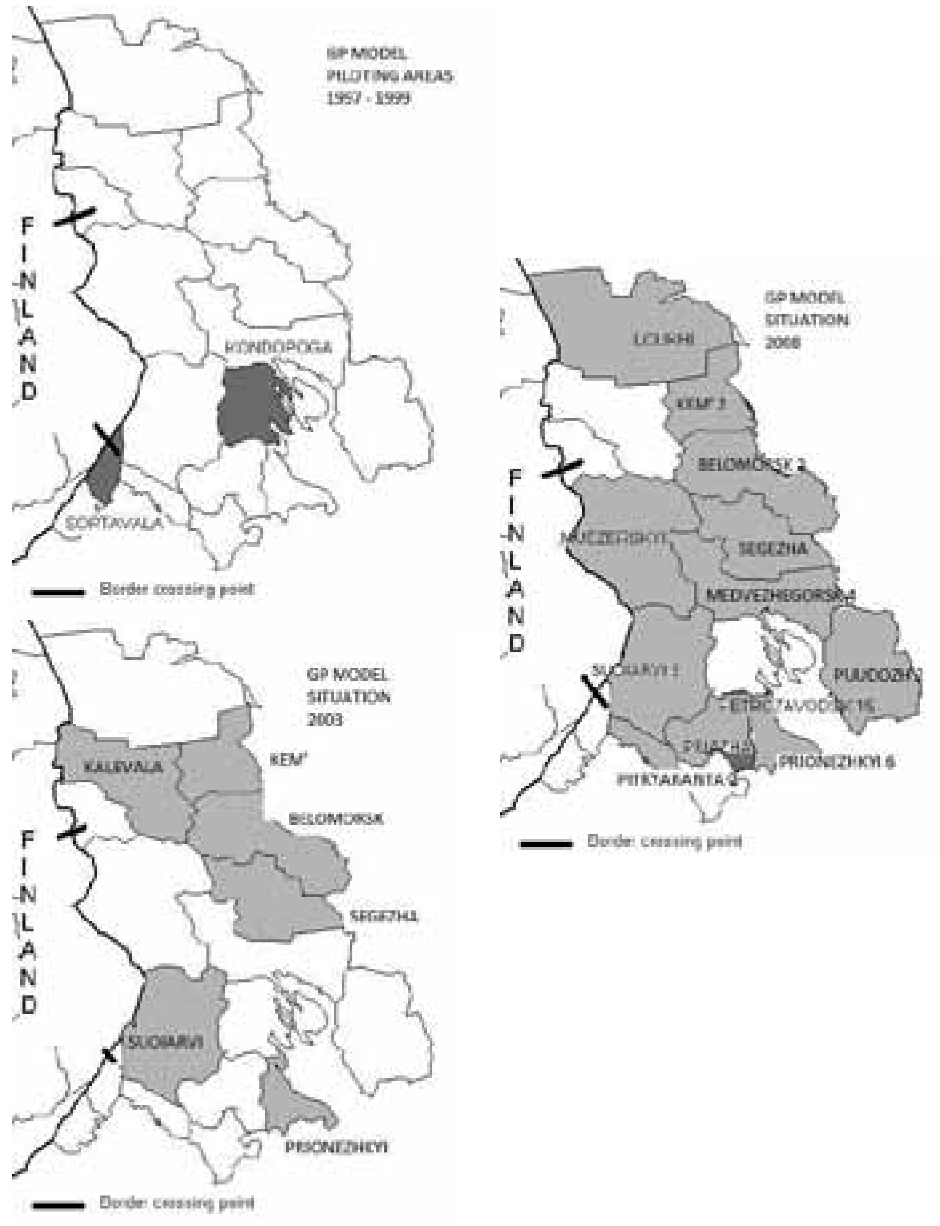

Figure 23: Districts in which the GP model was tested

When the spread of the GP model is considered, it is worth keeping in mind that after the TACIS project the general practice model was also supported by other international projects[244]. In September 2005, a Finnish-Karelian expert group car-

[244] E.g. "Health Promotion and Disease Prevention in the Framework of Primary Health Care" and "Improving Communicable Disease Control in Rural Areas of the Republic of Karelia under Conditions of Shifting of Primary Health Care to General Practice (2002 -2004)". Financed by the Baltic Sea Task Force (BSTF).

ried out monitoring of the Baltic Sea Task Force (BSTF)[245] project that concluded in 2004. Their task was to examine what kind of changes had taken place in that project's pilot institutions after the project in the districts of Suoiarvi, Kondopoga and Prionezhkyi. They were asked to pay special attention to the prerequisites for GP work. The monitoring report notes that the model of general practice was "alive": general practitioners were working in all visited *ambulatories* in the districts of Kondopoga, Suoiarvi and Prionezhkyi (Anttila et al. 2005).

Rese et al. (2001, 201) studied the spread of GP practice in Russia and note that "despite the scale of the reform taking place, and the large investment involved, little information is available on how the new model is working"; the same is true of Karelia. Most of the data available with regard to the GP situation in Karelia was obtained through personal contacts. Developments in Karelia correspond to those of the whole Russian Federation. Danishevski (2005), referring to the report of WHO of 2005 on human resources, writes that in spite of the fact that the idea of a change over to the family medicine and GP model have been pronounced in Russia since the end of the 1980s, the total number of GPs (GP as understood in Western countries) is only 1500 (about 0.2% of the total number of medical doctors in Russia). It is also unclear how many of them actually work as GPs as their position in the health care system remains undefined (ibid.). According to MHSD (2009, 56) there was a total of 2,788 doctors in Karelia in 2008 and if the number of GPs is about 40, the corresponding figure in Karelia would be about 1.4%.[246]

Social innovation 2: Training of social workers

As described in Chapter 3.3, health and social services were mainly provided by state enterprises in the Soviet era. After the revolution of 1917 in Russia, the functions of a social worker were carried out by representatives of the Communist Party and trade unions, employees of different institutions of the social sphere, doctors, and teachers (Mikkola 2007, 363-364)[247]. The need for 'home helpers' and trained social workers became obvious after the collapse of the soviet system, when many people became socially excluded on diverse grounds (Iarskaia-Smirnova 2004, 132-1; Samoĭlova et al. 2006, 141-153).

Social work started to take shape as a professional institution in Russia at the end of the 1980s. As a profession "specialist in social work" it was established in 1991[248]. In Russia, social work includes specialists in various professions: social workers, medical specialists, pedagogues, lawyers and psychologists (Kozlov 2004, 21-22; Mikkola 2007, 363 -364).

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[245] The Task Force on Communicable Disease Control in the Baltic Sea Region was established in 2000. In the cooperation participated Denmark, Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, Russia and Sweden. During the period 2001-2004, the Task Force implemented more than 100 projects in the north-western parts of Russia and the Baltic states. For more e.g. Hønneland and Rowe 2004.

[246] In Samara *oblast,* where all the local key actors supported the reform, the GP training started in the Medical University of Samara in 1996. In 2000 535 GPs were already working in the oblast, one third of all GPs working in Russia (Konitser-Smirnov 2003, 248).

[247] According to Jaatinen (2004, 437) in the FSU social work was considered as a part of health care and many of the developers of the field were medical doctors.

[248] For more on the development of social work in Russia see e.g. Sotsial'naia rabota… 2006; Mikkola 2007.

The need to train social workers and medical social workers was articulated in several official Karelian documents as one of the main tasks and priorities of the reform process (Administratsiia…1995, Ministerstvo obrazovania 1995, MOH Karelia 1995b). In 1995, when the five-year bilateral project between Karelia and STAKES started, one of its components was human resource development (HRD). The task set for the project's HRD working group was to assess the situation and requirements of training of health care and social sector professionals. Special attention was paid to the development of social field education as the tradition of training was lacking. At that time the social field was not a defined part of the educational structures and the education was fragmented. In The Conception of Professional Training (1999, 26-27) it states that until the mid 1990s the term "social worker" was not understood either by the legislation, the bodies of administration or the bodies of executive power.

After the first visit to Karelia in 1995, one of the Finnish members of the HRD working group reported "The question is not only of the training of social workers but about a need to develop the structures for social field education" (Räisänen 1995, 2-3). The start was challenging as in the mid 1990s there was neither, legislation on social protection and provision of services, nor laws or decrees on the qualification requirements or any registers of social field employees (Turpeinen 1995, 4-5).

Training of home-helpers and social workers was started in the districts at the beginning of the 1990s. In September 1993, a three-year social field training course was started in the Petrozavodsk pedagogical institute No. 2, offering two areas of specialisation: working with disabled children or the elderly (Kärkkäinen 1995b, 1-2; Räisänen 1995, 5-6). In addition to these, a basic level of primary training was introduced in some vocational schools in the districts of Olonets, Segezha and Kostomuksha (The Conception of Professional…1999, 24, 30-36; TACIS 1999c, 4). The aim was to train people to assist the staff of institutions in the care of old people, and to make home visits if needed. For instance, in Kostomuksha the training was started with mothers caring for their disabled children at home. The major problems at the beginning were the shortage of qualified teachers, a lack of knowledge of modern teaching methods and a shortage of teaching materials and equipment (Ministerstvo obrazovania 1995; TACIS 1999c, 5).

In September 1994 a position for a social worker had been established in all resident institutions and children homes. Often social pedagogues[249], who lacked special professional education, worked in these positions (Sinitsyna 1995, 25-26). In 1995, the Ministry of Social Protection of Karelia estimated that there were about 1000 people working in the social field in Karelia with insufficient or no training in social issues (Turpeinen 1995, 7)[250].

Although the need for training of social workers was recognised, the issue was new and the Karelian ministries involved in the bilateral project (MOH, MOE,

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[249] Social pedagogs work in schools and other educational institutions (Iarskaia-Smirnova et al. 2002, 129).

[250] In 2004 (133-1) Iarskaia-Smirnova assessed that in the Russian context "the vast majority of employees in the centers of social services have not got the diploma in social work". See also Kemppainen and Grigor'eva 2005, 124.

MSP) did not share a common view on how to proceed. They each had their own conception of the training needs (e.g. Räisänen 1995, 4-6; Turpeinen 1995, 6-8). In 1995, the expert of the Supreme Soviet on social issues was of the opinion that the Republic could not afford to hire very many people for the social field (Turpeinen 1995, 8). The Finnish experts recommended that the ministries develop together a concept for health care and social care education that would define the aims, structures, contents, and requirements of the training as well as how, where and for whom it was to be organised (Räisänen, 1995, 11-13).

Thus when the TACIS project started in 1997, the assessment of the situation was complete and some of the same experts continued working on the EU project. The new working group was tasked with the preparation of a long-term strategy for the training and retraining of health care and social care staff. Representatives of the MOE, MOH, MSP, academics and teachers from higher education institutions, colleges and basic vocational training institutions were invited to the working groups[251]. The working group defined three special groups that needed to be trained or retrained: unqualified basic social workers, social work teachers, and medico-social workers. (TACIS 1999a, 20.)

The relative advantage and complexity of the social innovation were both obvious. There was a real need for trained social workers. However, in addition to training other, structural changes were also expected as well as changes in the attitudes of the decision-makers and population. The absence of an earlier tradition in social work complicated the situation (Grigoryeva et al. 2005, 123-130). The innovation development process – the development of the curricula for social workers and social work teachers and training was carried out at republic and district level. Social work piloting was concentrated in the pilot areas of Olonets, Sortavala and Kondopoga.

Adoption and diffusion

The curricula developed were approved in Karelia. The training of 39 social work teachers from basic, secondary and higher education was started during the project. In the training courses for unqualified social workers (home helpers, paramedical staff and kindergarten nurse assistants) 35 students from Kondopoga, 41 from Olonets and 35 from Sortavala pilot districts participated (STAKES 1999, 12).

In addition, a programme of modular in-service training was developed and at the Institute of Further Qualification under the MOE a department of social work training was established. On the basis of the work started by the international HRD working group, Karelian experts finalised the strategy for human resource development in the social and health care fields of Karelia. (TACIS 1999a, 21; also Kananoja 1999, 26-27; Aaltonen 1998, 4; Mikkola 2007, 366-367; Stakes 1999,12.)

In Karelia, social work training has been provided in two institutions: secondary vocational education since 1993 in the Petrozavodsk pedagogical college and higher education since 1999 in the PSU. In all by June 2009, 508 specialists on social

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[251] Several documents that currently form the basis for the Karelian social work education system were drafted during the EU project (Mikkola 2007, 366-367).

work had graduated from the Petrozavodsk pedagogical college and 100 from the PSU (Personal correspondence June 2009; cf. Mikkola 2007, 368)[252]. No information about the working places of the graduates was available in the PSU or the MOE.

The situation of graduate social workers is reminiscent of that of the GPs. Iarskaia-Smirnova et al. (2004, 132-1) note that even though the quality of education of social workers in Russia has achieved good standards of performance, the legitimisation of social work has been hindered by several parallel dysfunctions. Elli Aaltonen[253] (2005, 135-139) argues that the Russian social welfare system has not yet recognised the full importance of social work, probably due to lack of links between theoretical education and practical work and the short history of social work. (also Urponen in Jaatinen 2004, 439.) Iarskaia-Smirnova (2004, 134, 137) takes the view that the situation is gradually improving because "the necessity of the partnership between education and practice as well as within different sectors of practical social work and other caring professions is being recognised".

The inadequate financing at federal and local levels has an effect on the quality of the services and the motivation of employees. Low salary levels affect the prestige of social work as a profession and while the need for social work professionals is extensive, their salary and status remain low (Iarskaia-Smirnova and Romanov 2002, 126; Iarskaia-Smirnova et al, 2004 233-1; also Kozlov 2004, 303-304). Especially in the rural areas social workers' work may be rather hard. During the fieldwork in Karelia it was reported in one district that during the winter time the social workers' main tasks consisted of carrying water and firewood for the elderly.

The institution of social work in Russia is only taking shape, the standards, criteria and requirements are still partly missing and where they exist, they are not always followed. (Interview EE 4 August 2009; cf. Mikkola 2007, 368, 374-381.) It is also important to acknowledge that training alone is not sufficient but that the knowledge needs to be translated into practical skills for use in different situations (Danilova et al. 2010, 33).

One of the Karelian interviewees (EE on 4 August 2009) noted that there are two main reasons for the weak position and low appreciation of social workers in Karelia: first, that the needs of the municipalities and recently qualified social workers do not coincide (cf. Danishevski 2005, 196-197) and second, the heads and directors of the social institutions, who themselves do not have any education in the social field, are unwilling to hire subordinates with a higher education and more knowledge of the subjects than they themselves possess. This leads to a situation where people with no relevant education are hired in the positions of social workers. (Mikkola 2007, 380-381.)

As with the GPs, the graduates of social work often "encounter hostility" when they start working in social services where people with inappropriate educational and professional backgrounds occupy the majority of the positions. Often the un-

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[252] In 2001, a chair of sociology and social work was founded in the PSU and in 2006 it was split into the chair of sociology and the chair of social work training (<http://www.petrsu.ru/Chairs/socialwork_e.html>)

[253] Elli Aaltonen has participated as an expert in several social sector projects in Russia since the beginning of 1990s.

qualified "professionals" have already established written and unwritten criteria for professional activity and "practices which may or may not correspond with existing models of social work" (Iarskaia-Smirnova et al. 2004, 134-1-135-1 ibid.). This kind of work environment can become impossible for young professionals.

5.3 THE TUBERCULOSIS PROJECT

Name of the project	Fighting Tuberculosis in Karelia 1999-2008
Background	In the 1990's the tuberculosis situation in the Russian Federation deteriorated drastically. Tuberculosis morbidity became a serious problem and created a threat to the population in Karelia. The Karelian Ministry of Health contacted the Finnish health care authorities and suggested cooperation in this field. In 1998 an agreement was signed for a three-year project. The Finnish partner organisation was the Finnish Lung Health Association FILHA[254].
Objective	Improved health of Karelian people by reducing the transmission and incidence of tuberculosis
Special objectives	Improved Tuberculosis Control with DOTS strategy[255] The three components of the project were: Early diagnosis of tuberculosis Case management Training on DOTS
Duration	1999-2008
Financing	MFA 1 183,700[256] Euros
Change agency	Finnish Lung Health Association (FILHA)
Local Partner	Tuberculosis Dispensary of the Republic of Karelia Ministry of Health
Pilot area	Petrozavodsk and Medvezhegorsk
Target group	Population of Karelia
SOCIAL INNOVATION	New approach in prevention of the spread of tuberculosis

Overview

In October 1997, the Minister of Health of the Russian Federation Tatiana Dmitrieva stated, "we will not cope with the tuberculosis problem" (Severnyi Kur'er 31 October 1997). The constantly increasing tuberculosis rates since 1991[257] also concerned the Karelian Government.

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[254] FILHA is an NGO in public health that fights against lung diseases by implementing prevention and treatment programmes, educating health care professionals and enhancing the networking of experts. Since 1997 FILHA acts as a WHO Collaborating Centre for the Prevention, Control and Treatment of Tuberculosis.

[255] DOTS stands for Directly Observed Treatment, Short course. The DOTS strategy consists of the following points: Political commitment with increased and sustained financing; Case detection through quality-assured bacteriology; Standardized treatment with supervision and patient support; An effictive drug supply and management system; Monitoring and evaluation system and impact measurement. http: //www.who.int/tb/dots/en/ visited 9.8.2010.

[256] MFA granted in total 1 380,000 Euros in 1999-2010 (Danilova et al 2010). As this study covers years 1992-2008 the share of grants for 2009 (Euro 70,000) and 2010 (Euro 126 300) was deducted from the total amount.

[257] e.g. FILHA 1999c, 7-15

During the Karelian Medical Conference in 1998, the Minister of Health of Karelia and representatives of FILHA met and discussed the possibilities for cooperation in combatting tuberculosis in Karelia[258]. After the Conference, the Karelian Government contacted the Government of Finland and requested cooperation in this field. Finland's MFA decided to support the project[259] and in February 1999 the MSAH of Finland, MOH Karelia and FILHA signed a cooperation agreement (FILHA 1999c, 10).

A Finnish-Karelian expert group conducted a comprehensive base line study[260] in spring 1999[261]. The point of departure for the project was favourable, as both sides were firmly committed to the cooperation and its long-term relative advantage was obvious. The advantages of the existing system (good networks, centralised information system, good personnel situation and strong preventive activities) were taken into account in the situation analysis (FILHA 1999a, 15). It was suggested that they would be strengthened in the future. The new Federal and Republic governments also endeavoured to consolidate the traditional Russian practice and international recommendations. (FILHA 2004, 12; cf. Shaw 2005; Van de Ven 54-55.)

The difficult financial situation in Karelia and the scarce resources of the Karelian TB programme forced the search for an effective and more economically sustainable strategy to curb the TB epidemic. The DOTS strategy had proved to be one of the most cost effective means of health intervention in countries with limited resources (FILHA 2004, 16-17; WHO 2001).

The cooperation aimed to strengthen the existing regional TB prevention programme, to modernise it and increase its effectiveness by following the DOTS strategy recommended by the WHO. Although the DOTS strategy was new for Karelia, some of its elements had been modified and applied in Karelia for a long time (FILHA 1999c, 27). The project focused on supporting laboratories, improving case management, providing medical training and producing health education materials. The Karelian institutional capacity was assessed as sufficient to implement the project, and the project was carried out with the existing infrastructure[262].

The project organised training for the personnel and there was also the option to participate in Russian national and international training. These training periods provided the Karelian experts with opportunities to liaise and exchange experiences on implementing the DOTS strategy with their Russian and foreign colleagues. They linked the TB work in Karelia to the work of international institutions and this had the effect of enhancing the motivation and performance of those working with the project. (Madaras et al. 2003, 14-15; FILHA 1999c, 33; FILHA 2004, 18-19.)

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[258] Telefax from FILHA (K. Koskela) to the Minister of Health of Karelia, G. Ogloblin on 9 December 1998

[259] The MFA granted for the planning phase approximately 33, 000 Euros (FIM 200, 000) in November 1998 (HELD871-127 of 13 October 1998).

[260] The situation assessment consisted of an analysis of the government and health sector policy including structures, population, economic situation, provision of services, health care financing, organisational structures and responsibilities; background studies, general health status of the population; specific information about TB. (FILHA 1999a.)

[261] Actually, a delegation from FILHA (then called Hengitys and Terveys) had already examined the tuberculosis situation in Karelia in 1995 (Hengitys jaTerveys, no date).

[262] Tuberculosis control in Karelia was under the Department of Medical Care and Prevention and the Head of Therapy in the MOH. The main institution for TB control is the Republic TB dispensary.

The relative advantage of the social innovation was obvious and innovation was clearly preventive in nature. The project plan of 1999 (FILHA 1999, 27) noted that during the three-year project it was possible to see the feasibility of the approach but "a decreasing incidence can only be observed after several years" and the real epidemiological impact of the measures only after several decades (FILHA 2004, 14).

Socio-cultural aspects were taken into account in information, education, communication, and in working with stigma in relation to TB (FILHA 1999c, 27-28). Nevertheless, adherence to Russian traditions in the diagnosis and treatment of TB was strong and especially in the beginning there was strong resistance to change among practically all the staff involved in the project and it seemed that not even all the doctors understood the meaning of the DOTS and its necessity (FILHA 2004, 7-19; Madaras et al. 2003, 12). The older staff in particular opposed the adoption of new working methods and treatment strategies and generally the staff resisted the extra work-load resulting from the new practices (Madaras et al. 2003, 5, 13).

Over time attitudes towards DOTS started to change[263]. The visibility of the good results started to have a positive influence on attitudes: the first evaluation report states that "after the first results of activities became visible, increasing satisfaction on the project was repeatedly expressed by health personnel towards the project staff and the evaluation team" (Madaras 2003, 18). The situation improved further and in 2007 the evaluators wrote that "the DOTS strategy is now well accepted by the specialists of TB services and physicians in general medical care" and "countrywide implementation of the DOTS strategy has been achieved during the second phase of the project" (Maryandyshev 2007, 14-16, 23).

Although the approach of the project initially met resistance it was compatible with the Karelian priorities (Madaras et al. 2003, 18) and with the goals of Finland's development cooperation strategy (FILHA 1999c, 26). It addressed the health of poor people and aimed at preventing the spread of TB in Karelia and to Finland. The evaluation report of 2007 assessed the cooperation as "highly relevant in the context of local needs" (Maryandshev et al. 2007, 22).

The project reported on progress in regional, Russian interregional[264], and international seminars (Maryandyshev et al. 2007, 23; Salovaara 2009a). All Karelian TB doctors were exposed to some information on DOTS (Madaras et al. 2003, 15). Improved inter-project and international cooperation and networking were considered essential to ensure the high quality of work and to tackle challenges related to extending the project to other districts (Madaras et al. 2003, 4; also Maryandshev 2007, 213). Nevertheless, communication between different Karelian actors was not without problems. Madaras et al. (2003, 13, 23) note that cooperation

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[263] According to Finnish experts (Pösö et al. 2003) who participated in another TB project (Tuberculosis in the Karelian Prisons, 2002-2005, financed by the Finnish Ministry of Justice) the support of the international projects helped th eimplementation of the DOTS strategy and "a great change in attitudes and knowledge of DOTS" could be observed.

[264] For instance, in spring 2000 it organised a seminar attended by 60 TB doctors from all districts of Karelia (Parkkali 2000). According to the final report (FILHA 2004, Annex 3), the project organised nine events, in which representatives from the other districts of Karelia participated. (also Maryandyshev et al. 2007, 19.)

both between ministries and among the prison authorities was weak and required reinforced attention (also Salovaara 2009a).

Initially Karelian Government committed to covering the costs of the staff, facilities and part of the costs of diagnosis, training and supervision (FILHA 1999c, 6, 31), and the MOH to paying for the construction of the Reference Laboratory in the new hospital (FILHA 2000). However, the weak economic situation of Karelia was reflected in health care resourcing (Salovaara 2009a). In the evaluation report of 2003 (Madaras et al., 20) the financial situation was mentioned as the greatest risk to the project and there was no indication that national or governmental funding would be increased in the period after 2004 (Madaras et al. 2003, 3). Due to the limited economic resources of the MOH to support the TB programme, the importance of international assistance became considerable (FILHA 2004, 15) and financial dependence on the external donors[265] increased (Madaras et al. 2003, 3; FILHA 1999c, 20). Although the financial situation improved after the first phase of the project, there remained a suspicion that the allocations for the tuberculosis programme were not sufficient (Maryandshev 2007, 26-27)[266].

In addition to the federal decrees[267], the Karelian Government issued a regional tuberculosis law in 1999 called "On TB care for the population and the prevention of TB prevalence in the Republic of Karelia". The document emphasised the role of the Government in TB control (FILHA 1999c, 10). Special Karelian targets were included in "On the prophylaxis and decreasing of TB incidence in the Republic of Karelia in 1998-2000".

The project report of 2004 (FILHA 2004, 21) states that "Government commitment – support of the local government to the TB programme – also in concrete material form, is ultimately the most important and critical factor for the success of the programme, this factor will be reflected either positively or negatively in all aspects of TB control". Nevertheless, the federal authorities were not always able to fulfil their obligations, for instance, with regard to the provision of medicines (Salovaara 2009a). Instead, according to the Finnish change agency, the Karelian partner mainly fulfilled its obligations by covering its share of project costs.

Change in personnel both in the Karelian MOH and in the TB structures influenced the adoption of the innovation and caused substantial delays in implementation. Changes of the key persons compelled training to be re-started in some pilot districts. Especially in the rural areas, the lack of personnel was also a hindrance. (FILHA 2004, 19; Salovaara 2009a; Maryandyshev et al. 2007, 11-13.)

The project focused on the training of trainers to ensure that future training could be carried out by local efforts (FILHA 2004, 13) and to ensure further knowledge transfer to staff (Maryandyshev 2007, 17). As a result of the project, access

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[265] The project cooperated with several other projects implemented in Karelia at the same time. See Madaras et al. 2003, 11, 19 - 20; Maryandyshev et al. 2007, 19, 23 - 24; Danilova et al. 2010.

[266] For instance, in the Evaluation Report of 2007 (23) it was noted that the laboratory sector remained dependent on external support.

[267] E.g. "On improving TB control of the population in the Russian Federation", November 1995; "Approval of standards (model protocols) of tuberculosis patient management", February 1998; "Urgent measures for TB control in Russia for the years 1998-2994", June 1998; "On improving TB control of the population in the Russian Federation", November 1995.

to examination and treatment became easier and quicker, patients received more effective care, the attitudes of the personnel became positive, new working methods were utilised and a more effective monitoring system was developed. After the second phase of the project in 2007, the evaluators noted that "as an effect of training a substantial change in mentality can be observed in the past four years, TB is no longer handled by the TB system alone, but includes the GHS (general health services) and public administration" and the attitude changes were obvious (Maryandshev 2007, 22-23). The Karelian TB dispensary and district level tuberculosis workers started to work more closely together and the skills of the professionals involved in the TB work improved (Salovaara 2009a). A new day-care hospital was opened in Petrozavodsk and the model of home-based treatment was introduced. The personnel have emphasised that due to the project, the situation in the districts has really changed. (Maryandyshev et al. 2007, 14-22.)

Adoption and diffusion

Originally the city of Petrozavodsk and the district of Medvezhegorsk were chosen as the pilot fields for the project,[268] but in January 2002 the activities were also extended to Kondopoga district. Approximately 51% of the population of Karelia lived in these three pilot areas (Maryandyshev 2007, 8). According to the project proposal, it was planned that the DOTS strategy would be replicated in all the remaining districts (FILHA, 1999c, 6, 29).

The Finnish CA considered diffusion of the DOTS strategy to the whole Republic as a challenge to the Karelian TB programme. The final report of the project noted (FILHA 2004, 21-22) that the training and supervision of activities at Republic level had been insufficient and the project resources would not allow total coverage of the territory. The international evaluation team (Madaras et al. 2003, 3) drew attention to the same fact stating that as there was no likelihood that national/governmental funding would increase in the period beyond 2004, the continuation of the programme would further depend on external financial and technical support. The group noted that countrywide implementation of the strategy would require more political commitment and recommended replication of the strategy in only 5 to 7 districts during the next project phase (ibid. 4-5, 13).

Nevertheless, given the good results in the pilots, in April 2003 the MOH decided to diffuse the SI to the entire Republic. During the second phase of the project the SI was diffused to the districts of Priazha, Kem, Belomorsk and Olonets in 2007-2009. (Maryandyshev et al. 2007, 8, 14.)

[268] These areas were selected "because of the proximity and easy supervision and also because of sufficient population coverage" (FILHA 1999c, 29). According to the project proposal (FILHA 1999c, 11) the highest mortality rates were in Sortavala, Muezerskyi, Pitkyaranta, Belomorsk, Segezha and Medvezhegorsk.

Figure 24: Replication of the Tuberculosis project in Karelia in 2000-2009

The Karelian health care authorities highly appreciated the cooperation with FILHA in controlling tuberculosis (HH, interview 4 August 2009). All staff involved in TB in Karelia was trained at least once in the frame of the project and the majority of the personnel attended different types of training several times. Despite the fact that the morbidity among children had decreased as a result of active prophylactic work, the overall epidemiological situation on TB remained critical in 2009 and the tuberculosis situation continued difficult in Karelia[269]. The situation was aggravated by an alarmingly wide spread of multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant TB (XDR-TB), and an ongoing epidemic of human immunodeficiency virus (HIV).

The project report (FILHA 2004, 12-14) noted that although the trend in the epidemiological development was heavily dependent on the functioning of the TB programme, it was also affected by the overall development of society, the

[269] http://petrozavodsk.rfn.ru/rnnews.html?id=7252 visited on 7.8.2009

social state of the population and the funding of health care. Despite the aims of the new legislation to consolidate traditional Russian practices and international recommendations, a strong attachment to the traditional Russian treatment system, the relatively high average age of the staff, low motivation for the new kind of monitoring and the additional work caused by the new registration system, slowed down implementation of the new strategy.

Both the CA and the evaluators of the project remarked on the duration of the project and stated that three years was too short a time to observe a reduction in the incidences of TB but long enough to demonstrate the effectiveness of the strategy to introduce the new method and to build trust between the partners (Madaras et al. 2003, 3, 26).

5.4 THE SEGEZHA PROJECT

Name of the project	**The development of the child welfare system in the district of Segezha 1997-1999**
Background	The general socio-economic crisis in Karelia strongly influenced families and children. The existing safety nets proved insufficient and authorities both at republican and district level recognized the need for development of the child welfare system.
Objective	Improvement of the position and wellbeing of children by reforming the child welfare system.
Special objective	Introduction of new approaches in provision of services for families and children Training of social workers working with children Stop the increase of social orphanhood by developing preventive and community services Creation of a model for development of the child protection system at local level From institutional to open forms of care Strengthening the relations between parents and children
Duration	1997-1999
Financing	MFA: Approximately 23,400 Euros
Change agency	Lastensuojelun keskusliitto (LSKL), Central Union for Child Welfare[270] (CUCW, Finland)
Local Partner	Segezha Town Council Ministry of Education Committee for Family, Youth and Child Affairs
Pilot area	Segezha district
Target group	Children and children with families
SOCIAL INNOVATION	Development of child welfare system New approach to development of preventive services and non-institutional care

[270] The CUCW's members comprise 96 NGOs and 36 municipalities http://www.lskl.fi/en/central_union/member_organisations visited 18.10.2011

Overview

In the Soviet era the problem of abandoned and disabled children was hidden from society as the children were often put into a well-developed system of boarding schools (*internat*) and children's homes. Many of these children were so-called social orphans i.e. their parents were alive but either materially or psychologically unable to take care of them. In Gorbatchov's time, the possibility for a more open discussion about social problems emerged, including the position of children in the children's homes.

The general socio-economic crisis in Karelia had a strong influence on families and children (see 3.3). The existing safety nets proved to be insufficient (Kemppainen and Grigor'eva 1998, 2005), and the need to develop a child welfare system was recognised by district and Republic authorities (MOE, 1995). In 1993-1994 new children's homes were established and groups of orphans formed in the kindergartens in Petrozavodsk, Pitkyaranta, Kondopoga and Pudozh, and, later, in 1995 in Kostomuksha, Louhi and Segezha (Gekkin 1995, 13).

The first international projects in this field addressed acute needs, such as training staff and the rehabilitation of disabled children (see Kostomuksha case). Improvement in children's wellbeing and developing new forms of support for families and children became one of the priority areas of the Karelian Government (MOE 1994). In 1995 a special programme "Children of Karelia" was started, which aimed at improving the position of children in the Republic.

Due to a lack of preventive work and poorly developed forms of open care, the problems were often only tackled at a late stage, which led to the placement of children out of the family with relatives or in institutions. Practically, out-of-home care was the only form of child welfare at the beginning of the 1990s. The placements were long and children's contacts with their own families often lost. Thus, the resources were bound to relatively expensive services whose results – from the point of view of the children – were not always positive. (Kemppainen and Grigor'eva 2005, 123; Kemppainen 1998, 91.)

In Segezha district, the difficult socio-economic situation reflected directly on the children and their wellbeing: there were about 1,000 families with over 2,000 children at risk. The district was unable to pay salaries or child allowances, or provide children with meals in nursery schools, schools or hospitals (Kemppainen and Grigor'eva 2005, 125). In the children's homes there were about 50 children and in both Kamennobor and Nadvoitsyi *internats* (boarding schools) over 100 children (LSKL 1998, no page). The district authorities were aware that the improvement in the children's situation would require a major change in the attitudes and "entrenched thinking and practices" (Kemppainen and Grigor'eva 2005, 124). The old approach of mere execution of regulations and rules coming "from above" was not sufficient in the new conditions.

At the beginning of 1996 the Segezha district authorities approached the Ministry of Education and Youth Affairs with a "view to renewing the child welfare system and developing new models designed to prevent social orphanhood" (Kemppainen 2000, 92; Seniukova 2000). At the request of the Karelian MOE, the Central Union

for Child Welfare from Finland[271] joined the project planning in autumn 1996. At the beginning of 1997 the MOE, the Committee for Family, Youth and Child Affairs and Segezha City Council signed a partnership agreement and jointly prepared the project plan "The development of the child welfare system in the district of Segezha 1997-1999". The project steering committee, including representatives of the district and Republic administration, closely followed the implementation of the project. The new approach stressed that priority should be put on preventive support of children and families and that all professionals, irrespective of their administrative sector, who worked with children and families should be involved in it. (Kemppainen and Grigor'eva 2005; Kemppainen 2000, Kemppainen 2009,124-126; Seniukova 2000)

The project plan was prepared with the local organisations responsible for child protection, and both Karelian and Russian legislation were taken into account in the plan (LSKL 1996, 9). The existing laws were considered to be a sufficient basis for child welfare development (LSKL 1999b, 9)[272]. The large scale of the problems and the underdeveloped service system required quick and large-scale actions in several directions at the same time (LSKL1999b, 3-4).

The project aimed to produce new solutions and models that would better meet the children's needs and guarantee their rights (LSKL 1996, 4). Its main task was to introduce different options of service provision and working methods, monitor the project progress and report it to the district and republic decision-makers (LSKL 1996, 2-4).

The reforms in Segezha were carried out by re-directing the available human resources from activities that had earlier concerned only children, to work with families, and by reorganising the existing services. Training of personnel and new job descriptions were an essential part of the reforming process. The project had several pilot institutions: two day-nurseries, two schools, one children's home, one residential school, one shelter, one social centre for families and children[273] and one vocational school. In the schools, kindergartens and child polyclinics vacancies were created for social pedagogues and social workers. (Kemppainen and Grigor'eva 2005, 124-25; Kemppainen 2000.)

In the frame of the project preventive and non-institutional social care was developed. Out-of-home care was reformed, for instance, by making institutions more open towards families and society. As a result of the project the Kamennobor boarding school[274] was transformed into a children's home in September 1999 and its children started to attend the public school of the village. Some of the children

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[271] Cooperation between MOE of RK and the CUCW had started already in 1989 in the form of exchange of knowledge and experience, including seminars, study visits, etc.

[272] Then Head of Department for Family Policy in the Ministry of Labour and Social Affairs Alexander Zinoviev, stated in November 2002 that the legislation supporting families was good in Russia. The problem was more in the fact that their observance in many regions of Russia was in question. To the question why the authorities did not follow observance of the laws the answer was that they simply did not have money for it. (Karjalan Sanomat 6 November 2002.)

[273] Both the shelter (1998) and the social centre were established by support of the project in 1997-1998. The centre for psycho-social support for youth was established in the city of Segezha in 1997. In 1998 its services were developed further and extended, and at the same time its name was changed to The Segezha Social Centre for Families and Children. (LSKL 1999, Annex 1, np.)

[274] In the school lived and studied 117 children. (Grinblat 1997, 40)

moved to the children's home in the city and some to their relatives. As a result the total number of children in the boarding school decreased to almost half of the original number. The living conditions in Segezha city's children's home improved remarkably when it was given an additional building. Communication with the parents became more regular, which led to 20 of the children returning home. (Kemppainen and Grigor'eva 2005.)

New approaches, skills and established structures created a good basis for the continuation of the development work in the district. During the project basic ideas about the directions of development of child welfare were perceived. The project activities were mainly covered by the financial support of the MFA[275] . On the other hand, by primarily relying on its own resources and deliberate utilisation of external support the emergence of dependency relations was avoided. Nevertheless, the project proceeded as planned. The strength of the project was in the fact that it depended on strong local commitment and ownership, and motivated local professionals. (Kemppainen 2009; LSKL 2000, 1- 6.) The local authorities and decision-makers supported the project, for example, by allowing work on the project during working hours. The project was also given the right to free use of the municipal facilities (Kemppainen 2009).

Information about the project was shared - or in the words of the only external expert of the project "the reputation spread" - in local, regional, all-Russian and international seminars and conferences as well as in newspapers (e.g. Karjalan Sanomat 19 July 2000). The project published a book "Na blago rebenka vmeste s semei" describing how the project was implemented in Segezha and introduces its main results[276].

The services designated for families and children were extended, their provision was reorganised and a new orientation towards preventive and community work was found. More than 1,000 Karelian professionals participated in the project. The most significant single indicator of effectiveness was the halting and downward trend in the numbers of children being taken into care outside their homes and the reduction in the need for long-term extra familiar care. (Kemppainen 1998, 93; LSKL1999a, 2.) Emphasis in the services was transferred towards preventive and non-institutional care. The number of long-term placements outside the home started to decrease[277] and in 1999 in schools, bigger kindergartens and children's *polyclinics* posts were opened for social pedagogues and social workers by changing job descriptions. In 1999, through the financial support of the district administration and other arrangements the situation of children without day-care started to improve. (LSKL 2000, 2; Kemppainen 2009.)

[275] The financial contribution of the district of Segezha was quite modest but it supported the project in all other possible ways. Due to scarce funds the project decided that np salaries or fees would be paid. However, according to Kemppainen (personal correspondence 18 June 2009) due to prevailing practices in other projects they started to pay small payments to project assistants and coordinators.
[276] The book was also distributed in some federal seminars, to partners in Estonia and Ukraine and one copy was even given to President V Putin.
[277] Deprivation of parental rights: 1996 – 48, 1997 - 36, 1998 - 22, 1999 – 22; placements in institutions: 1996 – 42, 1997-29, 1998 – 14, 1999 – 14; placements in families: 1996 -51, 1997 – 37, 1998 – 28, 1999 – 21 (LSKL 2000, 2).

During the project, the city administration took a number of decisions designed to improve the position of families and children (Seniukova 2000, 12-13; Kemppainen 2000, 95). Influenced by the project, the Segezha Town Council approved five development programmes (education, health care, culture, sport and welfare) for the district in December 1999. (Kemppainen 2000, 91-95; Kemppainen and Grigor'eva 2005, 123-126; LSKL, 1999.)

Adoption and Diffusions

The positive changes in Segezha were also noted at the federal level[278] and Karelia served as a pilot district for both federal and international expert groups[279]. The Segezha project contributed to the good reputation attributed to Karelia as an innovative area in the field of child welfare and thus improved its status among the other regions of Russia (Kemppainen 2009).

The project gave rise to the emergence of a new kind of child protection policy and a wider selection of services in the district. In Segezha a psychosocial centre for young people was opened (renamed in 1998 the Social Centre for Children and Families in Segezha) and preventive work in schools was activated. (Shilova 2000, 75-77; LSKL 1999a 2-3, Kemppainen 2000; Klevina 2000.)

In 2007, in the frame of another bilateral Finnish-Karelian project, an assessment of the wellbeing of the population in the district of Segezha was carried out (Administratsiia Segezha…2007)[280]. The report noted that the Social Centre for Children and Families, established during the Segezha project was still functioning. Also, if in the mid 1990s the weak position of children and families had been one of the most urgent problems in the district (Kemppainen 2000, 92), the 2007 assessment did not even mention this problem.

The new approaches and practices were adopted in Segezha. The project did not count on external support so much as on the efficient use of available local financial and human resources (Kemppainen 2000; Kemppainen, 2009). The Segezha project is an example of successful intersectoral cooperation[281].

According to the head of the project, Vera Seniukova (1998), the influence of the "Segezha model in family social work" was obvious at the level of practical work: if the social workers before the project were mostly dealing with families in crisis and the only way to help them was material, thanks to the project the social workers learned to support and consult the parents and children, and the school social pedagogues learned to work with the families, kindergartens,

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[278] In 2004, in the frame of a Finnish-Russian project it was decided to conduct a comparative study on child protection in Europe and Russia. The Russian partners of the project, the Ministry of Education of the RF and the Ministry of Health and Social Development of the RF, nominated Galina Grigor'eva of the MOE of Karelia on the Russian side as the head of the working group. In the introduction of the publication Grigor'eva is called "a reformer of child protection in Karelia". (Mikkola 2007.)

[279] E.g. in the frame of the TACIS project "Partnership in education, health and social assistance" a study visit to Karelia was made in April 2002.

[280] Support to implementation of the health promotion policy in the Republic of Karelia 2007-2009. The assessment was prepared by a working group of 15 persons from Segezha (nominated by the local authorities), a representative from the Preventive Centre from Petrozavodsk and one Finnish expert.

[281] In an interview (EE 4 August 2009) was said that in situation when all sectors lacked money, they decided to put their efforts together and search for new approaches.

unemployed parents, young people, and to provide social rehabilitation for disabled children.

The project was planned specifically for the Segezha district[282] but several other districts became interested in its results. The districts of Olonets, Kem, Kondopoga, and Priazha contacted the MOE and made a request for a similar kind of project (Kemppainen 2009; LSKL 1999: LSKL 1998b). The Segezha model was modified for Pitkyaranta[283] and Olonets in 2000-2002. The planning of new projects had already started during the Segezha project. These districts were selected due to the initiative of the local authorities and their location close to each other, which provided an opportunity to compare the development work in two districts and for cooperation. (LSKL 1999b, 4-6; Kemppainen and Grigor'eva 2005, 126-128.) In 2004-2006 the model was modified for Priazha and in 2007-2009 for Medvezhegorsk.

In April 2000 in Segezha an enlarged meeting of the MOE and the Committee on Youth of the Republic and the city and district administrations of Segezha was held. Representatives from all districts of Karelia attended the meeting as well as those of the MSP and Ministry of Internal Affairs. The meeting discussed the achievements of the project and decided to recommend the Segezha pilot as a model for other districts on the creation of conditions for the prevention of social orphanhood and the development of an individual and family centred child welfare system. (Doverie 13 May 2000.)

[282] Actually the project plan for 1997-1999 (LSKL 1996, 1) stated that initially it was planned to create a national model for development of child protection at district level. During the first year that plan was abandoned and it was decided to concentrate on the preparation of the development plan for Segezha. Also, the fact that implementation of a Republic-wide project would have required much more human and financial resources, which were not available, influenced the decision to implement the project in only one district (LSKL 1998, np).

[283] Lack of and inundequate legislation as well as the long process of their adoption by the Karelian Parliament led to difficult situations. For instance, in 2002 in Pitkyaranta district there were 18 families who had agreed to foster an orphan, however, due to lack of a law on custody for foster families, the process was halted. (Karjalan Sanomat 6 April 2002 and 6 November 2002.)

Figure 25: Diffusion of innovations of the Segezha project

Despite the good outcomes, this project also faced problems. At the beginning the goals set were not achieved due to scant financial resources and the lack of tradition and skills in working with families (LSKL 1998, np). The most difficult situation emerged as a result of good outcomes: a decrease in institutional care led to resistance due to fear of job losses. The problem was resolved by joint efforts of the authorities and institutions. (Kemppainen 2009.)

The Finnish CA noted continuity as one of the factors that clearly supported the change. There were no major changes in the key personnel of the project and therefore knowledge and experiences accumulated and communication between parties became open and easy (Kemppainen 2009). The attitudes towards work changed and new orientations including a client-centred approach, prevention, and working with the families were formed. The financial situation hampered the development of new homelike forms of foster care. The annual report for 1999 notes that it was difficult to recruit new foster families when the payments for

the already existing foster families could be even six months late. (LSKL 2000) No special follow-up of the project has been done. However, the information received from Olonets, Pitkyaranta[284] and Priazha has confirmed that the work started in Segezha continues (Kemppainen 2005, Kemppainen 2009).

Galina Grigor'eva[285] stated in 2007 (33-35) that Russia still lacked tools for securing children's rights. However, prerequisites for new approach in child protection exist: the long and fruitful cooperation with the Finnish partners; new regional legislation, the structural changes in children's homes, improvement of the service net and utilisation of the preventive measures in child protection were all processes started in the frame of the Segezha project.

5.5 THE KOSTOMUKSHA PROJECT

Name of the project	Support for the Rehabilitation Centre for Disabled Children in Kostomuksha in 1992-2010
Overall objective	To support the development of social services and in particular services for the disabled in the city of Kostomuksha
Specific objective	Coordinate the actions of the Finnish actors (in particular from Oulu district) in the Republic of Karelia with regard to disabled Development of open care services for disabled Dissemination of information about the methods and means of serving disabled Development of education and training system for the personnel working with the disabled (for the whole Republic)
Duration	1992-2008
Financing	MFA: About 4,000 – 5,000 Euros per year in the mid 1990s for planning of the cooperation from the[286] . At the end of the 1990s about 1,500-2,000 Euros per year.
Change agency	The province of Oulu
Local Partner	Rehabilitation Centre for Disabled Children The city authorities of Kostomuksha Ministry of Education of Karelia
Pilot area	City of Kostomuksha
Target group	Disabled children in the city of Kostomuksha
SOCIAL INNOVATION	Improvement of position of the disabled children New approach towards disabled Development of services for disabled children

[284] E.g. the publication Partnertstvo na blago detei Model Tsentra psihologo-mediko-sotsial'nogo soprovozhdeniia detei i semei Pitkyarantskogo raiona (Партерство на благо детей Молель Центра психолого-медико-социального сопровождения детей и семей Питкярантского района). A model of the centre for psycho-medico-social accompaniment of children and families in Pitkyaranta district. Pitkyaranta has also received an honourable mention in all-Russian contest on developing innovative models of fostering (Kemppainen 8 June 2009).

[285] The Ombudsman for children in the Republic of Karelia

[286] According to Marja-Leena Kärkkäinen (counsellor for social welfare, Province of Oulu, one of the initiators of the cooperation) at the beginning of the 1990s some funding for planning of the cooperation was also received from the Ministry of Internal Affairs of Finland. (Kärkkäinen 2010)

Overview

Issues related to the disabled[287] were among those that were hushed up in the Soviet Union. Officially "invalids" and their protection were considered important and fixed in laws but in practice the system of care and rehabilitation did not work properly. Public discussion on this issue was modest and the position of disabled in the society was taboo until mid the 1980s. According to Iarskaia-Smirnova (2011, 120) "Among the dominant themes in the Soviet approach to disability from the very beginning, the most persistent was "who does not work does not eat". Those injured in wars received more respect and attention while mental impairment, women, children and the elderly were excluded from the Soviet disability discourse."

In Russian literature the term "disabled" is often used to refer to an "invalid". Invalidity refers to a defect or handicap which causes disability and which is diagnosed by a doctor. In Karelia the disability policy did not have any independent position in the legislation and strategic planning in the mid 1990s. Its main task – according to the report of the Finnish experts – was to produce institutional services and provide social services and benefits. Disabled children were usually placed in residential institutions, orphanages and children's homes, while adults with disabilities were placed in old-age homes and they were provided with the same services and treated as the elderly[288]. (STAKES 1995, 1-4; Arrhenius 1995.)

In 1996, the Minister of Social Protection of Karelia, Valeri Semenov, mentioned (Sosiaali- ja terveysministeriö 1996) the issues related to the disabled as one of the four priority areas[289] of the Ministry. The prevailing negative attitude towards the disabled was recognised. In 1995 the deputy Minister of Social Protection Mr Vladimir Fomichev noted (MSP 1995, 1) that the positive attitude of people towards the problems of disabled is still taking shape as well as consideration them as equal members of society. Attitudes of the personnel in institutions for the disabled were also characterised as "rather reserved and negative than open and positive" (Korkhova et al. 1998, 113; also Hatunen 1999, 4-5). [290]

Responsibilities for the provision of services and benefits to disabled children were assigned in Karelia to four institutions. The Ministry of Social Protection was in charge of the institutions, the Ministry of Education was responsible for special education for disabled children in residential institutions; the Committee for Youth and Families for children's homes and the Ministry of Health for health care services for children under 3 years.

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[287] Instead of the term "disabled" the United Nations Department of Economic and Social Affairs (DESA) suggests using the term "person with disability" or "people with disabilities" (United Nations 2007). For the sake of simplicity in this study uses the term "disabled".

[288] The first (Republican) rehabilitation centre for adults of working age in North-West Russia was opened in Karelia (Marcialiye Vodi) in 2003 (Seniuakova 2005, 68, 73).

[289] This was during the official visit of the Permanent Secretary of the MSAH of Finland, M. Lehto to Karelia. The others were towards open care, analysis of the social situation of the population, improvement of the living conditions and social services for the population. (MSAH 1996.)

[290] The attitudes of the personnel sometimes confused the foreign experts visiting the institutions. In the frames of another project the experts were told during a visit to a rehabilitation centre that "seriously disabled children do not want to come to the centre where they would need to deal with other people" and "that seriously disabled children cannot come to the centre". The report ends with a statement "Our work in "X" seems impossible. Attitudes towards disabled children in Karelia are decades behind European attitudes" (Report of an expert).

At the beginning of the 1990s new institutions that provided support and services for the disabled started to emerge in Russia (Korkhova et al. 1998, 113, 119-123). In 1995-1996, 16 new types of social institutions, including centres for social assistance to families and children, social shelters for children and young people (in Petrozavodsk, Kem, Lahdenpohia, Medvezhegorsk, Olonets, in Loukhi), and three rehabilitation centres for disabled children operated in Karelia (Kostomuksha, Pudozh, Kalevala). (Komitet po delam…1996.)

The basis for the cooperation between the province of Oulu and the city of Kostomuksha had already been established in Soviet times in the 1970s, when Finnish building contractors were construction the city of Kostomuksha. Over the years the cooperation spread to other fields and levels.

In November 1993, the Province of Oulu and the Ministry of Education of the Republic of Karelia signed a Memorandum of Intent on cooperation in social welfare and training. Development of the care of disabled children, rehabilitation services, school and day-care functions and the care of elderly were mentioned as the primary fields of cooperation. Diffusion of the results achieved was planned to be utilised more widely in Karelia. (Oulun lääninhallitus 1994.) Development and improvement of the services for disabled children and training of personnel were mentioned as the main tasks of the cooperation. Since then the Province of Oulu, together with several other Finnish actors[291], has supported the Kostomuksha authorities in improving the welfare of disabled children and their integration into society, in training and strengthening the skills of the personnel of the centre, and in developing open forms of care (Vihavainen 2004, 34).

The first non-institutional day-care and rehabilitation centre for disabled children was established in Kostomuksha on the initiative of private persons in 1992[292]. The centre was called after its founder "Irina's school"[293]. Initially the staff worked on a voluntary basis (Oulun lääninhallitus 1994a). The personnel were highly motivated while also recognised their shortcomings in professional skills and knowledge about the care of the disabled[294]. Information on the working methods and professional training of personnel was not available at that time in Karelia (Oulun lääninhallitus 1994, 1994b 5). "We lacked the knowledge, skills and methods" ... "the centre was based only on a burning desire to help the disabled children, about whom society knew nothing. It was a world full of pain and loneliness" (Sergeeva 2002). Soon after its establishment a representative of the Province of Oulu visited the centre and asked if they could support the centre in some way. The answer was unambiguously – yes, by training personnel. Sergeeva

[291] Household and social field school of Suomussalmi, University of applied Sciences of Oulu, Oulun terveydenhuolto-oppilaitos, Merikosken ammattioppilaitos, Ortoosikeskus and Proteesisäätiö (Oulun lääninhallitus 1994b, 2-5). The first mentioned together with the Save the Children (Sotkamo section) and the Public Health College of Kajaani had started cooperation with the city of Kostomuksha already before the Province of Oulu (Oulun lääninhallitus 1993).

[292] See Thomson (2002) about emergence of corresponding centres in Saratov and Samara.

[293] Irina Sergeeva told to the author (in Feb 2008) that after visiting an institution for disabled children in Finland she, together with her colleagues, decided to try how it would work in Kostomuksha.

[294] The lack of information about working methods and professional training of the personnel was not a problem only in Kostomuksha but also in the other parts of the Republic (Oulun lääninhallitus1994).

(2002) noted that it was important for the centre to train the personnel in new working methods, which the Finnish experts knew, and to become familiar with Finnish experiences in rehabilitation. The first 20 children[295] were admitted to the Rehabilitation centre in September 1992. By January 1994 there were 80 and in 2005 a total of 120 children (Oulun lääninhallitus 1994b, 3-5; Kärkkäinen 2006, 12).

In addition to the rehabilitation centre, a children's home, a safe house for children and young people and an old-age home were opened in Kostomuksha. An urgent need for educated personnel had emerged and plans for starting social field training in Kostomuksha were prepared. With the support of Finnish colleagues a programme for three-year on-the-job training was prepared (first in March-June 1994), one year of youth education (in Autumn 1994) and a two-year social field education period (in September 1995). (Oulun lääninhallitus 1994, 2.) The close involvement of the local Karelian decision-makers in the cooperation enabled quick realisation of the project plans. The Kostomuksha city administration issued a decree No. 419 of 27 April 1995 "On opening a group for the training of social workers in PU-5" (Oulun lääninhallitus 1995). All training was carried out with Finnish educational institutions (Oulun sosiaalialan oppilaitos 1994). Students from the districts of Loukhi, Kem, Belomorsk, Kalevala, Muezerskyi, Pitkyaranta, and Segezha were also invited to the courses. (Oulun lääninhallitus 1995; Oulun lääninhallitus 1994; Kärkkäinen 1995a, 33-35; Kärkkäinen 1994; MOE 1995; Sergeeva 2002.)

The relative advantage of the social innovation was in the improved skills of personnel and in an improved situation and services for disabled children. The only incentives provided by the project to the local partners were the joint seminars, organised both in Karelia and Finland. The project challenged attitudes towards the disabled as well as the earlier working methods. The new approach advocated the integration of the disabled children into society and a new model of care.

Adoption and Diffusion

The Finnish CA formulated the objective for the cooperation so as to "implement in the city of Kostomuksha an experiment, in which Finnish expertise is used in the development of social welfare and especially services for the disabled" (Oulun lääninhallitus1994a, 2). A new approach to disabled children was introduced with information about Finnish experiences and good practices. The Finnish CA stressed that their departure point was not to try to "import" any "ready-made or fixed" models to Karelia but to introduce practices compatible with local circumstances and the Russian legislation. (Saavalainen 2008.)

The Oulu-Kostomuksha cooperation was pioneering work in improving the services and position of disabled children in Karelia. The primary beneficiary of the cooperation was the Kostomuksha Rehabilitation Centre but the experiences were also planned to be disseminated to other parts of Karelia (Oulun lääninhallitus 1993a; Oulun lääninhallitus, 1993b; Saavalainen 2008).

[295] The children had different kinds of disabilities: CP, mental defects, hearing and speaking problems etc. (Oulun lääninhallitus 1994).

The Kostomuksha partners highly appreciated the cooperation with Oulu. The director of the rehabilitation centre divided the cooperation into three phases. The first phase was characterised as mainly humanitarian aid and technical support; during the second phase the Kostomuksha professionals gained experience, were trained and started to share their knowledge with their colleagues from other Karelian districts. The third and on-going phase was characterised as collaboration between equal partners, in which both receive and give and learn from each other. (Kärkkäinen 2008.)

Even though the rehabilitation centre has been assessed as "supermodern" (HH 4 August 2009) for that time and as "the best of all the centres" (interview EE 4 August 2009), in January 1993 the future did not seem so promising. In an article "From whom can be help expected?" the founder of the centre, Irina Sergeeva, and the Minister of Health of Karelia, Anatoli Artemiev, were interviewed. Sergeeva was worried about the future of the centre due to uncertainty of funding. The Minister, for his part, deliberated on the need to establish corresponding centres in other parts of the country. He concluded that it would not be necessary to establish new centres in other districts but instead the Kostomuksha centre could serve the northern districts and another centre in Petrozavodsk, could serve the southern districts. (Severnyi Kur'er, 7 January 1993.)

However, gradually things started to change. In 1996, the Ministry of Social Protection supported the establishment of rehabilitation centres as an alternative to large residential facilities (*internates*) (STAKES 1996, 4) and in July 1996 the administration of the Head of the Government issued a recommendation[296] for the heads of local self-government to carry out the necessary actions for the establishment and development of rehabilitation centres for disabled children and young people. It was recommended that a centre be established if there were 20 or more disabled children registered in the district (Art 1.5). The organs of local self-government should establish, reorganise and close the centres (article 1.2) and finance them with the local budget (Art. 1.4) (Administratsiia 1996). The Kostomuksha Rehabilitation centre was taken as the model centre for the Karelian northern districts in 1996.

[296] Order No. 634 of 15 July 1996 "Confirmation of an exemplary Regulation on rehabilitation centre for disabled children and young people" In Russian "Об утверждении Примерного положения о реабилитационном центре для детей и подростков с ограниченными возможностями". Also Komitet po delam sem'i, molodozhi i detstva 1996.

Figure 26: Diffusion of innovations of the Kostomuksha project

The Kostomuksha centre distributed not only information but also equipment to other districts of Karelia that were starting corresponding actions (Sergeeva 2002; Sergeeva 2007, 21). The centre cooperated closely with the districts of Kalevala, Kem, Loukhi, Belomorsk, Segezha, Murzerskyi and Petrozavodsk and with seven Finnish municipalities and institutions (Sergeeva 2002, Annex 7), and it became a kind of node through which skills and information were transferred to both sides of the border. (Sergeeva 2002.)

The Kostomuksha model was not directly replicable[297] in the other districts of Karelia but the new approach and the model of service provision for disabled children diffused. Despite slight discrepancies in data from different sources (Sergeeva 2002, Seniakova 2005, Personal correspondence June 2009), it can be said that based on the Kostomuksha experiences four corresponding centres were established in Kalevala, Pudozh, Segezha and Petrozavodsk. In addition, departments for disabled children were established in social centres in thirteen districts.

[297] Kostomuksha is an urban district (about 90 % of the population lives in the city) while all the other districts (except for Petrozavodsk) are rural (see Table 2).

In 1999, Professor Liudmila Shipitsyna[298] noted that it is difficult to talk about social integration of the disabled in such a difficult situation as that in Russia. She said that society cannot be forced to accept the integration but needs to be given time to mature. Changes were needed not only in attitudes but also in the legislation in order to be able to improve the situation of the disabled. She affirmed that there was no functioning legislation with regard to the disabled, and early rehabilitation was practically non-existent and that during the first three years of life a child only receives medical help. "We need special rehabilitation centres and rehabilitation departments in the hospitals so that the children can get rehabilitative treatment from a young age onward". (Shipitsyna 1999; Urmancheeva 1999.)

Curtis and Roza (2002) came to the same conclusion, claiming that despite the promises, the disabled in Russia still face daily discrimination and attitudinal and physical barriers to education, employment, recreational activities, family life and majority of disabled children aged 7-18 are still isolated in their homes, segregated in specialized institutions, or receive no education at all. (also Cerami 2006, 5-6 and Iarskaia-Smirnova 2011,113.) Koloskov (2001) argues that the state continued, "to refrain from executing the current laws or developing regulatory acts to support these laws and specify the law enforcement procedures". Although it seems that few positive developments in relation to disabled children have taken place in Russia during the past two decades, Kolosova (2010, 13-14) argues that essential changes are taking place in relations between disabled and the society. The disabled are becoming aware of their even status in society and have started to claim realisation of their rights stipulated in the Russian legislation.

The process of the integration of disabled children into society started in Kostomuksha in the mid 1990s[299]. Against the above-described general situation in Russia, the results achieved in Karelia can be assessed good and the development trajectory correct.

[298] Rector of the Institute of Special Education and Special Psychology of the Raoul Wallenberg Institute for Family and Child in St. Petersburg.

[299] Several other projects addressed with the same issues in different parts of Karelia after the Kostomuksha project. For example, Support to the Implementation of the Social and Health Care Reform in the Republic of Karelia (both the bilateral by STAKES and TACIS), Social Integration and Empowerment of People with Mobility Disabilities in the Republic of Karelia (1996-1998) by Invalidiliitto and Ystävyyttä yhdenvertaisuutta 1996-1998 both by Invalidiliitto; Improvement of Professional Skills of Workers of Rehabilitation Institutions for Handicapped Children in the Republic of Karelia (2002-2003); Independence and Empowerment of disabled People in the Republic of Karelia (2005-2007); Improvement of Professional Skills of Workers in Rehabilitation Institutions for Handicapped Children in the Republic of Karelia (Nordic Council of Ministers); Interreg II Kate project in 1998-1999 (Kajaanin ammattikorkeakoulu).

6 Diffusion and Adoption of the Social Innovations

This chapter presents the results of this study. The chapter begins with a description of the findings of the survey. The second sub-chapter describes which factors influenced diffusion at both stages and adoption. At the end of the chapter answers are provided to the research questions and hypotheses. In this part, the three sectors health care, social protection and education are addressed separately.

The further the research proceeded the more obvious it became that first, the three variables (attributes of the innovations, communication and institutional framework) were not only closely interrelated but intertwined and, second, that these factors affected adoption, and external and internal diffusion in different ways, and third, that their influence varied between the cases. The same factor could in one case affect positively and contribute to diffusion and in another case prevent it. The results are presented below under three headings: 1) external diffusion, 2) adoption, and 3) internal diffusion.

6.1 BASIC INFORMATION AND SOME RESULTS OF THE SURVEY

In total 69 respondents participated in the survey: 17 from the health care, 30 from the social care and 22 from the education sector. In 11 districts more than the requested three persons attended the meetings organised. Answers of only those respondents, who best met the given criteria (4.2), were included. Thus the group of respondents consisted of 53 respondents (one health care representative did not attend the event). The average age and average amount of working experience (in years) in sectors are shown in Table 10.

Table 10: Respondents' average age in years and working experience

	Average total	Health care	Social care	Education
Age	48.8	49.2	48.3	48.8
Working experience (years in sector)	20.9	25.4	16.1	21.9

It is worth noting that both the health care and education sectors were strong in the Soviet era whereas social protection only started to develop independently at the beginning of the 1990s. Five respondents had long working experience in both

the social care and education sectors. In these cases the years were summed and considered as working experience in the sector which the person was representing at the time of this survey. All respondents, with the exception of one in the health care sector and two in the social care, had a higher education degree.

The main tasks and duties of the respondents:

Health care:

1. Coordination of activities in the health sector, organisation of the work of health care and social care institutions, health care management (four heads of social welfare/work or health care departments in hospitals or in municipal administration)
2. Decision-making, administrative and financial management, organisation of health care and medico-social services and emergency care (12 chief or deputy chief doctors of the district hospitals)
3. Therapeutic and social care (one respondent with secondary education).

Social care:

1. Supervision of social service institutions, coordination, management and implementation of social policy and social sector municipal activities in the district (seven heads and/or deputy heads of social department in the district administration)
2. Organisation of social services for the population, support for and work with the families and children at risk, provision of social services for the elderly and disabled, fostering and guardianship of children, organisation of day-care and other services for disabled children (ten directors and/or deputy directors of social welfare and work centres and rehabilitation centres, experts on children's rights)
3. One of the respondents did not give a description of her tasks. Her position was: vice head of district administration on social issues.

In the *education sector* the tasks fell into two groups in accordance with the tasks of the Ministry. The Ministry of Education was responsible for the planning and organisation of education and child welfare, children's homes and the provision of services for disabled children. The respondents were responsible for:

1. Supervision and management of educational institutions, organisation of actions of educational institutions, implementation of state policy in education (eight heads or deputy heads of education departments at district administration, chair of education committee, senior specialists).
2. Control of the work of institutions providing assistance to children, families and young people; preventive work with families at social risk, child protection and welfare; protection of children's health and lives; protection of rights of minorities; prevention of social isolation of children; identification of orphans; control of child adoptions (ten respondents - expert of child rights, directors of municipal centres for social support to children, director of children's home, specialist in child fostering)

6.1.1 Survey answering

Some basic shortcomings remained in the questionnaire, despite the pre-testing and corrections made based on it: 1) too long and too similar alternative questions (Q7 and Q8); 2) too difficult or not clearly expressed questions (Q10 and Q14); and 3) too "easy" (Q11) questions. Furthermore, as most of the respondents (38 of 53) did not answer questions 3 and 4 dealing with working with the change agencies of the case projects, these questions were excluded. The terminology used may also have caused some misunderstandings. Even though the key terms were explained and three Russian colleagues had commented on the questionnaire, some inexact words and expressions were overlooked[300]. (cf. Palosuo 2000, 45-46.)

Jyrinki (1976, 107-113) divides respondents into participants and non-participants. The latter can be further divided into those who refuse to answer, those not reached, and to those who participated but answered incompletely. Reasons for non-participation may vary: the topics are not of current interest, or they are annoying or sensitive. In this survey none of the 53 respondents returned an empty questionnaire and 23 of them answered all questions.

Data from the questionnaires was transferred into excel tables, summarised, categorised and analysed. Answers to the open questions were classified and categorised. The five-stage scale originally used in alternative questions was transformed into a three-stage scale. This change enabled differences to be seen in the relatively small group of respondents.

The five open questions were answered relatively well. Twelve respondents did not answer the question concerning participation in other international projects (Q6) and seven the question (Q15) about obstacles to further development of the social sector[301]. Six respondents left the question concerning the influence of international cooperation on their personal work (Q16) unanswered as well as question (Q21) that asked them to name people who knew the international social sector cooperation well.

The three closed questions Qs 1, 2 and 22 were answered well – only two respondents did not answer Q2. An interesting phenomenon, which also concerned the alternative questions, was that the questions were partially answered in that only positive "yes" answers were given. In these cases non-answers were considered as "no" answers. Palosuo (2000, 45-46[302]) writes about "the survey language" and the higher percentage of non-replies in Russian questionnaires and the same kind of experience as follows:

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[300] The words 'maternity', 'municipality', and 'process' raised discussion. 'Process' seemed to be too abstract and it was confused with the word 'project'. In the Russian language there is a special expression 'женская и детская консультация' (=women and child consultation), which includes services provided by both a child health centre and a maternity clinic. In the questionnaire it was mistakenly used instead of the word 'женская' word 'материнская' (= maternity). None of the Russian pre-testers commented on this.

[301] The questionnaire used the expression social sphere ("социальная сфера") which includes all three sectors in question. See footnote 3.

[302] The article addresses methodological problems in a comparative survey on health, health-related habits and attitudes of adult populations in Helsinki and Moscow in 1991.

> "For instance many more Russians apparently did not see the point of ticking (or circling) a "no" alternative in lists of items (…) They would mark only those symptoms which they had experienced. But we cannot be sure. Maybe they just could not tell or did not recognise the symptom, i.e. it was not in the language that they would speak about their experience. (…) A large proportion of non-response is always problematic. The safest way to handle the missing data in this and other similar questions was to interpret missing values in both data sets as "no" values".

The fifteen alternative questions were answered well except Q5, which concerned the respondents' participation in events organised in the frames of the case projects (eight respondents did not answer), and Q7 and Q8 that related to development processes supported by the case projects and their impact on local development. In both cases three respondents did not answer.

6.1.2 Observations

Silverman states (2000, 126) that if the researcher is physically present, two issues should never be neglected: 1) what you can see and hear, and 2) how you are behaving and being treated. The field visits provided a unique opportunity to make observations. (cf. Hemminki et al. 2010, 197-198.) In most districts the visit was well received and the general atmosphere was good and open. The events – in most cases – seemed also to serve as a welcome opportunity for meeting with colleagues. Answering the questionnaire took from 30 to 50 minutes, during which observations were made on the general atmosphere, disruptive factors and comments and questions.

The general atmosphere

The following classification was made based on the observations:

Informal and open atmosphere (6 districts): The respondents greeted each other, were busy but polite, had a cup of tea before the inquiry and talked freely about both work-related and private matters.

Formal but open (3 districts): An easy atmosphere but superior-subordinate relations of the respondents were easily recognised.

Reserved and slow/uncommunicative atmosphere (5 districts): Respondents sat quietly, no tea, no talking, no smiling and no comments; they filled in the questionnaire and left the room.

Superior – subordination –setting (4 districts): The superior tried to lead and guide the situation and give orders and advice on how to answer.

Disruptive factors

The events were organised during working hours on the premises of the district administration (with one exception)[303]. The fact that respondents arrived

[303] The organisation of interviews and surveys has also caused problems in other cases. See e.g. Salmi 2006, 80.

from different working places at different times caused some disturbance and, in addition:

- Telephone calls. This is a Russian habit; telephones are often switched on and calls are answered even during meetings.
- Thinking aloud
- Remembering together
- Visits of clients and colleagues to the meeting premises
- In many places too small a space for the purpose. The respondents sat very close to each other. In several places the meetings were organised in the office of the deputy head, not in a "neutral zone".
- In some events the respondents seemed to be in a hurry and it was obvious that they had difficulties concentrating on the questions.

The observations, questions and other comments are presented in Appendix 3. It also seemed that it was quite difficult for some of the respondents to express their own opinions. There were statements such as: "I am not able to answer as I have not seen any statistics or summary about this", "This is defined in our legislation", and "I would need to check how to answer". It appeared as if some of them were afraid of answering "incorrectly".

6.1.3 Recognition of the case projects and innovations

The survey made it possible to collect information from all districts during a relatively short period of time. In order to examine how widely information had spread about projects in Karelia, the respondents were asked which of the case projects they had heard about. In the question (Q1) either the name of the external CA or the donor[304] was given. In some cases (1, 4 and 5) the geographical pilot area was mentioned in the original name of the project.

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[304] In this case the name of the donor was given as the project is known in Karelia as "the EU" or "TACIS" project.

Table 11: Recognition of the case projects

Project[305]	Answered		Non-answered
	Yes	No	
Investigation of the risk factors and behavioural characteristics in Pitkyaranta (Institute of Public Health of Finland)	17	32	4
Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia in 1997-1999 (TACIS project, European Union)	45	7	1
Fighting tuberculosis in Karelia (Finnish Lung Health Association, FILHA)	33	19	1
The development of child welfare system in the district of Segezha in 1997-1999 (Central Union of Child Welfare, Finland)	24	26	3
Support to the Rehabilitation Centre for Disabled Children in Kostomuksha (Province of Oulu)	26	24	3

The TACIS project, which covered all three sectors, was the best recognised. This may be partly explained by the fact that the project, in principle, covered the whole Republic. Due also to ample funding – when compared with the other cases – the project was able to organise several big events and invite representatives from all the other districts[306]. The second best known was the tuberculosis project, which was originally implemented in three districts, but at the time of the survey, February 2008, the activities had already been expanded to new districts and the decision on diffusion throughout Karelia had been made. In total, 17 of the 53 respondents recognised the Pitkyaranta project; eight of them represented the health sector. In this case it is worth noting that the name of the project mentioned in the questionnaire may have confused some respondents; the questionnaire referred to the first joint project that started the long lasting cooperation. In Karelia, when talking about the cooperation between the North Karelia project and NPHI with Pitkyaranta district hospital, reference is often made to "Pitkyaranta project" without any indication of the scope or years. Respondents from seven districts in different parts of the Republic recognised all three "health projects"[307]. In five districts the health sector representative did not recognise two of the three projects.

The projects related to child welfare, the Segezha and Kostomuksha projects were recognised by approximately half of the respondents (24 and 26 respectively); in both cases most of these were from the social care and education sectors. The Segezha project was not known in two districts and the Kostomuksha project in five. The results confirm that information about the projects had spread outside the pilot areas. The result also showed that the number of years the respondents had worked in the sector did not correlate with their knowledge of the projects.

As to the projects related to child welfare, it was assumed that those responsible for organising or working in child protection would also know about the developments with regard to disabled children and vice versa. In one district

[305] Hereafter the case projects are referred to as follows: Pitkyaranta project, TACIS project, TB project, Segezha project and Kostomuksha project.
[306] In total over 1,500 Karelian professionals participated in the project activities (TACIS 1999b).
[307] Health projects refer to Pitkyaranta, TACIS and TB.

neither of the respondents recognised the two projects. The respondent of social care had over 10 years of working experience and acted as the deputy head of administration on social issues. The representative of the education sector had been working for over 20 years in the education sector and in 2008 was working as the head of the department of education responsible for the organisation and coordination of education in the district. Furthermore, in Q7 they both answered that they knew the processes supported by the mentioned child welfare case projects well. This may be explained by the fact that in addition to regional efforts and the mentioned two projects there were also several other projects implemented in the same field. Both respondents had participated in other international projects. The results show the same as in regard to the health projects – the information had spread to all parts of Karelia.

Generally, both child welfare projects were quite well known but there was a clear difference in their recognition. Knowledge of the Segezha project was quite evenly distributed through different parts of Karelia, whereas the Kostomuksha project was best known in the districts close to it. In total, thirteen of the respondents knew both cases, while eight respondents did not recognise either of them. Among those who did not recognise the projects were: the director of the municipal centre for social services (5 years in the sector); the deputy head of the district administration responsible for institutions providing social services (22 years); and the head of department for social policy in district administration responsible for guardianship and custody (2 years). Consequently, the information had not spread among all whom it concerned. Similarly, as with the health projects, the working years in the sectors did not correlate with knowledge of the projects.

In all, 33 of the respondents had participated in international projects including both the case projects and others (Q6). Of these, 16 had participated in the TACIS project, 14 in Kostomuksha, 10 in Segezha, nine in Pitkyaranta and five in the TB project.

Recognition of the social innovations

In Q7 the respondents were asked how well they knew the processes supported by the international social sector projects mentioned. Instead of "social innovation" the word "process" was used, which caused some confusion[308]. In two districts a clarification of what was meant by "process" was sought by the respondents. The social innovations were described in a very general and open form as the aim here was more to examine the distribution of information than to prove the explicit connection between the projects and innovations.

As the table below demonstrates the processes i.e. the social innovations, were better recognised than the projects themselves in three cases: Pitkyaranta, Segezha and Kostomuksha, while the TACIS and Tuberculosis projects were better recognised than their innovations.

[308] The response rate was at the same level as for the other questions. From 37 to 46 respondents answered this question. Three respondents left this question unanswered.

Table 12: Recognition of the projects and the social innovations

Project / innovation	Recognition of the project (Q1)	Knowing the social innovation (Q7)
Investigation of the risk factors and behavioural characteristics in Pitkyaranta	17	
SI: Investigation of the risk factors of chronic diseases[309]		27
Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia in 1997-1999	45	
SI: GP training, GP model		22
SI: Training of social workers		36
Fighting tuberculosis in Karelia	33	
SI: prevention of the spread of tuberculosis		24
Development of Child Welfare system in Segezha in 1997-1999	24	
SI: development of the child welfare system		42
Support to Rehabilitation Centre for Disabled Children in Kostomuksha	26	
SI: rehabilitation services for disabled children		40

The results of the survey indicate that information about the projects and innovations had spread or been communicated beyond the borders of the pilot districts. The innovations aimed at improving the position of children were the best known (Segezha and Kostomuksha). As for the TACIS project, the result was interesting: the project itself was best known while both GP training and GP model, were poorly known. Two of those who did not know them were medical doctors and in both of these districts the model had been tested after the project. In the cases of Pitkyaranta, Segezha and Kostomuksha the innovations were better known than the projects.

As to the recognition of projects and the innovations the following can be stated:

- All cases were recognised in different parts of Karelia
- Two thirds (34) of the respondents were of the opinion that they had not received *enough* information about the projects (Q22).
- The social innovations introduced or supported by the Pitkyaranta, Segezha and Kostomuksha projects were better known than the projects themselves
- Information about the projects and innovations had travelled across the sectors and beyond the pilot districts
- The Pitkyaranta, TACIS, Tuberculosis and Segezha projects were recognised quite evenly in all parts of Karelia, while the Kostomuksha project was best known in the districts close to it.

[309] Development of the health monitoring system was not mentioned in the questionnaire.

As noted earlier (4.2) the survey had certain limitations and the results – even though on many issues important information was obtained - did not fully correspond to those expected. Thus, it is appropriate to have a closer look at this issue and briefly assess what happened. The aim was to examine six issues mentioned in Table 13.

Table 13: Assessment of the results of the survey

	Examined issue	**Success in achieving the desired information**
1	How well the social sector professionals in districts knew the cooperation	good
2	How well the case projects were recognised	good
3	How well the social innovations introduced by the projects were known	satisfactory
4	Through which communication channels the respondents received information about international cooperation	good
5	How widely the social innovations were adopted or embedded in the pilot districts	weak
6	Whether diffusion had taken place	weak

It is obvious that interviews would have provided an opportunity to pose additional questions and thus elicit more information about the diffusion and adoption. Preparing a questionnaire is a demanding process which requires wide background work (both on the issue studied and on previous corresponding surveys), skills and knowledge of how to formulate questions correctly as well as the use of the correct terminology and expressions. It is especially important in this kind of case, where the terms used that have not yet become fully established (social innovation) or they can refer to different things (process), and where the operating environment differs distinctly from that of the researcher.

In this particular case, the preparation and conduct of the survey on the one hand produced – despite its limitations - a lot of useful information from the districts of Karelia, and on the other was a good learning process for the author. It is possible that if the survey was conducted a year later, the questions might have been more precise and the results likewise. However, due to changes in Karelia during the past few years[310], it might have no longer been possible to arrange this kind of round trip for this purpose in Karelia.

[310] The new Head of the Republic, Andrei Nelidov, has made notable changes in the administration. Some of those people who supported the author in organising the survey are not anymore working in the same positions. www.gov.karelia.ru/index_e.html

6.2 FACTORS INFLUENCING THE DIFFUSION AND ADOPTION OF SOCIAL INNOVATIONS

In this chapter the factors influencing each stage – external diffusion, adoption and internal diffusion – are considered separately in accordance with the three categories of variables: attributes of innovations, communication and institutional framework. In chapter 5 the factors affecting developments in each particular project were mentioned. In this part the factors of all cases are discussed together.

6.2.1 External diffusion

External diffusion refers to the period of introduction, development and testing of the social innovations in question. Mutual interest and agreements between the actors formed a firm basis for the cooperation in all cases. However, some differences between them became apparent at this stage.

All the social innovations corresponded to the priority areas defined by the Karelian authorities (Chapter 3) and were developed to meet local needs. It is also evident that the positive attitudes of both parties towards cooperation promoted external diffusion. (Rogers 2003, 236-239; Lagus 2003, 296-299.) Thus their *relative advantage* contributed to the external diffusion.

The social innovations were *complex* as they challenged the existing structures, attitudes and traditional ways of doing things. They were tested in difficult socio-economic circumstances and under continuous administrative reforms, which also affected the diffusion process. In order to demonstrate how the SIs worked in other countries, study visits[311] were arranged for the local experts and decision-makers in all cases. They also participated in international conferences and training that presented opportunities to exchange experiences with their foreign colleagues. Aarva (2011, 33) notes in the evaluation report that the during the study visits the Russian partners saw, in practice, what kind of differences exist between different countries and cultures, for instance, in social work, health promotion practices, health care administration and nursing. It also led to a clearer understanding of their development needs. Some of the problems were not solvable within the frames of the projects and required decisions from the local, regional or federal decision-makers (TACIS). Even good innovations can lead to unexpected and undesired results: in Segezha the reorganisation of work resulted in a need to reduce the number of employees in the institutions.

Training and education were considered, in all cases, as one of the main tasks of the projects and as elements that would secure sustainability. The project proposal of the tuberculosis project (FILHA 1999c, 26) notes that even if the continu-

[311] Study visits to more developed countries have positive and negative sides. One of the positive is that it enables the introduction of the SI in practice (see footnote 296, also Marquand 2009). The negative side is that it may produce a false impression that a change of a working method or approach is a key to all problems. E.g. introduction of the work of a GP in a well-organised health centre or a social worker in a social service centre in Finland may look attractive. However, starting the education of GP's and social workers in Karelia was only one step in that direction. The working premises, equipment and conditions - or legislation regulating the work - are not included in that package. Seeing how things could be may also discourage people when the participant understands how far they may be from what they see.

ation of the project fails "this project will still not have been wasted: the staff is trained in DOTS strategy and it can continue the implementation at a slower pace". In the survey, 50 respondents (of the 52 who answered this question) considered education and training as either a very important or an important form of international cooperation.

Incompatibility of the SIs with the working culture, traditions, and legislation was tackled in diverse ways in the projects. In all cases resistance to change appeared. In some cases the problems were solved by discussion and the provision of more information (e.g. Segezha) and in some others visibility of the good results following the testing changed the attitudes to more positive ones (e.g. TB).

Trialability, i.e. testing the innovations during the projects, was part of external diffusion and promoted it in all cases. The role of the external CA was essential at this stage and the progress in project implementation was shared at local and regional level events.

Diverse *communication* channels were used in the distribution of information about the projects and the SIs. Close communication between the external change agencies and the local partners promoted diffusion. The role of the external CAs was notable in all cases during this phase. They were partners as well as innovators and developers. In some cases, the CAs also contributed to the projects in very concrete ways during the testing. For instance, in the Pitkyaranta case, the results of the surveys (which formed the database for the health monitoring system) and the laboratory testing was done in Helsinki (Laatikainen et al. 2002). In the TB project the Finnish CA provided support in refurbishing the laboratories.

One distinctive feature between the cases was the relationship between the three parties: change agency, local partner and the main beneficiary. Although the regional ministries were involved in all cases, in two of them the main Karelian partners were from city or district level. In the cases of Pitkyaranta and Kostomuksha, the CAs communicated directly with the LPs and they implemented the project together (see Figure 27). In the TB project, the CA communicated primarily with the TB dispensary under the Ministry of Health, which coordinated the implementation of activities in the pilot areas (Figure 28). The CA wanted to support and strengthen the dispensary's coordination function and prestige in Karelia (Salovaara 2011). In the TACIS project, the CA mainly communicated with the Republic ministries while the project office, led by the European team leader, communicated with the LPs in the pilot areas (Figure 29). The project office guided and monitored the project implementation. In the Segezha project the CA communicated mainly with the Ministry, which, together with the Segezha district authorities, carried out the changes (Kemppainen 2011)[312] (Figure 30). In all cases, the external CAs[313] assessed communication with the local partners as good and open.

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[312] Martti Kemppainen (2009) emphasises that in the Segezha project the role and input of the MOE and especially of the head of department, who was responsible of the project was essential at all stages. MHSP was also involved in the project but in a minor role.

[313] Discussions with Tiina Laatikainen on 18 January 2008; Aulikki Kananoja on 8 January 2008; Martti Kemppainen on 10 January 2008; Tytti Tuulos 2 January 2008; Jan Lindgren and Kristiina Salovaara on 10 January 2008. Correspondence with Laatikainen 1 July 2009; Tuulos 1 July 2009; Kemppainen 18 June 2009.

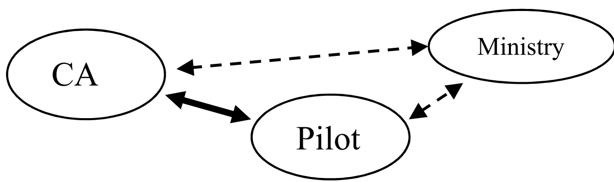

Figure 27: Communication between the change agency and the local partners in the Pitkyaranta and Kostomuksha projects

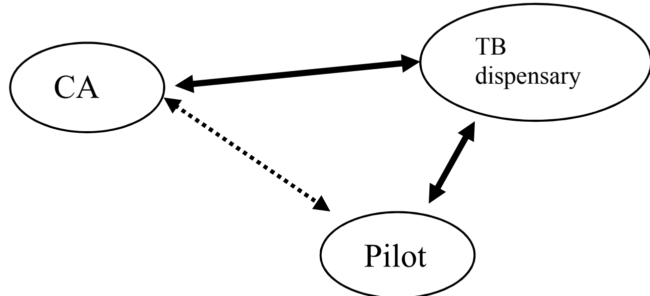

Figure 28: Communication between the change agency and the local partner in the Tuberculosis project

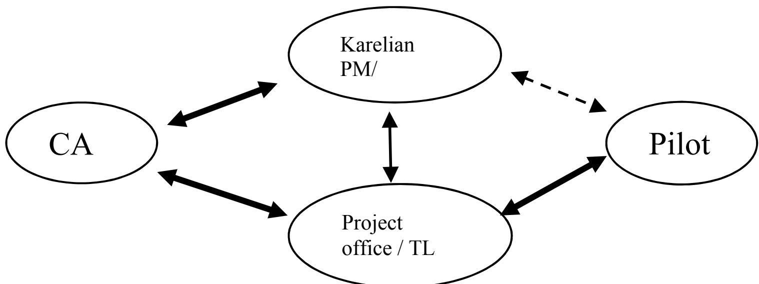

Figure 29: Communication between the change agency and the local partner in the TACIS project

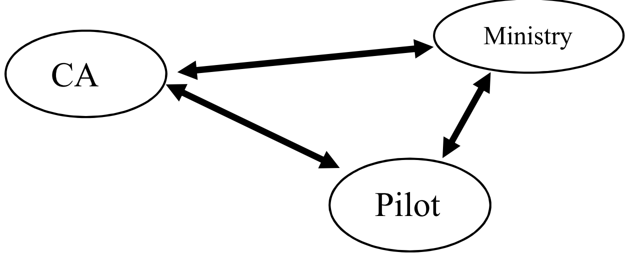

Figure 30: Communication between the change agency and the local partner in the Segezha project

direct communication relation
indirect communication

The results indicate that the direct communication between the CAs and the LPs positively influenced the commitment and increase in ownership of the LPs, especially in Pitkyaranta, Segezha and Kostomuksha cases. (cf. Nikula and Granberg 2011, 230.)

Within the projects, the role of local and foreign expertise varied greatly. The Segezha and Kostomuksha projects mostly relied on local expertise, while in the Pitkyaranta and TB projects there were a few Finnish experts, mainly in the role of trainers. The only foreign expert involved in the Segezha project characterised his role by saying that "I did not go there to make my mark but to support the locals, who knew best what needed to be done[314]". The TACIS project was the only one in which there were several short and long-term foreign experts.

The *institutional framework* as a whole promoted the external diffusion. The agreements between the donors and the Russian beneficiaries formed the legal basis and the frames for cooperation. At this stage, in some projects, the drafting of laws, concepts and recommendations started and in others these were adopted in order to support the adoption of the SIs. In the TB case, both the regional and federal authorities issued several laws and recommendations that supported the project implementation. In the Pitkyaranta, Segezha and Kostomuksha cases the district authorities made decisions based on the recommendations of the project and supporting the changes suggested by it. The law on GPs that was subsequently adopted by the Karelian Government was also drafted in the frame of the TACIS project. The required structural changes were made in all cases in the pilot areas and the financial insufficiencies were not so apparent at this stage.

All projects received external funding. The very start of the Pitkyaranta and Kostomuksha cases was funded by the CAs and LPs. In the cases of Pitkyaranta, Segezha and Kostomuksha, the external funding was relatively modest throughout the period under examination in comparison to that of the TB and in particular the TACIS projects. The amount of financial support provided did not seem to influence external diffusion.

[314] Kemppainen, interview on 10 January 2008.

The difficult financial situation influenced external diffusion to a varying extent but did not prevent it. All Finnish CAs[315] reported that insufficient funding and the difficult socio-economic situation had to some extent negative effect on project implementation. This led, in some cases, to the increased role of the international assistance (FILHA 2004, 15). On the other hand, the financial situation in Karelia was also considered to be a motive for change because it forced the local actors to consider new approaches and methods (Kananoja 1999b; also e.g. the Segezha case).

The lack of professionals emerged but it did not hamper external diffusion: training was organised, curricula developed and plans for further training and education developed. In all five cases external diffusion was successful. The problems that emerged were resolved by the joint efforts of the external and local actors from different levels. External diffusion was a period of testing and modifying the innovations implemented with external support and there was no compulsive need to consider how the SI works in some other conditions or without the support.

6.2.2 Adoption

Adoption was defined as a decision to make full use of the innovation (2.2.2). In practice adoption meant that the LP and/or beneficiary decide to continue the process started during the project and maintain the innovation by local resources.

Although all innovations were discovered to be good and beneficial to the LP either immediately or in the long-term, piloting did not lead to adoption in all cases. As noted earlier, during the projects in the pilot areas special conditions for testing were created with external financial and professional support. There were two factors that seemed to clearly affect adoption: first, the commitment of the local actors and professionals, and second, the nature of the innovations.

As with external diffusion, the relative advantage of the innovations was recognised in all cases. The law on local self-government delegated wide decision-making powers and organisational responsibilities to the municipal level (Chapter 3)[316]. The districts had the right to either adopt or reject the innovations tested. In the cases of the Pitkyaranta, Segezha, Kostomuksha and TB projects, adoption already took place during the project, whereas the GP model supported by the TACIS project was not adopted in either of the main pilot areas (Kondopoga and Sortavala)[317]. In the TB case, instead of the health authorities of the pilot districts, the Republic Ministry of Health, in accordance with federal policy, made the deci-

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[315] The Finnish actors of the case projects were asked the following questions: 1) In your opinion, what is the most remarkable achievement of your cooperation from the personal, district and Republic point of view; 2) Have the experiences of your project been utilized in other parts of Karelian, in which? 3) Did your project inform the other districts or actors about the achieved results? 4) Do you have any published articles about your project? 5) Have the achieved results/best practices been embedded in the pilot district? How does it appear? 6) What factors promoted and hindered most implementation of your project most? 7) Did the Karelian partner participate in the project by agreed input (human and financial)? If not, why?

[316] Marquand, note based on her experiences from Siberia that "It was unexpected to find that, whatever happens at federal level ... there is still plenty of room, approved by Moscow, for Regional Committees to carry on quietly with the development of good practice" (2009, 159).

[317] The factors influencing non-adoption are discussed separately below.

sion on adoption. This was the only case in which both the regional and federal health authorities committed to support adoption financially and materially. The federal funding for TB prevention increased after 2004 and the TB prevention programme covered the whole Federation[318]. However, according to the comments of FILHA in the third evaluation report, the support was not as strong as implied. In the comments of FILHA (FILHA 2011, 3) it is stated that the Ministry has countless times expressly confirmed that they 100% support the TB programme and the project "but constantly failed to do anything about the miserable drug procurement system, the lack of laboratory technicians and the allocation of sufficient funds to the dispensary". (Also Aarva 2011, 6-7 and FILHA 2010, 21.) As a result, the adoption has remained incomplete.

When the adoption of the innovations of the TACIS project is examined, it is important to remember that the education of new professionals was not the final objective but rather a means to an end. The objective was to improve access to health care services, in particular in the rural areas by cutting the cost of health care and training new professionals. The complexity and incompatibility of the SIs appeared at this stage. If adoption begins during project implementation, the LP benefits from external CAs support and the shift to new practices may be to some extent smoother. This was the case, for instance, in Kostomuksha, the TB project and Segezha. To some extent this also happened in the TACIS project, where conditions for the continuation of the GP model were created in pilot ambulatories. However, all pieces should be in place: education or working conditions alone are not sufficient if the other institutional structures do not support the change (e.g. Shishikin et al. 2006, 34-49).

Obtaining information for the examination of adoption of the GP model, as well as where the graduated GPs and social workers are working, proved challenging, as adequate statistics were either lacking, unavailable or difficult to obtain. (cf. Hemminki et al. 2010, 186-200.) Some information was obtained – from reliable sources though unofficially through personal contacts – about both the GPs and social work graduates. However, especially with regard to social work graduates the information received does not allow any conclusions to be drawn about the actual situation. A representative of the MOE noted that this kind of information is not officially collected or available in Karelia (interview, PP 4 August 2009). It was said that the social workers are working in hospitals, polyclinics, dispensaries, in social work and rehabilitation centres, shelters, in children's homes and schools, in the police, in the judicial system and in the pension system. It was estimated that approximately 25% of students continued their studies in institutes of higher education. Accordingly, it is not possible to assess whether the education had any of the expected impact in Karelia[319]. (personal correspondence 30 June 2009.) According to Iarskaia-Smirnova et al. (2002, 126) of the eight thousand social

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[318] Global Tuberculosis control WHO report 2009, pages 141-144 at http://apps.who.int/globalatlas/predefinedReports/TB/PDF_Files/rus.pdf (visited 1.8.2010) http://www.usaid.gov/our_work/global_health/id/tuberculosis/countries/eande/russia_profile.html (visited 1.8.2010).

[319] Information on the improvement of the situation at local level is available in the project documents e.g. Segezha, Kostomuksha projects.

work specialists graduated in Russia by 2000 only a limited number have gone on to work in social services due to low salary and less than 30% of social work graduates are employed according to their diploma.

Issues related to the complexity, incompatibility and the preventive character of the SIs, slowed down adoption but did not prevent it in the cases of Pitkyaranta, TB, Segezha and Kostomuksha. (cf. Vlasoff et al. 2008, 666). Incompatibility of the innovations with the culture, working culture, traditions and attitudes emerged in all cases. However, it was recognised and resolved to varying extents during the testing after which resistance decreased (see e.g. TB, Pitkyaranta, and Segezha Chapter 5). Trialability and observability seemed to positively affect adoption in the Pitkyaranta, Segezha, Kostomuksha and TB cases.

During the external diffusion *communication* between the external CA, beneficiaries and LPs was in a central role. For adoption the foundation was laid during the project implementation and the local actors were in a key role.

Especially in the Pitkyaranta, Segezha and Kostomuksha cases, the involvement and participation of the local decision-makers, opinion leaders and influential persons affected adoption positively. These cases concur with Arsalo and Vesikansa's (2000, 14) statement that in projects with lesser funds "the role of the soft incentives, personal and institutional motivation, ideology and commitment must play a greater role". In all three cases the adoption was a natural continuation of the testing. Thus, the role of the *local change agents* was significant for adoption. The adoption of the innovations of the TB project confirmed the importance and meaning of Republic and Federal support. (See Rese et al. 2005, 206; Thomson 2002)

The involvement and participation of those who were aware of the actual needs[320] as well as financial and human resources in the districts, and were in a position to decide on their use, proved of crucial importance for adoption. Rese et al. (2005, 206) note that, contrary to widely held assumption, the directors of the identified municipalities are as important stakeholders as the regional health authorities[321]. (Also Shekter 2003, 285-286.) Financial resources follow political decisions. Consequently, the enthusiasm of the local actors alone is not sufficient; political decisions and commitments are required for sustainable results. (see Kyrgystan 2005, 94-99, 107-108 and Uzbekistan 2007, 155-160.)

In the case of the TACIS project, the regional authorities recommended adoption (MOH, 1999) of the GP model but without any special support from the Republic[322]. Health sector and system reforms are complex (e.g. Rese et al. 2005; Atun et al. 2006, 28-31; Weyland 2006,182) and tend to be piecemeal (Weyland 2006, 143). Weyland compares health reform to social security privatisation[323] and notes that if the latter is a drastic breaking point, the former is a drawn-out, gradual

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[320] According to Shishkin, Chernec and Chirikova (2003, 26) municipal authorities close to the people and more sensitive to the satisfaction of the population living in the area are ready to support innovations that directly improve services for the population.

[321] Based on questionnaire survey among the directors of the GP training centres in Russia in 2002. For more Rese et al. 2005.

[322] As described in 5.2, adoption of the model required both additional financial and human resources.

[323] in this particular case in Chile

and never-ending process. The demands on systems and their capabilities are constantly changing and require adjustments, often made by changing one component of the multidimensional system at a time. This approach, the change of separate "modules" of a system, may entail other kinds of danger (chapter 2) and lead to unplanned outcomes (e.g. Romania 2000, 72-73). The SIs introduced by the TACIS project concerned the *Russian* welfare system and structures, and while assessed by the Karelian authorities among the best results of the project, were not compatible with the existing system and practices. In order to illustrate the situation with regard to the development of the PHC system and GP model in Russia a brief review is given in Appendix 5.

Since the beginning of the 1990s several crucial changes have taken place in the Karelian ministries (see chapter 5 pp. 108-109) and administration. Van de Ven (2008, 8, 23-25, 44-47) discusses the effects of changing personnel and the disappearance of the institutional memory in the innovation development process. On the one hand, personnel turnover is a positive fact as new people bring new, fresh ideas, but on the other hand, each departing person leaves with vital information. The newly recruited people lack the organisational or emotional memory related to the innovation. Changes in personnel can therefore result in a decreased commitment to the project and adoption of the innovation.

Restructuring, deformation and the emergence of diverse institutions in Karelia directly affected the personnel working in them. In the TB project, due to a change of the laboratory head responsible for the development of the TB laboratory system, the laboratory staff training was restarted twice (FILHA 2004, 19). Similarly in the TACIS project, changes in the Republic's administration after the elections slowed down the project implementation (Kananoja 1999c; cf. e.g. Romania, 2000, 72-75; Kazakhstan, 2007, 109-110; Mongolia 2007, 130). The chief doctor of the Pitkyaranta central district hospital, Dr. Mikhail Uhanov, (Helsingin Sanomat 23 August 2004) confirmed that the challenges in everyday work were easier to face when there was a good team spirit and the personnel did not change, but were interested in their work.

The unstable and difficult economic situation in the Republic directly affected the improvement of the health care system. The building of district hospitals in Priazha and Sortavala serves as an example of the difficult financial conditions. The construction of both buildings was started in the Soviet era (1987) but they were only completed and taken into operation in 2005 and 2006 (Kolesova 2008, 91-92). The decrease and insufficiency of the funding of health care was also noted in the Concept for Development of Health care in Karelia (1999, 3).

As the above illustrates, adoption of social innovations of a more concrete or *practical character* took place immediately after or even during the projects while adoption of the *systemic innovations* remained incomplete. In addition, the commitment of partners, whether local, republic or federal, promoted adoption. The innovations that were developed and modified with the participation of local professionals and influential key persons for specific needs in a certain district (health promotion activities, health monitoring system, child welfare services, and ser-

vices for disabled children) were adopted without any major problems. One more conclusion that can be drawn from the results is that the use and availability of local resources is of crucial importance for adoption. The innovations developed with some external support but mostly relying on local resources became institutionalised most quickly.

The local commitment was manifested in a common and shared view about the SI and its goal, which seemed to advance the adoption. The results of this study coincide with the outcome of the survey by Nikula and Granberg (2011, 233) carried out in Finland, Lithuania and Russia. They emphasise that "for the success of social innovation it is important to have a shared understanding over the means and goals of the local development efforts and partnership". The results of the TB and TACIS projects refer to the importance not only of regional but, even more importantly, federal support in the utilisation of innovations of a systemic character. Numerous institutional changes aiming to improve peoples' wellbeing in Russia have been carried out, but it seems that the changes did not support each other and that the common objective was not clearly defined[324].

6.2.3 Internal diffusion

The results prove that even in difficult socio-economic conditions it is possible to make changes and achieve good concrete results in developing practices in the social sector. As discussed above, not all innovations were equally diffusible. Full adoption and institutionalisation of the systemic innovations were dependent on federal policies.

Relative advantage also affected internal diffusion positively. In the TB, Segezha and Kostomuksha cases internal diffusion started during the projects when good results became visible. And despite the fact that the GP models were not adopted in the pilot districts, they started to diffuse to other parts of Karelia. In practice, the GP model became the most diffused SI in Karelia.

Despite the recognised relative advantage of the health monitoring system in the long-term (e.g. Kontseptsiia 1999, Karjalainen 13 August 2007), according to the materials studied this SI did not diffuse in Karelia. Some of its elements were used in other districts for instance in Olonets and Suoiarvi but not to the same extent as in Pitkyaranta. However, the evaluation report on neighbouring area cooperation (Aarva 2011, 29) states that the creation of the monitoring system for risk factors of chronic diseases has started in Karelia. The future will show how this process proceeds. Information about the development of the Pitkyaranta health monitoring system spread widely both nationally and internationally and the experiences have been followed and modified in other parts of Russia.

Complexity and incompatibility affected internal diffusion but they did not impede diffusion in cases where: 1) the local decision-makers were involved in the process,

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[324] Nikula et al. in their study of development rural areas and agriculture in Karelia state that institutional building is insufficient, there is "no clear concept of agricultural or industrial or regional policy, which would be supported by necessary institutions, regulatory legislation and financial means" (2005, 31). Danilova et al. (2010, 8) also propose that "the Karelian Health administration together with the RTDP should prepare a long term strategic plan to improve TB control activities in the region".

2) the implementation mainly relied on local resources (e.g. Segezha, Kostomuksha), or 3) when the Republic and the Federal authorities supported the process (TB).

The distribution and receipt of information are absolute preconditions for the diffusion of an innovation. If the role of *communication* was rather limited in adoption, so in internal diffusion it was significant.

How easy or difficult is it to find information about the international social sector projects and innovations in Karelia? Officially the Ministry of Economic Development[325] (MED) has been responsible for international cooperation and distribution of information since its establishment in 2002. However, in the 1990s, when most of the cases were carried out, each ministry and the projects themselves were responsible for that task[326]. The Karelian ministries collect information about projects running in their respective fields, as they are required to report on them annually to the Governor of Karelia, but there is no specific collection mechanism[327]. There have been attempts to create a database of all domestic and international development projects (by Petrozavodsk Local Support Office of EU-Russia Cooperation Programme) and to keep a record of social sector projects implemented in Karelia after 1995 in the frames of a bilateral Finnish-Karelian project[328]. In the former case, the updating of the database caused problems and in the latter some of the local actors were not willing – or "did not feel obliged" - to provide information to anyone but the donor without official authorisation (STAKES 2006, 6-7). The project report notes that this kind of work would be best performed either by a governmental organisation or an organisation officially appointed by the Governor of Karelia. Consequently, there are no records on international social sector projects available in Karelia.

Officially the MED's task is to accumulate and generalise the results, inform about them and cooperate with the executive powers[329]. According to information received from Karelia (Personal correspondence 20 June 2009) the information about international cooperation is: 1) available on the websites of the Ministry

[325] In 27 June 2002 the Ministry of Economy and Ministry of Foreign Relations were abolished and the Ministry of Economic Development was established. In the web pages of the MED there is a link to pages of the former Ministry of Foreign Relations, where there is brief information about international cooperation. Last update 4 July 2002. (visited 17 October 2011)

[326] For instance the TACIS project had a special working group for this purpose. The project published information bulletin on a regular basis. The circulation was small and it was mainly distributed among the civil servants of the ministries. Information about the project did not spread as anticipated: the head of the Committee on Social Policy in the Parliament of Karelia (Палата республики законодательного собрания), Nelli Prohorova, reported in Autumn 1997, that during her visit to childrens' polyclinic No 3 in Petrozavodsk she discovered that the personnel knew practically nothing about the TACIS programme (TACIS, Information biulletin 2/1997, 8).

[327] There is a coordination committee for international cooperation in Karelia. In April 2005 the author was invited to the meeting in which two ongoing social sector projects were introduced. The introduction did not raise any discussion or questions. The impression was that the meeting that was held for the records.

[328] Resource Centre for Development of Local Social and Health Services in Karelia 2004-2006 (STAKES IDC).

[329] Information about meetings with the Karelian authorities is often available on the official web pages of the Karelian Government. http://www.gov.karelia.ru/gov/News/2010/09/0917_2_e.html. (visited 11October 2010).

of Health and Social Development and Ministry of Education[330]; 2) shared with and distributed to the decision-makers and professionals in concluding seminars and conferences; 3) introduced in the meetings of the Coordination Committee on Healthy Life Style under the Head of the Republic; and 4) sent to the district administrations and social sector institutions. However, in practice this does not function properly. The web pages include very little information[331] and access to the Internet may be problematic, especially in rural areas[332]. Also, seminars and meetings have been found to be an ineffective method of sharing information (Peltola and Vuorento 2007, 55-56).[333]

How did the districts not participating in the cooperation then receive information (Q17)? More than half of the respondents named colleagues who had participated in the projects as the primary source of information, in second place were the ministries and in third, colleagues in the work place (table 14).

Table 14: Dissemination of information through diverse communication channels

Channel	**very much or much**	**some or very little**	**not at all**
Ministry (N49)	25	20	4
Colleagues at work (N45)	20	18	7
Colleagues who had participated in the projects (N48)	29	13	6
Foreign colleagues (N46)	15	14	17
Internet (N48)	19	15	14
Mass media (N45)	17	22	6
Other (N10)	4	1	5

Although the Kostomuksha and Pitkyaranta projects were best known in neighbouring districts, the results of this study do not indicate that geographical proximity played any special role in diffusion of the SIs. In the Kostomuksha project the neighbouring districts,[334] in particular Kalevala, Muezerskyi and Belomorsk (MOE, 1995), were involved in the cooperation but the model also spread to other parts of Karelia. However, it is worth mentioning that in 1993 a rehabilitation centre for seriously physically disabled children was established in Petrozavodsk, which may have influenced the appearance of centres in the "southern" parts of Karelia.

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[330] The pages were visited in 11 October 2010: MHSD: last update on international cooperation on 2 December 2, 2002; MOE has no reference to international cooperation.
[331] On 28 July 2010 there was no information about the implemented projects. The pages were last updated on 26 April 2000.
[332] During the field visit to Karelia the author was told in several districts that only the head of the administration had an internet connection. One of the reasons was the high maintenance costs.
[333] In April 2005 I was invited to the meeting of the Coordination committee for international cooperation. In the meeting two ongoing social sector projects were introduced but there was no discussion of them or of the cooperation in general. My impression was that it was just a meeting that was held for the records.
[334] Runo Axelsson (2002, 145-146) talks about horizontal integration meaning coordination of work between different individuals and units without mechanisms of organisational hierarchy. It may require consultation, information exchange, collaboration or conflict resolutions between the organisations. The Kostomuksha experience refers to this kind of contacts between the Karelian northern districts.

Administrative structures may serve as effective channels for the exchange of information. Shekter (2003, 284-285) notes that the influence of cooperation can diffuse beyond the borders of a local community through the organs of administration and even further through other channels. The results of the survey support this statement. About half of the respondents answered that they receive information from the Ministry (Q17 above) and the answers to question (Q18) confirmed that communication between the districts and ministries was relatively regular. More than half of the respondents (32) answered that they were in contact with the Ministry every week, 12 twice a month and 8 once or less in a month. However, regular communication does not guarantee that information is shared. For instance, one chief doctor of a district hospital, the senior health care officer in the district, who had worked over 15 years in health sector, did not recognise the TACIS project.[335]

Despite the fact that the majority of the respondents answered that they received information about the international cooperation from their colleagues, communication between the districts appeared rather sporadic. Among the 18 districts there was only one – Petrozavodsk – with which 13 other districts reported having weekly contact. However, none of the three respondents from Petrozavodsk city confirmed these contacts (two of them did not answer the question at all and the third named only a couple of districts with which she had contacts). This result most probably does not give an accurate picture of the situation and reveals a clear shortcoming of the survey due to the small group of respondents. Over 35% of the Karelian population lives in Petrozavodsk and all the central republic institutions are located there. Consequently, it is clear that Petrozavodsk is contacted more often than other districts and it also explains the answers of Petrozavodsk respondents. Communication with other districts may not be one of the responsibilities of the respondent[336]. The results show that the communication between the districts is not regular.

According to another survey conducted in Karelia, the space given to issues related to social policy in the Karelian newspapers increased between 1991 and 1999 (Pietiläinen 2002, 386) and writing on social issues in Russian newspapers changed after the *perestroika* (Pietiläinen 2010, 76-96). Though more was written on social issues, joint social sector projects and their objectives were only rarely mentioned in Karelian newspapers. In this study the annual circulations of two newspapers the *Leninskaya Pravda/Severnyi Kur'er*[337] and *Kareliia*[338], were examined from the years 1990, 1993, 1995, 1997, 1999. The following relevant articles were found: in 1993 (7 January, Severyi Kur'er), an article about the situation of disabled children in Karelia and about the Kostomuksha experiences; in 1995 (28 January, Severyi Kur'er) a large

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335 In the final report of the Kate project (Interreg Karelia II programme) was stated that they were surprised about the fact that the professional knowledge and skills developed in frames of the project did not spread very well outside the project and sometimes not even among the units participating in the project. (Kajaanin ammattikorkeakoulu 2000,8)

336 Some comments of the respondents during the inquiry meetings:"Why should I contact any other districts?", "I will mark only those I am in contact with"; " I do very seldom contact with the other districts, usually the heads do it".

337 Leninskaia Pravda was renamed to Severnyi kur'er in 1991. See Pietiläinen 2002, 192-195

338 Founded in November 1992 as a governmental organ (Pietiläinen 2002, 208-209).

article about the Finnish-Karelian cooperation and in particular about cooperation in Pitkyaranta district; in 1997 (9 February and 10 March, 6 June, 26 July Severyi Kur'er) about the TACIS programme generally; and several articles about the humanitarian aid provided to Karelia (9 and 20 April, 21 May, 17 June, 30 August). By contrast, *Karjalan Sanomat*"[339] a newspaper published in Finnish, included articles about the cooperation and international joint projects relatively often. The problem is that this information does not reach the Russian-speaking majority of the population in Karelia (Pietiläinen 2005, 99 and 102). The evaluation report on neighbouring area cooperation (2011, 30) notes, "… the newspapers have written a lot about the health sector projects implemented with Finns"[340]. This conclusion is made either on the basis of the writing in the Karjalan Sanomat or the number of articles in the Karelian newspapers has significantly increased since the millennium.

One third (15) of the respondents answered that they receive very much or much of information about international cooperation from their foreign colleagues. It could be assumed that those fifteen were from the districts where most of the Finnish-Karelian projects have taken place (e.g. Sortavala, Petrozavodsk, Pitkyaranta, Segezha, Kostomuksha). However, they represented 11 different districts[341], from all parts of the country. Consequently, the information flows through different channels including so-called 'weak ties'[342] (Granovetter 1983, 201).

The internet has become the most important source of independent information in Russia (Malinova 2010, 186-187; Helsingin Sanomat 11 October 2010) but television remains the most central, and also, for most, the only source of information (Nordenstreng and Pietiläinen 2010, 144-145; Ministry of Defence 2008, 23-24). In Karelia, except for in Petrozavodsk, the Internet is not yet in widespread use. In the survey 19 (of 46) answered that they get a very good amount or a good amount of the information through the Internet and 14 not at all.

Despite the fact that the horizontal inter-district communication looked quite modest (cf. Marquand 2009, 100-102, 142-143), the respondents knew their colleagues from the other districts and projects. They were asked to name persons (no more than three) who in their opinion would know well the international social sector cooperation (Q21). In total 47 respondents answered this open question and gave the names of 52 persons[343]. Most of them were mentioned once (38/52),

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[339] In 1971-1985 the circualtion was 13,000 and the share of Finnish subscribers was about 9,000 (Karjalan Heimo 2010, 3-4, 55). In 2000 the newspapers published in Finnish (Karjalan Sanomat and *Oma mua*) were read by one percent of the Karelian population (Pietiläinen 2005, 102). In 2010 the circulation of Karjalan Sanomat was less than 1,000 and about 300 of the subscribtions were from Finland .

[340] According to the head of the evaluation group this information was received from the Consulate of Finland in Petrozavodsk.

[341] All three respondents from two districts (Pitkyaranta and Kostomuksha located near the Finnish border) were in this group.

[342] During my visit to the village of Kalevala (Northern part of the republic of Karelia) in summer 2002, I visited the new local hospital, which was partly financed and built by Finns. When I was told that the representative of the MoH would arrive for the official opening of the hospital, I asked the medical staff whether they knew about the international health projects in Karelia. They answered that they had heard that there were projects but not what the projects were dealing with. I told them briefly about my background and about the projects that I was coordinating that time. Information about cooperation and projects can also spread in this way and in some cases raise curiousity to find out more about them.

[343] Among them was one Finn.

seven mentioned twice, four mentioned three times, one mentioned five times, one mentioned eleven times and one mentioned fourteen times. Common to all those mentioned three and five times, was that they either had worked or were working, at the time of the survey, in the ministries.

The two most mentioned persons were both women whose work was related to child welfare. One of them was from the Republic (TT) and the other from district (MM) level. They were key persons in the planning and implementation of the Kostomuksha and Segezha projects. MM was mentioned most often in the districts close to her own, while TT was mentioned evenly in different parts of the country. One distinction between them was that only representatives of the social and education sectors mentioned TT, whereas also representatives of the health sector mentioned MM. Both of them were also referred to in other contexts by Karelian and Finnish actors: "MM often invites us to different events"[344]; "TT has proved to be – in particular in difficult times – irreplaceable, a person who was able to guarantee the continuation and has been truly interested in and committed to the cooperation" (Finnish partner). The result does not permit the conclusion that they personally positively influenced internal diffusion but it does indicate that the information travelled between the sectors – at least in relation to child welfare issues – and that the role of this kind of influential person can be significant in the diffusion of innovations (see pp. 43-44).

The role of the external CA was central to external diffusion but small in adoption. How was it in internal diffusion? The assumption that the external CAs' efforts would contribute to external but not internal diffusion proved to be at least partly mistaken; good results spoke for themselves. In four cases (Pitkyaranta, TB, Segezha, Kostomuksha), internal diffusion started during the projects. In the same cases, the CA continued cooperation with Karelia after the project: in three cases with the same LP (Pitkyaranta, Kostomuksha and TB), and in one case (Segezha) with new LPs in other districts.

In the Pitkyaranta case the CA's presence did not seem to affect diffusion of the health monitoring system to other districts. In the Kostomuksha case, the same CA promoted internal diffusion as it supported organising events to which representatives of the neighbouring districts were invited. In the TB and Segezha cases, the role of the CAs in internal diffusion was obvious. In the TACIS case the CA had no role in internal diffusion.

To conclude, communication played a key role in internal diffusion. Information spread through different channels. The role of the external and internal change agents in internal diffusion varied between the cases. Insufficient information on international cooperation was not considered a problem among the respondents of the survey[345].

The results of this study indicate that internal diffusion can take place either based on the decision and support of regional and federal authorities or by the

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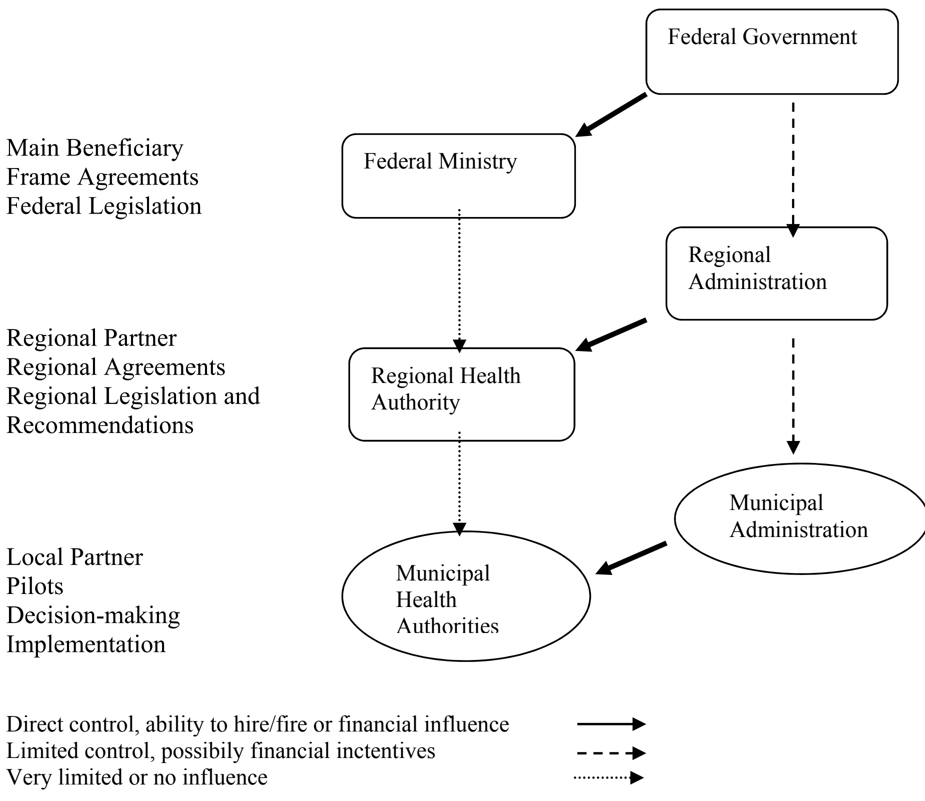
[344] See Granovetter's reference to Stack and Lomnitz (1983, 213 ref. to Stack and Lomnitz 1977, 209) about "reciprocity network" i.e. people living in difficult conditions start to support each other.
[345] Only three respondents considered lack of information as one of the main reasons hindering social development in Karelia (see Table 15).

decision of district authorities. In Karelia it happened in both ways. The municipalities can – financial resources permitting – utilise good practices tested in the other districts. Based on the results of case studies from six regions of Russia in regard to health care financing, regulation and delivery, Danishevski et al. (2006, 192) state "the municipalities play an absolutely central role in all aspects of health care provision". They also note that the new laws not only limited the influence of the federal ministries but also that of the regional governments. In practice, the municipal administration possesses the right and power to decide on the organisation and provision of services for the population at municipal level.

Figure 31 shows the complexity of the system with regard to the adoption and internal diffusion of the innovations. The federal legislation should be followed at all levels. However, as the powers for practical organisation of many services were delegated to the municipal level, the ministries can give recommendations for the municipal health authorities but not oblige them to follow them. (Danishevski et al. 2006, 183-192, Cook, 2007 76-84.)



Modified from Danishevski et al. 2006 Figure 2 p. 192

Figure 31: Informal top-down channels of influence in health sector

The implementation of primary health care reform has been difficult and slow. The driving force was not the systematically conducted policy of the federal organs but the enthusiasm of individual regional leaders, collectives of medical and educational institutions as well as the programmes of international organisations[346]. Shishkin et al. (2006) argue that in the local experiments remarkable experience has been gathered but it has not received the necessary methodological and legislative support from the Federation. Quite on the contrary, in some cases state policy has had a deleterious effect on emerging regional initiatives. In a way this also happened in Karelia, when the Federation cancelled the law on GP in 2006. (Rese et al. 2005; Shishkin et al. 2006, 3, 13-14, 21-24, 46-48.)

One of the Karelian health care professionals (SS, 4 August 2009) said, "the TACIS project introduced the GP model as a package including training, methods and equipment and it worked". This was very true during the project; the innovation worked when all the essential components were in place. For testing, good, but to some extent artificial, conditions were created with external support. A stronger commitment was required for the continuation of the practice. Konitser-Smirnov (2003, 261-262) notes in relation to the Samara experiences that, despite the good results of the "Samara model", it does not mean that it should or could be replicated throughout Russia. The good outcome was possible due to exceptional conditions in the Samara region, which would be difficult to reproduce in other regions[347]. (cf. Sheiman 1994 and 1995 on regional experiments.)

Shekter argues (2003, 286) that a shortcoming of the local projects, initiated from the bottom, is that it is difficult to replicate them without simultaneous legislative reform, a boost in economy and development of a uniform national strategy. The results of this study show that locally introduced innovations can diffuse provided that they are feasible and the local actors committed. The involvement of the local decision-makers is also crucial from the financial point of view. In cases when the federation and/or region do not directly support innovation adoption and diffusion, it is the municipalities who need to do it. According to a Karelian expert, the continuous changes in administration, legislative work (ensuring that the Republic laws correspond to the changing federal) and the general weak financial situation hindered diffusion of good experiences gained (field notes February 2008).

Kemppainen and Grigor'eva (2005, 129) note that despite a great desire to utilise the new models and approaches in child welfare it seems to be slow because of "the traditional, hierarchical system and an operating culture directed from above". Accordingly, it is not only the formal institutions but also the informal structures that slow the diffusion.

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[346] See World Bank projects in Armenia, Bosnia and Herzegovina, Kyrgysia, Moldova and Estonia in 2004-2005 (Shishikin et al. 2006, 27).

[347] He writes that in Samara was located "the enormous gift of the Soviet system of centralised planning - automobile works AvtoBaz, (колоссальный дара советской системы централизованного планирования) which together with the oil and gas industry supported the implementation of the model. They were also stable sources of tax revenues for the district. (Konitser-Smirnov 2003, 262.)

In the survey the respondents were asked to mention three main obstacles to the social development in the Republic (Table 15). As expected, insufficient financing was in first place, second was the absence of a common view and policies among the decision-makers and third the inadequate legislative basis.

Table 15: Obstacles for the social sector development in Karelia

Group	Obstacle	Total
I	INSUFFICIENT FINANCING Absence/insufficiency of finance at municipal level Under-financing of the social sector Deficit of budget of Republic of Karelia Insufficient development of the territory of the RK, many districts in Karelia depend on subsidies from the regional budget	30
II	ABSENCE OF COMMON VIEW ON THE DEVELOPMENT Absence of mutual understanding among decision-makers Imperfect intersectoral cooperation Absence of a federal strategy and programme Absence of objectives and clear planning of activities Insufficient dialogue between different levels of administration Insufficient development of the social sphere – in different districts the level of development of the social sector is different	13
III	INCOMPLETE LEGISLATIVE BASIS Absence of legislative basis for welfare services and social security Gaps in the regulatory and legislative framework Shortcomings in the Russian legislation Enhancement of legislative basis Incomplete legislation basis in Russia and Karelia with regards to implementation of authorities delegated to social welfare authorities at district and village levels Observance of delegated powers at all levels of authorities	11
IV	INSUFFICIENT AND UNQUALIFIED PERSONNEL Absence of opportunities for staff training and re-training Incompetence of specialists Insufficient qualified personnel Staffing problems in rural areas. Lack of healthcare and social care workers	11
V	INSUFFICIENT COMMUNICATION Absence of contact data of people/organisations from whom information about possible involvement into projects could be obtained Absence of a common databank of the families at risk Most of the population does not know about the pilot projects Insufficient information about the projects	5
VI	MATERIAL TECHNICAL BASIS Weak material and technical basis of institutions in social sector Insufficient material basis	5
VII	OTHER Insufficient infrastructure for social services to population, especially to the elderly (6) Poor knowledge of foreign languages (3) Geographical remoteness , large distances among settlements (2) Various (9) (e.g. Dissemination of experiences of other regions without testing at district level, poor understanding of the problems in social sector, bureaucratization of all processes, reluctance to work, customs formalities)	20

The TB case demonstrates that the decision on diffusion needs to be deliberate and all the elements in place. The fears of the Finnish CA and the evaluators, unfortunately, came true. The decision made by the MOH Karelia on the diffusion of the new TB prevention practice to all districts at the same time was premature. Due to financial insufficiencies, lack of professionals, skills, equipment and institutionalised working procedures the diffusion remains incomplete (Danilova et al. 2010, 35-36).

All three groups of variables influenced internal diffusion but among them the relative advantage, easiness of adoption, trialability and visibility of the results seem to be the most influential.

6.3 SUMMARY OF THE RESULTS

The case projects were selected on the basis of the criteria presented in Chapter 4 with the aim of having different kinds of cases that would illustrate various aspects of the phenomenon studied and possible differences between them with regard to the adoption and diffusion of the innovations. How successful then was this selection? According to the results it can be concluded that the selection proved good and clear differences between the cases were revealed (Appendix 4). However, it is necessary to make two comments. First, the chosen social innovations were very different in character, which led in Chapters 5 and 6 to an emphasis of the systemic innovations, as it was necessary to describe the background and wider context. Second, grassroots level projects were not included in the survey due to the assumption that their small size, meagre funds and very local character would not enable diffusion of the innovations beyond the pilot institutions or areas. The results of this study show that neither the financial resources nor the size of the project had a decisive role in diffusion (Table 16). Innovations diffused if they were feasible and met the needs.

Table 16: Project funding versus adoption and diffusion

Duration / External funding	short term (maximum of 3 years)	long term (over 3 years)
small (less than 100 000 €)	Segezha → adopted, diffused	Kostomuksha → adopted, diffused Pitkyaranta → adopted, not diffused
notable (from 300 000 to 2,6 mil. €)	TACIS → incomplete adoption, diffused	Tuberculosis → adopted, incomplete diffusion

To sum up the results of this study against the research questions presented in Chapter 1 (pp. 16-17) (Table 17):

1. The introduced and supported social innovations were adopted in the pilot districts except in one case (TACIS).
2. Diffusion was divided into two phases: external and internal diffusion. Innovations diffused outside the borders of the pilot areas to varying extents and in different ways. A characteristic of the diffusion was that except for the TB case, it was not systematic or guided from the top.

Table 17: Adoption and internal diffusion of the social innovations in Karelia

Project	**Social innovations**	**Adoption in the pilot district**	**Diffusion**
Investigation of the risk factors and behavioural characteristic in Pitkyaranta 1992-2008	Health monitoring system	Adopted and development continues.	Not diffused
	Health promotion Identification of the risk factors	New approach and working methods adopted. Embedded in the working practices.	Diffused to working practices in different parts of the country.
Support to the Implementation of Social and Health Care Reforms in the Republic of Karelia 1997-1999	GP training	The training programme adopted. Training continues. Incomplete institutionalisation of the profession.	-
	GP practice model	Not adopted in the pilot districts (in 2010). Incomplete institutionalisation of the GP model.	Continues. The model tested in 15 districts. (5.2) Adopted in five districts outside the original pilots.
	Training of social workers	The training programme adopted. Training continues. Incomplete institutionalisation of the new profession.	-
Fighting Tuberculosis in Karelia 1999-2008	New approach to TB prevention	Adopted. Republic decision on adoption the model in the whole Republic.	Incomplete diffusion to all districts (situation in February 2011).
The development of the child welfare system in the district of Segezha 1997-1999	Development of preventive services and non-institutional (open) care	Adopted and institutionalised in Segezha	Diffused and modified in Pitkyaranta, Olonets, Priazha, Medvezhegorsk
Support to the Rehabilitation centre for disabled children in Kostomuksha 1992-2008	Development of services for disabled children	Adopted and institutionalised in Kostomuksha	Diffused and modified in Kalevala, Loukhi, Kem, Belomorsk, Segezha, Pudozh, Petrozavodsk, Prionezhkyi and Olonets.

3. All three groups of variables influenced both diffusion and adoption to varying degrees, by stages. The most influential factors seemed to be the relative advantage, the commitment of the local partner and receipt of information. The table 18 below illustrates the factors that positively and negatively affected adoption and both phases of diffusion. However, the degree and form of the influence at each stage depended on the character of the innovation. The contextual factors seemed to have a bigger effect on the systemic innovations than on the practical. With regard to the latter the results confirm the statement of Nikula and Granberg[348] on the non-decisive role of contextual factors on local level adoption and the crucial role of factors related to the actors and the relations between them.

Table 18: Main factors promoting and slowing diffusion and adoption

Phase	**Promoted**			**Slowed**		
Factors	**external diffusion**	**adoption**	**internal diffusion**	**external diffusion**	**adoption**	**internal diffusion**
Attributes	relative advantage, trialability, observability	relative advantage, trialability, observ-ability	relative advantage, trialability, observ-ability, feasibility	complexity, incompat-ibility	complex-ity, incom-patibility nature of the SI	complex-ity, incom-patibility nature of the SI
Communi-cation	good re-lations between the CA and local partner	local change agency/ agent opinion leaders	dissemi-nation of informa-tion local change agency/ agent opinion leaders	lack of commu-nication strategy	resistance of the opinion leaders and /or influential groups	ineffective commu-nication structures, lack of diffusion plan
Institutio-nal frame-work	legislation financial and professional support institutional support commitment	legislation motivated and com-mitted lo-cal actors regional and fed-eral sup-port micro level develop-ment strategy	legislation available financial and human resources federal support commit-ment of the deci-sion- mak-ers	lack of consist-ent reform strategy insufficient financial resources lack of pro-fessionals	lack of reform strategy insuf-ficient funding lack of supportive structures and incen-tives lack of profes-sionals	inadequate legislation lack of consist-ent reform strategy insufficient financial support (at all levels)

[348] Nikula and Granberg consider (2011, 234) innovations at local level as novelties and niches, which may become innovations that challenge the rules and institutional structures.

If the impact of the factors is considered from the point of view of the three categories (2.2.3) the following conclusions can be formulated:

I. Relative advantage, trialability and observability promoted both external and internal diffusion and adoption; complexity hampered in particular the adoption of systemic innovations, incompatibility slowed down but did not impede adoption and internal diffusion,

II. Communication promoted both adoption and diffusion: the role of the external CA was most important during the external diffusion and only in some cases during the internal diffusion; the local change agents played a key role at all stages; resistance among the opinion leaders or other influential groups, ineffective use of communication structures and lack of a diffusion plan and development strategy delayed adoption,

III. Legislation both promoted and prevented, depending on the nature of the innovation and the stage, the commitment of the local decision-makers was crucial both in adoption and internal diffusion; the amount of external funding did not correlate with the results, i.e. adoption and diffusion of innovations. Lack of a federal guiding reforming policy, insufficient funding, lack of incentive systems and inadequacy in professionals impeded both adoption and diffusion.

In addition to the research questions two *hypotheses* were set for examination:

1. Only pilot districts benefitted from the cooperation and introduced social innovations;
2. No significant institutional changes resulted from the projects.

In Finland's neighbouring area strategies the entire Republic of Karelia has been mentioned as the principal target area (e.g. MFA 2004, 4). However, only seldom did development projects cover the entire country. The records show that the bilateral Finnish-Karelian projects are concentrated mainly on districts close to the Finnish border or close to Petrozavodsk. Consequently, it seems that these districts have benefitted more from the cooperation while some others have remained more peripheral and isolated from impacts of the cooperation position (Arsalo and Vesikansa 2000, 13).

The practice of piloting new models and practices has proved beneficial and is in widespread use. But has it, to some extent, turned against itself? The donors' desire to concentrate on certain geographical areas is understandable. In cases when pilot areas have been selected together with the Karelian authorities the accessibility of the district has played a role. At least partly due to this, several projects have been implemented in the same geographical areas, which results in an accumulation of knowledge, skills, experiences and new equipment in the same few districts. This, for its part, may lead to an *unintended* side effect, to an increase

in inequalities between the districts[349]. However, this is not to blame the donors as according to the agreement on cooperation it is the beneficiary's task to distribute information and diffuse experiences achieved in the frames of the projects. During the fieldwork in Karelia, one of the key persons of one of the border area districts noted that, in his opinion, his district – due to its location and historical background – has a right to and should benefit from cooperation more than the others. Such opinions can also hinder the sharing of the experiences gained.

In regard to international social sector cooperation the author would divide the Karelian districts into two groups. In the first group are those districts that so far seem to have benefitted most from the cooperation: Petrozavodsk, Prionezhkyi, Pitkyaranta, Kondopoga, Medvezhegorsk, Priazha, Segezha, Kostomuksha, and Sortavala. The second group consists of the "isolated" districts of Loukhi, Kalevala, Kem, Belomorsk, Muezerskyi, Pudozh, Lahdenpohia, Olonets, and Suoiarvi. Common to districts of the second group is that most of them are the most remote districts in the north and east and even though some of them are located at the Finnish border, there are no crossing points and they are at the end of long roads in poor condition. In these districts there are no cities – only rural settlements. This is not a homogenous group but includes large districts with low population densities and high unemployment rates.

Nevertheless, the results of this study show that information about the cooperation had indeed spread all over the Republic. Also, although some districts have benefitted more than others, all have received something: training, equipment, study visits. How this new knowledge, skills or equipment has been further utilised in the district is another question.

The second hypothesis argued that no significant institutional changes resulted from the projects. As the results of this study prove, introduction and adoption of the innovations resulted in numerous concrete changes in all cases. The changes were mostly practical and local in nature, but systemic changes also took place. A health monitoring and GP practice models were created, educational and child welfare systems were developed, and new working and treatment methods in the prevention of tuberculosis were introduced. It is also necessary to mention the various effects the projects and innovations had on further developments at local, regional and federal levels.

[349] Although the TB project was also implemented in rural areas of Olonets, Priazha, Kem and Belomorsk, where the problems are quite different from those in big cities, the Karelian team suggested the evaluators visit only Petrozavodsk and Kondopoga. The evaluators noted, "We understood from discussions that this region is one of the more advanced ones and others are yet not in the same level. In Belomorsk and in Priazha no TB specialists are in place and because of that it should not be necessary to visit these places". (FILHA 2011, 2.)

7 Conclusions

The Russian market economy and model of welfare provision is gradually taking shape, which hopefully will result in improving the wellbeing of the whole population. Economic stability and wealth create the basis for social development, which for its part promotes economic growth and sustainability. The further the research proceeded, the more convinced I became that the direction taken by the European Union and Finnish Government to support economic and social development with emphasis on economic cooperation is well founded. The social sector cannot be developed in a vacuum, separately from other sectors but it is of crucial importance to take account of the social aspects in all actions. The aim of this last chapter is to build a bridge between the findings of this study and future cooperation.

This study concerned a universal problem of how to share knowledge, how to embed good practices, and how to ensure the sustainability of the good results achieved. The social innovations examined aimed at changes in formal and informal institutions, which partly explains why they were not fully adopted and diffused. The influence of the institutional framework, itself in change, is evident on both processes. However, it is often not possible to consider and/or predict its effects on project implementation. Institutions change at varying speeds and some of the expected changes may not take place at all, which for its part may directly influence the project implementation. But it is important to allow for the fact that the existing institutions do not necessarily change as quickly as expected and that the project objectives are set accordingly.

As revealed in this study, the social issues and the development of the health care and social protection systems were not neglected in Russia and good and sustainable results have been achieved in separate projects in different parts of Russia, including Karelia. However, a system reform is a complex process that may lead to contradictory and fragmented outcomes especially in the absence of a clearly declared development strategy that guides the change and verifies the commitment to its implementation. The liberalisation process was started in Russia but not carried out in full and the re-centralisation of powers that started after the millennium have slowed it down further. Moreover, the meaning of liberalisation and free markets for social protection delivery was never really defined. Often the reforms remained declarative ministerial programmes.

Since the beginning of the 1990s, the financial and technical support for the social sector reform in Russia has been extensive but sometimes the results achieved seem rather modest. It is easy to assume that the utilisation of good practices takes place too slowly and that the beneficiary has not done everything that it should and could in order to adopt and diffuse innovations. However, it is important to remember that the changes in diverse fields of economy also affect social sector

as well as both the institutions and individuals involved in the cooperation. The unexpected turns and external factors, beyond the powers of the partners, may have an enormous effect on project outcomes. Such a situation is demanding for the authorities at diverse levels, who need to be prepared for continuous changes and adapt to the new conditions.

It is essential for successful and sustainable results that the objectives are set jointly, correctly and realistically. Monitoring and reporting to the donors and beneficiaries not only progress and success but also failures and mistakes, is crucial. It provides an opportunity to follow and re-assess the course, if necessary. Innovations are usually considered as something positive but their adoption may also cause negative side effects and unintended results, which need to be taken into consideration at whatever phase they occur. Equally important is the coordination of actions on both sides in order to avoid unnecessary waste of human and financial resources.

Although social innovations in this study were defined as actions that intended to change and develop institutions, it is good to keep in mind that change starts from individuals. Consequently so-called ”soft factors”, i.e. attitudes and ways of thinking influence everyday work and working practices are equally important for development processes as ”hard factors”. The involvement in project planning processes of those whom the change concerns is as important as the involvement of the decision-makers. Both approaches, top-down and bottom–up, are valuable and needed in development work.

External support is never free from ideological biases. The models and approaches introduced in Russia originated from western welfare state models and policies. The complex Russian institutional framework with strong informal institutions and deeply rooted traditions forms a very specific environment for cooperation. Due to the different backgrounds western models are not directly transferable to Russia. Russia is not in transition to any known market or welfare model; it is transforming to some still unknown model. Western models can offer good examples, but in most cases they require modification. Therefore it is important that the models and practices proposed are not directly transplanted, but applied, adapted and modified for the circumstances of the beneficiary country.

Over the years the Karelian Government has expressed its satisfaction with social sector cooperation with Finland and the EU. They have stated that international cooperation has efficiently complemented the efforts of the Karelian Government and supported the development of health care and social services in Karelia. The joint projects have resulted not only in concrete and visible changes but also in outcomes of diverse character. The prestige of the Karelian specialists, and the good experiences gained in Karelia have been acknowledged at the federal level. The cooperation between our countries might also serve as an example for others.

Recently the issue of supporting “rich Russia”, not only in the social sector but generally has been discussed in Finland quite regularly. Finnish taxpayers’ money is used for this purpose and they want to know how and where. That is

how democracy works. However, what is not sufficiently brought to the fore in this discourse are the facts about the actual use of the financial support granted. Usually, the funds are not sent to the beneficiaries to be used as they see fit but through agencies – in this case Finnish – which control their use and report on it to the funder. The agencies are allowed, depending on the funder's instructions, to cover their own expenses including salaries with these funds. Consequently, often only a minor part of the funds granted goes to "rich Russia". And this does not concern only Russia and Karelia but is a phenomenon of a more universal nature.

Whatever are the opinions about cooperation, the fact remains that the neighbouring area cooperation has benefitted both sides. In the evaluation report on Finland's neighbouring area cooperation of 2011 it is noted that Finland received up-to-date information about the situation and developments in Russia, the trust between the parties has increased and prejudices have decreased.

In March 2010, the Minister of Health and Social Development of Karelia stated that the health sector problems could be solved if the funds available were used more wisely. The deputy chair of the health committee of the city council of Petrozavodsk was not as optimistic; he argued that if nothing changed the health care system might collapse during the next few years. (Karjalan Sanomat 31 March 2010.) Consequently, although many changes have taken place during the past twenty years, the situation is still difficult and many of the same problems persist. The "threats" have not disappeared and not only our support is needed but it is in our interests to provide it.

The Agreement on cooperation between Finland and the Russian Federation was signed in 1992. The support was planned to be temporary and both sides have recently recognised a need to change the agreement. The bilateral projects discussed in this study, are only one form of Finland's neighbouring area cooperation. Since the turn of the millennium and in accordance with Finland's strategy, the emphasis in Finland's neighbouring area cooperation has moved from bilateral to cooperation through the Northern Dimension partnership programmes and with international organisations. Accordingly the projects may be implemented mainly within the framework of these programmes and cooperation. The Government of Finland is committed to cooperation in the frames of Northern Dimension partnerships and international organisations and thus it seems that their financing will be ensured in the years to come. Instead, the future of the bilateral cooperation remains to be seen. This is somewhat worrying as Finland's support for bilateral neighbouring area cooperation has since 2007 decreased year by year, and for 2012 is only about half of what it was a year earlier. It would be crucial to ensure funding for the cooperation carried out by Finnish NGOs.

Consequently, we are witnessing the beginning of a new period in cooperation between Finland and Russia. In Finland's neighbouring area cooperation, 2012 is going to be a transition year to a new kind of cooperation that will start in 2013. This is a good time to reshape the cooperation as on the Russian side too, the situation has changed. In October 2009, the responsibility for neighbouring area cooperation was transferred from the Ministry for Foreign Affairs to the Ministry for Regional Development. In spring 2011, the Ministry for Foreign Affairs of Russia

officially turned to the Ministry for Foreign Affairs of Finland and suggested a revision of the existing agreement on cooperation of 1992. The suggestion was to revise and update the agreement taking into account changes that have taken place since 1992 and also to increase transparency in the implementation of the joint projects[350]. The suggestion corresponded to the views of the Government of Finland, which already noted the need for adjustment of the objectives and forms of cooperation in the strategy of 2004. Both parties also call for cooperation on an equal basis.

There is clearly, on both sides, a need to re-define the rules of the game, the objectives and forms of cooperation as well as to re-confirm the mutual commitment to it. In this regard, the evaluation report (earlier referred Aarva, 2011) includes several good proposals worth consideration. It recommends considering different forms of cooperation, which are not mutually exclusive including regional cross-sectoral cooperation, communication between authorities, expert exchange, greater involvement of NGOs in the cooperation, and allocation of some funds for open tendering.

This is also the place and proper time to re-consider the forms and levels of cooperation: the development of 'practical' innovations at local level or support of 'systemic' innovations and structural changes at higher levels of administration. The experiences of the other former socialist countries, as well as those reported in this study show that there must be a political will and clear, consistent policies to follow when implementing reforms. The agreements and local strategies alone are not sufficient; both parties need to commit to them at the highest possible level. This is especially important if sustainable changes are expected. Resources follow policies and cooperation requires resources – human and financial - on both sides.

Further research

As the results of this study show, despite the fact that the innovations have not been adopted in full, diffused and utilised as much as could have been expected, good results have been achieved and real changes have taken place. In addition to concrete changes in working practices, attitudes have changed, the rhetoric has changed. Both in health care and social protection, the emphasis is moving from treatment to prevention. Finland's support to Karelia's social reform has year by year decreased and due to change of funding instruments, the EU has not funded any big social sector projects in Karelia after the TACIS project discussed in this study. As the cooperation most likely will continue, the available funds should be used more effectively.

In order to establish a firm basis for future cooperation it is *firstly*, important to examine the options for social sector cooperation and achieving sustainable institutional changes. If the recentralisation of powers in Russia continues and the

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[350] http://www.minregion.ru/activities/international_relations/Cross-border_coop/Finland/1319.html visited 18 October 2011 ”Ревизия российско-финляндского Соглашения 1992 года позволит привести его в соответствие со сложившимися за прошедшее со времени его подписания реалиями, повысить транспарентность реализации совместных проектов приграничного сотрудничества и придать ему равноправный характер.”

decisions concerning regional developments are also made in Moscow, cooperation with the federal structures seems the best option. This does not exclude the possibility of regional and local cooperation, which in that case would have an explicitly local character. If the district level cooperation continues it may also be necessary to reconsider the geographical target area: the whole Republic of Karelia or only the border districts.

Secondly, it might be useful to examine how the funds granted for neighbouring area cooperation were used in real terms: how much was used for the project activities in the beneficiary country and how much for other purposes in Finland. This is a very sensitive issue but might be worth closer consideration.

Thirdly, the role of NGOs was only very briefly touched on in this study. Some research has been conducted on the role of NGOs as providers of social services. The results of this study show that the northern districts of Karelia do not benefit from the projects as much as the southern districts. Therefore it would be interesting to study what the role of the local social sector NGOs is in the provision of services in the rural northern areas of Karelia, and to assess what kind of support they might possibly require.

Finally, the combination of the two theories, diffusion and institutional change and the concepts of social innovation and institutions worked well in this context and can be recommended for other corresponding research. Development of the theory itself was not within scope of the study. It would, however, be interesting and indeed quite useful to continue the elaboration of the approach introduced in this study and try to build a theoretical framework that could then be used more widely in planning cooperation.

Sources

LITERATURE

Project documents including travel reports, agreements, memorandums, project reports and other project related documents used in this study are listed under heading *Project documents*. All mentioned documents are available and can be provided for examination on request (marja.tuomi@kolumbus.fi).

Aaltonen, Elli (2005): Developing Social Work in Conjunction with Social Services in Russia. In: Mannila and Aaltonen (Eds. 2005), pp. 132-143.

Aarva, Pauliina (Ed. 2011): Suomen ja Venäjän välinen lähialueyhteistyö vuosina 2004-2009 Evaluointiraportti Ulkoasiainministeriö. Helsinki. Available at http://formin.fin-land.fi/Public/default.aspx?nodeid=348278=contentlan=1&culture=FI

Aarva, Pauliina, Ilchenko Irina, Gorobets Pavel, Rogacheva Anastasiya (2009): Formal and informal payments in health care facilities in two Russian cities, Tyumen and Lipetsk. Health Policy and Planning 2009:1-11.

Alanen, Ilkka, Nikula Jouko, Granberg Leo and Kopoteva Inna (2003): Monitoimisuutta ja palstaviljelyä – maaseudun sopeutuminen kapitalismiin Venäjän Karjalassa. Idäntutkimus 2/2003, pp. 11-17.

Alasuutari, Pertti (1994): Laadullinen tutkimus. Vastapaino. Tampere 1994.

Aldridge, Alan and Levine Ken (2001): Surveying the Social World Principles and Practice in Survey Research. In: Bryman (2001), pp. 51-52

Aleksandrova, Angela (2005): Local Self Government Reform in the Republic of Karelia Northern Dimension Advisory Network. North Karelia Polytechnic. Joensuu. Available http://www. kareliainfo.org (visited 13.5.2008)

Alexseev, Mikhail (2000): The Unintended Consequences of Anti-Federalist Centralization in Russia. Available http:// www.gwu.edu/~ieresgwu/assets/docs/ponars/pm_0117.pdf (visited 20.3.2011)

Arsalo, Ali and Vesikansa Sanna (2000): Experiences of Finnish cooperation in the health and social sectors in the Republic of Karelia (north-western Russian Federation) A case study Policy Learning Curve Series, Number 3 December 2000. World Health Organisation Regional Office for Europe. Copenhagen.

Atun, Rifat A., Kyratsis Ioannis, Jelic Gordan, Rados-Malicbegovic Drazenka and Gurol-Urganci Ipek (2007): Diffusion of complex health innovations - implementation of primary health care reforms in Bosnia and Herzegovina. Health Policy and Planning Vol. 22, No.1, pp. 28-39 (January 15 2007).*185*

Averin, A.N. and Pražnov G.S. (1995): Sosiaalinen ja taloudellinen kehitys Venäjällä. In: Venäjä Yhteiskunta ja hallinto (1995), pp. 36-58.

Axelsson, Runo (2002): Institutional Development in the Russian System of Social Security: Organizational and Interorganizational Aspects. Social Policy & AdministrationVol. 36 No 2, April 2002, pp. 142-155.

Barabási, Albert-László (2002): LINKIT Verkostojen uusi teoria. Suomentanut Kimmo Pietiläinen. Terra Cognita, Helsinki. Alkuperäisteos LINKED. The New Science of Networks.

Blaho, Andras (1994): Russian Transition – Chinese Reforms A Comparative View. The United Nations University UNU World Institute for Development Economics Research (UNU/WIDER). Forssa.

Boĭchenko, Larisa (2005): Järjestöt Karjalan tasavallan kansalaisyhteiskuntaa rakentamassa. In: Leppänen (Ed. 2005), pp. 236-243.

Borodkinaia, O.I., Mannila S., Titkov D. (Eds. 2010): Invalidy v sovremennom obshchestve: opyt Rossii i Finliandii Sbornik stat'eí. Skifia-print. St. Petersburg.

Braithwaite, Jeanine D. (1997): The Old and New Poor in Russia. In: Klugman (Ed. 1997), pp. 29-64.

Bryman, Alan (Ed. 2001): Understanding Social Research series Open University press Buckingham-Philadelphia.

Buwa, Dragudi and Vuori Hannu (2006) "Rebuilding a health care system: war, reconstruction and health care reforms in Kosovo". European Journal of Public Health, Vol. 17, No. 2, 226-230.

Carrington, Peter J., Scott John and Wasserman Stanley (Eds. 2005): Models and Methods in Social Network Analysis Series Structural Analysis. Social Sciences 27. Cambridge University Press. Cambridge.

Cerami, Alfio (2009): Welfare State Developments in the Russian Federation: Oil-led Social Policy and "The Russian Miracle". Social Policy & Administration Vol. 43, No. 2, April 2009, pp. 105-120.

Cerami, Alfio (2006): Poverty and Social Structure in Russia: An Analysis of the First Decade of Transition. Luxemburg Income Study Working Paper No. 445. Available at http://ideas.repec.org/p/pra/mprapa/8387.html

Chadwick, Bruce A., Bahr Howard M., Albrecht Stan L. (1984): Social Science Research Methods Prentice-Halli, Inc. Englewood Diffs. New Jersey.

Channell, Wade (2005): Lessons not learned: Problems with Western Aid for Law Reform in Postcommunist Countries Democracy and Rule of Law Project. Carnegie Endowment for International Peace. Available at http://carnegieendowment.org/files/CP57.Channell.FINAL.pdf

Chirikova, Alla (2007): Sotsial'nye reformy v sovremennoi Rossii v otsenkah regional´nyh liderov. Sotsial'noe issledovanie 11/2007, pp. 41-50.

Conger, Stuart D. (2009): Social Inventions. The Innovation Journal Volume 14/2, 2009 available at http://www.innovation.cc/books/conger_social_inventions1_09232009min.pdf (visited 26.6.2010)

Cook, Linda (2011): Russia's Welfare Regime: The Shift toward Statism. In: Jäppinen et al. (Eds. 2011), pp. 14-37. *186*

Cook, Linda J. (2008): The Politics of Welfare Reform in Russia: The Dominance of Bureaucratic Interests. Russian Analytical digest No 37, 19 March 2008. Available at http://www.isn.ethz.ch/isn/Digital-Library/Publications/Detail/?ots591=0c54e3b3-1e9c-be1e-2c24-a6a8c7060233&lng=en&id=48770 (visited 5.6.2011)

Cook, Linda J. (2007): Postcommunist Welfare States Reform Politics in Russia and Eastern Europe. Cornell University Press. Ithaca.

Creswell, John W. (2003): Research Design: Qualitative, Quantitative and Mixed Methods Approaches. Second edition. Sage Publications. Inc. Thousands Oaks.

Creswell, John W. (1998): Qualitative Inquiry and Research Design Choosing Among Five Traditions. SAGE Publications.

Creswell, John W. (1994): Research Design: Qualitative & Quantitative Approaches. SAGE Publications. London.

Crewe, Emma and Harrison Elizabeth (1998): Whose Development? An Ethnography of Aid. Zed Books. London.

Curtis, Bruce and Roza Denise (2002): Access to an Equal Education for Children and Youth with Disabilities in Russia. Disability World, issue 15, Sept-Oct 2002. Available http::/ www. disabilityworld.org/09-10_02/children/Russia.shtml (visited 8.6.2010)

Dahlström, Margareta, Eskelinen Heikki and Wiberg Ulf (Eds.1995): The East-West Interface in the European North 1995. Nordisk Samhällsgeografisk Tidskrift. Uppsala.

Danishevski, K., Balabanova D., MakKi M., Gutkovskaia L. Detsentralizatsiia v zdravoohranenii Rossii: mogut li administrativnye reformy povysit' effektivnost' upravleniia? In: Danishevski (Ed. 2005), pp. 153 – 185.

Danishevski, K. (2005): Chelovecheskie resurcy v zdravoohranenii Rossii. In: Danishevski (Ed. 2005), pp. 196-218.

Danishevski, K. (Ed. 2005): Problemy Zdorov'ia Naseleniia. Otkrytyǐ Institut Zdorov'ia. Moskva.

Deacon, Bob, Castel-Kanerova Mita, Manning Nick, Millard Frances, Orosz Eva, Szalai Julia, Vidinova Anna (Eds. 1992): The New Eastern Europe Social Policy Past, Present and Future. SAGE Publications. London.

Deacon, Bob (1992): East-European Welfare: Past, Present and Future in Comparative Content. In: Deacon et al. (Eds. 1992), pp. 1-30.

Dearing, James W. (2009): Applying Diffusion of Innovation Theory to Intervention Development. Research on Social Work Practice 2009 19:503-518.

Demidov, Andrei and Heininen Lassi (2006): The Third International Summer School in Karelia (ISSK'06) in Petrozavodsk, the Republic of Karelia, Russia in May 25-31, 2006. Final report. Available at http://www.google.fi/search?q=Andrei+Demidov+and+Lassi+Heininen&ie=utf-8&oe=utf-8&aq=t&rls=org.mozilla:fi:official&client=firefox-a

Demograficheskiǐ ezhegodnik Respubliki Kareliia (2008): Statisticheskiǐ sbornik. Kareliiastat. Petrozavodsk 2008.

Denzin, Norman K. and Lincoln Yvonna S. (Eds. 1994): Handbook of Qualitative Research. SAGE Publications. Thousand Oak.*187*

DiMaggio, Paul and Powell Walter (1991): Introduction. In: Powell and DiMaggio (Eds.1991) pp. 1-38.

Dusseault, David (2010): Elite Bargaining and the Evolution of Centre-Periphery Relations in Post-Soviet Russia: A Comparative Analysis Available at http://urn.fi/URN:ISBN:978-952-10-6158-5.

Dzhibladze, Juri (2005): Kansalaisaktivismi vahvan valtion puristuksessa. In: Leppänen (Ed. 2005), pp. 171-90.

Ebbinghaus, Bernhard (2005): Can Bath Dependence Explain Institutional Change? Two approaches Applied to Welfare State Reform. Max-Planck-Institute for the Study of Societies Discussion Paper 05/2.

Eskelinen, Heikki and Zimin Dmitry (2003): Karjalan talouskurimuksesta kehitysuralle. Idäntutkimus 2/2003, pp. 3-9.

Eskelinen, Heikki, Haapanen Elisa and Druzhinin Pavel (1999): Where Russia Meets the EU. Across the Divide in the Karelian Borderlines. In: Eskelinen et al. (Eds. 1998), pp. 329-346.

Eskelinen, Heikki, Liikanen Ilkka and Oksa Jukka (Eds. 1998): Curtains of Iron and Gold Reconstructuring Borders and Scales of Interaction Ashgate Publishing Ltd, Aldershot.

Eskelinen, Heikki (1995): Transport Infrastructure in a Forest Periphery: Russian Karelia as a Corridor and in a Network. In: Dahlström et al (Eds. 1995), pp. 85-96.

Eskelinen, Heikki, Oksa Jukka, Austin Daniel (Eds. 1994): Russian Karelia in Search of a New Role, Karelian Institute University of Joensuu. Joensuu.

Eskelinen, Heikki (1994): Russian Karelia as a Peripheral Gateway Region. In: Eskelinen et al. (Eds. 1994), pp. 163-172.

Esping-Andersen, Gøsta (1990): The Three Worlds of Welfare Capitalism. Cambridge Polity Press.

European Commission (2004): Aid Delivery Methods Project Cycle Management Volume 1 Supporting effective implementation of EC External Assistance European CommissionBrussels available at http://ec.europa.eu/europeaid/multimedia/publications/documents/tools/europeaid_adm_pcm_guidelines_2004_en.pdf.

Fenger, H.J.M. (2007): Welfare regimes in Central and Eastern Europe: Incorporating post-communist countries in a welfare regime typology. Department of Public Administration, Erasmus University. The Netherlands.

FINLEX (1992a) Valtiosopimukset 62/1992 Asetus Venäjän federaation kanssa yhteistyöstä Murmanskin alueella, Karjalan tasavallassa, Pietarissa ja Leningradin alueella tehdyn sopimuksen voimaansaattamisesta ja sen eräiden määräysten hyväksymisestä annetun lain voimaantulosta http:/www.finlex.fi/fi/sopimukset/sopsteksti/1992/19920062.

FINLEX (1992b): Valtiosopimukset 63/1992 Asetus Venäjän federaation kanssa suhteiden perusteista tehdyn sopimuksen voimaansaattamisesta http:/www.finlex.fi/fi/sopimukset/sopsteksti/1992/19920063.

Foley, Mark C. and Klugman Jeni (1997): The Impact of Social Support: Errors of Leakage and Exclusion. In: Klugman (Ed. 1997), pp.189-210.*188*

Förster, M.F. and Tóth I. (2001): Child Poverty and Family Transfers in the Czech Republic, Hungary and Poland. Journal of European Social Policy 11.4, pp. 324-341. London. Available at http://www.sagepublications.com.

Friedland, Roger and Alford Robert R. (1991): Bringing Society Back in: Symbols, Practices, and Institutional Contradictions. In: Powell and DiMaggio (Eds. 1991), pp. 232-263.

Gekkin, Gennadi (1995): Lapsen asema Karjalan tasavallassa. In: Kemppainen and Grigor'eva (Eds.), pp. 12-13.

Gel'man, Vladimir (2009): Subnational Authoritarism in Russia. Russian Analytical Digest No 67 9 November 2009. pp. 2-5.

Gerner, Kristian and Hedlund Stefan (1994): Homo Oeconomicus Meets Homo Sovieticus. In Idäntutkimus 1/1994, pp. 8-26.
Golovina, Svetlana (1995): Lastensuojelun asiantuntijain koulutuksesta Karjalan tasavallassa. In: Kemppainen and Grigor'eva 1995, pp. 65-66.
Granberg, Leo (Ed. 1998): The Snowbelt Studies on the European North in Transition. Aleksanteri-instituutti & Kikimora publications – series B. Helsinki.
Granberg, Leo and Riabova Larissa (1998): Social Policy and the Russian North. In: Granberg (Ed. 1998), pp. 171-198.
Granovetter, Mark S. (1983): The Stength of Weak Ties: A Network Theory Revisited. Sociological Theory, Volume I, pp. 201-233.
Granovetter, Mark S. (1973): The Strength of Weak Ties. American Journal of Sociology Volume 78, Issue 6, pp. 1360-1380.
Grigor'eva, Irina, Hämäläinen Juha, Puurunen Pia, Voronova Elena (2006): The origin of Social Work within NGOs. In: Social Work and Civil Society. International project. St Petersburg. pp. 118-139.
Grigor'eva, I.A., Kozlova A.A., Samoĭlova V.A. (Eds. 2006): Sotsial'naia rabota i grazhdanskoe obshsestvo. Kollektivnaia monografiia. Sankt Peterburg. Original in Russian Социальная работа и гражданское общество 2006. Коллективная монография под редакцией И.А. Григорьевой, А.А. Козлова, В.А. Самойловой. Международный проект, Санкт Петербург.
Grigor'eva, Galina and Kemppainen Martti (Eds. 2002): Partnerstvo na blago deteĭ Model' tsentra psihologo-mediko-sotsial'nogo soprovozhdenniia deteĭ i semeĭ Pitkyarantskogo raĭona. Periodika. Petrozavodsk.
Grigor'eva, Galina and Kemppainen Martti (Eds.2000): Na blago rebenka vmeste s sem'eĭ Razvitie sistemy zashchity deteĭ v Segezhekom raĭone. Periodika. Petrozavodsk.
Grinblat, Jakov (1997): Segezhan lastensuojelun näkymiä. In: Kemppainen and Grigor'eva (Eds. 1997), pp. 40-41.
Hanhinen, Sari (2001): Social Problems in Transition Perceptions of Influential Groups in Estonia, Russia and Finland. Kikimora Publications Series A:5. Helsinki.
Harvey, Brian (1995): Networking in Eastern and Central Europe. A Guide to Voluntary and Community Organisations. Community Development Foundation. London.
Haukkala, Hiski and Saari Sinikukka (Eds. 2009): Russia Lost or Found? Patterns and Trajectories. Ministry for Foreign Affairs of Finland. Helsinki.
Heiskala, Risto (2003): Instituutiot, sosiaaliset innovaatiot ja yhteiskunnan rakenteellinen muutos. In: Melin and Nikula (Eds. 2003), pp. 15-28. *189*
Helanterä, Antti and Tynkkynen Veli-Pekka (2002): Maantieteelle Venäjä ei voi mitään. Ajatus Kirjat Gummerus Kustannus Oy. Helsinki.
Hemminki, Elina, Larivaara Meri, Dubikaytis Tatiana, Gissler Mika, Rotkirch Anna and Kuznetsova Olga (2010): Peculiarities in Doing Public Health Research in Russia. In: Huttunen and Ylikangas (Eds. 2010), pp. 184-200.
Heusala, Anna-Liisa (2005): The Transitions of Local Administration Culture in Russia. Kikimora Publications. Helsinki.
Huttunen, Tomi and Ylikangas Mikko (Eds. 2010): Witnessing Change in Contemporary Russia. Kikimora Publications Series B 38. Helsinki.

Hønneland, Geir and Rowe Lars (2004): Health as International Politics: Combating Communicable Diseases in the Baltic Sea Region. Ashgate Publishing Limited.

Hämäläinen, Hannu (2008): Innovation activities offer solutions to the future challenge of the welfare state. Unpublished.

Hämäläinen, Hannu (2005): Innovaatiotoiminnalla ratkaisuja hyvinvointiyhteiskunnan tulevaisuuden haasteisiin. Yhteiskuntapolitiikka 2/2005, pp. 197-204.

Hämäläinen, Timo and Heiskala Risto (2004) Sosiaaliset innovaatiot ja yhteiskunnan uudistumiskyky. Edita/Sitra.Helsinki.

Iarskaia-Smirnova, E. (2011): "A Girl Who Liked to Dance": Life Experiences of Russian Women with Motor Impairments. In Jäppinen et al. (Eds. 2011), pp. 104-124.

Iarskaia-Smirnova, Elena, Romanov Pavel, Lovtsova Natalia (2004): Professional development of social work in Russia. Social Work & Society, Volume 2, Issue 1, 2004. Available http://<www. socwork.de/Iarskaia-Romanov-Lovtsova 2004-1.pdf. (visited 30.5.2010)

Iarskaia-Smirnova, Elena and Romanov Pavel (2002): "A Salary in not Important Here": The Professionalization of Social Work in Contemporary Russia. Social Policy &Administration, Vol. 36, No 2 April 2002, pp. 123-141.

Iivonen, Jyrki (1993): Neuvostoliiton hajoaminen ja Venäjän poliittinen kehitys. In: Piirainen (Ed.1993) pp. 39-60.

Jaatinen, Marjatta (2004): Sosiaalialan koulutus lisääntyy Venäjän yliopistoissa. Yhteiskuntapolitiikka 69 (2004)-4, pp. 437-439.

Jepperson, Ronald L. (1991): Institutions, Institutional Effects, and Institutionalism. In: Powell and DiMaggio (Eds.1991), pp. 143-163.

Johanson, Jan-Erik, Mattila Mikko, Uusikylä Petri. (1995): Johdatus verkostoanalyysiin Menetelmäraportteja ja käsikirjoja 3/1995. Kuluttajatutkimuskeskus. Helsinki.

Jyrinki, Erkki (1976): Kysely ja haastattelu tutkimuksessa Kolmas painos. Oy Gaudeamus Kustannustoimi. Helsinki.

Jämsen, Arja, Knaapi Jouko, Leskinen Sirkku, Salo Mikko A. and Syrjäläinen Soile (Eds. 1998): Inkerin vanhustenhuollon kehittämishankkeen arviointi. Joensuun yliopisto. Yhteiskuntapolitiikan ja filosofian laitos. Joensuu.

Jäppinen, Maija, Kulmala Meri and Saarinen Aino (Eds. 2011): Gazing at Welfare, Gender and Agency in Post-Socialist Countries Cambridge Scholars Publishing. Newcastle upon Tyne, UK.*190*

Järvinen, Tomi (2007): Empowerment A Challenge of Non-Governmental Organizations in Development Cooperation Partnership Acta Universistatis Tamperensis 1244. Tampere University Press. Tampere.

Jűtting, Johannes (2003): Institutions and Development A critical review OECD Development Centre Working Paper No. 210 July 2003 DEV/DOC (2003)08.

Kangaspuro, Markku (2003): Mielikuvien Karjala. Idäntutkimus 2/2003, pp. 1-2

Kangaspuro, Markku (Ed. 2000) Russia: More different than most Kikimora Publications Series B:16. Helsinki 1999.

Kangaspuro, Markku, Nikula Jouko, Stodolsky Ivor (Eds. 2010): Perestroika: Process and Consequences. Finnish Literature Society. Helsinki.

Karelia putevoditel' (2006): Scandinavia. Petrozavodsk.

Kay, Rebecca (2011): Social security, Care and the “Withdrawing State” in Rural Russia. In: Jäppinen et al. (Eds. 2011), pp. 145-169.
Kemppainen, Martti (2005): Kokemuksiani lastensuojelutyöstä Karjalassa. In: Leppänen (Ed. 2005), pp. 155-162.
Kemppainen, Martti and Grigor’eva Galina (2005): Children cannot wait – Karelia Responsies to Child Welfare Challenges. In: Mannila and Aaltonen (Eds. 2005), pp. 121-131.
Kemppainen, Martti (2000): Results and lessons of the child welfare development project in the district of Segezha. In: Grigor’eva and Kemppainen (Eds. 2000), pp. 91-95.
Kirkinen, Heikki (1996): Monenlainen Karjala. Tilastokeskus, 3/1996, pp. 58-64
Kirkinen, Heikki, Nevalainen Pekka, Sihvo Hannes (1994): Karjalan kansan historia. Werner Söderstöm. Porvoo.
Kivinen, Markku (2010): The Political System in Contemporary Russia. In: Huttunen and Ylikangas (Eds. 2010), pp. 11-20.
Kivinen, Markku (2009): Russian Societal Development: Challenges Open. In: Haukkala and Saari (Eds. 2009), pp. 112-144.
Kivinen, Markku (2008): Venäjän poliittinen järjestelmä vakiintuu. Venäjän aika 1/2008.
Kivinen, Markku (2003): Venäjän yhteiskunnan kokonaismuutos. In: Melin and Nikula (Eds. 2003), pp. 234-244.
Kivinen, Markku (2002): Progress and Chaos. Kikimora Publications. Helsinki.
Klevina, N.I. (2000): Tsentr sotsial’noĭ pomoshchi sem’e i detiam (opyt sotsial’noĭ raboty s sem’iami). In: Grigor’eva and Kemppainen (Eds. 2000), pp. 56-67.
Klugman, Jeni (Ed. 1997): Poverty in Russia Public Policy and Private Responses EDI Studies. The World Bank. Washington, D.C.
Knoke, David (1990): Political Networks The Structural Perspective. Cambridge University Press. Cambridge.
Kolesova, T. (Ed. 2008) Karelia – territoriia razvitiia (1990-2005): Skandinavia. Petrozavodsk.
Kolodko, Grzegorsk W. (1999): Ten Years of Postsocialist Transition. Lessons for Policy Reforms The World Bank Policy Research Working Paper 2095 Lessons for Policy Reforms available at http://siteresources.worldbank.org/INTPOVERTY/Resources/WDR/malaysia/kolodko.pdf (visited 10.2.2011)*191*
Koloskov, Sergey (2001): The Desperate Situation of Children with Disabilities in Russian Institutions. International Children’s Rights Monitor, Volume 14, No 2, May 2001. Available http: / www.disabilityworld.org/01-03_02/children/russia.shmtl (visited 27.2.2011)
Kolosova, G.V. (2010): Sotsial’nia podderzhka invalidov v Cankt-Peterburge. In: Borodkinaia et al. (Eds. 2010), pp. 12- 27.
Konitser-Smirnov, Andrew (2003): Othod ot sotsial’nogo kontrakata sovetskoĭ epohi: post-sovetskoe razvitie sotsial’noi politiki v Uljanovskoĭ i Samarskoĭ oblastjah. In: Twigg and Schester (Eds. 2003), pp. 237-274.
Konstitutsiia Respubliki Karelia # 473-3RK. Priniat Palatoĭ Predstaviteleĭ RK 7 fevralia 2001 goda Odobren Palatoĭ Respubliki ZC RK 5 fevralia 2001 goda.
Korkhova, Inna and Jyrkinen-Pakkasvirta Teela (1998): Invalidity and Disability Pensions. In: Turuntsev and Simpura (Eds. 1998), pp. 113-126.

Kortelainen, Jarmo (2004): Luottamus venäläisessä tehdasyhdyskunnissa. Idäntutkimus 2/2004, pp. 3-10.
Kosonen, Riitta (2004): Yritysten sopeutuminen Viipurissa. Idäntutkimus 2/2004, pp. 11-26.
Kozlov, A.A. (2004, Editor-in-chief): Sotsial'naia rabota Vvedenie v professional'nuiu deiatel'nost. Logos. Moskva.
Kurilo, A., Nemkovich E. and Seniushkin E. (2007): Sotsial'no-ekonomicheskie reformy v Respublike Karelii (v 1990-2005 gg.). Petrozavodsk.
Laatikainen, Tiina (2009c): Terveystilanne Karjalan tasavallassa. Idäntutkimus 3/2009, pp. 3-8.
Laatikainen, Tiina, Vlasoff Tiina, Korpelainen Vesa, Pokusajeva Svetlana, Uhanov Mihail (2006): The Health Behaviour in the Pitkyaranta – results of the health behaviour survey in the Pitkyaranta district in the Republic of Karelia, Russia in 1998, 2000 and 2004. North Karelia Center for Public Health. Joensuu.
Laatikainen, Tiina, Korpelainen Vesa, Vlasoff Tiina, Uhanov Mihail and Puska Pekka (no date, 2003?) The Pitkäranta Project: A successful pilot programme in non-communicable disease prevention in the Republic of Karelia. Draft.
Laatikainen, Tiina, Delong Laura, Pokusaeva Svetlana, Uhanov Mihail, Vartiainen Erkki, Puska Pekka (2002): Changes in cardiovascular risk factors and health behaviours from 1992 to 1997 in the Republic of Karelia, Russia. European Journal of Public Health 2002; 12: 37-43.
Laatikainen, Tiina (2000): Cardiovascular risk in the Republic of Karelia, Russia: Comparison of major risk factors with North Karelia, Finland. Publications of the National Public Health Institute A2/2000. Helsinki.
Laatikainen, Tiina (2000): Terveystutkimusta Karjalan tasavallassa. Erikoislääkäri 5/2000, pp. 231-237.
Laatikainen, Tiina (1996?): The Smoking cessation intervention in Pitkäranta, The Republic of Karelia.
Laatikainen, Tiina, Vartiainen Erkki, Puska Pekka, Pokusajeva Svetlana, Uhanov Mihail (1996): Pitkäranta-projekti. Risk factors and health behavior in the Republic of Karelia, in 1992 and 1994 Publications of the National Public Health Institute B5/1996. Helsinki.*192*
Lagus, Maria (2003): Mozhet li mezhdunarodnoe sotrudnichestvo sposobstvovat' sotsial'nomy splocheniiu v Rossii? Uroki shvedskogo opyta. In: Twigg and Schester (Eds. 2003), pp. 290- 306.
Laine, Antti (2003): Karjalan tutkijan vuosikymmeniltä. Idäntutkimus 2/2003, pp. 30-31.
Laine, Antti (1994): Karelia Between Two Socio-Cultural Systems. In: Eskelinen et al. (Eds. 1994), pp. 13-25.
Laine, Antti and Ylikangas Mikko (Eds. 2002) Rise and Fall of Soviet Karelia. Kikimora Publications. Helsinki.
Lainela, Seija and Sutela Pekka (2004): European Union, Russia, and TACIS. Bank of Finland BOFIT – Institute for Economies in Transition. Helsinki.
Lebedev, Ilya (1995): Invalidiasioita koskevan sosiaalipolitiikan pääsuuntaukset Venäjän Federatiossa Presentation in the seminar on 13.-16.3.1995.

Lehtinen, Erno and Palonen Tuire (1999): Kasvatustieteen tyyssijat – Tutkimus tiedeyhteisön rakenteesta ja tietokulttuureista. In: Mattila et al. (Eds. 1999), pp. 180-199.

Leppänen, Airi (Ed. 2005) Kansalaisyhteiskunta liikkeessä yli rajojen Sosiaali- ja terveysalan järjestöt lähialueyhteistyössä. Palmenia-kustannus. Helsinki.

Leppänen, Airi (2005): Diabetes-yhteistyötä Lounais-Venäjällä. In: Leppänen (Ed. 2005), pp.146-154.

Leppänen, Airi (2005): Karjalan terveydenhuoltoa uudistamassa Lääkäri Tapio Hämäläisen haastattelu. In: Leppänen (Ed. 2005), pp. 163-168.

Leppik, Lauri (1995): Historical roots of social welfare policy in Estonia. In: Simpura (Ed. 1995), pp. 23-30.

Liborakina, Marina and Rotkirch Anna (1999): Social Consequences of the 1998 Crisis in Russia: Household Strategies and Their Challenge to Municipal Social Policy. Idäntutkimus 2/1999, pp. 24-48.

Liikanen, Ilkka (2002): Civil Society and Politics in Late Soviet Society: Reflections on the Breakthrough of Voluntary Associations in Russian Karelia. In: Laine and Ylikangas (Eds. 2002), pp. 178-200.

Liikanen, Ilkka, Zimin Dmitry, Ruusuvuori Juha and Eskelinen Heikki (2007): Karelia – A Cross-border Region? The EU and cross-border region-building on the Finnish-Russian border. University of Joensuu. Karelian Institute. Joensuu.

Lindner, Johannes (2003): Institutional stability and change: two sides of the same coin. Journal of European Public Policy 10:6 December 2003: 912-935.

Lopez-Claros, Augusto (2003): Rol' mezhdunarodnykh finansovykh organizatsiĭ v perekhodnyĭ period v Rossii. In: Twigg and Schester (Eds. 2003), pp. 307- 338.

Malinova, Olga (2010): Making Social Discussions Possible: Perestroika and the Development of the Public Sphere. In Kangaspuro et al. (Eds. 2010), pp. 171-190.

Mannila, Simo and Aaltonen Ursula (Eds. 2005): What Are We Doing There? Experiences and lessons learned from development cooperation in health care and social welfare (1990-2005). STAKES National Research and Development Centre for Welfare and Health. Helsinki.*193*

Mannila, Simo, Nosova Tatjana, Pakkasvirta Teela, Poretzkina Evgenia, Simpura Jussi (2000): Where Did the Ideology of the Social Welfare Contract Go? Conjecture on Development of Public Opinion Based on Interviews of St. Petersburg Families in 1998-2000. Idäntutkimus 3-4 /2000, pp. 26-40.

Manning, Nick (1992): Social Policy in the Soviet Union and it's Successors. In: Deacon et al. (Eds. 1992), pp. 31-66.

Markov, Vladimir (1998): Trends in Socio-Economic Sphere and Social Policy. In: Turuntsev and Simpura (Eds. 1998), pp. 63-73.

Marquand, Judith (2009): Development Aid in Russia Lessons from Siberia. St Anthony's Series Palgrave Macmillian in association with St Anthony's College, Oxford. Great Britain by CPI Antony Rowe, Chippenham and Eastbourne.

Marsden, Peter (2005): Recent Developments in Network Measurement. In: Carrington et al. (2005), pp. 8-30.

Marshall, Catherine and Rossman Gretchen B. (1995): Designing Qualitative Research. Second edition, SAGE Publications.

Martin, Brian (2006): Social testing in Social Alternatives, Vol. 25, No. 4, 2006, pp. 39-42 Available at http://www.uow.edu.au/~bmartin/pubs/06sa2.html. (visited 27.6.2010)

Matilainen, Tiina, Vartiainen Erkki, Puska Pekka, Alfthan Georg, Pokusajeva Svetlana, Moisejeva Nina, Uhanov Mihail (2006): Plasma Ascorbic Acid Concentrations in the Republic of Karelia, Russia and in North Karelia, Finland. European Journal of Clinical Nutrition 50, 115-120.

Mattila, Mikko and Uusikylä Petri (Eds.1999) Verkostoyhteiskunta Käytännön johdatus verkostoanalyysiin. Gaudeamus Oy. Helsinki.

McAlister, Alfred L., Gumina Tamara, Urjanheimo Eeva-Liisa, Laatikainen Tiina, Uhanov Mihail, Oganov Rafael, Puska Pekka (2000): Promoting smoking cessation in Russian Karelia: a 1-year community-based program with quasi-experimental evaluation. Health Promotion International Vol. 15 No.2 pp. 109-112. Oxford University Press, Great Britain.

Melin, Harri (Ed. 2005): Social Structure, Public Space and Civil Society in Karelia. Kikimora Publications B 34. Kikimora Publications, Helsinki.

Melin, Harri (2005): Social Structure, Public Space, and Civil Society in Karelia. In: Melin (Ed. 2005), pp. 145-151.

Melin, Harri (2005): Towards New Paternalism in Kondopoga. In: Melin (Ed. 2005), pp. 61-76

Melin, Harri (1998): In the Shadow of the Plan Factory Management and the Problem of Social Transition in Russia. In: Granberg (Ed. 1998), pp. 133-152.

Melin, Harri and Nikula Jouko (2005): Social structure of Karelia. In: Melin (Ed. 2005), pp. 11-24.

Melin, Harri and Nikula Jouko (Eds. 2003): Yhteiskunnallinen muutos Osuuskunta Vastapaino. Tampere.

Melin, Harri and Nikula Jouko (2003): Mitä on yhteiskunnallinen muutos? In: Melin and Nikula (Eds. 2003), pp. 253-264.

Merriam, Sharan B. and Associates (2002): Qualitative Research in Practice Examples for Discussion and Analysis. Jossey-Bass. San Francisco.*194*

Metsämuuronen, Jari (2005): Tutkimuksen tekemisen perusteet ihmistieteessä. International Methelp Ky. Helsinki.

Mikhalev, Vladimir (1996): Social Security in Russia under Economic Transformation. Europe-Asia Studies Vol. 48, No 1, 1996, 5-25.

Mikkola, Virge (Ed. 2007): Zashchita deteĭ v Evrope i Rossii. Palmenia-kustannus. Helsinki

Ministry for Foreign Affairs of Finland (2004): From Support to Partnership – Finland's strategy for cooperation in its neighgouring areas. Ministry for Foreign Affairs. Helsinki.

Ministry for Foreign Affairs of Finland (2000): Finland's strategy for cooperation in the neighgouring areas. Division for Eastern Affairs Unit for Cooperation with Neighbouring Areas.Helsinki.

Ministry for Foreign Affairs (2000): Guidelines for Project Planning, Monitoring and Reporting. FTP International Oy Finnconsult Oy 26.5.2000. Helsinki.

Ministry for Foreign Affairs of Finland (1998): Annual report Aims, Implementation and Future Outlook for Cooperation Between Finland and her Neighbouring Areas in Northwest Russia and the Baltic States. Helsinki.

Ministry for Foreign Affairs (1997a): Guidelines for Project Planning, Monitoring and Reporting. MFA. Helsinki.

Ministry for Foreign Affairs of Finland (1997b): Annual report Aims, Implementation and Future Outlook for Cooperation Between Finland and her Neighbouring Areas in Northwest Russia and the Baltic States. Helsinki.

Ministry of Defence of Finland (2008): Russia of Challenges. Ministry of Defence. Finland. Helsinki.

Morozova, Tatjana (1994): The Emergence of Open Unemployment in Russian Karelia. In: Eskelinen et al. (Eds. 1994), pp. 109-119.

Mošes, Arkadi (2009): Venäjän muutoksia saadaan odottaa vielä pitkään. Helsingin Sanomat 8.7.2009.

Nelson, Lynn D. and Kuzes Irina Y. (1998): Russian Economic reform and the Restructuring of Interests. The Journal of Post-Soviet Democratization 6 1998, p. 480-503: 480-503. available at http:<//www.demokratizatsiya.org/bin/pdf/DEM%2006-03%20nelson.pdf (visited 5.6.2011)

Nemkovič, Jevgeni, Družinin Pavel, Baibušinov Šamil (1994): Economic Reforms and Structure. In: Eskelinen et al. (Eds. 1994). pp. 70-77.

Nemkovič, Jevgeni, Družinin Pavel, Baibušinov, Šamil (1994): Economic Reforms and Scenarios. In Eskelinen et al. (Eds. 1994), pp. 78-86.

Nemtsov, Boris (2003): Sotsial'nia sostavliaiushchaia perekhoda Rossii k rynku: obzor problem neslozhivshegosia obshchestva. In: Twigg and Schester (Eds. 2003), pp. 363-381.

Niemelä, Heikki, Saari Juho, Salminen Kari (1996) Sosiaalipolitiikan teoreettisia lähtökohtia. Eläketurvakeskus, Tutkimuksia 1996:2. Helsinki.*195*

Nikula, Jouko, Kopoteva Inna, Niska Miira, Butkeviciene Egle, Granberg Leo (Eds. 2011): Social innovations and social partnership in Finland, Russia and Lithuania. University of Helsinki. Finnish Centre for Russian and Eastern European Studies. available www. Helsinki.fi http://www.helsinki.fi/aleksanteri/julkaisut/aleksanteri_papers.html.

Nikula, Jouko, Kopoteva Inna, Granberg Leo, Alanen Ilkka (2005): Traditional in Modern – Local economy and Community in Priazha. In: Melin (Ed. 2005), pp. 25-60.

Nordenstreng, Kaarle and Pietiläinen Jukka (2010): Media as a Mirror of Change. In: Huttunen and Ylikangas (Eds. 2010), pp. 136-158.

North Douglass C. (1993): The Prize Lecture. The Sveriges Riksbank Prize in Economic Sciences in Memory of Alfred Nobel 1993. Available atwww.http://nobleprize.org/nobel_prizes/economics/laurates/1993/north-lecture.html (visited 23.5.2008)

North, Douglass C. (1990): Institutions, Institutional change and economic performance. Cambridge University Press. Cambridge.

Nystén-Haarala, Soili (2009): Institutions Matter. In: Haukkala and Saari (Eds. 2009), pp. 145-185.

Nystén-Haarala, Soili (2001): Russian Law in Transition Law and Institutional Change. Kikimora Publications Series B:21. Helsinki.

OECD (2005): Institutional Change and Violent Conflict. OECD Issues Brief. Development Assistance Committee (DAC) Mainstreaming Conflict Prevention.

Oganov, Rafael (2007): Interview in Karjalainen 13.8.2007.

Oksa, Jukka (1999): The Changing Border and the Many Images of Karelia. In: Eskelinen et al. (Eds. 1998), pp. 285-297.

Oksa, Jukka and Saastamoinen Olli (1995): Cross Border Interaction and Emerging Interest conflicts in the Forest Sector of Russian Karelia. In: Dahlström et al. (Eds. 1995), pp. 97-110.

Oksa, Jukka and Varis Eira (1994): Karelian Republic: Population, Settlements and Administration in Russian Karelia. In: Eskelinen et al. (Eds. 1994), pp. 57-69.

Paasi, Antti (1994): The changing Meanings of the Finnish-Karelian border. In: Eskelinen et al. (Eds. 1994), pp. 26-40.

Palosuo, Hannele (2000): How Good is ”Normal” Health? An Exercise in Russia-Finnish Comparative Survey Methodology. Idäntutkimus 3-4/2000, pp. 41-70.

Pasti, Svetlana (2005): Return to Media Serving the State: Journalists in Karelia. In: Melin (Ed. 2005), pp. 117-143.

Paulovica, Inita (1995): The situation of the disabled in Latvia: Characteristics of the existing situation and perspectives for future. In: Simpura (Ed. 1995), pp. 76-88.

Peltola, Ulla and Vuorento Mirkka (2007): Juurruttamisen edistäjät ja estäjät Kokemuksia työl-listymispalvelujen kehittämishankkeista. Kuntoutussäätiön työselosteita working papers 33/2007. Helsinki.

Percival, Valerie and Sondorp Egbert (2010): “A case study of health sector reform in Kosovo”. Conflict and Health 2010:4:7. Available at: http://www.conflictandhealth.com/content/4/1/7.

Pidde, A., Krivosheev G., Kiselev A. (2003): Bringing the Russia Health-Care System Out of Its Crisis. Sociological Research, vol 42, no 4 July-August 2003, pp. 81-96. *196*

Pietiläinen, Jukka (2010): “Perestroika and Changed Reporting of Social Problems in Newspapers”. In: Kangaspuro et al. (Eds. 2010), pp. 76-96.

Pietiläinen, Jukka (2005): Media in the Life of Russians in Structure, Public Space and Civil Society in Karelia. In: Melin (Ed. 2005), pp. 99-116.

Pietiläinen, Jukka (2002): The Regional Newspapers in Post-Soviet Russia Society, Press and Journalism in the Republic of Karelia 1985-2001. The University Press. Media Studia. Available at http://acta.uta.fi/pdf/951-44-5463-4.pdf.

Piirainen, Timo (2005): Developing Social Services in Transition Countries: from Paternalism Towards a Customer-Oriented System. In: Mannila and Aaltonen (Eds. 2005), pp. 196- 203.

Piirainen, Timo (1997): Towards a New Social Order in Russia Transforming Structures and Everyday Life. Dartmouth Publishing Company. Aldershot.

Piirainen, Timo (1995): Social Policy Models and Reform Objectives in the CIS Countries: The Ukraine as an Example. Idäntutkimus 4/1995, pp. 19-31.

Piirainen, Timo (Ed. 1993): Itä-Euroopan murros ja Suomi. Helsingin yliopisto Sosiaalipolitiikan laitos. Tutkimuksia 1/1993. Gaudeamus. Helsinki.

Pol, Eduardo and Ville Simon (2009): Social innovation: Buzz word or enduring term? The Journal of Socio-Economics 38(2009) 878-885.
Popova, Marina (1994): Social welfare during the Economic Transition in Russian Karelia. In: Eskelinen et al. (Eds. 1994), pp.120-133.
Powell, Walter W. and DiMaggio Paul J. (1991): The New Institutionalism in Organizational Analysis. University of Chicago Press. Chicago.
Powell, Walter W. (1991): Expanding the Scope of Institutional Analysis. In: Powell and DiMaggio (Eds. 1991), pp. 183-203.
Pursiainen, Christer (2001): Soft Security Problems in Northwest Russia and Their Implications for the Outside World. A Framework for Analysis and Action.
Puska, Pekka (1997): Chronic Disease Prevention in the New Independent States: Finnish Experiences. pp. 335-354. available at http:://www.nap.edu/openbook.php?record_id=5530&page=335 (visited 6.9.2010)
Puska, Pekka, Vartiainen Erkki, Laatikainen Tiina, Jousilahti Pekka, Paavola Mari (Eds. 2009): The North Karelia Project: From North Karelia to National Action. National Institute for Health and Welfare (THL) in collaboration with the North Karelia project Foundation. Helsinki University Printing House. Helsinki.
Puska, Pekka, Berg Mari-Anna, Matilainen Tiina, Torppa Jorma, Vartiainen Erkki (1994): Virolle ja Karjalalle apua kansanterveyden kohentamisessa. Sosiaalinen Aikakauskirja 3/94, pp. 36-43.
Puska, Pekka, Matilainen Tiina, Jousilahti Pekka, Korhonen Heikki, Vartiainen Erkki, Pokusajeva Svetlana, Moisejeva Nina, Uhanov Mihail, Kallio Irena, Artemjev Anatoli (1993): Cardiovascular Risk Factors in the Republic of Karelia, Russia and in North Karelia, Finland. International Journal of Epidemiology 22, pp. 1048-1055.
Raka, Lul and Pupovci Dukagjin (2009): National Background Report on Health Research for Kosovo (under UNSCR 1244) available at http://www.wbc-inco.net/attach/NationaLBackgroundReportonHealthforKosovoUNSCR1244.pdf. *197*
Randma, Tiina (2002): Pitfalls of Foreign Aid: Lessons learnt from Estonia. Available at http://www.worldbank.org/html/prddr/trans/marapr02/pgs28-30.htm.
Rasell, Michael and Wengle Susanne (2008): Reforming the L'goty System: The Future of In-kind Benefits in Post-Soviet Russia. Russian Analytical Digest 37/08, pp. 6-13. Available at http://www.isn.ethz.ch/isn/Digital-Library/Publications/Detail/?ots591=0c54e3b3-1e9c-be1e-2c24-a6a8c7060233&lng=en&id=48770 (visited 5.6.2011)
Rautava, Jouko and Sutela Pekka (2000): Venäläinen markkinatalous. Werner Söderstöm Osakeyhtiö, Helsinki.
Rautio, Vesa (2004): Kontupohja – paternalismin kukkanen. Idäntutkimus 2/2004, Näkökulma, pp. 30-31.
Rese, Andrey, Balabanova Dina, Danishevski Kirill, McKee Martin, Sheaff Rod (2005): Implementing general practice in Russia: getting beyond the first steps. British Medical Journal Volume 331, 204-207.
Rimashevskaia, Natalia (2003): Sem'ia i deti v usloviiah tranzitnoĭ ekonomii. In: Twigg and Schester (Eds. 2003), pp. 93-116.

Rogers, Everett M., Medina Una E., Rivera Mario A., Wiley Cody (2005): Complex adaptive systems and the diffusion of innovations. The Innovation Journal: The Public Sector Innovation Journal. Volume 10(3), article 29.

Rogers, Everett M. (2003): Diffusion of Innovations. Fifth Edition. Free Press. New York.

Rogers, Everett M. and Shoemaker Floyd F. (1971): Communication of Innovations. A cross-cultural approach. 2nd ed. The Fee Press, New York.

Roland, Gerard (2004): Understanding Institutional Change: Fast-Moving and Slow-Moving Institutions. Available at http://www.econ.berkley.edu/~groland/pubs/gr3.pdf (visited 27.6.2010)

Rose, Richard (2003): Sotsial'nye potriaceniia, sotsial'naia uverennost' i zdorov'e. In: Twigg and Schester (Eds. 2003), pp. 119-143.

Rouge-Oikarinen, Regis (2009): Rajan ylittävä yhteistyö muuttuvassa Euroopassa Euroopan unionin Tacis-ohjelma (1996-2004) Suomen lähialueyhteistyön toteuttamisvälineenä. Nordia Geographical Publications. Oulu.

Rowland, D. and Telyukov A. V. (1991): Soviet health care from two perspectives. Health Affairs, 10, no. 3 (1991):71:86.

Ruutu, K. and Johansson M. (1998): Public administration in the Republic of Karelia, the City of St Petersburg, Leningrad oblast, Murmansk oblast and Kaliningrad oblast (1998). In Ruutu and Johansson Division of Power and Foundation of Local Self-government in Northwest Russia and the Baltic States (WP 1998:5). Available >www. nordregio.se/File /wp9805. pdf.

Ryan, Michael and Stephen John (1996): General practitioners and family doctors in the Russian Federation. British Journal of General Practice, 46 (409) p. 487- 489 availble at http:// www. ncbi.nlm.hih.gov/pms/articles/PMC1239723 (visited 14.5.2010)

Saari, Juho (Ed. 2008) Sosiaaliset innovaatiot ja hyvinvointivaltion muutos. Sosiaali- ja terveysturvan keskusliitto. Helsinki.

Saari, Juho (2008) Sosiaalisten innovaatioiden aika. In: Saari (Ed. 2008), pp. 7-43.

Sakwa, Richard (2008): Russian politics and society. Fourth edition. Routledge. Oxon. *198*

Salicheva, Nadeshda (2000): Main institutions of the Russian Administrative Law in the Sphere of the Administration of Economy. In: Tolonen and Topornin (Eds. 2000), 85-122.

Salmenniemi, Suvi (2009): Vallanpitäjiä valvova aktivismi uhkaa painua Venäjällä maan alle. Helsingin Sanomat 21.8.2009.

Salmenniemi, Suvi (2005): Vallan vahtikoira vai sylikoiria? Valtion ja kansalaisjärjestöjen suhteiden kehitys 2000-luvun Venäjällä. In: Leppänen (Ed. 2005), pp. 191-203.

Salmi, Anna-Maria (2006): Social Networks and Everyday Practices in Russia. Kikimora Publications A 13. Kikimora Publications, Helsinki.

Samoĭlova, V.A., Vishniauskiene M., Vaisianen R., Viachkene N., Govadac P., Godvadene L., Grigor'eva I.A, Kanishauckaĭte V., Koskinen S., Lazutka P., Liobikiene N., Miettinen M-L., Nauianene R., Repelinen A-M., Smal M., Hamalainen I. (2006): Rol' NGO/ NKO v reshenii problem povsednevnoĭ zhizni. In: Grigor'eva et al. (Eds. 2006), pp. 140-189.

Sarhimaa, Anneli (1998): The Divisive Frontier: The Impact of the Russian-Finnish Border on Karelia. Idäntutkimus 4/1998, pp. 5-29.

Schienstock, Gerd and Hämäläinen Timo (2001): Transformation of the Finnish Innovation system A network approach. Sitra Reports Series 7, SITRA Helsinki.
Scott, John (1991): Social Network Analysis A Handbook. SAGE Publications Ltd, Biddels Ltd, Great Britain.
Scott, Richard W. (1995): Institutions and organizations. SAGE Publications, Inc. California.
Scott, Richard W. and Meyer John W. (1991): The Organization of Societal Sectors: Propositions and Early Evidence. In: Powell and DiMaggio (Eds. 1991), pp. 108-142.
Shaw, Kenneth A. (2005): Institutional Change: The Why and The How. Conference presentation New York City, November 3-4, 2005. Available at http://www.tiaa-crefinstitute.org/pdf/research/dvds_books/030106_12_Shaw.pdf (visited 28.6.2010)
Sheiman, Igor (1995): New methods of financing and managing health care in the Russian Federation. Health Policy 32(1997), pp.167-180.
Sheiman, Igor (1994): The Development of market approaches in Russia. International Journal of Health Planning and Management, Vol. 9, 39-56(1994).
Shekter, Keith (2003): Deĭstvennye modeli mezhdunarodnoĭ pomoshchi. In: Twigg and Schester (Eds. 2003), pp. 275-289.
Shilova, T.L. (2000): Deti v detskih domah. In: Grigor'eva and Kemppainen (Eds. 2000), pp. 75-77.
Shipitsyna, Ludmila M. (2007): Psychology of Orphans. iUniverse Bloomington, U.S.A.
Shipitsyna, Ludmila (1999): Kehitysvammaisten aseman kohentaminen Venäjällä alkaa asennemuutoksesta. Interview in Ketju 2/1999, pp. 32-34.
Shishikin, C.V., Shevskyi V.I. (2006): Reformirovanie pervichnoi meditsinskoio pomoshsi: prepiatsviia i perspektivy. Institut ekonomiki perehodnovo perioda. Moskva. available at http:/www.iet.ru/files/text/usaid/prvich.pdf (visited 1.7.2010)
Shishkin, S.V., Chernets V.A., Chirikova A.E. (2003): Politic-economic analysis of transformation of the mechanisms of health care and education financing. Institute of economy of transition period. Moscow. *199*
Shlapentokh, Vladimir (2001): A Normal Totalitarian Society: How the Soviet Union Functioned and How it collapsed. M.E. Sharpe, Armonk.
Shlapentokh, Vladimir (1989): Public and Private life of the Soviet People Changing values in Post-Stalin Russia. Oxford University Press, Oxford.
Silverman, David (2000): Doing Qualitative Research A Practical Handbook. SAGE Publications.
Simpura, Jussi (1998): Social policy in rapid social and political change: theoretical perscpectives. In: Turuntsev and Simpura (Eds. 1998), pp. 5-22.
Simpura, Jussi (1995): An Introduction. In: Simpura (Ed. 1995), pp. 5-22.
Simpura, Jussi (Ed. 1995): Social Policy in Transition Societies Experiences from the Baltic countries and Russia. Experience from the Baltic countries and Russia. The Finnish ICSW Committee The Finnish Federation for Social Welfare, Helsinki.
Simpura, Jussi, Eremitcheva Galina, Evdokimova Elena, Mannila Simo, Nosova Tatjana, Pakkasvirta Teela, Poretzkina Evguenia. (1999): No Limits to Patience? Experiences of the Russian Economic Crisis of 1998 in the Everyday Lives of Ten Middle-Class Families in St Petersburg. Idäntutkimus 2/1999, pp. 49-68.

Sinitsyna, Valentina (1995): Karjalan tasavallan sosiaali- ja terveydenhuollon uudistus. In: Kemppainen and Grigor'eva (Eds. 1995), pp. 25-26.
Skvortsova, Anna (2007): NGOs in Russia. Presentation in the seminar Division of Labour between State, Private Sector and Third Sector in Helsinki 2007. Available at http://cemat.aalto.fi/en/seminars/2007/02102007/.
Skvortsova, Anna (2005): Yhteistyön pietarilaiset ulottuvuudet. In: Leppänen (Ed. 2005), pp. 31-40.
Sotsial'naia rabota Vvedenie v professional'nuiu deiiatel'nost' otvetsvennyi redaktor A A Kozlov Mezhdunarodnyi proekt Moskva 2004 Социальная работа Введение в профессиональную деятельность. Международный проект, Москва, 2004. Social work Introduction into professional activities, 2004. Handbook for higher school of XXI century. A.A. Kozlov (Editor in chief). International Project 2004, Moscow.
Stake, Robert E. (1995): The Art of Case Study Research. SAGE Publications. Thousand Oaks.
Stake, Robert E. (1994): Case studies. In: Denzin and Lincoln (Eds. 1994), pp. 236-247.
Statisticheskiĭ biulleten (2006): Rynok truda: 1991-2005 gody Statisticheskiĭ biulleten Upravlenie federal'noĭ gosudarstvennoĭ sluzhby zaniatosti naseleniia po Respublike Karelia 2006. Petrozavodsk. 2006. Original in Russian: Рынок труда: в 1991-2005 годы Статистический бюллетень Управление федеральной государственной службы занятости населения по Республике Карелия. Петрозаводск. 2006.
Sutela, Pekka (2003): The Russian Market Economy. Kikimora Publications Series B:31 Helsinki 2003 Second edition. Kikimora Publications. Helsinki.
Svynarenko, Arseniy (2005): Growing to Be a Citizen: Civil Society and Youth Policies in Russian Karelia. In: Melin (Ed. 2005), pp. 77-98.
Taipale, Ilkka (Ed. 2007): 100 Social Innovations from Finland 2007 Itämerikeskussäätiö Baltic Sea Centre Foundation. Helsinki.
Taipale, Vappu and Hämäläinen Hannu (2007): Kertomuksia Sosiaalisista Innovaatioista. STAKES Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus. Helsinki.*200*
Temmes, Markku (2002): Public Administration in Transition - The role of Tacis and Phare. Presentation in 2nd Aleksanteri seminar "Western Aid and Advice to Eastern Europe - Effects and Side-effects" 29 Nov 2002. Helsinki.
Thomson, Kate (2002): Regional Welfare System Developments in Russia: Community Social Services. Social Policy & Administration Vol. 36 No 2 April 2002, pp. 105-122.
Tilastokeskus (1996): Suomen Lähialueet Karjalan tasavalta 3/1996. Tilastokeskus. Helsinki.
Tilastokeskus (1999): Suomen Lähialueet Karjalan tasavalta ja Viipurin talousalue 4/1999. Tilastokeskus. Helsinki.
Tolonen, Juha and Topornin Boris (Eds. 2000): Legal Foundations of Russian Economy. Kikimora Publications Series B:14. Kikimora Publications. Helsinki.
Topornin, Boris (2000): Constitutional Foundations of the New Russian Economy. In: Tolonen and Topornin (Eds. 2000), pp. 21-84.
Tragakes, E. and Lessof S. (2003): Health care systems in transition: Russian Federation. Copenhagen, European Observatory on Health Systems and Policies, 2003:5(3). Copenhagen.

Tsygankov, Anatoli (2004): Palatsivallankumous Kontupohjassa. Idäntutkimus 2/2004, pp.27-29.

Tsygankov, Anatoli (2001): Evolution of Political Systems in Karelia During 1989-1998. In: Laine and Ylikangas (Eds. 2002), pp. 252-281.

Turuntsev, Evgeny and Simpura Jussi (Eds. 1998): Russian Social Policy in the Early 1990s. Proceedings of the Russian-Finnish Seminar on the Development of Social Policy, 1991 to 1994. Foundation of Economic Policy. Moscow.

Turuntsev, Evgeny and Piirainen Timo (1998): Social Policy in Transition Societies: A Conclusion. In Turuntsev and Simpura (Eds. 1998), pp. 153-157.

Twigg, Judith L. and Schester Kate (Eds. 2003): Sotsial'nyĭ capital and sotsial'noe rassloenie v sovremennoĭ Rossii. Alpina. Moscow. Original in Russian Социальный капитал и социальное расслоение в современной России.

Ulkoasiainministeriö (2004): Tuesta kumppanuuteen – Suomen lähialueyhteistyön strategia 22.4.2004.

Ulkoasiainministeriö (1999): Suomen lähialueyhteistyön toimintastrategia; tarkistus 8.3.1999. Suomen ulkoasianministeriö. Helsinki. available at http://formin.finland.fi/public/default.aspx?nodeid=34827&contentlan=1&culture=fi-FI.

Ulkoasiainministeriö (1999): Ulkoasiainministeriö Kehitysyhteistyöosasto / KYO -33 Yhteenveto: Lähialuetuki, Esitetyt 1999, 17.2.1999.

Ulkoasiainministeriö (1998): Selvitys lähialueyhteistyön menettelytavoista, hallinnosta ja niiden kehittämistarpeista. Helsingin Yliopiston Tietopalvelut Oy. Helsinki.

Ulkoasiainministeriö Päätösluettelo HELD871-127 13.11.1998.

Ulkoasiainministeriö (1996): Keski- ja Itä-Euroopan toimintaohjelma Suomen lähialueyhteistyön toimintastrategia 1996. Kauppapoliittinen osasto. Keski- ja Itä-Euroopan toimintaohjelmat. Helsinki. available at http://formin.finland.fi/public/default.aspx?nodeid=34827&contentlan=1&culture=fi-FI.

Ulkoasiainministeriö Päätösluettelo 27.8.1996.

Ulkoasiainministeriö (1994): Lähialueyhteistyö Venäjän federaation kanssa; alueelliseen yhteistyöhön varatut määrärahat 11.8.1994. Päätösluettelo 23.6.1994. *201*

Ulkoasiainministeriö (1993): Keski- ja Itä-Euroopan toimintaohjelma Suomen toimintastrategia, 1993. Ulkoasiainministeriön julkaisuja 5 / 93. Helsinki. available at http://formin.finland.fi/public/default.aspx?nodeid=34827&contentlan=1&culture=fi-FI.

United Nations (2007): United Nations Department of Economic and Social Affairs Statistics Division http://unstats.un.org/unsd/publication/SeriesM/SeriesM_67rev1E.pdf.

Valente, Thomas W. (1999): Network Models of the Diffusion of Innovations. Hampton Press.

Valtionavarainministeriö (1997): Karjalan tasavallan julkishallinnon rakenne. Lähialueiden hallinnon kehittäminen 1997. Esiselvitys. Valtionvarainministeriö. Helsinki.

Valtonen, Hannu and Noro Anja (Eds. 2004): Health and Well-Being in Transition Societies. STAKES National Research and Development Centre for Welfare and Health, Helsinki.

Van de Ven, Andrew H., Polley Douglas E., Garud Raghu, Venkataraman Sankaran (2008): The Innovation Journey. Oxford University Press. Oxford.

Venäjä Yhteiskunta ja hallinto (1995): Hallinnon kehittämiskeskus. Valtionvarainministeriö Hallinnon kehittämisosasto. Helsinki.

Vihavainen, Rosa (2004): Selvitys lääninhallitusten lähialueyhteistyöstä.

Vinogradova, Yelena (2003): Gosudarstvennoe upravelenie v sotsial'noĭ sfere: neobkhodimost' i vozhmosnost' modernizatsii. In: Twigg and Schester (Eds. 2003), pp. 50-72.

Vlasoff, Tiina, Laatikainen Tiina, Korpelainen Vesa, Uhanov Mihail, Pokusajeva Svetlana, Rogacheva Anastasiya, Tossavainen Kerttu, Vartiainen Erkki, Puska Pekka (2008): Ten Year Trends in Chronic Disease Risk Factors in the Republic of Karelia, Russia. European Journal of Public Health, 2008, 18(6), pp. 666-673.

Wedel, Janine R. (1998): Collision and Collusion The Strange Case of Western Aid to Eastern Europe 1989-1998. St. Martin's Press. New York.

Wejnert, Barbara (2002): Integrating Models of Diffusion of Innovations: A Conceptual Framework. Annual Review of Sociology: 2002; 28, p. 297- 326.

Weyland, Kurt (2006): Bounded Rationality and Policy Diffusion Social Sector Reform in Latin America. Princeton University Press. Princeton.

WHO (2001): The African Health Monitor January-June 2001, pp. 1-4.

Wollmann, Hellmut and Gritsenko Elena (2009): Local Self-Government in Russia - between de-centralisation and re-centralisation. Available at http://amor.cms.hu-berlin.de/~h0598bce/docs/HW-EG-2007-Local-Self-Government-Russia.pdf. Published in Ross, Cameron and Campbell, Adrian (Eds.), Federalism and Local Politics in Russia, Routledge: London, pp. 227-248

World Bank (2011): Who Governs Rural Russia? Preliminary Outcomes of the 2006 Decentralisation Reform March 2011 Available at http:/www-wds.worldbank.org/external/default/EDSContentServer/WDSP/IB/2011/03/10/00033 (visited 5.6.2011) Кто управляет сельской Россией? Предварительные результаты реформы Всемирный банк 2011, ix, 17-18.

World Bank (2002): Transition The First Ten Years Analysis and Lessons for Eastern Europe and the Former Soviet Union. The World Bank, Washington, D.C. Available http://siteresources.worldbank.org/ECAEXT/Resources/complete.pdf.*202*

Yin, Robert K. (2003): Case Study Research Design and Methods. Third Edition. Applied Social Research Methods Series Volume 5. SAGE Publications.

Yin, Robert K. (1993): Applications of Case Study Research Applied Social Research Methods Series Volume 34. SAGE Publications.

Zdravomyslova, Jelena (2005): Venäjän kansalaisjärjestöt ja kansalaisaktiivisuus Venäjälllä. In: Leppänen (Ed. 2005), pp. 204-214.

Zimin, Dmitry (2004a): Macro-level reforms and regional change in Russia. http://www.hse.fi/NR/rdonlyres/8A2D0BAF-3DCD-4948-9F78 41F91ED79FA5/0/Macro_reforms_regional_change_Russia.pdf. Published in the compilation Northwest Russia: current economic trends and future prospects. 2004.

Zimin, Dmitry (2004b): Russian Karelia: future scenarios till 2015. http://www.barentsrussia2015.net (visited 29.5.2008)

Zucker, Lynne G. (1991): The Role of Institutionalization in Cultural Persistence. In: Powell and DiMaggio (Eds. 1991), pp. 83-107.

PROJECT DOCUMENTS

All MFA's strategy documents and annual reports (1997 and 1998) are available at http://formin.finland.fi/public/default.aspx?nodeid=34827&contentlan=1&culture=fi-FI.

Aaltonen, Elli (1998): Mission report 20.-27.5.1998 EDRUS 9516 Support to the Implementation of Social and Health Care Reform in the Republic of Karelia.

Aarva, Pauliina (1994): Travel report Tiivistelmä vierailusta Petroskoissa 28.11.-2.12.1994.

Administratsiia (1996): Administratsiia Glavy Pravitel'stva Respubliki Karelia (1996) Ob utverzhdenii Primernogo polozheniia o reabilitatsionnom tsentre dlia deteĭ i podrostkov s ogranichennymivozmozhnost'iami No. 634 15 Iulia 1996.

Administratsiia Glavy Pravitel'stva Respubliki Karelia and HEDEC Otdel zarubezhnoi pomoshsi Tsentr po issledovaniiam i razvitiiu v oblasti sotsial'nogo obesbecheniia i zdravoohranennia STAKES (1995): Plan proekta Programma podderzhki reform zdravoohraneniia, sotsial'noi zashshity naseleniia v Respublike Kareliia na 1995-2000 gg. 31.3.1995.

Administratsiia predesedatelia pravitel'stva Respubliki Karelia (15.2.1995): Zaiavlenie o predostavlenii tehnicheskoĭ pomoshsi so strorony EES. Application for EU funding 15.2.1995.

Administratsiia Segezhskogo munitsipal'nogo raĭona (2007): Otchet o blagopoluchii Segezhskogo munitsipal'nogo raĭona. Karelsko-finljanskii proekt Podderzhka politiki formirovaniia zdorovogo obraza zhizni v Respublike Kareliia. Segezha 2007.

Anttila, Marja, Hämäläinen, Tapio, Rinne, Pirjo, Tsymbal, Tamara (2005): Monitorointimatka entisiin BSTF hankkeen pilotteihin.

Arrhenius, Viveca (1995): Matkaraportti Vammaispalveluryhmän tutustumismatka Karjalan tasavaltaan 28.8.-1.9.1995; tutustumiskäynnit. *203*

Cooperation in the European North (2005): International projects digest in Karelia in 2003-2005. Council of Non-governmental Organizations under the Chairperson of the Legislative Assembly of the Republic of Karelia with assistance from the LSO Tacis in Petrozavodsk and NP "Karelian Resource Centre of NGOs". Petrozavodsk.

Danilova, I., Danilovits M., Madaras A. (2010): Fighting Tuberculosis in Karelia 2008-2010 Evaluation. September 2010 Final report.

Dorshakova, Natalya (1999): Training of general practitioners, based on the practical needs of the Republic of Karelia. Presentation in the International conference Reforms on health care and social protection in the Republic of Karelia: results, conclusionsand recommendations. Petrozavodsk 27.-28.1.1999.

EC TACIS (1996): EC TACIS 1995 Technical assistance programme for Human resources / Social development Terms of Reference Support to the implementation of the social and health care reforms in the Republic of Karelia, Russian Federation. Brussels 1996.

European Commission (1996): Terms of Reference, 1996. Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia, Russian Federation. Brussels.

FILHA (2011): Comments on the evaluation report concerning the project: Fighting Tuberculosis in Karelia 2008-2010. Personal correspondence.

FILHA (2010): Fighting Tuberculosis in Karelia Final Report 1999-2010. FILHA (1998): Telefax 9.12.1998 from K Koskela to Ministry of health of the Republic of Karelia Mr Ogloblin.

FILHA (1999a): Situation analysis on Tuberculosis Control in the Karelian Republic. April 1999.

FILHA (1999b): Information of the Ministry of Health of the Republic of Carelia concerning the preliminary analysis of the TB situation together with the Finnish Lung Health Association. Telefax of 12.4.1999.

FILHA (1999c): Fighting Tuberculosis in Karelia 2000-2002 Project proposal prepared by The Karelian ministry of Health and Finnish Lung Health Association (FILHA) August 1999.

FILHA (2004?): Fighting Tuberculosis in Karelia Final Report Years 1999-2004. Prepared by Filha in cooperation with Ministry of Health, Republic of Karelia Republic TB Dispensary.

FILHA (2001): Telefax of 19.12.2001 from H Hellberg to Minister of health of the Republic of Karelia Mr. Ogloblin .

FILHA (2000): Project: Fighting TB in Karelia 2000-2002. Annual plan for the year 2000.

Finnish Red Cross (1992): Final Report Finnish Red Cross Humanitarian Assistance Programme in Russia 27.12.1991-13.7.1992. Finnish Red Cross International Development October 1992.

Fomichev, Vladimir (1995): The state of assistance to invalids in the Republic of Karelia (a brief information). Support to the Implementation of social and health care reform in the republic of Karelia. Fax to Stakes 17.10.1995.

Grigor'eva, Galina (2007): Lastensuojelu Karjalan tasavallassa. In: Oulun lääninhallitus 2007 #116. Annex 6, pp. 33- 35. *204*

Grigor'eva, Galina and Kemppainen Martti (Eds. 2000): Na blago rebenka vmeste s sem'eĭ Razvitie sistemy zashchity deteĭ v Segezhkom raĭone. Lastensuojelun keskusliitto. Periodika. Helsinki.

Hatunen, Hellevi (1999): Kadonneita kuntoutuslaitteita etsimässä. Matkaraportti 20.-23.10.1999.

Hengitys ja Terveys (1998?): Hankesuunnitelma tuberkuloosin ehkäisyn ja hoidon parantamiseksi Karjalan tasavallassa 1998-2000. http://www.ndphs.org/?database,view,project,543.

Hengitys ja Terveys (1997?): Hankesuunnitelma tuberkuloosin ehkäisyn ja hoidon parantamiseksi Karjalan tasavallassa 1998-2000.

Hämäläinen, Tapio (1997): Terveydenhuollon reformin tavoite. Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia.

Ijäs, Hannu (1999): Kunnan sosiaalitoimen asiantuntemus lähialueyhteistyössä Karjalan tasavallan sosiaalihuollon reformin kuvaus kuntatoimijan näkökulmasta. Kuopion yliopiston täydennyskoulutuskeskus.

Invalidiliitto (1999): Ystävyyttä Yhdenvertaisuutta Invalidiliiton ja Karjalan Tasavallan invalidiliiton yhteisprojekti. Loppuraportti. Helsinki.

Itä-Suomen lääninhallitus (1998): Sosiaali- ja terveydenhuollon lähialueyhteistyö Pohjois-Karjalassa Lähialueyhteistyörekisteri.

Itä-Suomen lääninhallitus (1997): Sosiaali- ja terveydenhuollon lähialueyhteistyö Joensuun palveluyksikön alueella. Lähialueyhteistyörekisteri. Sosiaali- ja terveysosasto Joensuun palveluyksikkö. Joensuu.

Joensuun yliopisto (1994): Joensuun yliopiston Karjalan tasavaltaa, Pietaria, Leningradin aluetta ja Baltian maita koskevat hankkeet vuonna 1993. Joensuun yliopiston täydennyskoulutuskeskus, Itäinnova. Helena Koivisto, Arja Kettunen, Leena Westman. Mekrijärven tutkimusasema Eira Varis.

Joensuun yliopisto (1994a): Sopimus sosiaalialan koulutus- ja tutkimusyhteistyöstä Karjalan tasavallan Aunuksen piirin, Joensuun yliopiston yhteiskuntapolitiikan ja filosofian laitoksen, Outokummun ammatillisen oppilaitoksen / Pohjois-Karjalan ammattikorkeakoulu ja Joensuun yliopiston vieraiden kielten laitoksen välillä.

Joensuun yliopisto (1994b): Sopimus sosiaalialan koulutus- ja tutkimusyhteistyöstä Petroskoin Kasvattajaopiston, Outokummun ammatillisen oppilaitoksen sosiaali- ja terveysalan koulutus (Pohjois-Karjalan ammattikorkeakoulu) ja Joensuun yliopiston yhteiskuntapolitiikan laitoksen välillä.

Joensuun yliopisto (1992a): Aiepöytäkirja sosiaalialan yhteistyön kehittämiseksi.

Kajaanin ammattikorkeakoulu. Kate –projekti (2000) Loppuraportti, sosiaali- ja terveydenhuollon kehittämisprojekti 1994-2004. Kajaani.

Kananoja, Aulikki (1999a): Impact of the Tacis project on health and social care reform in Karelia. Key note in the Concluding Conference of the Tacis Project EDRUS-9516 “Support to the Implementation of Social and Health Care Reforms in the Republic of Karelia” Petrozavodsk, January 27-28, 1999. Concluding Conference in Petrozavodsk, January 1999.

Kananoja, Aulikki (1999b): Karjalan Reformista kannattaa oppia. An unpublished article. March-April 1999. *205*

Kananoja, Aulikki (1999c): Telefax to D Leitch no date.

Kananoja, Aulikki (1998): Sosiaali- ja terveydenhuollon reformi Karjalassa: Lähipalveluja kehittämällä syrjäytymistä vastaan. Presentation at a seminar Pohjois-Suomi ja Luoteis-Venäjä yhteistyössä sosiaali- ja terveydenhuollossa syrjäytymisen ehkäisemiseksi 26.5.1998.

Kananoja, Aulikki (1997a): Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia, Russian Federation. Mission Report 1.-10.12.1997.

Kananoja, Aulikki (1997b): Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia, Russian Federation. Mission Report 1.-10.12.1997.

Kananoja, Aulikki (1995b): Minutes of the meeting of the project groups of the “Programmes for development of health care and social protection in the Republic of Karelia in 1995- 2000”.

Kansanterveyslaitos (2003?) Kansanterveyslaitoksen epidemiologian ja terveyden edistämisen osaston lähialueyhteistyö Kroonisten tautien ehkäisyn ja terveyden edistäminen Karjalan tasavallassa Pitkärannan piirissä Monitoring health behaviours – collaboration between Finland and the Baltic countries – project. Vuosiraportti 2002.

Kansanterveyslaitos (1994a): Raportti hankkeesta Pitkäranta-projekti Karjalan Tasavallan demonstraatio-ohjelma terveyden edistämisen ja kansantautien ehkäisyn alalla.

Kemppainen, Martti (2011): Personal ecorrespondence Tuomi/Kemppainen August 2011.

Kemppainen, Martti (2009): Personal ecorrespondence Tuomi/Kemppainen 18.6.2009.
Kemppainen, Martti and Grigor'eva Galina (Eds. 1997): Yhteistuumin lapsen hyväksi 3-4. Suomalais-karjalais-virolainen lastensuojelun asiantuntijatapaaminen 10.-13.6.1996 Lohusalu 11.-15.8.1997 Segezha. Lastensuojelun Keskusliitto. Helsinki.
Kemppainen, Martti and Grigor'eva Galina (Eds.1995): Yhteistuumin lapsen hyväksi 2. Suomalais-karjalais-virolainen lastensuojelun asiantuntijatapaaminen 21.-24.8.1995 Joensuu. Lastensuojelun Keskusliitto. Helsinki.
Komitet po delam sem'i, molodozhi i detstva (1996): Letter No. 172 of 11.4.1996.
Kontseptsiia razvitiia zdravoohraneniia v Respublike Kareliia na 1999-2003 gody. Rossiiskaya Federatsiia Respublika Kareliia Predsedatel' Pravitel'stva Respubliki Kareliia (1999). Postanovlenie ot 1 aprelia 1999 No. 163.
Kärkkäinen, Marja-Leena (2011): Personal correspondence Tuomi/Kärkkäinen 12.-13.10.2011.
Kärkkäinen, Marja-Leena (2008): Presentation in the seminar in Kuusamo 16.-17.10.2008 in Oulun lääninhallitus 2008/125.
Kärkkäinen, Marja-Leena (2006?): Vammaisten lasten ja nuorten integraatio Karjalan tasavallassa. In: Oulun lääninhallitus (2006).
Kärkkäinen, Marja-Leena (1995a): Oulun läänin ja Karjalan tasavallan yhteistyöhankkeet sosiaali- ja terveydenhuollon alalla. In: Kemppainen and Grigor'eva (Eds.), pp. 33-35.
Kärkkäinen, Marja-Leena (1994): Letter of 14.1.1994.
Laatikainen, Tiina (2009a): Personal correspondence Tuomi/Laatikainen 12.6.2009.
Laatikainen, Tiina (2009b): Personal correspondence Tuomi/Laatikainen 1.7.2009.
Laatikainen, Tiina (1995?) Selvitys Kansanterveyslaitoksen ja Pitkärannan sairaalan välisestä tieteellisestä yhteistyöstä.
Lastensuojelun Keskusliitto (2000) :Vuoden 1999 toimintaa koskeva hankeraportti. *206*
Lastensuojelun Keskusliitto (1999a): Vuoden 1998 toimintaa koskeva hankeraportti.
Lastensuojelun Keskusliitto (1999b): Hankesuunnitelma vuosille 2000-2002.
Lastensuojelun Keskusliitto (1999c): Letter 21.12.1999.
Lastensuojelun Keskusliitto (1998a): Vuoden 1997 toimintaa koskeva raportti.
Lastensuojelun Keskusliitto (1998b): Hankesuunnitelma 1999-2001.
Lastensuojelun Keskusliitto (1996). Kansalaisjärjestöjen kehitysyhteistyötukihakemus vuosille 1997-1999.
Madaras, T. A., Mariandyshev A., Danilovits M. (2003): Fighting Tuberculosis in Karelia 2000-2002. Project Evaluation April 2003. The Karelian Ministry of Health and Finnish Lung Health Association.
Maryandyshev, A., Danilovits M., Madaras A. (2007): Fighting Tuberculosis in Karelia 1999-2007 Evaluation, March 2007. Final report.
MHSD, Ministerstvo zdravoohraneniia i sotsial'nogo razvitiia Respubliki Kareliia (2009): Otchet ob itogah deiatelnosti v 2008 gody i zadachah na 2009 god. Petrozavodsk 2009.
Ministerstvo obrazovaniia (1995): Perspektivi i problemy v proekte Kostomuksha (6.9.1995)
Ministerstvo obrazovaniia Karelii (1994): Osnvnye napravleniia deiatel'nosti.

Ministerstvo obrazovaniia Karelii (1993?): Predlozheniia Ministerstva obrazovaniia RK v proekt programmy po sotrudnichestvu mezhdu Respublikoi Karelia i Ministerstvom sotsial'nogo obespecheniia i zdravoohraneniia v Respublike Karelia v 1994-2000 goda.

Ministertvo sotsial'nogo obezbecheniia Respubliki Kareliia (1995): Telefax concerning assistance to disabled in the Republic of Karelia (brief information) of 17.10.1995

Ministerstvo sotsial'noĭ zashchity Respubliki Kareliia (2000): Podprogramma Deti-invalidy na 2001-2003 respublikanskoĭ programmy Deti Karelii na 2001-2003 gody.

Ministerstvo sotsial'noĭ zashchity Respubliki Kareliia (1997): Predlozheniia Ministerstva sotsial'noĭ zashchity Respubliki Kareliia dliia vybora pilotnyh territorii po proektu TASIS.

Ministerstvo sotsial'noĭ zashchity Respubliki Kareliia (1995): Sostoianie pomoshsi invalidam v Respublike Kareliia (kratkaia informatsiia) 17.10.1995.

Ministerstvo sotsial'noĭ zashchity Respubliki Kareliia (1994) Predlozheniia Ministerstva sotsial'noĭ zashchity Respubliki Kareliia po sovmestnoi rabote s Finskoi storonoi v ramkah "Programmy razvitiia zdravoohraneniia i sotsial'nogo obecpecheniia Respubliki Kareliia na 1995-2000 gg" Petrozavodsk 1994.

Ministerstvo zdravoohraneniia Karel'skaia ASSR (1994): Informatsiia dlia uchastnikov rabochei vstrechi po podgotovke "Programmy razvitiia zdravoohraneniia i sotsial'nogo obecpecheniia v Respublike Kareliia na 1994-2000 g.

Ministerstvo zdravoohraneniia i sotsial'nogo razvitiia Respubliki Karelia Otchet itogah deiatel'nosti v 2008 gody i zadachah na 2009 god. Petrozavodsk.

Ministerstvo zdravoohraneniia Karelii (2002): Polozhenie ob organizatsii deiatel'nosti VOP (semeĭnogo vracha) #350 of the MoH of 20.11. 2002.

Ministerstvo zdravoohraneniia Respubliki Kareliia 1997(?): Spravka po rezul'tatam ekspertnoĭ otsenki Programmy tehnicheskoĭ pomoshchi Evropeĭskogo Soiuza v ramkat Programmy TASIS *207*

Ministerstvo zdravoohraneniia Karelii (1995a): Telefax to STAKES HEDEC on 16.8.1995.

Ministerstvo zdravoohraneniia Karelii (1995b): Telefax to STAKES HEDEC on 19.9.1995.

Ministerstvo zdravoohraneniia Karelii (1994a): Osnovnye napravleniia razvitiia sluzhby okhrany zdorov'ia deteĭ v respublike Karelia do 2000 g.

Ministerstvo zdravoohraneniia Karelii (1994b): Kontsptsiia ohrany materinstva i detstva v respublike Kareliia na period 1995- 1997 gg.

Ministry for Foreign Affairs of Finland MFA (1995): Finland's economic assistance programme to CEEC and CIS. Evaluation carried out by Finnconsult.

Ministry of Health of Karelia (1999): Information of the Ministry of Health of the Republic of Carelia concerning the preliminary analysis of the TB situation together with the Finnish Lung Health Association.

Ministry of Health of Karelia (1995): Information for the meeting planning the "Programme for development of health care and social protection of the Republic of Karelia in 1994-2000". Helsinki 2.-6.1.1995.

Ministry of Social Affairs and Health (2003): Action Plan for Co-operation with Areas in North-West Russia and the Baltic States in the Field of Social Protection and Health 2003-2005. Publications 2003:4. Helsinki.

Moiseev, Anatoly (2001): Local Capacity Building to Improve Programme Co-ordination: Example from Karelia. Northern Dimension Forum, 22-23 October 2001, Lappeenranta, Finland.

Murray, Scott (1997): Mission report April 4-21, 1997. To work on developing the training of General practitioners.

National Public Health Institute (1996a): Project plan: Finnish-Karelian Collaboration for Chronic disease prevention and Health promotion in the Republic of Karelia 1995-2000. June 1996. Draft.

National Public Health Institute (1994b): Draft 4.12.1994 Project plan The Pitkäranta project: A communitybased demonstration project for integrated prevention of major non-communicable diseases and promotion of health in Pitkäranta district, Republic of Karelia (Russia)Pitkäranta Central Hospital National Public Health Institutie North Karelia Project.

Oulun lääninhallitus (2008) Julkaisu No. 125. Terveellinen ja turvallinen lähiympäristö lapsille ja nuorille. Lähialueyhteistyöseminaari Kuusamo 15.-16.10.2008 Oulu.

Oulun lääninhallitus (2007): Julkaisu No. 116 Lastensuojelun ja perhetyön kehittäminen. Lähialueyhteistyöseminaari Petroskoi 30-31.8.2008. Oulu.

Oulun lääninhallitus (2005): Publication No. 106. Annex 5. Karjalan tasavallan terveydenhuollon, sosiaalikehityksen ja urheilun varaministerin Seniukovan V.J. puheenvuoro aiheesta Sosiaalipalvelujen kehittämisen näkymät Karjalan tasavallassa. Oulu 2005.

Oulun lääninhallitus (1995): Aiesopimus sosiaalityön kehittämisestä (”Kostamus-projekti”) Oulun läänin hallituksen ja Karjalan tasavallan opetusministeriön välillä. 16.3.1995.

Oulun lääninhallitus (1994a): Memorandum of 14.1.1994

Oulun lääninhallitus (1994b): Projektisuunnitelma 4.4.1994.*208*

Oulun lääninhallitus (1994c): Suomalais-Karjalais-Virolainen asiantuntijatapaaminen lastensuojelusta Kostamuksessa 16.-20.5.1994. Lisätietoa sosiaaliaktiviteeteista Kostamuksessa projektin alkuaikoina.

Oulun lääninhallitus (1993a): Esittelykirje Karjalan ja Kostamuksen kaupungin sosiaalitoimen ja alan koulutuksen yhteistyö- ja kehittämisprojekti. Letter to the Ministry of Internal Affairs # A 155 170 15.3.1993.

Oulun lääninhallitus (1993b): Aiepöytäkirja sosiaalitoimen ja alan koulutuksen yhteistyöstä Karjalan tasavallan ja Oulun läänin välillä 15.4.1993

Oulun lääninhallitus (1993c): Vammaishuollon Kostamus-seminaari 17.-19.1.1994 Vammaiset lapset Suomessa ja Karjalassa –liittyviä luentoja

Oulun sosiaalialan oppilaitos (1994) Oulun sosiaalialan oppilaitoksen suunnitelma kaksivuotisen sosiaalialan koulutuksen järjestämisestä Kostamuksessa. 10.6.1994.

Parkkali, Liisa (1999): Travel report to Karelia on 23.-28.1999.

Pohjois-Karjalan Projektien tuki ry (1997?): Projektisuunnitelma EU:n Karjala Interreg II –ohjelma Toimintalinja 2: osaaminen ja lähialueyhteistyö Kahden Karjalan terveysprojekti.

Pohjois-Karjala projekti (1996): Pitkäranta-projekti – Terveyden edistämisen lähialueyhteistyöhanke Karjalan tasavallassa Pitkärannan piirissä 12.10.1996.

Pohjois-Karjala projekti (1994?) Raportti hankkeesta Pitkäranta-projekti Karjalan tasavallan demonstraatio-ohjelma terveyden edistämisen ja kansantautien ehkäisyn alalla.

Pohjois-Karjalan lääninhallitus (1994?): Sosiaali- ja terveysalan lähialueyhteistyö Neuvottelut ja yhteistyön alku. Muistio.

Pohjois-Karjalan lääninhallitus (1993): Pohjois-Karjalan lääninhallituksen ja Karjalan Tasavallan sosiaaliturvaministeriön ja terveysministeriön välinen Aiepöytäkirja yhteistyöstä sosiaali- ja terveydenhuollon alalla 1993-1995.

Pohjois-Karjalan Lääninhallitus (1993a): Pohjois-Karjalan lääninhallituksen sosiaali- ja terveysosaston ja Karjalan tasavallan sosisaaliturvaministeriön neuvottelu yhteistyösopimuksesta sosiaalialalla. Muistio 19.7.1993.

Pokusaeva, Svetlana (1999): New Types of Prevention of Chronic Non-infection Diseases in Pitkaranta District. Presentation at International conference Reforms on health care and social protection in the Republic of Karelia: results, conclusions and recommendations. Petrozavodsk 27.-28.1.1999.

Rossiĭskaia Federatsiia Federalnyĭ zakon Ob obshchih printsipah organisatsii mestnogo samoupraveleniia v Rossiĭskoĭ Federatsii No. 131-ФЗ ot 6 oktiabria 2003 goda.

Personal correspondence (2008?): STAKES projects in the Republic of Karelia. Assessment of the projects implemented by STAKES.

Pösö, Hannu, Parkkali Liisa, Pääkkö Kari (2003): Report on Supervisory Visit to Karelia on 25-31.5.2003. http://www.baltichealth.org/cparticle77142-7717a.html (visited 25.8.2004)

Postanovlenie No. 196 of 19.8.1994. Postanovleniie Predsedatelia Pravitel'stva Respubliki Kareliia ot 19 avgusta 1994 goda Polozhenie o Ministerstve sotsial'noi zashsity Respubliki Kareliia.

Protokol (1995a): Protokol sovmestnogo karelsko-finskogo seminara v Helsinki 22.-24.5.1995. *209*

Protokol (1995b): Zasedaniia karel'skoi proektnoi gruppy i rukovoditelei grupp 28.11.1995g. Programma podderzhki reform zdravoohraneniia i sotsial'noi zashsity v respublike Karelia 1995-2000 gg.

Räisänen, Anu (1995): Matkaraportti Karjalan tasavaltaan 12.-16.6.1995 Karjalan tasavallan sosiaali- ja terveydenhuollon uudistusten tukeminen vuosina 1995-2000. Henkilöstön kehittäminen –alaprojekti.

Saavalainen, Tapio (2009): Personal correspondence Tuomi/Saavalainen 1.7.2009.

Saavalainen, Tapio (2008): Personal correspondence Tuomi Saavalainen 16.1.2008.

Salo, Petri (2007) Suomen lähialueyhteistyö. Tiedotustilaisuus alueiden välisistä kansainvälisistä yhteistyön ohjelmista, Lahti 4.9.2007.

Salovaara, Kristiina (2011): Personal correspondence Tuomi/ Salovaara on 28.3.2011.

Salovaara, Kristiina (2009a): Personal correspondence Tuomi/ Salovaara on 25.6.2009.

Salovaara, Kristiina (2000): Travel report to Karelia 30.10.-3.11.2000.

Seniukova, Vera (2005): Sosiaalipalvelujen kehittämisen näkymät Karjalan Tasavallassa. Presentation in the seminar in Oulu on 22.-24.8.2005 Available http://www.intermin.fi/lh/biblio.nsf/FCF45D0B9FCA5769C2257228003C909A/$file/Julkaisu_106.pdf (visited 18.1.2009)

Seniukova, Vera (2000): Realizatsiia proekta Razvitie sistemy sotsial'noĭ zashchity deteĭ v Segezhkom raĭone (1997-1999 gody). In: Grigor'eva and Kemppainen (Eds. 2000), pp. 8-14.

Seniukova, Vera (1998): The Segezha model in family social work in Aaltonen 1998.
Sergeeva, Irina (2007): Presentation in the neighbouring area seminar in Kuusamo 4.-5.6.2007.
Sergeeva, Irina (2002): Presentation in the neighbouring area seminar in Kuhmo on 28.-29.5.2002.
Sosiaali- ja terveysministeriö (1996): Matkaraportti kansliapäällikön virallisesta vierailusta Karjalan tasavaltaan 13.-15.10.1996.
Sosiaali- ja terveysministeriö (1995): Karjalan tasavallan ja Suomen välinen yhteistyö Karjalan tasavallan sosiaali- ja terveydenhuollon uudistusten tukemiseksi vuosina 1995-2000. Sosiaali- ja terveysministeriön asiantuntija-apu hankkeelle.
Sosiaali- ja terveysministeriö (1993) Sosiaali- ja terveysministeri Jorma Huuhtasen virallinen vierailu Karjalan Tasavallassa 1.-4.9.1993.
Sosiaali- ja terveysministeriö (1993a): Käytöstä poistettujen sairaalatarvikkeiden vienti Viroon ja Suomen lähialueille Venäjän Federaatiossa. Loppuraportti 30.12.1993.
Sosiaali- ja terveysministeriö (1993b): Sosiaali- ja terveysministeri Jorma Huuhtasen virallinen vierailu Karjalan Tasavallassa 1.-4.9.1993.
Sosiaali- ja terveydenhuollon lähialueyhteistyö Pohjois-Karjalassa. Lähialueyhteistyörekisteri. http://www.intermin.fi/suom/laanit/islh/laluere.html#tektyö
STAKES (2006): Final report Republican Resource Centre for Development of local social and health services in Karelia 2004-2006. Stakes. Helsinki.
STAKES (2005): Health Promotion and Disease Prevention in the Framework of Primary Health Care Development in the Republic of Karelia. Progress report 2005. Stakes. Helsinki. *210*
STAKES (1999): "Support to the Implementation of Social and Health Care Reforms in the Republic of Karelia, Russian Federation. EDRUS9516. Final Report.
STAKES (1998): Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia. Contract 96-5600.00. Extension plan 10.7.1998.
STAKES (1996a): Support to the Implementation of the Social and Health Care Reform in the Republic of Karelia, Russian Federation. Tacis project proposal.
STAKES (1996b): Bilateral project: Support to the Implementation of social and health care reform in the republic of Karelia, 1996. Annual Report for 1996. STAKES International Development Collaboration.
STAKES (1995): Karjalan Tasavallan sosiaali- ja terveydenhuollon uudistusten tukeminen 1995-2000. Vammaispalvelujen kehittäminen Karjalan Tasavallassa Vuosiraportti 1995.
STAKES (1994): Kuvaus suomalaisista sosiaali- ja terveydenhuoltoalan yhteistyö- ja avustushankkeista Karjalan Tasavallassa 1992-1994.
TACIS (1999a): Report on the outcomes of the Tacis project "Support to the Implementation of Social and Health Care Reforms in the Republic of Karelia, Russian Federation. (Analysis, conclusions and recommendations) Petrozavodsk.
TACIS (1999b): Materials of the concluding conference.
TACIS (1999c): Human Resource development in the social and health care sectors. Human Resource Development Strategy. Petrozavodsk. Unpublished.
TACIS (1998): Information bulletin 3-4, 1998.

TACIS (1997a): Information bulletin 1/1997.
TACIS (1997b): Information bulletin 2/1997.
TACIS (1997c): Information bulletin 5/1997.
Tacis Moscow (1998): Monitoring Reports No 4, No 5.
Tacis Moscow (1997): Monitoring reports No 1, No 3.
The Conception of Professional Training and Skills Improvement for Social Workers in the Republic of Karelia (1997). Petrozavodsk 1997.
Turpeinen, Aune (1995): Karjalan tasavallan sosiaali- ja terveydenhuollon reformin tukeminen. Matkaraportti 12.-16.6.1995.
Ulkoasiainministeriö (2004): Ulkoasiainministeriö Itäosasto ITÄ-24. Suomen lähialueyhteistyön strategia. Muistio 8.4.2004. Liite 1. Lähete HEL0574-26 22.4.2004.
Ulkoasiainministeriö (2008): Personal correspondence Hyrkkänen/Tuomi 29 January 2008.
Van Andel, Frans (1997): Health care financing and organisation in Karelia. Report on mission in April 1997. Support to the Implementation of the Social and Health Care Reforms in the Republic of Karelia.

NEWSPAPERS AND JOURNALS

Doverie

13.05.2000 Opyt Segezhan odobren.

Helsingin Sanomat

29.11.2010 Lääkäri tulee usein ulkomailta.
21.08.2009 Vallanpitäjiä valvova aktivismi uhkaa painua Venäjällä maan alle
08.07.2009 Venäjän muutoksia saadaan dottaa vielä pitkään
25.03.2009 Lähialueiden tuberkuloosista kannettava huolta Suomessakin
03.07.2008 Pohjois-Karjalan kuntiin omalääkäri Venäjän Karjalasta
23.08.2004 Pitkärannan terveydenhuolto kelpaa malliksi muulle Venäjälle

Idäntutkimus, The Finnish Review of Eastern European Studies

3/2009 Laatikainen Tiina: Terveystilanne Karjalan tasavallassa
2/2004 Kortelainen Jarmo: Luottamus venäläisessä tehdasyhdyskunnissa; Kosonen Riitta: Yritysten sopeutuminen Viipurissa; Rautio Vesa: (2004) Kontupohja – paternalismin kukkanen; Tsygankov Anatoli: Palatsivallankumous Kontupohjassa.
2/2003 Alanen Ilkka, Nikula Jouko, Granberg Leo and Kopoteva Inna: Monitoimisuutta ja palstaviljelyä – maaseudun sopeutuminen kapitalismiin Venäjän Karjalassa; Eskelinen Heikki and Zimin Dmitry: Karjalan talouskurimuksesta kehitysuralle; Kangaspuro Markku: Mielikuvien Karjala; Laine Antti: Karjalan tutkijan vuosikymmeniltä
3-4/2000 Palosuo Hannele: How Good is ”Normal” Health? An Exercise in Russia-Finnish Comparative Survey Methodology; Mannila Simo, Nosova Tatjana, Pakkasvirta Teela, Poretzkina Evgenia,Simpura Jussi: Where Did the Ideology of the Social Welfare Contract Go? Conjecture on development of Public Opinion Based on Interviews of St. Petersburg Families in 1998-2000
2/1999 Liborakina Marina, Rotkirch Anna: Social Consequences of the 1998 Crisis in Russia: Household Strategies and Their Challenge to Municipal Social Policy; Simpura Jussi, Eremitcheva Galina, Evdokimova Elena, Mannila Simo, Nosova Tatjana, Pakkasvirta Teela, Evguenia Poretzkina: No Limits to Patience? Experiences of the Russian Economic Crisis o f1998 in the Everyday Lives of Ten Middle-Class Families in St Petersburg
4/1998 Sarhimaa Anneli: The Divisive Frontier: The Impact of the Russian-Finnish Border on Karelia;
4/1995 Piirainen Timo; Social Policy Models and Reform Objectives in the CIS Countries: The Ukraine as an Example
1/1994 Gerner Kristian and Hedlund Stefan: Homo Oeconomicus Meets Homo Sovieticus

Karelia

04.10.2000 Na blago rebёnka vmeste s sem’eĭ.
18.01.1996 Budem zdorovy

Karjalainen

13.08.2007 Sydän- ja verisuonikortti kaikille Karjalassa
07.08.2006 Miljoona vähemmän joka vuosi
27.04.2005 Tuhoisat tavat lyhentävät elämää Karjalassa
10.05.2002 Sairauksien ehkäisy orastaa Pitkärannassa
14.12.1996 Tupakoinnin lopettaminen toi palkintomatkan Suomeen

Karjalan Maa

02.11.1995 Lähialueyhteistyöhankkeissa mukana noin 40 eri tahoa.
14.10.1994 Karjalan lapsista yhä useampi sairas.

Karjalan Sanomat

31.03. 2010 Terveysministeri Elmira Zilber uskoo, että terveydenhuolto voisi toimia paljon tehokkaammin kuin se toimii nyt
11.07.2007 Louhen piirin terveysohjelma etenee vähitellen
16.11.2006 Terveydenhuollon sekamuodosta täytyy luopua.
06.11.2002 Hyvät perhelait eivät toimi
31.08.2002 Usko omiin voimiin kuolee viimeisenä
06.04.2002 Pahimpana esteenä epätäydelliset lait
20.03.2002 Tuotanto nousi, mutta väestön reaalitulot jäivät ennalleen
16.03.2002 Tuberkuloosi ei tunne rajoja
27.02.2002 Karjalan maaseudulle on luotu omalääkärimalli.
26.01.2002 Karjalan ulkoministeriö kehittää yhteistyötä EU:n kanssa
21.02.2001 Uusi verolaki ja energianlähteiden kallistuminen vaikuttavat kielteisesti tuotannon kannattavuuteen
03.02.2001 Budjetti – 2001: Toimitaan tulojen lisäämiseksi
19.07.2000 Lasten hyväksi yhdessä perheen kanssa Segezhan piirissä toteutetun lastensuojelun projektin tulokset julki
05.07.2000 Perhelääkärien toiminnalla ei ole lakipohjaa
25.03.2000 Poverty
09.02.2000 Karjalassa taistellaan tuberkuloosia vastaan yhteistyössä Suomen kanssa
19.01.2000 Palkat, hinnat ja väestön toimeentulo

Severnyi Kur’er

31.10.1997 Umiraiut ot Tuberkulez
07.01.1993 Ot kogozhdut pomoshcni?

Ketju

2/1999 Kehitysvammaisten aseman kohentaminen Venäjällä alkaa asennemuutoksesta. p. 32-34
2/1999 Yhteistyö viranomaisten kanssa tuo tuloksia. p. 34

Sydän

5/2001 Lähialueyhteistyö ehkäisystä kuntoutukseen pp. 34-35

The New York Times

03.12.2000 An Ailing Russia Lives a Tough Life That's Getting Shorter The project "Struggle against tuberculosis in Karelia" http://gov.karelia.ru/gov/ Power/ Ministry/Health/021202_e.html. 13.5.2010

The Wall Street Journal

14.01.2003 Finns find a Fix for Heart Disease: Vast Group Effort

University of Joensuu Karelian Science Centre

The Republic of Karelia in 2006. May 2007. Joensuu.

Biannual Reviews. The Republic of Karelia 2003. Joensuu

The Republic of Karelia in 2001 Bi-annual monitoring review. May 2002. Joensuu

The Republic of Karelia in the first half of 2002. Biannual monitoring review. November 2002. Joensuu

The Republic of Karelia in the 90's. December 2000. Biannual Review. Joensuu.

AUTHORS OF THE HEALTHS SYSTEMS IN TRANSITION REVIEWS

(below is used the citation suggested in the publications)

Albania: Nuri, B. In: Tragakes, E., ed. Heath care systems in transition: Albania. Copenhagen, European Observatory on Health Care Systems, 2002: 4(6).

Armenia: Hakobyan T, Nazaretyan M, Makarova T, Aristakesyan M, Margaryants H, Nolte E. Armenia: Health system review. Health Systems in Transition, 2006; 8(6): 1–180.

Azerbaijan: Holley J, Akhundov O, Nolte E. Health care systems in transition: Azerbaijan. Copenhagen, WHO Regional Office for Europe on behalf of the European. Observatory on Health Systems and Policies, 2004.

Belorussia: E. Richardson et al. Belarus: Health system review. Health Systems in Transition, 2008; 10(6): 1–118.

Bosnia and Herzegovina: Cain, J. et al. In Cain, J. and Jakubowski, E., eds. Health care systems in transition: Bosnia and Herzegovina. Copenhagen, European Observatory on Health Care Systems, 4(7) (2002).

Bulgaria: Georgieva L, Salchev P, Dimitrova S, Dimova A, Avdeeva O. Bulgaria: Health system review. Health Systems in Transition, 2007; 9(1): 1–156; Koulaksazov, S. et al. in Tragakes, E. (ed.) Health care systems in transition: Bulgaria. Copenhagen, European Observatory on Health Care Systems, 5(2) (2003).

Croatia: Voncina L, Jemiai N, Merkur S, Golna C, Maeda A, Chao S, Dzakula A. Croatia: Health system review. Health Systems in Transition, 2006; 8(7): 1–108.

Czech Republic: Bryndová L, Pavloková K, Roubel T, Rokosová M, Gaskins M and van Ginneken E. Czech Republic: Health System Review. Health Systems in Transition. 2009; 11(1):1-122

Estonia: Koppel A, Kahur K, Habicht T, Saar P, Habicht J and van Ginneken E. Estonia: Health system review. Health Systems in Transition. 2008; 10(1): 1-230; Jesse M, Habicht J, Aaviksoo A, Koppel A, Irs A, Thomson S. Health care systems in transition: Estonia. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.

Georgia: Gamkrelidze Amiran, Atun Rifat, Gotsadze George, MacLehose Laura, McKee Martin Georgia. Health Care Systems in Transition, 2002.

Hungary: Gaál P. Health care systems in transition: Hungary. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.

Kazakhstan: Kulzhanov M, Rechel B. Kazakhstan: Health system review. Health Systems in Transition, 2007; 9(7): 1–158.

Kyrgyzstan: Ibraimova A, Akkazieva B, Ibraimov A, Manzhieva E, Rechel B. Kyrgyzstan: Health system review. Health Systems in Transition, 2011; 13(3):1–152.

Meimanaliev A-S, Ibraimova A, Elebesov B, Rechel B. Health care systems in transition: Kyrgyzstan. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005.216

Latvia: Tragakes E, Brigis G, Karaskevica J, Rurane A, Stuburs A, Zusmane E, Avdeeva O and Schäfer M. Latvia: Health system review. Health Systems in Transition. 2008; 10(2): 1–253.

Lithuania: European Observatory on Health Care Systems Health Systems in Transition Lithuania 2000

Moldova: Atun R, Richardson E, Shishkin S, Kacevicius G, Ciocanu M, Sava V and Ancker S. Moldova: Health system review. Health Systems in Transition. 2008; 10(5): 1–138.

Mongolia: T. Bolormaa et al. Mongolia: Health system review. Health Systems in Transition, 2007; 9(4): 1–151.

Poland: Kuszewski K, Gericke C. Health Systems in Transition: Poland. Copenhagen,WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005.

Romania: Vlădescu C, Scîntee G, Olsavszky V, Allin S and Mladovsky P. Romania: Health system review. Health Systems in Transition, 2008; 10(3): 1-172; European Observatory on Health Care Systems Health Systems in Transition Romania 2000;

Slovakia: Hlavačka S, Wágner R, Riesberg A. Health care systems in transition: Slovakia. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.

Slovenia: Albreht T, Turk E, Toth M, Ceglar J, Marn S, Pribaković Brinovec R, Schäfer M, Avdeeva O and van Ginneken E. Slovenia: Health system review. Health Systems in Transition 2009; volume 11(3): 1-168.

Tajikistan: Khodjamurodov G, Rechel B. Tajikistan: Health system review. Health Systems in Transition, 2010, 12(2):1–154; EuropeanObservatory on Health Care Systems Health Systems in Transition Tajikistan 2000

The former Yugoslav Republic of Macedonia Gjorgjev D, Bacanovic A, Cicevalieva Sulevski Z, Grosse-Tebbe S. The former Yugoslav Republic of Macedonia: Health system review. Health Systems in Transition, 2006; 8(2):1–98.

Turkmenistan: European Observatory on Health Care Systems Health Systems in Transition Turkmenistan 2000

Ukraine: Lekhan V, Rudiy V, Richardson E. Ukraine: Health system review. Health Systems in Transition, 2010; 12(8):1–183.; Lekhan V, Rudiy V, Nolte E. Health care systems in transition: Ukraine.Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.

Uzbekistan: Ahmedov M, Azimov R, Alimova V, Rechel B. Uzbekistan: Health system review. Health Systems in Transition, 2007; 9(3): 1–210.217

WEBSOURCES

Agreements

FINLEX, Valtiosopimukset:62/1992. http://www.finlex.fi/fi/sopimukset/sopsteksti/1992/19920062/19920062_2 read 21.3.2009

Albania

http//albania.usaid.gov/?fq=brenda&m=shfaqart&aid=57&kid=52&tit=Local_Government_and_Decentralization_in_Albania_%28LGDA%29

Bosnia and Herzegovina

http://www.ohr.int/dpa/default.asp?content_id=380

Croatia

http://ec.europa.eu/enlargement/candidate-countries/croatia/financial-assistance/index_en.htm.

Disabled, people withh disabilities, http://unstats.un.org/unsd/publication/SeriesM/SeriesM_67rev1E.pdf

European Union

http://ec.europa.eu/enlargement/the-policy/conditions-for-enlargement/index_en.htm

http://ec.europa.eu/enlargement/candidate-countries/croatia/financial-assistance/in-dex_en.htm.

http://ec.europa.eu/enlargement/candidate-countries/the_former_yugoslav_republic_of_macedonia/financial-assistance/index_en.htm.

Information on Karelia

Official site of the Government of Karelia www.gov.karelia.ru

http://www.karelia-zs.ru/history.html

http://www.gov.karelia.ru/gov/News/2010/09/0917_2_e.html

http://www.baltichealth.org/cparticle77142-7717a.html

www. karjalansanomat.ru/old news/2010/2010-03-31.html

http://www.petrsu. ru/ Chairs/socilawork_e.html.

Institutional change

http://www.mpifg.de/people/ws/downloads/Introduction_Institutional_Change.pdf

ISSA

http://<www.issa.int/Observatory/Country-Profiles/Regions

Kareliastat

http://krl.gks.ru/digital/region13/2007.zdarv1.htm, read 7.8.2009218

Macedonia
http://ec.europa.eu/enlargement/candidatecountries/the_former_yugoslav_republic_of_macedonia/financial-assistance/index_en.htm.

NGOs in Karelia
http://www.google.fi/search?hl=fi&rlz=1T4GGLD_fiFI310FI310&q=NGOs+in+Karelia+in+1990s&start=30&sa=N

Martha organisation
http://www.martat.fi/in_english/

Karjalan Sanomat
Karjalansanomat.ru/old news/2010/2010-03-31.html

Russian Federation
Federal districts: hppt://faolex.fao.org/docs/pdf/rus23848.pdf

Social Innovation
Social Innovation Centre. Hpps://soualinnovation.ca/about/social-innovation
Statistics
Kareliastat: http://krl.gks.ru/digital/region13/2007.zdarv1.htm, read 7.8.2009

TACIS
TACIS (2000): An evaluation of the Tacis country programmes in Russia Final report volume 2 January 2000: http://eu.europe.eu/europeaid/how/evaluation/evaluation_reports/reports/tacis/951500_annex_en.pdf

Tuberculosis
http://apps.who.int/globalatlas/predefinedReports/TB/PDF_Files/rus.pdf (visited 1.8.2010)
http://www.usaid.gov/our_work/global_health/id/tuberculosis/countries/eande/russia_profile.html

University of Petrozavodsk, social work
http://www.petrsu. ru/ Chairs/socilawork_e.html.

USAID support
http//albania.usaid.gov/?fq=brenda&m=shfaqart&aid=57&kid=52&tit=Local_Government_and_Decentralization_in_Albania_%28LGDA%29

Vepsian volost
http://www.cemes.org/current/LGI/158-eng.htm

World Bank
siteresources.worldbank.org/INTPOVERTY/Resources/WDR/malaysia/kolodko.pdf visited 10.2.2011219

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The updated information is available at http://<www.issa.int/Observatory/Country-Profiles/Regions<(visited 15.5.2011)

Albania

2006 National social insurance becomes compatible with international standards
1997 Introduction of a social insurance number
1996 Conditions for receipt of a survivor pension relaxed
Period of coverage extended in favour of survivors Early retirement pension for miners

Armenia

2005 Social Protection Administration Project
2001 Changes to calculation and payment of contributions
1998 Preferential treatment for mothers of large families

Azerbaijan

2010 Retirement age increased
2006 Mandatory social insurance for foreigners
Pension reform in its full implementation
Poverty reduction measures are in operation
2005 Strengthening social protection
Strengthening national social protection

Bulgaria

2011 Bulgarian Parliament adopts pension overhaul
Measures to reduce the public pension system's deficit
2010 Pension reform proposal
2006 Silver Fund
Economic and Social Development Pact
Contribution rate reduced
Introduction of a fourth pillar and increase in pensions
2003 Improvements in the social insurance system
Integrated financial supervisory agency to be created
1998 New private pension funds

Croatia

2000 New law delays implementation of pension reform

1999 Law on multipillar pension scheme passed
Plans to reform sickness insurance
Restrictions on benefits
Family benefits now state funded
1998 Court ruling forces pension increases
1997 Three tier pension system proposed
New employment act

Czech Republic

2010 Measures to stabilize the country's state-run pension system
2008 Pension reform at stage two
Cabinet approves pension reform proposals
2007 New social services package for people in need of attendance
2006 Introduction of two new benefits for children and foster parents
Amendment to disability insurance
New register of insured persons
2005 Bill on sickness insurance reform
2004 Pension reform expected for mid-2006
Changes to the competent institutions for family benefits
Changes to social security program resulting from new Employment Act
Changes in entitlement to and benefits from parental allowance
Extension of sickness insurance coverage and changes to calculation of benefits
Reallocation of contributions and changes to the minimum assessment base for self-employed
Various reforms made to strengthen pension system's finances
Public budget reform affects social security benefits
First steps toward pension reform
2003 Changes to the sickness and to the pension insurance schemes
Pension increases and changes in benefit calculation
Reform of the public budgets
Creation of state reserves
2002 Regions get more responsibilities
Changes in state social support
Social Insurance Company to be introduced
Extension of health care coverage to certain foreigners
Supplementary occupational pension insurance to be established
2001 Changes in funding and institution
Changes in pension benefit calculations
2000 New method of calculating daily sickness benefits results in higher benefits
1998 Pensions and benefits frozen for 1998
New housing and heating allowances
Reductions in family allowance - coverage and amount

Estonia

2010 Retirement aged to be increased
National Parliament adopts increase in retirement age
2009 Social guaranties reduced
Effort to reduce the financial burden of the public pension system
2006 Modification of the family allowance scheme
2005 Changes in medicine discount rates and home visit fees
2003 Changes introduced by the Health Insurance Act
Increase in childcare and pension benefits
2002 A new act on funded pensions in effect
Unemployment Insurance Act introduced
2001 Changes to social protection for unemployed persons
Subsidised medicines for persons with disabilities
Developments in old age, survivor, disability and national pensions
2000 Increase in minimum wage paid during community works
Sickness benefits now paid out by regional sickness insurance funds
1998 Changes to provision of primary health care services
Extension of rights to refugees
Increases in unemployment benefits
Increases in family allowances
Work injury reforms planned
Multi-pillar pension system to be established
1995 New Child Benefit Law
Proposal to introduce a supplementary earnings-related pension

Georgia

2005 Anti-poverty measures put into operation

Hungary

2011 Hungary adopts major overhaul of pension system
Strengthening of the public pay-as-you-go program
2009 Public pension reform package passed
2007 Reforming health care system
2006 Tax reform and its impact on social security financing
New pillar in the Hungarian pension system
2005 Reform package for the healthcare sector
2003 New insurance scheme for nursing and home care
Changes in the health care system
Changes to contributions
2002 Role of private pensions reduced
2001 Across the board increase in benefits
2000 Privatization plan
1998 Extension of coverage to independent workers
Sickness benefits for parents of sick child

Voluntary coverage for medical care
Changes in maternity benefit
Changes in employee contributions
Control of social security funds returned to government
New social identity card
New multi-pillar pension system

1997 Reductions in benefits
Changes in employers contributions
Reforms to boost pension funds
Changes in maternity benefits
Income tests for family assistance

1996 Raising of pensionable age

Kazakhstan

2005 Towards a three-pillar system
Public health system to be reformed
Further development of the funded pension system

2004 Mandatory Social Insurance in operation

2001 Targeted assistance" to people below the poverty line"

1997 Introduction of individual pension accounts

1995 Plan for the reform of the pension scheme

Kyrgystan

2005 Draft law on financing of the funded part of the pension

1999 Measures to combat poverty and develop social protection on a regional basis

1998 New three tier pension structure

Latvia

2010 Preventive disability law

2009 Cuts in social security benefits
Cuts in social security benefits
Pension home delivery becomes payable
Changes in the two-pillar pension system financing

2005 New indexation rules for state pension benefits

2004 Long-service pensions under debate

2003 Insurance periods to be extended

2001 Progress in construction of a three-pillar pension scheme

2000 Increase in retirement age

1998 Birth grant
Amendments to pension scheme

1996 Reduction in survivor benefits coverage
Patient contribution for medical care
Insurance against work injuries and occupational diseases
New Employment Fund

Social tax contributions
Funeral benefits
Employers responsible for sickness benefit
Greater availability of maternity benefits
Pension reform

Lithuania

2010 Cuts in social security benefits
2009 Effort to reduce the financial burden of the public pension system
2005 The new unemployment insurance comes in force
2004 Changes to legislation concerning occupational accidents and diseases enacted
New scheme for early retirement
Amendments to the Law on the State Social Insurance under discussion
Increase in maternity (paternity) benefits
Pension reform: shift towards the second pillar
2003 Pension system reform progresses with the vote of a first law on pension reform
Pension savings schemes to be introduced
2002 Law on Sickness and Maternity Social Insurance has been introduced
1998 Changes to survivor pension
1997 Increases in retirement ages
New health insurance scheme
1996 Sickness insurance legislation passed
1995 Income support to families in need

Macedonia

2009 Basic Healthcare for All
2005 Supplementary pension mandatory in 2006
2000 Independent sickness fund to be set up
Introduction of a three-tier pension scheme planned

Moldova

1999 Pension reform law passed

Mongolia

2001 Two-step pension reform to introduce a system based on individual savings accounts
1998 Individual pension accounts being considered
Changes in pension scheme
1996 Reforms to contribution ceilings and minimum pension rates

Poland

2009 Early retirement is over!
2006 Permanent disability pensions abolished

2005 Amendments concerning the Agricultural Social Insurance Fund
New family benefit scheme in force
One-time payments for pensioners
Increase in benefits for agricultural workers
Amendments to the structural pension program included in the law on agricultural social insurance
Procedure specified for declaring work disability in KRUS
2004 Voluntary individual retirement accounts in operation
Revised indexation of pensions
Creation of a centralized national health fund
2003 Increase in farmers' benefits
Cost-reduction proposals for pension management
2002 Legislation increases administrative control
Changes in health care contribution
Administrative implementation of reformed pension system
2001 Reform of agricultural social insurance under discussion
1998 New system of health care funds
Delay in implementing new pension system
1997 Mandatory pension funds to be introduced
1996 Employers to pay Sickness Benefits

Romania

2010 Overhaul of the public pension system to reduce budget deficit
2007 Restructuring of the pension system
2006 The private pension supervisory commission established
Creation of a multi-pillar pension system
Separation of the branches of the social security system
Changes to the indexation method of public system pensions
Revision of calculation method for public system pensions
2004 Act on privately managed pension funds approved
2001 Improvements in maternity benefits
Survivors' benefits now also payable to widowers
Separation of policy and administrative functions
2000 Increase in the minimum state pension
Plans to raise the state pension
1999 Remuneration of general practitioners
New health insurance system
Additional family benefits
1998 Revised parental leave
Reform concerning disabled retired persons
Protective measures for mass redundancies
1997 Mining accident insurance fund set up

1996 Sickness benefit reforms
New draft law on social security reform
Early retirement

Russia

2010 Plans to upgrade healthcare system
2009 Employer contribution to replace the Single Social Tax
Employer contribution to replace the Single Social Tax
New pension reform's package in Russia
State support for citizens' pension savings
Combating 'under the table' payments
National anti-crisis programme submitted by Government for public discussion
2007 Pension's objectives set by the Russian President
2006 New benefit to support childbirth
Urgent measures to be adopted to combat declining population
Oil could finance public pensions
2005 Law on the budget of the Russian Pension Fund
2004 Crucial reform on special in-kind benefits
Reduction of the Single Social Tax
Pension reform: a minimum contribution rate is established
Russian pension fund may invest in mortgage bonds
2003 The first index funds in place
Funded part of labour pension has been invested
Reformed pension system requires new logistics
Medical insurance for pensioners to be improved
Further implementation of the pension reform confronts administrative issues
Moscow child birth grant under discussion
Russian pension reform in full implementation
2002 New regulation on pension investments
New pension laws are in effect
Mandatory occupational pension insurance to be introduced
Procedure of investment to finance the funded part of the labour pensions
2001 Russian Pension Fund takes over entitlement and payment of public pensions
Government approves pension reform programme
2000 Framework law on occupational safety adopted
Single social tax
1999 Basic legislation on principles governing mandatory social insurance
Pension reform programme
1998 Proposed introduction of work injury insurance scheme

Serbia and Montenegro

2005 Pension reform project loan
2004 Expansion of the mandatory pension scheme
2003 Serbia commences pension reform

2002 Serbia plans to introduce voluntary pension insurance

Slovak Republic

2009 Measures to cushion the effect of the financial crisis on the pension system
2006 Amendments to the Act on Social Insurance
Family benefits reforms
New private pension scheme in force
2005 Package of six health care reform laws approved
2004 Introduction of old age pension savings
Change in child benefit
The social insurance system changes enacted
Reduction in cash sickness and maternity benefits
2003 Fully funded second pillar
Implementation of legal framework for the social insurance system
Increase and adjustment of pension benefits
Adjustment of parental allowance
Child benefits dependent on age group
Legal framework for the social insurance system implemented
2002 Changes to child and parental allowances
Voluntary participation in sickness insurance
Principles of social insurance to be strengthened
Changes to eligibility and benefits under unemployment assistance
Changes in employer's contribution for unemployment insurance
Unemployment insurance expands coverage
1998 Responsibility for disability decisions moved
Increases in pensions
1996 Supplementary pension funds agreed
Administration of health insurance funds
Supplementary retirement funds

Slovenia

2004 Healthcare reform plan presented to social partners
2003 Further changes to the method of pension indexation
2002 New regulation for the indexation of pensions
2001 Establishment of supplementary insurance schemes
New Act on pensions introduced
2000 New Pension and Invalidity Insurance Act changes the system substantially
1998 Changes to pension adjustment
More 'active' approach to unemployment benefit
Draft law on major reform of age and disability pensions
1996 Calculation basis modified

Tajikistan

2010 Considerable increase in minimum pension
1998 Proposed voluntary pension fund
Changes to payment arrangements
Proposed structural changes

Turkmenistan

2005 Reform of public health care system

Ukraine

2005 New pension benefit amounts established
New minimum social standards introduced
2003 Adoption of new pension laws
2001 Various acts become effective in the areas of unemployment, maternity benefits and work accident
Personal identification certificate created
2000 New regulatory body for pharmaceutical products
1999 Minimum pension
Basis created for a social insurance system

Uzbekistan

2010 Increase in benefits
2009 Increase in salaries and pensions
2005 Mandatory individual account system introduced

APPENDIX 2
QUESTIONNAIRE

Date of birth ....

Sex F M

Education ....

Work position ....

....

In total worked in the field of health care ___years, in social protection ___ years, in education ___ years

My main duties ....

....

Questions about concrete projects

1. Please mark all the projects you have heard about. (The name of the foreign actor given for orientation)

A) Investigation of the risk factors and behavioural characteristic in Pitkyaranta (1992-1994) (Institute of Public Health of Finland)
Yes No

B) Support to the Implementation of Social and Health Care Reforms in the Republic of Karelia 1997-1999 (European Commission)
Yes No

C) Fighting Tuberculosis in Karelia 1999-2004 (Finnish Lung and Health Association)
Yes No

D) The development of the child welfare system in the district of Segezha 1997-1999 (Central Union for Child Welfare)
Yes No

E) Support to the Rehabilitation centre for disabled children in Kostomuksha 1992-1994 (Province of Oulu)
Yes No

F) Support to the Implementation of the Social and Health Care Report in the Republic of Karelia in 1997-1999 (Stakes)
Yes No

2. Has your district been a pilot region of any the project mentioned below Circle the correct answer

A) Risk factors in Pitkäranta (Institute of Public Health of Finland)
Yes No Don't know

B) Support to the Implementation of the Social and Health Care Report in the Republic of Karelia in 1997-199 (European Commission)
Yes No Don't know

C) Fight against tuberculosis in 1999-2004 (Finnish Lung and Health Association)
Yes No Don't know

D) Development of the child protection in Segeza in 1997-1999 (The Central Union of Child Protection of Finland)
Yes No Don't know

E) Support to the Development of the rehabilitation Centre for disabled children in Kostomuksa in 1992-1994 (Oulu)
Yes No Don't know
F) Support to the Implementation of the Social and Health Care Report in the Republic of Karelia in 1997-1999 (Stakes)
Yes No Don't know

3.	excluded If you have participated in any of the projects mentioned, please assess how in your opinion the foreign actor took into consideration the views of the local authorities during the planning process?	very well	well	little	did not con-sider	don't know
	A)					
	B)					
	C)					
	D)					
	E)					
	F)					

4.	If you have participated in any of the projects mentioned, please assess how in your opinion the foreign actor took into consideration the views of the local authorities during the implementation process?	very well	well	little	did not con-sider	don't know
	A)					
	B)					
	C)					
	D)					
	E)					
	F)					

5. Have you personally participated in the activities of the project mentioned below?

Name of the project	participant of a seminar	expert	study tour	some other activity or role	not participated
A. Risk factors in Pitkäranta					
B. Support to the Implementation of the Social and Health Care Report in the Republic of Karelia in 1997-1999					
C. Fight against tuberculosis in 1999-2004					
D. Development of the child protection in Segeza in 1997-1999					
E. Support to the Development of the rehabilitation Centre for disabled children in Kostamuksa in 1992-1994					
F. Support to the Implementation of the Social and Health Care Report in the Republic of Karelia in 1997-1999					

No answer 11

6.	**If you have participated in some other project, please give the name of the project, time of realisation and experience gained.**	**participant of a seminar**	**expert**	**study tour**	**other role administration-member of a working group etc**	**not participated**

7.	**The aim of social sector international co-operation is to support different development processes in Karelia. Below are mentioned some processes supported by the projects mentioned earlier in this form. Please mark how well you know the listed processes.**	**very well**	**well**	**small**	**very small**	**don't know**
	investigation of the risk factors					
	development of the model of general practice					
	health care prevention					
	the model of integrated actions of health care, social and education sectors					
	division of tasks between doctors and other medical personnel					
	development of rehabilitation services for disabled children					
	development of child protection system					
	development of maternity consultations					
	creation of medico-social register					
	draining of social workers					

	education of GP's					
	training of medical personnel					
	development of primary health care					
	prevention the spread of TB					

8.	**In your opinion, what kind of influence had/have they on the development processes in your district?**	**very well**	**well**	**small**	**very small**	**don't know**
	investigation of the risk factors					
	development of the model of general practice					
	health care prevention					
	the model of integrated actions of health care, social and education sectors					
	division of tasks between doctors and other medical personnel					
	development of rehabilitation services for disabled children					
	development of child protection system					
	development of maternity consultations					
	creation of medico-social register					
	training of social workers					
	education of GP's					
	training of medical personnel					
	development of primary health care					
	prevention the spread of TB					

General questions

9.	**Social sector international cooperation is carried out in different forms. In your opinion how important are the forms mentioned below for Karelia?**	**very important**	**important**	**little**	**not important**	**don't know**
	humanitarian					
	support in development of legislation					
	consultation on some concrete questions					
	direct financial support to the government of Karelia					
	training of the personnel					
	direct financial support to districts					
	building of premises of social meaning					
	support in development of general strategies					
	purchase of equipment					
	support in creation of communications systems					
	other					

10.	**excluded** **Cooperation with foreign actors can be carried out at different levels. At what level on your opinion should the cooperation be realised in order to reach sustainable results? Please put in order of importance: 1- priority, 2- second, 3 – third place**	**1**	**2**	**3**	**don't know**
	Republic level				
	District level				
	Municipal level				

11.	**In your opinion, does the cooperation correspond to the needs of Karelia?**	**very well**	**well**	**to some extent**	**not at all**	**don't know**

12.	**To what extent do the parties mentioned below benefit from the international social sphere cooperation between EU/Finland with the Republic of Karelia?**	**very much**	**much**	**some**	**not at all**	**don't know**
	population of Karelia					
	population of the border regions of Finland					
	population of Finland					
	other subjects of RF					
	administration of the Republic of Karelia					
	foreign actors of the projects					
	personnel of the social sector of Karelia					
	the Karelian actors participating the projects					
	Some other					

13.	**Which factors in your opinion influence the success of international social sector projects?**	**very much**	**much**	**to some extent**	**not at all**	**don't know**
	Availability of local funding					
	participation of the local authorities in the project planning process					
	knowledge of local culture and traditions by the foreign partners					
	knowledge of Russian language					
	knowledge of the political and economic situation of Karelia					
	availability of foreign funding					
	common terminology					
	other					
	No answer					

14.	**excluded** **In your opinion, at what level should the decisions be taken in order to achieve sustainable results in the social sector? (1- first place, 2– second, 3 – third, 4 – fourth)**	**1**	**2**	**3**	**4**	**don't know**
	At federal					
	At republican					
	At district					
	At municipal					

15. In your opinion, what are the biggest obstacles to the development of the social sector in Karelia?

1. ....

2. ....

3. ....

16. Which achievement or activity in the frameworks of international social sphere cooperation has had the biggest influence on your personal work?

....

....

Dissemination of information

17.	**How much concrete information about the international projects in Karelia do you receive through**	**very much**	**much**	**some**	**very little**	**not at all**
	your sector ministry					
	colleagues					
	colleagues who have participated in the projects					
	foreign colleagues					
	Internet					
	the media					
	some other source?					

18.	**How regularly are you in contact (telephone, internet, telefax, meet-ings) with your ministry?**	**at least once a week**	**2 times a month**	**once a month**	**less than once a month**	**not at all**

19.	**How regularly are you in contact (telephone, telefax, Internet, meet-ings) with your colleagues from the other districts?**	**at least once a week**	**2 times a month**	**once a month**	**less than once a month**	**not at all**
	Belomorsk					
	Kalevala					
	Kem					
	Kondopoga					
	Kostomuksha					

	Lahdenpohia					
	Loukhi					
	Medvezhegorsk					
	Muzerskyi					
	Olonets					
	Petrozavodsk					
	Pitkyaranta					
	Priazha					
	Pudozh					
	Segezha					
	Sortavala					
	Suoiarvi					
	Prionezhkyi					

20.	**How often are you in contact with colleagues from other sectors in your own district?**	**at least once a week**	**2 times a month**	**once a month**	**less than once a month**	not at all

21. Would you be able to name in Karelia some people who know the international social sector projects well? (not more than 3 names). The names you give will not be shown in the results. The information will used for the examination and description of information flows in Karelia.

....

....

22. Do you receive enough information about the international projects and their results?

Yes No Don't know

Very positive, positive, neutral, negative, very negative

Cooperation with the third sector

23.	**What is your attitude toward cooperation in the social sector with the NGO's?**	**very positive**	**positive**	**neutral**	**negative**	**very negative**

24.	**What is your attitude toward co-operation in the social sector with religious organisations?**	**very positive**	**positive**	**neutral**	**negative**	**very negative**

25.	**How much information about the activities of religious organisations do you receive from**	**very much**	**much**	**some**	**very little**	**not at all**
	the mass media					
	Internet					
	meetings at work					
	from acquaintances					
	other options					

26. Do you think that the religious organisations are capable of organising effective social services? Social services does not refer to voluntary charity work but to services complementing those provided by the state or municipalities.

Yes No Don's know

27. If NGOs organise social services for the population, who in your opinion should finance these? Please tick the option you chose

The organisation itself

the State

the organisation and local authorities

local authorities

don' t know

foreign donors

28. If religious organisations organise social services for the population, who in your opinion should finance these? Please tick the option you chose

Church or the religious organisation itself

the State

the religious organisation and local authorities

local authorities

don' t know

foreign donors

29. Does the third sector provide social services in your district?

Yes No Don't know

30. Are the religious organisations active in the social field in your district?

Yes No Don't know

31. In your opinion, how could the local authorities and third sector cooperate in social field?

....

....

Comments

....

....

Thank you!

Contact details Marja Tuomi email address Telephone

APPENDIX 3
OBSERVATIONS AND COMMENTS DURING THE SURVEY IN KARELIA

	Atmosphere	Disruptive	Questions on	Comments
A	Free and open	Small room, all sitting close to each other Telephone calls People visited	3, 4, 6	“Is this anonymous?” ”A difficult questionnaire.” “Can’t remember the name of the project but it concerned smoking.” “I am from education sector and these questions concern mostly health care so I am not able to answer all of them.” “Can I name a person from my own district?”
B	Free and open	Telephone calls	10, 12, 14, 31	“Do you mean projects, processes or programmes?” “How to understand NGO?” “It is difficult to answer as I have not seen the document.” “I don’t know who benefits from the cooperation.” “I Would need to check this but can’t do it here.” Do you mean district cooperation or the whole Karelia?” “What do you mean by “in your opinion”? “I’m sure there are some reviews on this but I have not seen them.” (Q12) “Stakes’s project in Sortavala is ending. We would also like to have a project.“ “We would also like to be a pilot area.” “This is a very extensive question.” (Q31) “The district and municipal levels are the same in our country.” “I will not write anything but it would require an enormous work and preparation.” (Q31) “How could they produce social services as they need them themselves?” (Q29)
C	Superior – subordination –setting	Small room		The head of administration:” “They do not know how to answer.” “It is not fair that we need to answer so quickly.” “Interesting questions, made me think.” “Difficult questions.”

	Atmosphere	Disruptive	Questions on	Comments
D	Reserved	The head's office Telephone calls, Respondents ”thinking aloud” The respond-ents had not been in-formed prior		"It is difficult to remember the names of the projects." "I will mark only that question on which I know something." "I can´t get information by internet as don't have a computer." "How could I know this – I have worked not long in this position." "Questions concerning the third sector are difficult." "What is this third sector?" "This is my opinion but I know that many of my colleagues have a posi-tive attitude and are satisfied with the services." "Some Finns came here and offered hospital equipment and then they dis-appeared." "We would need something for the children." "The foreign donors owe nothing to us." "I have not participated in the projects – it was my colleague." "These are all our problems regardless of how you try to support us." "What is the third sector?" "We were suggested work with the church." "How could the population of Finland benefit of the cooperation?" "Pelastakaa lapset did good work here in 1990s."
F	Free and open atmosphere	Small room Clients visit the room Deep sighs Telephone calls	10, 31	"A very difficult question." (31) "Should have here somebody who has participated in the projects?" "Two of us participated in a seminar "social policy at local level." "I don't understand this question." (10) "If our ministry participates in a pro-ject, we will receive all information about it."(MOE) "Thank you for coming here – we are visited seldom as we are located so far." "Cooperation between the sectors does not work and it is a big problem."
G	Reserved and uncom-municative atmosphere	Big and cold meeting room The respond-ents had not been in-formed prior All in a hurry		"Answering is difficult as we have not participated in these projects."

	Atmosphere	Disruptive	Questions on	Comments
I	Formal, but open	Telephone calls all the time	19, 21	"I don't want to give any names." (Q21) "Difficult to answer - I communicate with all of them sometimes." (Q19) "A good questionnaire."
K	Superior – subordination –setting	Small room		"Are you really going to travel to Loukhi? It is so far." "Where can I mention the Stakes project?" "What is humanitarian cooperation?" "Does social sector include health care?" "In education sector only few projects." "This is not difficult." "The person who has participated in the project is not here." "What if I have contacted more often than once a day? " "It does not matter what I answer. Nothing can be changed."
L	Reserved, quiet, slow	The respondents came one by one, the last came 30 min after the event had started. Introduction to each of them separately, which probably disturbed the others	7	"Process – do you mean in relation to the projects or generally?" "What do you mean by duties?" "I could write many pages about the gained experiences." "We use all the time the experience we have gained, we have get good materials and we use them." "This is not a difficult questionnaire."
M	Free and open	Telephone calls, A small room, all sitting close to each other Thinking aloud		"I can't remember all this – I have to check it." "I remember that I participated in one seminar but can't remember on what and when." "I don't write anything – I will write "don't know"." "What should I write here?" "What is maternity consultancy? There is not such a term as материская консультация. I have never before heard this term, I will answer no". "We do not have internet in our rooms – only the head has." "All the money goes to the federation and to Petrozavodsk – if we could get even a small part of it." "Why should I contact any other districts?" "I will mark only those with whom I have contacted the rest I will leave empty. " "I know the Filha project."

	Atmosphere	Disruptive	Questions on	Comments
N	Free and open atmosphere	Small room, sitting too close to each other How to answer		"I can't remember weather we participated or not but we use this method (=DOTS)" "We have well educated medical personnel, don't we?" "Our district is not so attractive for the cooperation because we are not close to the border" "I have now answered to those questions I will answer" "What does M/N mean"? (MT: it comes from a Russian word "международная", international)
O	Reserved, quiet, slow	Telephone calls	8	"What kinds of effects these processes would have…" "I have not participated and will not answer" "Health care and social (=ministry) do not invite us to any seminars, but education does" "Preventive health care – I would like to know about this but don't know" "The biggest problem is that different sectors do not work together." "The federation gives the orders and the districts are often not able to fulfil them due to lack of resources." "Norway helps." "Oulu invites for seminars"
P	Superior – subordination –setting	Telephone calls	8	"Does it mean that we were a pilot territory if we participated in some seminars?" "Training of social workers – what do you mean? I have never heard about this!" "What do you mean by decision making process?" "Does this concern only the projects or all information?" "We do not have time for the development work as we have so much work to do." "We participated in those Stakes projects, didn't we" "You participated in this, do you remember?" "Where do I mention if I participated in some other project?" "Soon there is beginning a new TB project, in which we will participate" "Sometimes I feel that we (districts and republic levels) talk about totally different things." "I heard that Sortavala has participated in this project" "Who was it – that woman representing Stakes?" "I contacted other districts and they have neither received any new information." "Irina Seregeva often invites us"

	Atmosphere	Disruptive	Questions on	Comments
R	Formal, but open	Telephone calls. The re-spondents wanted to make use of the situation and discuss also work-ing business (now when we met….")	14, 19	"I did not participate in this project in Kostomuksa but on the continuation." "What do you mean by socio-medical register? " "Common agreed terminology, very important – I think we often talk about different things because understand the terms differently." "I will mark only those with whom I contact and leave the rest open." "I do not want to write any names." "What are my main tasks? I don't know."
T	Formal, but open		12, 14, 16, 19,	"Who benefit or do you mean should benefit?" "It is difficult to answer from the point of view of the whole population." "Decisions should be taken at the com-munity level but they are not and there is no money." "Do you mean projects or cooperation in general?." (Q16) "I have worked only for a couple of years, so maybe my answers are not correct." "I will mark only those I am in contact with." "The cooperation should be realised at district level." "There could be also some research cooperation in social sphere."
U	Free and open atmosphere	Telephone calls	10, 14	"We participated but not in this project – it was later." "I don't know how to answer to this question?" "Oh, I did not read the questions." "Do I have to answer right now? I would like to check all these things in order to answer correctly." "The correct answer would be republic, but unfortunately it does not work." "I do very seldom contact with the other districts, usually the heads do it." "The border regions should live better than the other due to their location."
V	Formal, but open	The head's (who is not participating in the inquiry) big room, all sitting close to each other's The head making tel-ephone calls.	6, 11	"We are a forgotten district."
X	Reserved	No discussion	-	-

APPENDIX 4
ASSESSMENT OF SUCCESS OF THE SELECTED CASES

No	Criteria	Justification	Outcome
1	At least the first phase of the project was ended.	The adoption and diffusion of an innovation often takes place only after the project has ended.	The adoption and diffusion have taken place both during the projects and after it in all cases.
2	The project either introduced or supported a social innovation as defined in this study.	Both local and introduced innovations were considered. Humanitarian aid was not considered a social innovation.	The origin of the innovation – local or external – did not affect adoption or internal diffusion.
3	The projects were to cover different geographical parts of the Republic of Karelia.	In order to examine if differences between the districts affect adoption and diffusion and information flows.	There was no case from the most northern districts of Karelia. The location of the pilot district did not seem to affect adoption or internal diffusion if the relative advantage was visible, the social innovation was feasible and the local change agents motivated and committed.
4	The projects were to be carried out both at republic and district levels.	To be able to consider if this fact influenced adoption and diffusion.	The cases in which the main local partner was from district level were adopted successfully in pilot areas; social innovations of a concrete nature and developed for certain districts with participation of the local change agents started to diffuse quickest.
5	The supported innovations were to differ from each other.	To consider how the nature of an innovation influenced adoption and diffusion.	All social innovations were considered advantageous by the local partners. The more concrete and closer to the decision-makers and end users the innovation was the better it was adopted and diffused. Adoption and internal diffusion were negatively affected if the innovation was of a systemic nature or concerned informal institutions.
6	The European change agency was to be different in each case.	To explore the role of the change agency.	The role of the external change agencies varied in all cases by stages. In some cases the CAs role was notable also in internal diffusion.
7	The projects were to differ from each other in duration and funds available.	To consider how duration and funds available affected adoption and diffusion.	The duration of the cooperation did not seem to affect external diffusion and adoption but the duration had a positive influence on internal diffusion. Project funding did not correlate with the adoption and diffusion.
8	The projects were to be realised at different times.	To study if the changes that had taken place in Karelia had influenced adoption and diffusion processes.	The time of implementation did not seem to have any influence on adoption or internal diffusion

APPENDIX 5
THE DEVELOPMENT OF THE PRIMARY HEALTH CARE AND GENERAL PRACTICE IN RUSSIA IN BRIEF

The replacement of the narrow specialist system with a system centred on general practitioners was one of the key elements of the health care reforms in the transition countries (Rese et al. 2005, 204). The concept of family medicine was not completely unknown in the Soviet Union: it had been embodied in the separate and semi-secret health service for the party and government elite (Ryan and Stephen, 1996, 488). In the order of the MOH of the USSR "About the Experiment on training of general practitioners" of 1987 (Shishkin et al. 2006, 10) the perspectives of primary health care reform were described for the first time and in 1989 the post-graduate training for GPs was started in Leningrad (Ryan and Stephen 1996, 488).

In the beginning the MOH favoured experimentation with the GP model on a voluntary and local basis but in 1992 it took a firmly pro-active stance and indicated that all regions should move to adopt the principle of family medicine[351]. In 1993, the Russian government enacted the law "Concerning the fundamentals of the Russia Federation's legislation on health care" (article 22) and conferred on all families the right to choose a family doctor to provide a service based on their place of residence (ibid.). Ryan and Stephen (1996, 487-489) questioned whether this right could be realised when the general tendency was towards regional self-determination, which affected the health care organisation.

The GP model was tested e.g. in Samara, Leningradskaia *oblast*, Karelia, Tula, Kemerovo beginning in the 1990s and the experiences were positive. However, the positive results were achieved in regions that managed to attract additional external resources, e.g. international projects and loans or where the wealthy region supported the change (Konitser-Smirnov 2003, 262). Konitser-Smirnov (2003, 248-252) notes, based on the Samara experiences, that the involvement of the local key actors in reforming the process positively affected the outcome. Adoption of the model helped to cut health care costs, which enabled the allocation of more funds to other purposes including social services (ibid.). However, the PHC reforms have remained local in Russia and no reform on the scale of the whole country has been implemented. (Shishkin et al. 2006, 15- 20.) [352]

The situation with the PHC reform in Russia remains problematic. The resistance to change is wide, including some of doctors who consider the model inadequate for the real conditions and the federal powers who have been unwilling to carry out the reforms due to the risk of exacerbating social tensions. The change from the narrow specialist system to generalists would require, at least, major investments, institutional changes and the creation of an incentive system. (Rese et. al, 2005; Shishkin et al. 2003; Shishkin et al. 2006.) Among the groups resisting are the influential chief doctors who are afraid that the reforms would lead to a

[351] "Concerning the gradual transition to the organization of primary medical care on the principle of a doctor of general practice" issued a model of curriculum, created the legal status of the new specialism.
[352] cf. Estonia (2006, 28-29) where deep changes were implemented quickly and successfully.

decrease of financing for their institutions or stimulate a flow of qualified personnel out of them. Chief doctors hold key positions in the reform and in its efficient implementation (Shishkin et al. 2006, 27). But it is not only doctors who call the new model into question. The people, patients, are not fully ready to approve new forms of health service provision. Shishkin et al. (2006, 3-8, 30-37) argue that the resistance results from a lack of information about the reform, the general low level of trust in primary health care, unwillingness for any organisational changes or simply due to pure fear of the unknown.

The newly trained staff – also social workers – has faced problems in their workplaces. They often became isolated, met major barriers in applying their new skills and opposition from the other doctors[353]. The financial structures supporting the change were missing, the equipment available was scarce, they lacked support and felt even hostility on the part of the health administration. As the position and tasks of the GPs were not clearly defined, the narrow specialists felt that their status and professional dominance was undermined, which led to boundary disputes[354]. The vague federal legislation and the lack of specific local provisions impeded implementation of the reform. (Rese et al. 2005, 204-205.) According to a survey by Rese et al. (2005, 204-206) in 2005 among the directors of 15 GP training centres operating in Russia, 75% of the trained GPs returned to work in traditional district policlinics and 5% in outpatient facilities linked to industries.

Danishevski (2005) argues that one of the reasons for the situation that emerged is the Russian education structure. With some exceptions – among which is the Karelian PSU and its medical faculty – the federal MOH is responsible for higher medical education, its coordination, and financing. The education programmes need to be approved by both the federal MOE and MOH. The problem itself comes from the mismatch between supply and demand. Most of the health care institutions belong to the local authorities, where also most of the workplaces are, while the institutions providing higher medical education are subordinate to the abovementioned federal ministries. The ministries are interested in the education of large numbers of medical doctors and "often do not orientate in the needs of the immediate employers" (часто не ориентируясь на нужды непосредственных работодателей), whereas the local authorities, who would know the real need, are not in a position to influence decisions made at federal level. Danishevski notes that the necessity of shifting to the GP system has been stated at all levels of the Russian administration but as long as the new model is not supported by the key persons there will be no funding and the implementation of the programme will be delayed. Consequently, although there was the formal decision to move to a family doctor model (GPs), in practice the actions taken in that direction at the federal level were minimal. (Danishevski 2005.)

[353] The same phenomena observed in Armenia (Shishkin et al. 2006, 27).

[354] The same kinds of problems were observed e.g. in Tajikistan and Lihuania. Also Piirainen (2005, 199 and Anttila et. al 2005, 8) note that a fear that it could result in increase of the number of unemployed special doctors.

Marja Tuomi

Diffusion of Social Innovations Across the Borders

Social Sector Cooperation with the Republic of Karelia

This study concerns international social sector cooperation and examines which factors influenced diffusion and adoption of social innovations introduced by the joint projects in the Republic of Karelia. The results show that the commitment of the local partners to the cooperation helped to overcome many practical obstacles including financial problems, and that the republic, and particularly federal support, was of crucial importance for both adoption and diffusion of innovations. The study covers the period 1992-2008.

Publications of the University of Eastern Finland
Dissertations in Social Sciences and Business Studies

ISBN 978-952-61-0637-3
ISSN 1798-5749