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Trying to be strong

A study of the impact of economy and culture on lifestyle choices and use of health care institutions in the Murmansk region of Russia



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Preface

This report presents an analysis of the challenges of fighting non-communicable diseases in the Russian Barents Region, with particular focus on lifestyles, health behaviour and use of healthcare institutions. The report is financed by the Health Co-operation Programme in the Barents Euro-Arctic Region, and administrated by the Norwegian Ministry of Health and Social Affairs

The study has been implemented by researchers from Fafo Institute for Applied International Studies (Norway), Institute of Economic Problems, Kola Science Centre (Russia) and the Norwegian Institute for Urban and Regional Research (Norway). A large number of persons have been involved in various phases of the study, and our gratitude goes out to all. Some people deserve particular mention: Elisabeth Helsing for inspiration, and interesting suggestions and recommendations along the way, and for helping to come up with the idea for the study. Yuriy Shaposhnikov for helping us get access to information and informants in the various health care institutions in Apatity, and for his great patience in explaining and describing the situation to us. Stephen Heyns and Jon Lahlum for thorough editing of language and lay out.

A number of colleagues from Fafo have been involved in the project: Aadne Aasland, took part in the initial phase of the study, and was strongly missed after he left Fafo. Anne Hatløy has provided invaluable input and suggestions for the analysis of nutrition, and, together with Trude Arnesen, provided fruitful comments for the rest of the manuscript. Research director Jon Pedersen helped seeing the potential in the data, and provided support and guidance in interpreting and using the material collected.

Finally, but most importantly, we wish to thank all our informants for sharing their stories with us. It is our hope that this report may lead to changes that can help them live a longer and better life.

In spite of all contributions and support, it goes without saying that any error or misunderstanding in this report is the sole responsibility of the authors.

Introduction

A strong increase in the incidence of both communicable and non-communicable diseases in recent years, with a subsequent increase in mortality rates, has led both researchers and politicians to talk about a crisis of the health care system in Russia. A number of factors have been presented to explain the increased mortality, often tied to changes in lifestyle and changes in the public health care system.

The long-lasting economic crisis in Russia is often blamed for the health problem. It is argued that people cannot afford to take care of their own health, and that health care institutions do not have the resources they need to provide the Russian population with adequate services. But even before the onset of the economic reforms, mortality rates were significantly higher in Russia than in other industrialised countries, indicating that at least parts of the 'health crisis' has its roots, not only in the economic crisis, but in habits and institutions that have a longer history in the Russian society (Cockerham 1997).

With this report we attempt to portray the health challenges and problems that individuals face in the Russian north, based on interviews with more than 50 ordinary Russian citizens, health care workers and representatives from public administration in the city of Apatity and a nearby village.

Our study finds that the economic problems of Russia have often changed the way people live, and that these changes often influence people's health, both positively and negatively. High mortality rates from non-communicable diseases cannot be explained solely with reference to the economic crisis – many of the major health problems in Russia today are illnesses associated with affluence rather than with poverty. Furthermore we should bear in mind that even within the framework of an economic crisis, health care workers, administrators and ordinary people make choices – choices that influence people's health for good or for bad. These choices and priorities are the focus of our report. We wish to bring attention to how the people in the Russian north think about lifestyles and health in their everyday life, and how this is reflected in the choices they make.

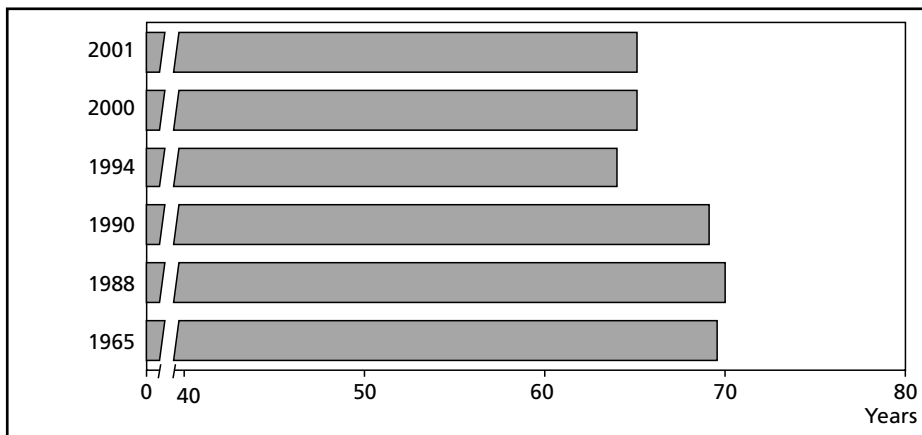
The backdrop: Low life expectancy and a high occurrence of lifestyle-related illnesses

Statistics on life expectancy at birth can be used to summarise the health and mortality conditions for a population.¹ In 2001, life expectancy at birth in Russia was 65.2 years (58.9 for men and 72.3 for women) (WHO 2002). This is low, not only relative to the wealthier European countries, but also when compared with other transitional economies. In 2001, life expectancy for men in Russia was lower than that in all other post-Soviet states, with the exception of Kazakhstan where men are expected to live 0.1 years less.

From 1988 to 1994 overall life expectancy dropped from 70 to 64 years (to less than 58 years for men and about 71 years for women), a reduction unparalleled in the peacetime experience of industrialised countries (WHO Europe 2002). From 1995 onwards there was a trend towards somewhat better health indicators, but in 1999 life expectancy fell again, and in 2002 it is still clearly below the 1990 level. (WHOSIS 2002; WHO Europe 2002).

In spite of large fluctuations in life expectancy during the 1990s, problems of low life expectancy are not new to Russia. While most European countries had an average increase in life expectancy of four years between 1970 and 1995, there had

Figure 1: Life expectancy at birth in Russia (selected years)



¹ Life expectancy at birth in a given year is a statistical calculation based on the age-specific mortality rates of that year. It reflects the number of years a child born in a particular year could be expected to live if the age specific mortality rates of that year apply throughout the child's life. Life expectancies are better than crude death rates (the raw number of deaths per 1 000 population in a given year) for comparing mortality conditions across time or place. This is because death rates can be affected by differences in population age structure, with older populations having higher crude death rates. This is not the case for life expectancy.

been no significant improvement in life expectancy in Russia for several decades prior to the 1990s. Life expectancy at birth reached a peak in 1965, at 69.6 years, and with the exception of 1987 and 1988 when it reached 69.9 and 70.1,² it stayed below this level and has declined sharply since 1990.

Russia is not different from other European countries only in having particularly *low* life expectancy, the *structure* of the mortality is different from what we find both in Europe and in other parts of the world. Most countries with a life expectancy similar to that of Russia are characterised by high infant mortality. In Russia infant mortality is relatively low, while there are extremely high mortality rates for men between 15 and 59. According to 2001 data, the mortality rate of men in this age group is 440 per 1 000. In other words, only 66% of 15-year old males are expected to reach the age of 59 (WHO 2002). Of the 191 World Health Organisation (WHO) member states, 33 countries have higher mortality rates for men in this age group than Russia. However, most of these are in Africa where Aids and other infectious diseases lead to increased mortality of adults of working age. Of all WHO member countries with probability of death for men of 400 per 1 000 or more, only Russia, Nauru, Haiti and Afghanistan are not on the African continent. Only Nauru and Russia have a combination of low infant mortality and high mortality for adults. Furthermore, Russia is peculiar in that the high mortality rates are only found for men, not women. Female life expectancy at birth is 72.3, more than 14 years longer than for men. Among women who are 15 years or older, more than 84% can expect to reach 59 years or more (compared to 66% for men). In

Table 1: Structure of mortality in the Russian Federation and other selected countries

	Life expectancy at birth (years)		Probability of dying (per 1 000)			
	M	F	Under age 5		Between 15 and 59	
			M	F	M	F
The Russian Federation	58.9	72.3	22	17	440	159
Kazakhstan	58.8	67.2	59	45	375	209
Belarus	62.9	74.2	14	11	368	134
Ukraine	62.2	73.3	18	13	183	89
Nauru	58.7	66.2	18	13	475	310
Afghanistan	41.1	43.7	252	249	527	418
Haiti	45.6	54.7	118	103	615	397
Kenya	52.3	55.0	123	107	440	383
Norway	76.1	81.4	5	4	101	60

Source: WHO 2002

² It has been suggested that the temporary improvement in life expectancy between 1985 and 1987 came as a result of reduced alcohol consumption after an anti-alcohol campaign started in 1985 by then President Gorbachev.

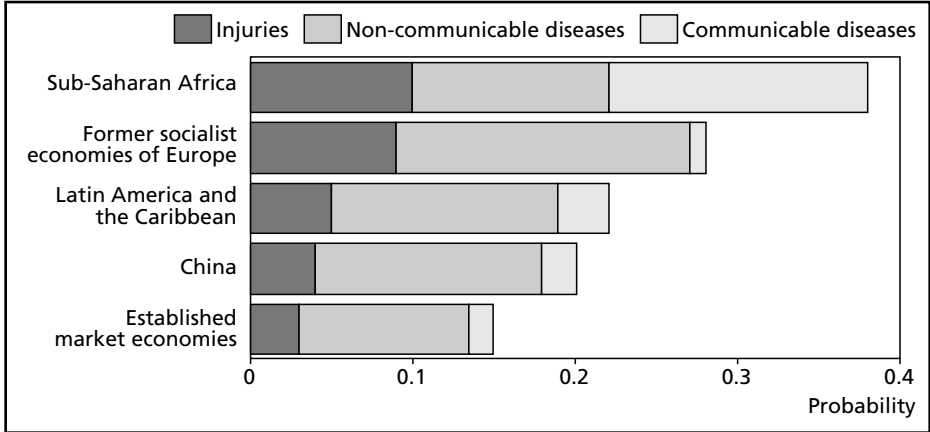
most countries men are likely to die at a younger age than their female counterparts but the situation in Russia is unique: in no other country are the differences between men and women this large (according to 2001 estimates from the WHO).

Infectious diseases are an important cause of death in most countries with mortality statistics as high as we find in Russia. In Russia, even though some infectious diseases has been on the rise in the 1990ies, deaths from infectious diseases account for just a small part of the overall mortality, while non-communicable diseases are by far the most common cause of death. By the end of the 1960s, several infectious (communicable) diseases were close to being eradicated in the Soviet Union and, as in other parts of the industrialised world, non-communicable diseases such as heart disease and cancer were on the rise. However, compared with the established marked economies of Europe and the USA, the former socialist countries of Europe were not as successful in fighting non-communicable diseases. By 1990 mortality rates for middle-aged Russian men (35–69 years old) from non-communicable diseases were among the highest in the world – nearly double the rates observed in the USA and United Kingdom (Zaridze 1999).

Since 1990 the situation in Russia has deteriorated further. The sharp increase in mortality in Russia between 1990 and 1994 affected both sexes and all age groups, but the largest increase occurred among middle-aged men. More than 75% of the decrease in life expectancy between 1990 and 94 was due to increased mortality rates of individuals in the age group 25–64 years, with cardio-vascular diseases and external causes accounting for half of the decline. (OECD 2001).

Cardio-vascular disease is the most common cause of death in most industrialised countries, and Russia is no exception in this respect. But, compared with most

Figure 2: Regional probability of death for males aged 15 to 60, 1990



Source: Zaridze 1999

of their European neighbours, Russians, and Russian men in particular, are exposed at a much earlier age.

The second most common cause of death among Russian males is external causes such as accidents, suicide, homicide and accidental poisonings. The mortality of Russian men from external causes is six times higher than for their Norwegian neighbours (WHOSIS 2002). Among Russian women, external causes is the third most common cause of death after cancer.

We should note that, during the 1990s, Russia has witnessed a re-emergence of infectious diseases such as tuberculosis and diphtheria, even polio. Sexually transmitted diseases are on the rise as well (OECD 2001). It can be argued that Russia is now fighting 'the double burden' in health care. It faces an increase in communicable diseases caused by factors common in developing countries – malnutrition, lack of clean water and lack of epidemiological surveillance. At the same time, Russia has to fight lifestyle-related illnesses common in industrialised countries, caused by stress, smoking, a high-fat diet and high alcohol consumption.

Understanding and explaining lifestyles

Based on Weber (1948), Cockerham (1997) and Palosuo (2000), lifestyles are here understood as a domain of health-related behaviour influencing consumption and living habits. Perceptions of lifestyles, illness and good health are conditioned by culture and traditions. As for other types of social action, social structures and access to resources empower and constrain health-related behaviour. But within the framework of these social structures, or life chances, individuals evaluate and choose their course of action. Lifestyles thus manifest themselves as individual, yet collectively, economically and culturally conditioned choices. Lifestyles should be understood as a combination of choices and life chances and, as good health is an important resource which can be invested in, for instance, the labour market, lifestyle choices and life chances are likely to interact and influence one another.

What is perceived as a healthy way of living varies between different cultures and social groups, and even between various traditions of medicine. Some factors, like smoking, are generally agreed to have a negative influence on health, while the impact of other factors is more disputed. In this report we do not seek to distinguish between people who have a healthy lifestyle and those who do not. Rather, we wish to give an overview of how ordinary people and health care workers reflect and act in relation to good health, and why they make the choices they do. This information is compared with recommendations put forward in modern medicine.

Cardio-vascular diseases and deaths from external causes

With industrialisation and modernisation, we have seen a steady decline in infectious diseases in large parts of the world, often explained as due to increased focus on hygiene, combined with higher literacy rates and education. But, in many countries, this decline in infectious or communicable diseases has been accompanied with a steady increase in non-communicable and often lifestyle-related diseases such as cardio-vascular disease, cancer, diseases of the lungs and liver, and non-insulin dependent diabetes. These non-communicable diseases may be referred to as diseases of 'affluence' or socio-economic modernisation, and are largely linked to lifestyle factors such as being overweight, a lack of exercise and alcohol and tobacco consumption.³

Much research has been done on the causes of cardio-vascular disease (CVD) and, even though some issues are still disputed, there is general consensus in medical research on which factors cause, or increase, the risk of these illnesses: The threat of CVD grows with age, and men seem to be more vulnerable than women. It is influenced by genetic factors, but a healthier lifestyle strongly reduces risk, even for genetically predisposed individuals. The major risk factors for CVD are generally agreed to be smoking, overweight, little physical exercise and psychological stress (Persson et al. 1998). A diet with a high level of animal (saturated) fat and sugar (especially in the absence of fruit and vegetables) increases the risk of CVD.

The relationship between alcohol and CVD is widely debated in medical literature. Much research (in particular from France and Great Britain) has indicated that *moderate* alcohol consumption reduces the risk of CVD. At the same time, a significant amount of research in Eastern Europe indicates that alcohol *increases* the risk of CVD. It is possible that differences in drinking patterns account for these divergent findings. While the population in England and France traditionally drink beer and wine relatively often, but in small quantities, the drinking pattern in Eastern Europe is often binge drinking of hard liquor.

Chenet et al. (1998) argue that the pattern of binge drinking is an important cause of the high rates of sudden cardiac death in Russia. Through analyses of Moscow City death certificates, they find that there is a significant increase in deaths from alcohol poisoning, accidents, violence *and cardiovascular diseases* on Saturdays, Sundays, and Mondays. This is especially marked for sudden deaths. This pattern is consistent with the known pattern of increased drinking in Russia over weekends. As they found no other obvious explanations for this weekend-related increase, Chenet et al. conclude that there is a causal relationship between alcohol consumption and sudden cardiovascular death. Another often-presented argument for a causal

³ By affluence we here refer to the society at large, not individuals. Cardio-vascular diseases are more common in affluent *societies* but, within these societies, the poorer segments of the population are often more at risk.

connection between cardiovascular death and alcohol consumption in Russia is the decrease in CVD mortality during the anti-alcohol campaign in the period 1985–87 (WHO Europe 1999).

High alcohol consumption is tied to increased mortality risks for other reasons as well. In the long run, alcohol may cause or contribute to chronic diseases such as liver cirrhosis while, in the short term, alcohol is linked to deaths from accidents and poisoning. It is clear that alcohol is an important factor linked to the high rate of deaths due to external causes in Russia today. In the structure of mortality from external causes, there is a striking proportion of accidental poisonings (17.5%), including 12.5% of deaths caused by alcohol poisoning. This is higher than the number of deaths from traffic accidents (11.1%, 1995 data) (WHO Europe 1999). Accidents of undetermined cause accounted for 14% of deaths, while accidental falls, drowning and other accidents accounted for 27% of all deaths from injury and poisoning. A significant number of these deaths are believed to be related to the consumption of alcohol. (WHO Europe 1999). It is worth noting that also mortality rates due to external causes were reduced during the 1985–87 anti-alcohol campaign.

Sample and methods

The main body of data used for this report was produced during three periods of fieldwork that took place between September 1999 and October 2000. In each period of fieldwork, one or two Russian-speaking Norwegian researchers lived in Apatity for up to two weeks, and worked together with Russian researchers from the Kola Science Centre to produce data. Most of the fieldwork was carried out in the form of interviews. In addition, some methods derived from Rapid Rural Appraisal, such as listing, pile-stacking and focus groups, were used.

Study groups; families with children, unemployed and industrial workers

In this study we have chosen to focus mainly on three groups that face different conditions and challenges in maintaining good health.

Firstly, we focus on families with children. Children are particularly vulnerable to incorrect nutrition and lack of medical services. At the same time, families with many children are often subject to poverty.

The second group we focus on is unemployed persons. Unemployment is associated with increased economic insecurity and stress, which increases the risk of

depression and increased alcohol consumption. Compared to families with children, this group is rarely targeted by government or other aid programmes, and is strongly dependent on family and other networks.

The last target group in this study is male industrial workers. As mentioned above, the mortality rate for Russian men between 15 and 60 was among the highest in the world by 1990, and it has increased during the 1990s. Industrial workers usually have above-average incomes in Apatity, and their lifestyle choices are therefore less likely to be constrained by a lack of financial resources than is the case for the other groups in our study. However, many of the jobs in heavy industry in Apatity are associated with increased health risks through fumes, gases, physical strain, accidents and other factors. Many industrial workers are faced with the choice between no income on one hand, and employment with serious health risks on the other.

More than 50 interviews were carried out during fieldwork, each lasting between 40 minutes and two hours. Clinics, health centres and hospitals were visited, and interviews conducted with doctors and nurses, as well as patients and relatives of patients. Interviews were also conducted with various decision-makers in both Apatity city and Murmansk oblast'. About 23 interviews were conducted with representatives of our target groups, usually conducted in their private homes. As it was difficult to get people to participate voluntarily, private informants (that is, not health care personnel and administrators) were paid US\$20 for taking part in an interview. Participants in focus group meetings were paid US\$10. Qualitative interviews are not common in Russia, and many respondents were initially very reluctant to take part. Several had prepared themselves for taking part in some kind of medical experiment, and were relieved when they realised that we only wanted them to *talk* about health. In spite of this initial reluctance, all those selected participated in interviews, and more than 90% of those asked to take part in focus groups came to the agreed place at the agreed time. The participants found the questions and exercises strange but intriguing, and several informants (in particular focus group participants) thanked us for the opportunity to engage in an hour of what they saw as stimulating and interesting conversations. They appreciated that we wanted to listen to their stories and perspectives, and at the same time seemed to feel intrigued discussing a topic they usually spend little time contemplating.

The respondents were not randomly selected, they were chosen in order to maximise information at each stage in the fieldwork process and in order to deepen, cross-check, verify or falsify our developing understanding of how medical institutions are used and lifestyle choices made. For example, after having conducted several interviews with unemployed men with a low level of formal education, we sought unemployed men with higher education to check whether the same mechanisms influence the choices they make.

As a consequence of this approach, we do not presume to present a representative picture of Murmansk in a quantitative sense. Instead we try to discover how options for healthier living are utilised, and which factors are important constraints for people's choices.

The basic premise for the analysis is a simple one, namely that people who act do so in relation to their perception of how their world is oriented. Even if the economic and political changes in Russia have turned people's lives upside down, this has happened in a manner that can be perceived and understood by those involved. As long as there is a structure or order in what is happening, responses can also be structured and ordered, both according to the resources and opportunities people have when they respond, and how they perceive their resources and options. To a large extent we can map these responses, actions and views through interviews. This report is replete with examples, and the text is structured as a running comment and interpretation of statements, descriptions and observations made by respondents during interviews.

The research site

This report focuses on lifestyle-related health problems in Russia, exemplified with the situation in Murmansk oblast', and more specifically in the city of Apatity and surrounding areas. We will not claim that the situation in Apatity is in any way 'typical' for Russia, nor particularly good or bad.

Our choice of research site has been made based on three criteria. First, Norway share borders with Murmansk, and thus has a special interest in, and a certain responsibility for, this region. Across the Norwegian-Russian border there is one of the largest gaps in living standards in the world – the comprehensive Norwegian welfare state stands in sharp contrast to the limited financing for health services in Murmansk.

A second reason for choosing Murmansk is that it gives us a chance to look at the special conditions that have developed in Russia's northern areas. Earlier, the northern areas were largely populated by young people that came to the region to work. In the days of the Soviet Union, wages were higher and public services were generally better here than in most other Russian regions. People would move to the south before they reached retirement age. Today the situation is very different. Net out-migration from this area has been extremely high; in the three years 1992–95, the Northern Economic Zone experienced an average population decrease due to migration of 5.8% of the total population every year. Only the Far-Eastern regions had higher negative migration rates (Goskomstat 1996). However, it is no longer

mainly older people that leave. The wealthier and more educated parts of the population are leaving, while people with fewer resources stay behind. From being a region with a rather young and healthy population and a well-developed welfare system, Murmansk now has an ageing population with few resources, at the same time as government services are being severely cut back. We believe this situation demands special attention.

Thirdly, we wanted to look the health care systems in an area with predominantly standard governmental health care services. We therefore chose not to focus on Murmansk city, since it as the oblast' administration centre have a wider variety of specialised governmental as well as private services. Thus, within Murmansk oblast', the project is concentrated in Murmansk oblast's second largest city, Apatity, and one village about one hour's drive outside Apatity.

Murmansk oblast'

In spite of the ageing population, difficult conditions in the industries and relatively high unemployment rates, the population in Murmansk in 1999 was among those economically best-off in Russia, with an average per capita household income of 2 392 roubles compared to a national average of 1 594. In 1999 only seven other regions in Russia had a higher average income (Moscow, and six regions of Siberia and the Far East).

In terms of poverty, Murmansk is better off relative to the other regions of Russia. The proportion of Murmansk's population below the official poverty line in 1999 was 19.8%, compared with a Russian average of 29.9%. Only the wealthy Siberian region Tyumensk had a smaller proportion of people with income below the poverty line in that year. However, the poverty rates are still high, in particular compared with its wealthy Scandinavian neighbours. Furthermore, we should note that 1998 poverty rates in Murmansk were only slightly below the national average. While poverty in most Russian regions increased severely due to the economic crisis of 1998, Murmansk was not as severely hit (Goskomstat 2000).

With a life expectancy at birth for men of 62.4 in 1999, Murmansk was not only above the Russian average, but is one of the best-off regions in the Russian Federation, bypassed by only five regions in Northern Caucasus (four of which are ethnically-defined republics) and two relatively rich districts in Siberia.⁴ For women, life expectancy of 72.8 years is closer to the national average (Goskomstat 2000). As mentioned above, life expectancy (especially for men) increased in Russia in 1997

⁴ Regions with higher male life expectancy than Murmansk are Ingushetya (68.10) Dagestan (65.20) Yamalo-Nenets AO (65.29) Adygeya (63.37), Khanti-Mansi AO (63.28) Karachayevo-Cherkessiya (63.03) Stavropol (62.52) (Goskomstat 2000).

and 1998, but fell sharply in 1999. However, this reduction did not take place in Murmansk, and the oblast' maintained a relatively high male life expectancy. (Goskomstat 2000).

Apatity

This city is located in the centre of the Kola Peninsula, at the confluence of the main transport routes, connected with other cities of the Murmansk region and central regions of Russia by highway and railway. The Khibiny airport is located near to the town.

In January 2000, the population of Apatity was an estimated 69 100, close to 7% of the population of the Murmansk region. Over the last decade, the number of inhabitants has decreased considerably, following the overall regional trend.

Table 2: Number of inhabitants in Apatity, 1990–2000 (thousands)

	1990	1995	1996	1997	1998	2000
Number of inhabitants	86.0	73.2	71.8	71.0	70.4	69.1

Source: Murmansk Regional Committee of State Statistics 2001.

The main employer in Apatity is the chemical industry, but a significant proportion of the population is employed in research, and Kola Science Centre, the biggest scientific centre in the northern Russia, is located in the town. The third most important employment sector is transport.

In 1999 63% of the population was of working age. Among these, 56% are employed at big and medium-sized enterprises, 2% in small enterprises, and about 9% are self-employed. Although the industrial sector is the dominant employer, its importance in this regard has declined dramatically. In 1999 it employed 43% of the economically active population, compared with 60% in 1993. The proportion of people employed in the so-called budget sphere (for example, education, culture and health care) increased from 37% to 40% from 1993 to 1999.⁵ For Murmansk at large, 16% of the economically active population was unemployed in 1999 according to official figures, but only 4% were formally registered as unemployed (Murmansk Regional Committee of State Statistics 1998). In spite of a reduction of 5% from 1998, the estimated unemployment in Murmansk is above the Russian average of 13% (Goskomstat 2000). In Apatity, 3 300 unemployed persons were officially registered at the centre of employment in 1998, making up 7.5% of the population of working age. However, due to extremely poor unemployment benefits and complicated procedures for registration, we may expect actual unemploy-

⁵ Data reported in meeting with Apatity Municipal Committee of Statistics.

ment to be higher. Among the unemployed people we interviewed in our survey, nobody reported that they were officially registered, either because they were not entitled to unemployment benefits, or because it was too far and costly, or time-consuming to get to the unemployment office to get the very limited unemployment benefits on offer. As most of our informants without formal employment have to do some kind of work in order to survive (for example, collecting berries, knitting sweaters for sale or taking casual jobs in the market place whenever possible), almost none of the respondents in our study could be classified as unemployed according to the International Labour Organisation standard definition (that is, they would not be defined as unemployed in a standardised labour force survey).

The Murmansk region has 87 different medical institutions affiliated to Minzdrav (Ministry of Health), employing about 3 500 doctors and 11 000 nurses and other medium and lower medical personnel (Evdokimov 1999). Apatity city has a hospital, two polyclinics (one for children and for one for adults), one maternity hospital, a dermatological polyclinic, and one governmental as well as several private dentists. The Murmansk regional psychiatric hospital is situated in Apatity. Under the Soviet system, big enterprises and organisations owned so-called 'departmental' health care institutions which provided their workers with health services. These were often of better quality than those provided by municipal health institutions. Some workplaces still have their own medical service, and in Apatity the employees at Kola Science Centre has its own polyclinic and hospital, financed through the federal budget. A number of other employers have agreements with municipal health care institutions for medical service, including compulsory yearly medical checks. In some workplaces, employees have to have valid medical certificates (renewed every year) to stay in their jobs. These yearly compulsory checks are referred to as 'yearly health commissions' in this report.

Complicated treatments that cannot be done in the municipal hospitals and polyclinics are transferred to the regional hospital in Murmansk City. In Moscow and St Petersburg there are specialised hospitals and clinics 'of federal importance'. These institutions have the most advanced facilities and receive patients from all over the country. Formally, treatment in these specialised institutions is supposed to be financed through regional medical insurance funds. However, our survey indicates that this transfer does not always occur and that, due to heavy bureaucracy and time-consuming procedures, patients sometimes have to cover these expenses themselves. This is dealt with in more detail below.

The village

Some of the interviews were conducted in a small village an hour drive from Apatity city. The village used to be tied to a state forest enterprise (*lespromkhos*). Now

the timber industry has been privatised, and most of the inhabitants of the village have left. During Soviet times about 1 000 people lived in the village. Now the population is about one third of this. A large proportion of the adults are unemployed. No official estimate was available, but some residents claimed that about half the adult population is without formal employment and a steady income.

There is one medical service centre in the village, employing two *feldshers* (health personnel trained in basic medicine and first aid), one of whom has worked in the village for 37 years. The *feldshers* in the medical service centre do basic diagnosis, follow-ups of basic medical treatment, and prescribe medicine. In addition, they distribute free milk to households with children under two years of age. The main patients in the health centre are families with children, the elderly and the disabled. Earlier, various specialists would visit the medical centre regularly. Specialists seldom visit the village these days, if ever, because of the reduced number of inhabitants in the village, the fact that the village no longer can offer lodging (the 'hotel' was torn apart and used for building materials and firewood) and general cutbacks in medical services in Russia as a whole. For more advanced medical services, the villagers have to travel into the nearest city. A bus goes twice a day, in the morning and evening, costing about 30 roubles for a return ticket. For the unemployed, the bus ticket is almost unaffordable (the standard monthly unemployment benefit at the time of our survey was 116 roubles), and those with stable work need to take a whole day off in order to visit health institutions in the city.

Lifestyle choices between economy and culture

In the Russian media the nation's poor health statistics are often explained as due to (or interpreted as an indication of) the economic problems and hardship experienced by a large part of the population. This perception is often expressed among health care personnel, administrators and ordinary people as well. They argue the main health problem is poverty, which leads to malnutrition (or more specifically undernutrition), and a lack of necessary medicines combined with high economic insecurity and stress. We will not argue that these are not significant health problems in Russia today, but as we have argued above, the main 'killers' in Russia today are non-communicable diseases such as cancer and cardio-vascular diseases which usually are not associated with poverty, but rather with socio-economic modernisation.

The reasons for the high mortality rates from cancer, cardio-vascular diseases and accidents must be sought in lifestyle. In order to understand how these diseases can be fought, we need a better understanding of how people make their lifestyle choices; to what extent individuals are conscious about the choices they make, and to what extent health-related behaviour is determined by household economy and medical infrastructure. Since mortality is much higher among men than women, we should pay particular attention to gender differences in the choices people make.

In this section we present and discuss the viewpoints of ordinary people and health personnel and administrators with regard to diet, alcohol, smoking, stress, mental health, and workplace security.

Dreaming about meat and white bread

There are three different types of issues we may address when dealing with malnutrition.⁶ First, we may look at undernutrition; when adults and children don't get

⁶ Malnutrition results from imbalance between the body's needs and the intake of nutrients, which can lead to syndromes of deficiency, dependency, toxicity, or obesity. Malnutrition includes *undernutrition*, in which nutrients are undersupplied, and *overnutrition*, in which nutrients are oversupplied. **Undernutrition** can result from inadequate intake; malabsorption; abnormal systemic loss of
(cont.)

enough energy (in terms of calories from fat, sugar and carbohydrates) to cover their need for growth and daily activities. Secondly, there might be a problem of general malnutrition; people may get enough energy, but lack proteins, vitamins or other nutrients of a healthy diet. Moreover, a person may get *too much* of potentially damaging dietary components, such as saturated fat. Finally there might be a problem of overnutrition, when the diet contains too much fat or energy, leading to overweight or obesity. Overweight and obesity are important determinants of health and lead to adverse metabolic changes, including increases in blood pressure, unfavourable cholesterol levels and increased resistance to insulin. They raise the risks of coronary heart disease, stroke, diabetes mellitus, and many forms of cancer (WHO 2002).

The design of our survey did not allow for quantifications or measurements of nutritional value among our respondents. Therefore, to put our analysis in a wider perspective, we will supplement our presentation with data from relevant surveys conducted in Russia during the 1990s.

Fighting overweight and undernutrition at the same time

Although moderate undernutrition occurs, serious undernutrition is not very common in Russia today. According to the Russian Longitudinal Monitoring Survey⁷ (RLMS) the incidence of 'stunting' (chronic malnutrition resulting in low height for age) of children under 2 years old has declined constantly from a peak of 16.3% in December 1994 to 8.3% in October 1996. (Economic Research Service 1997). With the reduction in poverty seen in the latter part of the 1990s, we may expect the level of stunting to have been further reduced since then.⁸ The RLMS survey also showed that acute malnutrition (the incidence of wasting) is not a major problem among Russian children. However, among children aged 3 to 9, 45% were overweight (Popkin 1996; Economic Research Service 1997). In other words,

nutrients due to diarrhoea, haemorrhage, renal failure or excessive sweating; infection; or addiction to drugs. **Overnutrition** can result from overeating; insufficient exercise; overprescription of therapeutic diets; excess intake of vitamins, particularly pyridoxine (vitamin B₆), niacin, and vitamins A and D; and excess intake of trace minerals.

⁷ This is a co-operative survey done by Russian and foreign survey research and nutrition experts that has monitored the economic and health status of Russia's population since 1992.

⁸ Unicef has published comparable data on stunting of children under the age of 5 (most recent data available from the 1995–2000 period) (Unicef 2002). With stunting of 13% of all children under 5, in the mid 1990s Russia had about the same level of stunting as countries such as Colombia (14%), Georgia (12%), Iran (15%), Libanon (12%), Panama (14%), Tunisia (12%) and Turkey (16%). Most countries in Sub-Saharan Africa have a significantly higher level (25–45%) while most European countries are on a much lower level

although some undernutrition does occur, overweight seems to be a problem which is at least as large among Russian children.

Overweight may be defined using BMI, or body-mass-index (the ratio of weight to height ($\text{kg}/(\text{m})^2$). According to WHO standards, a BMI of 18.5–25 is considered normal, while a BMI of 25–29.9 is considered overweight (or pre-obese) with increased morbidity risk. A BMI above 30 is considered obese, with moderate to severe morbidity risks. Little data are available for all of Russia, but 1995 data from Moscow and Novosibirsk (collected by WHO) may be an illustration, and we will assume that the situation in these two relatively different regions is also representative for other regions of Russia. Mean BMI, overweight and obesity in these two regions is illustrated in Table 3 (data from two European regions are included for comparison).

The situation in Moscow and Novosibirsk illustrate that a high fat/high energy diet is a significant problem in Russia too – around half the population is overweight, while 8–17% of men, and 22–35% of women are clinically obese – overweight with serious health threats. Overweight is receiving increasing attention in Europe as a serious health problem, and as the table indicates, overweight and obesity are more common among women in Moscow and Novosibirsk than in both Bremen and Strasbourg.

Data on BMI or nutritional intake are not available for Murmansk oblast'. However, we should keep in mind that Murmansk had one of the lowest poverty rates in Russia in 1999 (Goskomstat 2000) and, to the extent that mal-/under-nutrition is tied to poverty, we should expect it to be less common in Murmansk than in Russia at large.

Table 3: Estimations of overweight and obesity in population aged 35 to 64 in regions of Russia, Germany and France

		Mean BMI	Overweight (%) BMI>25	Obesity (%) BMI >30	N
Men					
Russia	Moscow	25	46	8	556
	Novosibirsk	26	52	17	586
Germany	Bremen	27	66	16	393
France	Strasbourg	27	72	22	526
Women					
Russia	Moscow	27	55	22	527
	Novosibirsk	29	68	35	598
Germany	Bremen	26	54	19	431
France	Strasbourg	26	49	19	523

Data from the WHO MONICA (Monitoring Cardiovascular disease) project (WHO 2000)

It might seem strange to focus on overweight and overnutrition in a country where large proportions of the population struggle to cover their daily needs. However, overnutrition has emerged as a significant problem, also in developing countries, often in association with increased levels of urbanisation. Overnutrition is particularly common in transitional societies where the majority can afford enough food, but large proportions of the population remember periods of hunger. In such a situation, malnutrition typically occurs in the form of 'over-' and 'under-' nutrition side by side, even within households. This is the case in Russia as well (Doak et al. 2000). In these societies there is a danger is that one is so preoccupied with the problems of undernutrition that one misses the growing epidemic of overnutrition (Horton 2001).

Too much fat, too few vegetables

Studies of dietary intake in Russia conclude that consumption of fat (especially saturated fat) and sugar is generally too high, and the intake of vegetables and fruit is too low (UNDP 2000; Martinchik et al. 1997). Lack of fresh fruits, combined with too much saturated fat, and smoked and salted meats result in high death rates from cardio-vascular diseases, gastric cancer (which is the second most common cancer for males in Russia) and other cancers of the digestive tract. Low consumption of fresh fruits and vegetables (coupled with excessive intake of hard liquor) also increases the risks associated with smoking-related illnesses (Zaridze 1999; Döbrössy 1994).

In 1990, over 42% of the Russian food supply was in energy from fat, making the Russian diet one of the richest in the world in terms of meat and dairy consumption.. However, by October 1996 the percentage of fat in the diets of all age groups had fallen below 30% (Economic Research Service 1997). Although prices for bread and other products made from grain had risen at about the same rate as dairy prices, bread and other grain-based products captured an increased proportion of the total consumption. At the same time, potatoes and vegetables became more important, as did vegetable oil as a substitute for animal fat.

Given the health risks associated with high-fat diets, these changes are generally agreed to be for the better. However, there is still room for improvement in the Russian diet – even the poorest 10% of the population consume more meat than what is recommended by the Russian Institute for Nutrition (RIN). RIN has composed a thrifty, but adequate average annual recommended food basket for consumption in Russia. Based on data on Russian food consumption, RIN conclude that Russian households should decrease their meat consumption and increase consumption of pulses (peas and beans). Pulses, and to some extent pasta, are good sources of protein, and both contain virtually no fat. Pulses cost only 20% as much

as the average sausage product, and pasta only 25% as much. Overall, during the first nine months of 1996, Russians consumed only 13% of the pulses recommended by the RIN. Other products Russians are encouraged to consume more of is skimmed milk and other low-fat dairy products (substituting whole milk and sour cream), fish, vegetables and fruits, vegetable oil and margarine (as a substitute for butter) (Economic Research Service 1997).

With a reduction of energy consumption in the form of fats, an increase in consumption of grain-based products and vegetables, and the use of vegetable oil as a substitute for animal fat, the diet of the overall population in Russia has improved, in nutritional terms, during the 1990s. However, as we will see below, these changes seem to be caused by economic constraints rather than being an active choice for a healthier diet. Most of our respondents see ‘the way they used to eat’ as the healthy diet, and hope to be able to eat like that again if their economic situation improves.

“In the Russian north you need meat and fatty food”

Most of the health care workers or administrators we talked with argued that improper diets caused health problems among people living in Apatity and surrounding areas. However, their focus was exclusively on the poor – the ones who cannot afford to eat ‘proper’ food. They would often express worries that a large share of low-income families have a diet mostly based on pasta and dark bread, which they argued were low in energy and nutrients. Both health care workers and administrators alike claimed that, due to the harsh climate, residents in the Russian north need more fat and meat in their diets than southerners. Undernutrition of children and pensioners was emphasised as a particular problem. Overweight and the problem of diets with high levels of saturated fat and sugar were never mentioned in the discussions we had on lifestyle and lifestyle-related problems, not even in discussions around prevention of cardiovascular disease.

Problems with nutrition and healthy diets were thus portrayed as a problem only for the poorer segments of the population. The only solution that was suggested was to increase people’s incomes. Health care workers and administrators did not see it as their task to inform or bring greater awareness around questions of diet, and did not give the impression of being well-informed about the problems themselves.

“Before we always had meat on the table”

In our interviews with ordinary people, we would usually first discuss the daily diet of the members of the household, what they would usually buy and prepare, what

they prioritise and how, and what they miss and would have bought and prepared if money was not an issue. We then asked informants how they would evaluate their diet in health terms, and what they would characterise as a healthy diet.

The majority of our informants argued that money was the major determinant for what they could buy and eat. However, even though almost all complained about lack of variation, only a few (mothers in low income households with many children, and some unemployed men living alone/in households where nobody was in formal employment) said they actually went hungry in the weeks prior to our interview, or indicated a diet that lacked central nutrients. A number of informants in low- and medium-income households complained that they could not buy healthy or 'proper' food.

Very few said their everyday diet could be characterised as healthy. The context of the questions in a health survey probably influenced some answers; even if the informants believe the food they eat is healthy, we should not expect them to say they are content with the way they eat, as it is almost always possible to eat better. What we will focus on here is what they see as the healthy components in their diets, and what they think they should change in order to improve them.

The basic components of the everyday diets described were relatively similar: Dark bread with butter or margarine, tea with sugar, pasta and potatoes are central components in all households. Soups are common, often based on cabbage or potatoes. In most households meat is not an everyday item but, with the exception of the most vulnerable groups (see below), all households had sausage, meatballs, chicken or other types of meat regularly, at least a couple of times a month – especially right after wages have been paid. What all households have in common is that they wish they could eat more meat:

Ira (48), her husband and 19-year old daughter are clearly not among the most well-off families economically, but they never go hungry:

– For supper yesterday we had cabbage soup, potatoes, liver. We have salad with tomatoes and cucumbers every day. Some pasta. In the morning we had coffee with sugar – and sandwiches. We buy dairy products for our daughter. I don't really like apples – but we buy them anyway. Is this healthy? No – we used to eat much better before. Then we always had meat on the table.

Ira is representative of a large group of informants. The diet she describes is relatively well balanced in nutritional terms, with a high intake of fruits and vegetables, and relatively little fat. Still, she does not see it as a healthy diet; as many other informants she insists that in order to eat healthy, you need to eat meat more often, preferably every day. Some respondents are aware of that eating too much meat is not good for you:

Lidiya (43) is unemployed, and supports her 14-year daughter alone on her very limited widower's pension:

– We usually eat twice a day – yesterday we had mushroom soup for lunch and fried potatoes in the evening. In the morning we don't eat much – yesterday I made some pancakes for my daughter, but I didn't want any myself – I only had some coffee, with sugar, and some sweets. The girl gets free lunch in school – but she does not like it, and rarely eats it. I sometimes buy vegetables, beets to make borsch perhaps twice a week. And then I make mushroom or pea soup. Without meat of course. Meat is too expensive. I love tomatoes, I buy them this time of year when they are so cheap. Fruits? No never. I bought some apples after the summer vacation. I love apples too. If I didn't have to think about money, I would probably buy meat. And potatoes. Potatoes are still quite cheap, so we still buy them, but in the winter we will only be able to buy potatoes for soup. Then I would have bought sausage – there is one they have in the stores that I have never tried.

When we asked her whether she would buy more fruits or vegetables, she replied:

– Maybe I would buy more tomatoes. Is what we eat a healthy diet? Of course not – what we eat is only to avoid going hungry. But it might be good that we don't eat much meat. They say that meat makes you look old. To eat healthily we should eat more vegetables.

Lidya argued that she only eats what she can afford, and that there is no consideration of nutrition. We will not try to assess the nutritional value from the limited information we have, but as she saw it, the only healthy element in their diet is that they do not eat much meat. Still, if she had money, meat is what she would buy. She mentioned vegetables, which is what she characterises as healthy food, only after we explicitly asked about this.

Among our informants, particularly in low-income households, pasta is a central component of the everyday diet. Pasta is a cheap and good source of energy, which contains some proteins and is low in fat. The Russian Institute of Nutrition recommends an increased consumption of pasta. However, pasta is only eaten to avoid going hungry – nobody, not even health care personnel, characterise pasta as healthy food.

Vegetables are important for children

Soups are important in the Russian diet – often made from potatoes, beetroot or cabbage. For most households, these soups were the major source of vegetables. In

upper and mid-income families (and also among those that have lunch at the workplace) ‘salads’ are common – sometimes with only tomatoes and cucumbers, but often with mayonnaise and sour-cream as central components – enough animal fat to counterweight the positive effect of this relatively limited amount of vegetable food. As the consumption of meat has gone down during the 1990s, the Russian population has started to eat more vegetables. However, for the mid- to upper-income families who can afford to eat meat regularly, meat is preferred over vegetables.

Masha is 25, and lives together with her husband and her 5-year old daughter. Both Masha and her husband work and, even though they don’t earn a lot, they never go hungry.

– Yesterday we fried potatoes and mushrooms for dinner. This is not what we usually eat – usually we have meat – at least after wages, and macaroni. And rice. I wouldn’t say this is particularly healthy food – we try to give the child fruits, juice and yoghurt, but sometimes she has to do without it. We think of the child first – first her – then us. I suppose what we eat isn’t very healthy. My husband would like to have more meat – I miss fruits – grapes – and yoghurt.

Like Masha, most parents said they would try to make sure that the children got vegetables and fruits, if possible every day, but at least once a week. However, there seems to be a perception that fruit (and vitamin-rich food in general) is important only for children, not for adolescents and adults. For adults, fruits were often regarded as a luxury item, on a par with white bread and candy. Many adult men simply claimed they do not like fruits and vegetables, and thus do not eat them. All our respondents were aware that vegetables and fruit were a major source of vitamins, and as such central components of a healthy diet, but many said this was not necessary for them. A healthy diet seemed to be thought important only for the weaker members of society, in particular children and people who are ill. Thus ‘strong men’ do not need vegetables – for them the most important thing is to get adequate energy, preferably from meat.

Even though meat was an item that was universally missed, some respondents also claimed that they would have liked to eat more vegetables and fruits. However, meat was still the first priority.

Viktor is 28. He and his wife live on one income, and are among the middle-income families in our survey. For dinner the day before the interview they had meatballs and potatoes, but no other vegetables.

– We try to have meat for dinner when we can, but we do not eat much vegetables or fruits, as they are too expensive. But I have this dream – that there is

always juice for breakfast... and that there are always apples lying in here. We try to do that for celebrations and holidays.

Viktor earns enough to be able to eat meat regularly, but not every day. He knows that it would be good for them if they ate more fruits and vegetables, but says he cannot afford them. In September when our survey was done, 1kg of chicken (the cheapest meat available) cost the same as 3kg of apples (see table 4 below). Viktor's dream of always having apples would not be out of reach if he were willing to eat meat a little less frequently. He does not seem to have considered the possibility of buying meat less often in order to be able to afford more fruit and vegetables.

According to respondents who were in hospital or had just been discharged, even the hospital diet is influenced by these food priorities. Dinner always includes meat, often served with rice, but vegetables are rare. The only fruits patients get are what they buy themselves or get from relatives or friends. If the hospital administration wanted to have more vegetables and fruits in the patients' diet, it could replace meat with pulses and vegetables a few days a month, and get a more balanced diet with the same financial resources.

Table 4: Food prices in Apatity city, prices per 100 Kcal for cheapest available type within each product group

	February September		Kcal/- kg	Price per 100 Kcal	
	February	September		February	September
1kg chicken (cheapest meat),	48 roubles		1 280	4 roubles	
Sausage (1kg)	52 roubles		2 330	2 roubles	
Eggs normal size (10)	20 roubles		1 470	2 roubles	
Cucumbers (1kg)	120 roubles	27 roubles	93	129 roubles	29 roubles
Tomatoes (1kg)	80 roubles	18 roubles	190	42 roubles	9 roubles
Cabbage (1kg)	13 roubles	3 roubles	244	5 roubles	1 rouble
Apples (1kg)	25 roubles	16 roubles	418	6 roubles	4 roubles
Oranges (1kg)	35 roubles	23 roubles	284	12 roubles	8 roubles
Bananas (1kg)	29 roubles		573	5 roubles	
Milk (1 liter)	11 roubles		660	2 roubles	
Macaroni (1kg)	14 roubles		3 480	0.4 roubles	
Dark bread (1kg)	11 roubles		2 400	0.5 roubles	
Sugar (1kg)	15 roubles		4 060	0.4 roubles	
Butter (1kg)	68 roubles		7 480	0.9 roubles	
Pack of cigarettes("Belomor")	3 roubles		-	-	
Vodka (0.5 litre)	46 roubles		2 350	4 roubles	
Beer (0.5 litre)	11 roubles		390	6 roubles	

(100 roubles = US\$3.2 (March 2002))

The majority of our interviews were done in autumn, when many had access to mushrooms and berries from the forests surrounding the city. Forests near Apatity on a Sunday afternoon in September are quite crowded with people picking mushrooms and walking in the woods. In the village, self-picked mushrooms and berries were a welcome addition to a diet which normally has little variation. However, for many villagers, self-picked mushrooms and berries are not consumed by the household members themselves. Some of the poorest households would sell these in the village shop, as foraging for mushrooms and berries was their only source of income.

Living on soup once a day

Very few of our respondents spoke about hunger or described a diet with total lack of central nutrients. The main exception was unemployed people (usually men) living alone, or households where nobody had stable employment. Many in this group claimed that they lived on soup (often based on artificial concentrates with no vegetables) once a day, and bread. In some cases the little money available would be spent on vodka and cigarettes, not food. Vodka made up the most important source of energy in the diet of these people. Some of the young men in the village would go out fishing or collecting berries in the forest in order to sell or exchange the proceeds for vodka. Unemployed men, also those without any clear alcohol dependency would go for days without proper food. We might speculate whether the low intake of important nutrients makes it more difficult to get a proper job and to escape poverty. For Volodia (32), this might seem to have been the case.

Volodia is a 32-year old man living in the apartment of his retired father. He had been unemployed more or less continuously for the last few years. Because two people were living on his father's limited retirement pension, food had been predominantly soups from artificial concentrates and bread. A few months previously Volodia got a job in road construction, but after only two months he fell ill with pneumonia and lost the job. Working outdoors without proper clothing in bad weather, he would often be cold and wet. The first month's salary was spent on repaying some old debts, the second he had not yet received at the time of the interview. He could not afford any treatment for the pneumonia, and was sent home from the hospital (pneumonia cases are usually hospitalised in Russia). The only 'medicine' he took was a shot of vodka every evening. (We saw an almost full vodka bottle on his shelf.)

We can only speculate whether Volodia's illness was triggered by the lack of a sufficient intake of central nutrients the months before he started to work. We may assume, however, that his chances of recovering from pneumonia in the absence of

medical care would improve significantly if he would have a somewhat higher energy intake and more varied diet. After months and sometimes years of living on a very limited diet, often combined with high alcohol consumption, the body is very susceptible to disease, and recovery is made more difficult.

Oleg, one of the alcoholics in the village, is not able to mention any direct dangers to health from drinking, but as far as he understands it, it is the alcoholics, the young men, who get tuberculosis:

– You can get tuberculosis from drinking. If you get tuberculosis you get food as treatment – kefir. However, not enough to live on. It is people who drink that get tuberculosis.

It is worth noting that Oleg does not think getting tuberculosis is bad – after all, people with the disease get free food. Oleg and his brother live mainly on vodka, soup and bread.

Families with many children said they often go hungry, not necessarily the children, but the adults, and the mothers in particular. For children, getting enough protein and energy is extremely important for growth, so Murmansk health personnel and administrators give special attention to the nutritional needs of children. Free milk is delivered to all children younger than 2 years of age from the children's clinic in Apatity, and from the health centre in the village. All children in school age get at least one free meal a day in school or nursery school, and some of our respondents said their children would get two, or even three meals a day in school. The quality of the food served in school was sometimes questioned (although seldom in the poorest households), but the complaint was usually that the children did not like the food.

In the village, children get one meal a day in school. In addition, the children and teachers collected fruits and berries from the forest in autumn, and preserved these to last through the winter. According to the local *feldsher*, the number of children suffering from colds and influenza was at a record low during the previous winter. She was convinced that the major reason for this was the high intake of vitamins through these foods.

It goes without saying that adults also need a balanced diet in order to function well, but in all households with children, discussions on nutrition and healthy food focused almost entirely on the diet of the children. In the poorest households the mothers were extremely reluctant to say what they had been eating the day before themselves, perhaps because they had eaten little or nothing, or because they were ashamed for eating anything at all when they felt they could not provide properly for their children.

Marina is only 26 years old, and she has already four children aged 5 to 10. She recently threw her husband out, as he was always drunk and had lost his job. Now she supports her four children alone. She is a rather small woman, wearing a dress much too big for her. She works on a collective farm, doing a physically tough job by choice – the hard work pays better than most other jobs in the farm. She has an income of 3 000 roubles a month. The school has a special programme targeting the poor, and the girls of school-going age get breakfast when they come to school, lunch, and often a light meal before they go home. The kindergarten also provides three meals a day. In addition, Marina prepares an evening meal. She claims that she doesn't eat much herself, perhaps only once a day. The meal consists of pasta and bread, and perhaps some meat or vegetables if her parents have been visiting or right after she has been paid.

Marina's situation was particularly difficult, but her story was typical in several ways for many of the low-income families we visited. Firstly, the children received several free meals in school and nursery school, but the mother still insisted that they should get most of their food at home. With her physically challenging job, Marina needs energy to get through the day. She cried silently several times during our interview. We were not able to tell how much food Marina actually ate, but we knew that she *felt* that she should not eat much herself, as long as she could not provide 'properly' for her children. As a good mother, she felt it was her duty to be strong, and to sacrifice herself for the children.

Ijulia is 40, and lives together with her four children, all younger than 18. She stays at home with the youngest child, and her husband works as a plumber. Altogether they live on less than 2000 roubles a month. Her husband has started to drink. She describes a daily life with severe economic constraints; it is difficult to find money for the most basic needs – when someone in the family is ill, she sometimes has to choose between bread and medicine. They largely live on bread, macaroni and soup from artificial concentrates. She is certain their everyday diet is not healthy – the children and her husband are constantly ill. The youngest child gets free milk from the children's hospital, and they try to get him an apple or a banana once in a while. The children eat first, and sometimes there is not much for her. But cigarettes are good for stopping the hunger. She smokes a pack a day, sometimes more.

All households with many children that we visited had 'fathers' who consumed so much alcohol that other household members described it as a problem. The women live under constant pressure, and even though, in some cases, they have more disposable money per person than other households, constant economic worries and the drinking of their husbands creates a strong sense of insecurity.

'Vodka is part of our culture'

Good data on patterns of alcohol consumption in Russia are not available, but estimates of average alcohol consumption vary from 11 to 15.5 litres of pure alcohol per adult person per year, of which about 6.5 to 8.5 litres are believed to come from illicit sources. According to these estimates, the Russian Federation has the highest per capita alcohol consumption in Europe, together with countries like Poland and France. However, while beer and wine constitute an important part of the alcohol consumed in Poland (50%) and France (82%), vodka constitutes about 80% of the total consumption in Russia (WHO Europe 1999).

So do Russians drink too much? The topic of alcohol turned out to be a sensitive issue in our interviews with health care workers and administrators. Many Russians are uncomfortable with the image often presented abroad, of the vodka-drinking Russian who is always ready to get drunk, and many got very defensive when we touched upon this question. We were often met with statements such as 'Russians do not drink more than people in other countries' or 'I have lived in Germany, and the Germans do not drink less than us'. Others would insist that alcohol was a central component of Russian culture, and that there was nothing that could be done to change this: 'Russians have always been drinking, drink now and are always going to drink. There is nothing we can do about it', one of the leading physicians at the hospital told us. In general, very few mentioned the health risks of alcohol – the recent increase in the use of drugs and narcotics was seen to be a much larger problem. Again and again, alcohol was defined, not as a health problem, but as a social problem, about which health care workers could do nothing.

Table 5: Per capita alcohol consumption (liters of pure alcohol per adult person per year) for selected countries

	Officially registered	Illicit sales/ domestic production	Total consumption	Share of hard liquor in total consumption
Russia	8	6.5	14.5	80%
Ukraine	4.2	7	11.2	80%
Poland	8.4	6.2	15.2	50%
Finland	8.3	2	10.3	25%
Germany	12	(no data)	12	20%
Norway	4.97	2	7	20%
United Kingdom	9.5	(no data)	9.5	20%
France	13.7	0.9	14.6	18%

WHO estimates 1993–96⁹ (WHO Europe 1999)

⁹ The data are rough estimations, and cross-national comparisons should only be conducted with great care. The lack of a global consensus on survey questions, time frames and definitions of terms renders the data inconsistent, difficult to interpret, and not comparable cross-nationally.

Strong men do not develop an alcohol problem

As with other lifestyle choices, the decision to use alcohol or not is not a free lifestyle choice; also this choice is constrained by normative expectations set by tradition. In Russia there is no strict social control on drinking, and heavy drinking is a tradition of the male culture, much less so for the female culture (Palosuo 2000). For most of our respondents, the decision to use alcohol did not take health dangers into account.

A common theme in almost all our interviews was that alcoholism was not initially defined or perceived as a problem in itself. When a person or a group of persons start drinking a lot, our respondents claimed this was an indication that something else was wrong. The general perception was that as soon as the other problems were solved, the person would stop drinking and become a responsible citizen again (see the next section on unemployment and alcohol). Alcohol dependency and difficulty with stopping drinking was given very little attention. Alcoholism was thus almost never defined in terms of dependency; rather it was seen as being linked to lifestyle and social status. According to many of our respondents, a person with a family and a job cannot be an alcoholic.

Ira (48) is a woman with higher education, who has been unemployed for several years:

– Does alcohol have an impact on people's health? It depends on what type of alcohol you drink. Vodka, for instance, can be bad for your heart. But I know a lot of people who drink vodka who are healthy as horses. Alcohol becomes a problem when people no longer care about their duties, stop going to work. It does not have anything to do with how often you drink. I know a lot of people who drink every day, but go to work. They are not alcoholics.

Ira is only one of many who define alcoholics in social terms – people that have ruined their lives. A large number of respondents would express the view that it is all right to drink a lot, as long as you can handle it. Alcoholism is a problem for the weak. So what happens when people start drinking every day, and lose their jobs and family? To many respondents this is an indication of character flaw – many argue that alcoholism is genetic.

Anya (33) lives in a relatively high-income household, and she has a higher education:

– The social problems associated with alcohol are more dangerous than the physical ones. An alcoholic may function well physically – there are a lot of strong men that can drink a lot – but the social problems for the family, work and for the society at large can be serious. If there are physical problems... I don't

know... I am not a doctor, but I think that it isn't good for the body. But there will always be a certain number of people who drink, because alcoholism is a genetically-transmitted illness. There will always be people like that in the society.

In our visits to the village outside Apatity, the high alcohol consumption among certain groups made a strong impression on us. On our first visit we finished our first interview by 11 am. We asked the respondent to direct us to a house where we could find an unemployed man, since the unemployed were an important target group for our survey. Our respondent found the task difficult, and had to think for a long time. He said there was no lack of unemployed men – half the men in the village were unemployed. However, it might be a problem to find someone who was not already too drunk to have a meaningful conversation.

Alcohol plays a significant role in the lives of almost all our informants in the village. Most men and several women drink regularly, and many young men have died in recent years as a result.

When we told the *feldsher* we had the impression that there is large alcohol problem in the village, she laughed and said:

– Yes – we have these kind of people here. You have these people everywhere – and here too. But these people rarely visit me at the health centre. My patients are largely disabled, elderly, and children.

She has 'treated' a few cases of delirium by giving them a shot of vodka, but she did not think that alcoholism is a very large problem:

– People are bored, there is nothing to do here except drink – especially for the young. But they are young and strong – they will do OK.

Thus, even the *feldsher* argued that alcohol is not a problem for strong men. Linking strength, personal control and alcohol is not particular to Russians, it has been described as one of the key aspects of addictive behaviour in general (Bateson 1972). However, what was striking in our interviews was that most people would mention strength explicitly and systematically in the discourse on drinking. The belief that strong men do not develop an alcohol problem was thus not just an attitude we found among those in danger of developing a problem themselves, but among people from all parts of society

If they just get a job they will stop drinking

From health care workers to administrators to ordinary people, everybody suggested there are good reasons why people drink: 'Life is tough now', they said. 'Many are unemployed and have economic worries'; 'People drink to forget', 'If only people

had a job, they wouldn't have this problem.' But is it that easy – do people only drink because they are unemployed?

Among our respondents, the unemployed were the heaviest drinkers. Or perhaps it is more correct to say that the heaviest drinkers among our respondents had all *become* unemployed. The most common story amongst women who were married to men who drank a lot, or who had been married to such men, was that once he started to drink heavily, he gradually proved unable to keep his job. Alcoholics themselves more often argued that they started to drink after they became unemployed.

Oleg (42) is unemployed and lives in the village. He drinks every day, as long as there is money:

– Everybody drinks here – working people too. But when I worked as a driver in the military I didn't drink, only on holidays and after sauna. I would stop drinking if I only got a decent job again.

Oleg is convinced that if he had a job, he would stop drinking. However, he did not draw the link between drinking and unemployment – in his view, the unemployed are not the only drinkers in the village.

Grigoriy is 49 and, when he works, it is for the private lumber company linked to the village:

– In the wintertime it can be very cold working out in the woods, so we usually bring some vodka to keep warm. When you live in the north you need vodka to get through the winter. Now when I am unemployed there can be long periods – up to a month – when we don't drink at all – when we don't have any money. But when we have money, we drink every day.

Grigoriy argued that he drinks more when he has a job, as he then has access to money. Still, later on in the interview, he argued that if only he had a job, he would stop drinking, as if it is something he needs to believe himself, or something he feels he is supposed to say. Moreover, it is interesting to note that it was common to drink, not only on the evening before people go to work, but also while they were at work. And the villagers were not the only ones to talk about drinking at work to keep warm.¹⁰

Valodia is a 32-year old man, and when we visited him he was sick with pneumonia. When he got sick he lost his job in the road construction company which he had had for two months:

¹⁰ Drinking vodka as a means of keeping warm is generally accepted, even among health personnel.

– The weather was really bad at times – a lot of rain. Some of my colleagues would bring vodka to work. We were not allowed to drink at work, and had to hide it from the boss. But vodka is good to have when the weather is like that. To keep warm.

In Russia, drinking, and heavy drinking, is clearly not linked only to the unemployed. Some become unemployed because they drink too much, even though they wish to believe themselves that they would stop drinking again if they only got a job. But do Russians drink more now than they did 10 years ago? Opinions are divided – some say yes, others argue that the main difference between then and now is that people have started to drink more openly.

However, some things have changed, according to Grigoriy:

– People would drink before too (when the village was a state forest enterprise) – probably just as much, but it was different then. First of all, they would drink proper vodka from the shops, not the cheap low-quality ‘vodka’ that is sold illegally now. And in the ‘old days’, they would drink with dinner. Now people empty a bottle of vodka with only a piece of bread to go with it.

Oleg confirmed this:

– If there is no money there are places where you get vodka if you promise to pay when you get money. So we go fishing, and sell the fish, and pay back.

One of the nurses in the hospital expressed it this way:

– Before, everybody would work. I don’t think they drank less then, but at least they all had a job.

The liberalisation of the labour markets has made people who drink a lot more vulnerable to being fired. The increasing unemployment has made the alcohol problem more visible, while at the same time reducing people’s incomes, so that drinking on an empty stomach has become more and more common. The patterns of alcohol consumption may have changed somewhat in the last decade, but the fact that the Russians drink a lot is not a new phenomenon which accompanied liberalisation and the introduction of capitalism.

Bad quality alcohol is the main health risk

With respect to alcohol, one new phenomenon which has emerged in the last 10–15 years is illicit and bad-quality vodka. From about the time of Gorbachev’s anti-alcohol campaign at the end of the 1980s, liquor from illicit sources, home made

samogon and sometimes even methanol from industrial production is sold at a low price as vodka. Autopsy reports show that a high number of deaths from alcohol poisoning result not from the concentration of alcohol *per se*, but from high concentrations of toxins in the alcohol (DaVanzo & Grammich 2001). In the village where we conducted our survey, there were signs in the windows of several dwellings advertising alcohol for sale. According to our respondents, illicit vodka was available for about 22–23 roubles per half litre bottle, compared with 35 roubles for the cheapest vodka available at the village shop (100 roubles = US\$3.2 in March 2002). But respondents were very aware of the bad quality of illicit vodka, and the associated health threat:

Oleg explained:

– Whether vodka influences health depends on what kind of vodka you drink. If you drink bad vodka you get ill. I don't get very ill myself, but my brother cannot eat the day after he drinks it. His stomach hurts. A lot of people in the village have gastric ulcers. But that is not from alcohol – it is from working long hours outside in the cold.

Possibly as a result of extensive news coverage of people dying from drinking illicit vodka, people from all social and occupational groups and health care personnel mentioned illicit alcohol as one of the major health risks tied to alcohol:

One of the leading doctors in the hospital argued:

– Russia has always been drinking, drinks and will continue to drink. There is nothing we can do about that. However, one of the problems now is that after alcohol production was privatised, there is no quality control any longer. People drink bad alcohol, and a lot of people die.

All our respondents, both in the city and in the village, knew that they ran a risk if they drank illicit vodka, but many choose to drink it anyway. This being the case, is it right to say that the bad quality alcohol is the problem? Ordinary vodka is available everywhere and at almost any time, and it is cheap compared with neighbouring European markets. We will argue that when a large number of people die from poisoning after drinking methanol or bad-quality homemade vodka, this is rather a symptom of widespread alcohol dependency. This problem will not be solved by subsidising the vodka available in stores, or punishing those who sell homemade alcohol.

Vodka as medicine

Almost all respondents agreed that alcohol in large quantities can be damaging, but most were also convinced that a little vodka does you good.

According to Viktor (28), they learnt this in school:

– I had a teacher once who told us that smoking is bad for you, but drinking a little every day is good for you. Not to drink – but to drink a little. Especially for us that live in the north.

In focus group discussions and interviews, ordinary people suggested many reasons why they thought drinking vodka was good for you. They said it protects against nuclear radiation, it is good for low blood pressure, and for high blood pressure, it regulates the stomach, it increases the appetite, it can be used as prevention and as cure, even to treat pneumonia. The most commonly-mentioned ‘medical’ use of vodka was to deal with psychological problems and stress.

After his wife left him, Sasha (33) drank every day for a long time, but stopped after his father told him to pull himself together.

– Vodka is good to have when things are difficult. You just get drunk – and when you wake up next morning life is not so bad after all. At least you can go on living. I don’t drink that often now – it varies. Whenever I see my friends, but I don’t see them that often. But now I only drink when I want to drink myself, and I don’t have to drink every day. Alcohol in itself is not bad for the health, everything, even food is bad if you overdo it. ‘They’ even recommend drinking vodka for health reasons – it is good for you as long as you don’t drink too much. When it is too much? I would say that alcohol starts becoming a problem when a person drinks every day for two or three years, then you can tell by looking at a person’s face that he drinks too much. I suppose a lot of people in Apatity drink too much. You know what they say – in the North, only fools and drunks can survive.

Vodka is an integral part of the Russian culture, and many of our respondents clearly said that this is not something they want to get rid of. The fact that they live in the north was often cited in support of drinking vodka. Whether vodka can have a positive effect on some physical or mental conditions is difficult to establish, but most Russians are convinced it does. There is however, a general lack of knowledge of the physical and mental hazards that come with a regular consumption of alcohol or binge drinking. If the Russian people were aware of the price they are paying for their pattern of alcohol consumption, would they still defend the widespread consumption?

Living with the alcohol problem

When a person develops alcohol dependency, the whole family is affected. According to one of the doctors in the children's hospital, one of the major health problems among children in Apatity was that young children live under constant stress from strained family relations linked to alcohol and drug abuse.

Marina was only 26, and mother of four girls aged 5 to 9. She threw her husband out a few months previously. He had been drinking for a long time, and ended up losing his job. For Marina the situation was extremely stressful, having to provide for her children and manage on her own. She did not have much energy for the children:

– If I am tired I start yelling at the children. My nerves cannot take it. I start yelling at them. Earlier I could have these large fights with them. Now, perhaps I have given up.... The oldest is getting very responsible. Now she is the one who yells at the others. And I tell her – how can you yell like this inside this small apartment. And then I try to send them all to bed. But they do not want to lie down and be quiet. I say: if you don't behave I will leave you too – like your father did. You have to respect your mother – you shouldn't bother me so much! I yell at them every day. Whether it is stress or not, I don't know. My friends tell me I look better now, after I divorced my husband. More relaxed. But I don't expect things to get better. Things always just get worse.

Marina talked fast and incoherently about the way her life turned out, how difficult it was to make ends meet, and from time to time tears ran down her cheeks.

Svetlana (37) lived in the village and was a widow. Her husband died from a heart attack a few years previously.

– He was unemployed, and drank a lot. He died suddenly one night, in a friend's house. They didn't even call for an ambulance – he died immediately. We knew that he had a high blood pressure, and he had had several heart attacks before he died. But he didn't get any treatment for the high blood pressure. We couldn't afford it. He should have been in the hospital in the city, and even though the hospital stay in itself is free, I would need to take the bus in there regularly to buy him food and cigarettes. And we would have to pay for medicines. So we couldn't afford it.

Her husband's drinking made Svetlana drink more herself, and it reduced the already limited economic resources of her family. It was a source of constant stress for both Svetlana and her children. After her husband died, her life became calmer and she drinks less herself.

It might seem like Svetlana chose not to prioritise medical treatment for her husband's heart condition. In many ways her husband was ill long before he developed high blood pressure and heart problems. Although he was offered treatment for high blood pressure, nobody offered to help him stop drinking. Even though Svetlana felt sad about losing her husband, she also seemed somewhat relieved that he had died because this allowed her to get on with her life.

Getting help for an alcohol problem

As we have argued above, alcoholism is portrayed as a symptom of other problems, not as a problem in itself. When 'things go back to normal' and people get a job, alcoholics are expected to stop drinking. Alcohol dependency was not seen as a problem. This was reflected in the way the medical institutions perceived and treated alcoholics. As it is generally believed that people who have a high consumption of alcohol would be able to stop drinking if they need to, treatment is not seen to be necessary. Even health care workers and policy makers seem to believe that only the weak develop alcohol dependency. And weak people cannot be helped.

The *feldsher* in the village was a little surprised when we asked what kind of treatment she could offer people with an alcohol problem:

– The alcoholics? Before we had a specialist that would come and treat them. But he does not come any more. We do not pay attention to these things any longer. But if a person himself acknowledges that he is an alcoholic, and comes to us for help, we will send him to a specialist. They don't go away for treatment, but stay here in the village. There are different types of medicines that they can get. Earlier people would come and ask for this kind of help – but not any longer. They don't care any more.

Only one of our respondents (a woman with higher education) had ever considered seeking help for an alcohol problem (her husband's). However she did not know about any governmental treatment programmes, and she did not know where to go to ask for help. She had heard that there were private clinics somewhere, but she did not believe this was something her family could afford. Her husband had been unemployed for 10 years at the time of the interview, and even though she could not say for sure when it started, we got the impression he had been drinking at least that long. At the time of the interview it seemed like both she and her husband had given up. Neither thought he would ever get a job again, nor that he would stop drinking for more than a couple of weeks at a time.

Smoking is a man's thing

Smoking prevalence in the Russian Federation has been estimated by epidemiological surveys conducted mainly in the largest cities (Moscow and St Petersburg). According to data from the Ministry of Health, the proportion of smokers among adult males increased from 53% in 1985 to 67% in 1993. This is one of the highest rates, not only in Europe, but in the world. Women smoke significantly less than men, but the number of female smokers increased significantly over this period – from 10% in 1985 to 25–30% in 1993 (WHO 1999).

Most of our respondents smoked regularly. The men in our study were only somewhat more likely to be smokers than women. However, men usually admitted to smoking more cigarettes a day and to using stronger tobacco.

Compared to the relatively limited knowledge of health effects of alcohol and high-fat diets, the respondents were relatively well informed about the dangers of smoking. However, a significant amount of our respondents based their evaluation of the health effects of tobacco on what they could feel themselves. Some even maintained that tobacco might affect others, but it didn't affect them.

Oleg (42) explained:

– I don't smoke much – about 10 a day, Byelomore Kanal [a strong Russian brand of papirosy]. I don't know if smoking influences health, I have been smoking for a long time, but I have been doing sports, skiing and skating, I don't feel the difference. Other people? It depends; some people are affected by it, but not all. [...] Now young kids have started to smoke. They even smoke at school (outside). Adults smoke less than they did before, since they cannot afford to buy cigarettes. But people smoke regardless of the price, I do not know anybody who has quit smoking in the last years, in spite of the economic difficulties we have had.

Others focused on the observable effects smoking has on their own health.

Sasha (33) was also a Byelomore Kanal smoker:

– I smoke less than my father used to smoke, probably about 15–20 cigarettes a day. Smoking is definitely bad for health – before I could run long distances, but not any longer. I can of course still run – but not like before. The lungs are getting bad. Some people start coughing, but I don't. Russians probably smoke too much – you know, Russians are 'maximalists' – if we smoke, we smoke much. It will not help to raise the price of cigarettes, high prices will not stop people from smoking, they buy cigarettes before bread. There are lots of people like that.

Ijulia (40) smoked a pack of cigarettes a day – sometimes more, when life was particularly stressful, like it was at the time of the interview. Her husband had not had any additional jobs in a while. ‘Cigarettes are good for stopping hunger’, she claimed. She smoked the cheapest type, the ones without filters:

– I know that smoking is bad for you – I cough a lot when I smoke a lot. I once thought I had tuberculosis. I’ve smoked for 20 years, and tried to quit several times, when I have been pregnant or breastfeeding, but I always started again as soon as I could.

Ijulia, Sasha and Oleg were probably the financially worst-off respondents in our survey. The two men lived alone, were unemployed and lived largely on bread and soup. Ijulia had to obtain food for a family of six with only 2 000 roubles a month. All three talked about hunger, but they still prioritised buying cigarettes daily. A pack of Byelomore Kanal cost about 3 roubles (see Table 4 for food prices at the time of the data collection). They all agreed that it is almost impossible to quit.

The strong focus on dependency and how difficult it is to stop smoking stands in stark contrast to the lack of focus on dependency in our conversations on alcohol. Smokers and non-smokers alike argued that once you have started to smoke, it is almost impossible to stop. Only one of our respondents was an ex-smoker and, perhaps not surprisingly, he had higher education. The majority of the smokers in this study had given up trying to quit, and nobody would express that they had plans to quit, or even wanted to quit, in the near future.

In conversations about smoking and its dangers, almost all our respondents saw the fact that teenagers had started to smoke openly as a problem. Many also mentioned that women had also started to smoke. For men it is socially accepted to smoke. The fact that the majority of the men smoke is acknowledged to be a problem, but not a very serious one. Women and children are ‘not supposed to’ smoke, and it was often argued that anti-smoking campaigns should first and foremost target these groups. This shows again that the traditionally weak groups of society – women and children – were considered to be at greater risk, even though men are more often smokers, smoke stronger tobacco, and smoke more cigarettes a day. As men are perceived as stronger, they are also believed to be less vulnerable to the dangers of tobacco.

Coping when the world turns upside down

Financial problems affect people's well-being in more ways than just inadequate food or poor nutrition. Economic hardship can be a source of anxiety, psychological distress and impaired mental health. Stress and anxiety can have a direct effect on health through increased risk of high blood pressure, and an indirect effect through increased alcohol consumption and other high-risk behaviour.

Amidst rapid social change, when goals and norms are being redefined, high rates of *alienation* are likely to prevail. Those left behind blame themselves and their environment, see their future as hopeless, and experience loss of control and helplessness, when it seems that many people around them achieve much more than they do (Kopp et al. 2000). Research from other East European countries indicates that socio-economic deprivation alone cannot explain variation in morbidity in itself. However, when socio-economic deprivation is combined with indicators of depression, it may predict a substantial part of the variation in morbidity (Kopp et al. 2000). In other words; it is not financial difficulty in itself, but the subjective evaluation of the relative disadvantage which seems to be the most significant factor.

Alienation may be seen as a form of giving up and an adaptation mechanism in a situation where few active coping mechanisms are available. An alienated person has become detached from the values and common goals of society, and may not be particularly motivated to follow generally accepted norms. In the context of health, this means that an alienated person may not be interested in keeping fit or healthy (Palosuo 2000).

When you lose control over life, and life loses its meaning

Based on his studies on suicide in the beginning of last century, Emile Durkheim (1997) concluded that whenever a serious readjustment take place in the social order, whether or not due to a sudden growth or to an unexpected catastrophe, men are more inclined to self destruction.

About ten years ago, the world was turned upside down for most Russians. From living in a relatively stable and predictable society in the Soviet Union, with a paternalistic state which told you what to do and how, people are now expected to make their own decisions, pay their own bills and be in charge of their own destiny. Insecurity has increased almost everywhere. For many years inflation skyrocketed, wiping out the savings of most people. Since inflation has calmed down, unemployment has prevailed. Social structures changed rapidly, as persons with little or no education could make a fortune on the deregulated market, and formerly high-status occupations have been re-evaluated. Many people educated under the former

regime found that their expertise was no longer in demand. When the economic situation of many households had finally stabilised towards the end of the decade, another economic crisis hit Russia in 1998.

How do people cope with changes like this? Many of our respondents expressed frustration over lack of control in their daily life:

Marina (26), who had recently thrown her drinking husband out, did not expect her life to be better:

– Things always just get worse. New problems occur. First the price for one thing goes up – then another... Now they say we have to pay for heating, if not they will turn it off. But there is no way I can afford to pay for that.

Sasha was 33 years old, divorced and lived alone at the time of the interview. His eight-year-old son lived with his ex-wife. Sasha had been unemployed for four months at that point, but had not had stable employment for several years. Sometimes he was able to find casual employment together with a friend who was also without work, but incomes were low, and unstable:

– I hate the insecurity associated with being unemployed. Not being able to pay for the apartment. My son needs skis, but how would I be able to pay for that? I worry about money all the time. Food is not important – I am not that fond of eating – don't need much food. But the stress that comes with not having money... And not having something to fill your days with... Earlier it was particularly bad. I sometimes even thought about killing myself – life sometimes seems totally meaningless. Especially when you realise that there is nothing you can do to change things... But now I have learnt to close my eyes and not think about it, to turn off radio and TV and not listen to politicians. They always promise that it will get better – but it never does.

This was not the only frustration in their daily lives – the difficult situation that Russia is in occupied the minds of many. After having lived most of their lives in what they thought was a strong and influential superpower, they were suddenly expected to accept that communism had failed, and that the Soviet Union collapsed. This left Russia a smaller and poorer state which was no longer part of setting the world agenda; rather, it was a state reduced to being dependent on international aid.

Anya (33) claimed that the general situation of the country does not stress her as much as it used to.

– I try not to take it in. But the tragedy with Kursk, the submarine, upset me. What is wrong with the Russian state? When even the submarines fall apart and

are unsafe to be on, can there then be anything in our society that we can expect to work well?

These sentiments cropped up, in various guises, in all our interviews. People expressed frustration over being powerless, some even felt that life is meaningless. These, according to Seeman (1959), are two of the five basic meanings of alienation, as seen from the individuals' point of view.

Nurses in the intensive care unit of the hospital in Apatity said they witnessed daily examples of self-destructive behaviour. Some people seemed to want to drink themselves to death, others deliberately cut themselves or injured themselves, ending up in hospital. The nurses did not have much sympathy for this group of patients. They were either perceived as mad, or as cheaters or parasites who wanted to be admitted to hospital in order to get free food.

Quite often, the hospital took in patients who had tried to take their own lives. In the period 1991–94, the number of suicides in Russia increased by 60%. In recent years, this rate has fallen, but it remains extremely high. In 1998, the mortality rate due to suicides in the Russian Federation was among the highest in WHO's European Region (WHO Europe 2001). According to the nurses in the intensive care unit in Apatity, there had been an increase in the number of young people trying to kill themselves in recent years.

When they received patients who have unsuccessfully tried to commit suicide, nurses and doctors saw their task as caring for their physical health, not for their psychological or social problems. A psychiatrist usually came to talk to the person while he or she was still in hospital, but there were no routines for follow-up after the person had gone back home. 'It isn't normal people who try to commit suicide', one of the nurses explained. 'There is no use in offering them psychological help.' Often the same patients came back after a while, and if they did not return, the nurses assumed that they had succeeded.

There is little understanding of people who find themselves unable to cope. The general view is that life is tough for everyone, and most people manage. Those who do not cope are seen to have a character flaw. People are expected to manage on their own, perhaps with the help of vodka. But none of the respondents had ever considered visiting a psychologist.

It is better to handle your problems yourself

Very few expressed any belief that a psychologist (or psychiatrist) could be of any use to cope with stressful events or psychological problems. Our respondents seemed to perceive psychologist as people who classified people as mentally sane or insane.

Since they did not want to risk being classified as insane, they did not want to voluntarily consult a psychologist.

Dimitriy (39) said:

– When we go through the yearly health commission at work, we have to go to a psychologist. They ask questions to check if you drink, or do drugs and stuff like that, but you never volunteer to tell them about you problems. How can I explain this – I think it is better never to visit a psychologist. Perhaps it is possible in your country, but here if you go to his office and talk about your troubles, this record will stay forever. If it is recorded that you have visited a psychologist, it will strongly influence your further destiny. Most importantly it will be difficult to find work. It is difficult to explain why you went to the psychologist. It is as if you have a mental disease – it is a stamp you have to live with the rest of your life. Thus it is better to never visit. However, there are private doctors now – in Kirovsk (neighbouring town) for instance – where you can go and nobody will know about it.

Firstly, to Dimitriy, going to the psychologist would in itself be tantamount to admitting you have a mental disease. And if you were marked with this ‘stamp’, he argued, no-one would ever believe that you have been cured. But perhaps even more importantly, he did not even consider the possibility that hospital records could be treated confidentially. He assumed that they would be made available to prospective employers. We had no way of testing whether Dimitriy’s belief is valid or not. To some extent, his attitude must be understood as a legacy from the former regime, when there was little regulation on the exchange of data between government departments. As long as psychologists are still widely used in ‘controlling’ functions for both governmental and private workplaces, as is the case where Dimitriy works, there is little chance that the general public will start trusting that these doctors will respect patient confidentiality. Other doctors and health care personnel focus almost exclusively on the physical conditions of their patients, and give little or no attention to their psychological state.

Tatyana’s son had been in and out of hospitals for four years, and she and her husband had been fighting a long time for a diagnosis and correct treatment for him (see section under use of health care institutions below):

– In the four years since my son started to get ill, I feel like I’ve been living under constant pressure. Every day I wake up with the feeling that the end is near. I lost one child some years back, and I cannot help being afraid I will lose this boy too. If my husband is home late, I am certain a catastrophe has happened. I was close to a nervous breakdown a couple of months ago – but then I visited

a homeopath in St Petersburg with my boy. The homeopath just looked at me and said: 'The child is one thing, but you have to pay attention to yourself. How can the child get well if his mother falls apart?' He gave me some medicine I should take – and I feel a bit better now. I never went back to the homeopath. I can just as well I heal myself – the boy's health is most important.

Both Tatyana and Dimitriy argued that it is better to handle stress and mental problems yourself. Visiting a psychologist implies that you are unable to handle your problems yourself, and in this sense it is perceived as an indication of weakness. To Dimitriy, admitting to this kind of weakness would be bad because it might damage his professional career or reputation if the information came out, while Tatyana felt it is the duty of a mother to be strong when her child is ill. It is worth noting that, except for the private homeopath, nobody in the numerous hospitals and clinics she had visited with the boy had given special attention to the mother's psychological state, or even tried to help her out with practicalities like finding accommodation and so on. The people at the institutions expected Tatyana to manage on her own. She found this natural – after all it was the boy that was ill, and it was her duty as his mother to be strong and support him.

The best jobs are high-risk jobs

In spite of the decreased levels of output, working conditions in all branches of Russian industry have been deteriorating in the last decade. In industry, construction and transport, one in five workers has to work in conditions which do not meet health and safety standards (Zaridze 1999). One of the target groups of this study was industrial workers, and among our respondents a significant proportion worked in high-risk workplaces. In some of these workplaces accidents happened regularly. Others were exposed to fumes, gases or noise which they knew could lead to illness and permanent handicaps. Our respondents were aware of the risks they were running, and several expressed concern about the long-term effects their jobs could have on their health. Still, none of our respondents considered changing jobs because of health risks.

Nicolay was 36 years old and lived alone at the time of the interview. He worked as a driver in one of the mines outside the city. His work schedule was two days on, two days off. However, he often worked for three days, followed by one day off. Each shift was 12 hours and, since the mine was quite far away from where he lived, he was away from home for 16 hours on an ordinary working day.

Earning about 10 000 roubles a month, he was on the top of the wage hierarchy in Apatity. In addition to his salary, he had a number of fringe benefits, including subsidised holidays, health and life insurance. He could look forward to retiring at the age of 45.

– Working as a driver in the mine is extremely dangerous. The cars are huge and very heavy, and sometimes the road is icy, and the view very bad. We cannot stop the car... We are about 120 drivers of this type of car, and usually one person dies in an accident every year. You have to be in very good physical and psychological condition in order to have this job, and we have to pass a health commission examination every year – if you don't pass, you will be sent to another, less dangerous job. Less dangerous jobs are less well-paid, of course.

Nikolay was clearly proud of his job – he liked talking about the money he earned and the fringe benefits, but also how dangerous and how difficult it was to get a job like his. He admitted that he was sometimes afraid, and that the dangers were stressful. But he did not consider quitting, at least not for a less well-paid job. Being downgraded to a less well-paid and less dangerous job was something he saw as disgraceful. In nine years he would be able to retire, and then he would move south.

In our conversations with unemployed respondents, we asked whether there was any type of jobs they would refuse if it were offered to them. Most of the male respondents did not understand the question – as long as the job was paid (not necessarily decently paid), they would take it. What made a job good or bad was pay, fringe benefits and stability. Health risks were not seen as relevant. Interestingly enough, among the female unemployed (also those living alone) the threshold for taking a job seemed to be higher. Several women insisted that the pay had to be decent, and also that the job should not be too heavy or dirty. In female-dominated jobs, there was no direct relationship between the pay and the health risks or physical strain (rather the opposite), and most women did not have to weigh good pay and health risks against each other. However, we feel this is only part of the explanation. Our female unemployed respondents seemed generally more at ease about being unemployed. They referred to tough labour market conditions, and emphasised how they filled their days caring for family members, and visiting relatives and friends. The unemployed men were often more isolated, and several of them expressed embarrassment that they could not provide for their families, not even for themselves. For Russian men, the kind of job you have is part of who you are, and not working at all is stigmatised. Men were therefore willing to accept more hazardous or poorly-paid conditions to get back into the labour market. The high level of competition on the labour market also makes it more difficult to change

and improve working conditions. As some of our respondents said, if you don't like your job you can always leave – there is always someone there ready to take over from you if you complain.

While most respondents took care to avoid accidents, protective equipment to prevent long-term damage to hearing, eyesight and inner organs was often not used even when it was available.

Viktor (28) said:

– Thus far I haven't developed any professional illnesses, but there are several people at work who have. For welders, the most common illnesses are reduced hearing and eyesight. And some have lung problems. One person had to quit because of lung problems, but he gets his pension. If you start having hearing problems... I don't know ... perhaps you'll have to find another job. There is ear protection that we may use, but we don't use it all the time – perhaps half the time. There is some help in it – but... There are masks/respirators we can use to avoid breathing in the fumes and gases, I use them more often. But not always. They are very warm and uncomfortable to wear ...

Generally, respondents were aware of the dangers of fumes and gases, and potential dangers to hearing and eyesight. Several signed a sheet of paper daily, declaring that they had been informed about the dangers and safety routines pertaining to their work. However, to most respondents the immediate security of having a job was more important than the long-term effects of breathing in gases or being exposed to high levels of noise.

Nicolay (36) said:

– When we drive in the mines we are exposed to a large number of risks: high altitudes, polluted air, bad lighting, high voltage – the list is long... There is a health commission that looks after security in the mine. They don't let you in there without helmet – that's the only safety equipment we use. There used to be air filters/ventilators in the cars before, but they no longer work.

Responding to whether he uses a mask or any other protective items, he said:

– No – perhaps we should have had that...

Had it become more dangerous to work in the mines over the last few years?

– No – not really. Rather better. Now they pay more attention to technical stuff – there are more controls on the cars.

What about the air-ventilation system in the cars?

– No, details like that they don't pay attention to.

Misha (22) worked as a mechanic in one of the major factories in Apatity. His working schedule was 12-hour shifts for two days, followed by two days off. He was satisfied with the security at his workplace, and believed his workplace to be much better than most others:

– Any job has a risk to it. Mine too. The ventilation is bad, and the cars give out many exhaust fumes. Sometimes everybody have to leave the room because it is very uncomfortable. And the floor is slippery – you can fall. You can hurt your back from carrying something. Accidents happen – but... not often. Perhaps twice a month in my section [where there were about 100 persons working]. We do not use any protective equipment There is a security commission that comes by regularly – and our boss looks after us – tells us to be careful. Accidents happen because people are not careful – are in a hurry or something.

According to Misha, accidents can be avoided if you are good at your job and know what to do. It therefore seems unnecessary to use protective equipment, because he does not expect accidents to happen to him. However, it is worth noting that many of the high-risk jobs had working schedules with 12 hour shifts. Who would not be a little careless after 11 hours at work?

Institutions – access to and use of health care facilities

With the adoption of the 1992 law “On Health Insurance of Citizens of the Russian Federation”, access to free and comprehensive medical services was guaranteed – as it had been in the Soviet era (OECD 2001). During the past decade, a substantial volume of new health legislation has been passed on both the federal and the regional level: In the 1996–97 session alone, the Federal parliament (the State Duma) considered 79 different instruments related to health and social issues. New laws on Sanitation, health protection, safety at work, and environmental protection were enacted soon after the transition (Tkatchenko et al. 2000).

However, during the 1990s real public expenditure on health care fell by more than 30%, so even though a number of laws were adopted, they were rarely followed by adequate funding. In practice, many laws are never, or only partly, implemented. The problem seems not to be a lack of laws, but rather a failure to prioritise expenditure on health care.

By 1 January 2000, the Murmansk regional budget owed the medical institutions 297 million roubles – money that was allocated to medical institutions in the budgetary process, but never actually paid due to lack of resources. This lack of resources (and lack of predictability in how large funding they will actually get) has limited the ability of health care institutions to invest in updated medical equipment. Perhaps more importantly, it has forced medical administrators and health care personnel to ration the services they offer.

For ordinary citizens this implies that the health services they can expect to get for free (in particular expensive diagnostics and medicines), may vary between cities and regions, and over time. When the implementation of legal instruments is not adequately funded, there is also a greater chance of differentiated treatment, depending on the type of patient, or the medical personnel that prescribe treatment.

In this section we will look at what services people get, which costs are associated with medical treatment, and how people themselves evaluate the services they get in Murmansk today. First we give a brief introduction to the financing and organisation of the health services in Murmansk and in Russia in general.

Organisation and financing of health care in Russia

The Soviet health system is structured differently to that of most European countries, with more emphasis (going by statistics) on quantifications such as the number of doctors, hospital beds, tests performed and so on. Russia has more hospital beds per capita than Western European countries, and the largest number of doctors per capita of any major nation in the world (one physician for every 259 people) (Tkatchenko et al. 2000). Our research site is no exception. In spite of recent reductions in number of nurses and doctors per capita, Apatity is still above the regional average.

With the passing of a law on local self-government, regional and municipal/local levels of government were granted more power and responsibility over a number of functional areas, including health care. At the beginning of the 1990s, the regionally administered compulsory medical insurance (CMI) Fund took over financing responsibility from federal government. The CMI is financed in large part from payroll-based mandatory contributions of 3.6% paid by employers. Most of the contributions are used locally, and only 0.2% is transferred to the federal CMI Fund. Regional CMI Funds are supplemented by funds from regional and local budgets and, to a lesser extent, from the federal budget to cover the cost of care for the non-working population. Expenses for medical facilities owned by various levels of government are financed entirely by those levels. The major part of funds obtained from regional budgets are allocated to health care facilities owned by regions (nearly 70% of regional funds in 1997). The required local funding is calculated on a flat per capita basis, with the amount decided through negotiations between regional and local authorities. However, the local funding must be at least equal to the average per capita contribution made by employers in the region. (OECD 2001)

Salaries in health care are low, and in recent years these have been further reduced relative to the average wage (from about $\frac{3}{4}$ of average wage in 1993 to two thirds in 1998) (OECD 2001). It has been argued that this had led to pressures for informal payments from patients, reductions of time spent on official activities by medical personnel, and other practices that potentially damage the performance and integrity of the system.

Hospitals usually lack medicines and medical equipment. Infrastructure of many medical institutions in the region and in the town of Apatity is in critically bad condition: buildings and sewerage facilities are old and need repair, and medical transport has not been replaced since 1993. Furthermore, lack of finances does not allow for regular ongoing training of medical personnel, which in the long run may lead to a deterioration in the quality of medical services.

Some pay for quicker access and better service

According to the law, and also according to Murmansk health administrators, health care should be free and available to all, with the possible exception of cost of medicines, when these are not available at the hospital. A number of surveys and reports on the Russian health care system say that, due to the shortage of public funds, few households can gain access to health services without paying formal or informal charges, and that the universal access to health care established under the Soviet system has been replaced by a system based on ability to pay rather than on need. The experience of most of our informants is that relatively extensive health services in Apatity are available to them for free, with the exception of medication. Some of our informants still chose to pay for services, arguing that this would give them quicker or more convenient access (for instance getting doctors/specialists to make home visits), but also because they believed this would give them better service. But even for those who received free services, medical treatment was often associated with large expenses due to high cost of medication. Few were covered by additional medical insurance, and the expense of medicines were usually drawn from the household budget.

During the 1990s, a market for private health care institutions in Russia has emerged. These target the small, wealthy population that has gained from the economic reforms in the country and, increasingly, the middle class. However, the absolute majority of private institutions are found in Moscow and St Petersburg, and the rest are found in the regional centres, in the more affluent oblasts and republics. At the time of our study, there was no private hospital or clinic in Apatity. However, according to some of our respondents, some doctors in Apatity operate unofficial private services, and do home consultations for a small fee.

Nikolay (36) had a very well paid job as a driver in one of the mines surrounding Apatity. Earning about 10 000 roubles a month, he was one of the top wage earners in the city. Through his job he had health and life insurance, and a number of other fringe benefits.

– I think the medical services in Apatity are very good! I never had any problems with doctors here. But to be honest – now I go to a private doctor here in Apatity. It is better to pay some money so you get the best quality service. The medical personnel in public hospitals earn very little – I think that people that earn more money do a better job.

It might be worth noting that Nikolay and his colleagues have to go through a thorough health check (health commission) every year. Those who are not in perfect health are downgraded to less well-paid (and less prestigious) jobs. Many industri-

al workers are afraid that these yearly ‘commissions’ will discover health defects, so they try to avoid initiating discussions on health problems with medical personnel because they do not want their medical records to indicate any ‘weaknesses’. One of the legacies of the former regime has been that many Russians do not trust public health institutions to keep information on their health condition confidential. This might be an additional incentive for Nikolay to use ‘unofficial’ health services.

Anya (33) also prefers private services for herself and her family. She is among our financially better-off informants.

– We spend a lot of money on medicine – and my family is quite healthy. Nobody has ever been seriously ill. I will estimate that we use between 10–20% of our income on medicines and other health-related expenses. We usually use the public services in Apatity, but if somebody in my family got seriously ill, I think I would go somewhere else – to a private clinic. Here the equipment is bad. And the specialists are better in private clinics. There are good people here too – but they have little scope for professional development.

– I think the public health care for children is particularly bad – in order to have a blood test, you have to go to the clinic and sit and wait – they refuse to send a nurse home to you, even if you offer to pay extra. In order to get access to a specialist you have to contact your doctor, and they refer you to the specialist who will treat you free of charge. Often you have to wait up to one month before you can get an appointment. But if you contact the specialist yourself, he might help you immediately. Sometimes you need to pay – sometimes not... No – this is not paying under the counter – it is not because you pay extra that you don’t have to wait – it is because you contact them directly. They never ask for money – I offer to pay myself. I know that doctors don’t earn much – and if doctors look after my child in a good way I want to reward them. I think good specialists should earn well – so I offer them some money. If you need a specialist you can often invite them to come home to you – and of course you pay, because this is their spare time, and it is additional work for them.

– I would prefer to be able to pay for health care – for good specialists. And I am sorry there are no private clinics in Apatity. Private clinics usually have better equipment and service. Some time ago I had an abortion in a private clinic in St Petersburg. I think the most important difference is in the way they treat you. This was the first time I had an abortion myself, but a woman I met there said she had had abortions in public institutions before and this was the first time after an abortion she felt like a woman, and not like a criminal.

The stories of Nikolay and Anya describe an almost formalised, but unofficial, system of private health care in Apatity. Nikolay was willing to pay for better-quality services, and we assume that he also valued the confidentiality of these unofficial services. In addition to better medical services, Anya was willing to pay for easier access and better treatment on a personal level (not only medical). They did not perceive their payments as bribes or under the counter payments. Anya argued that she paid to show her gratitude for easy access, or good quality. Nikolay did not even see a link with public institutions, and felt that what he buys are actually private services. According to both Anya and Nikolay, what they pay for is not part of the doctors' ordinary jobs, but additional work.

It is important to stress that, among all our informants, these two were the only ones that admitted to actually having paid for services in Apatity (except for chocolate, champagne or flowers at the end of a hospital stay). Several informants categorically refused that it is possible to pay for better service.

Elena (39) has higher education, and a well-paid job in the city police. She laughed when we asked if she had to give any gifts or pay a little extra to make sure her mother had the best possible service during her three-year treatment for cancer.

– This is a small town, and the doctors we have here would never have accepted it. If I had been in another city I think I would have had much more problems – but here they take good care of you – and you don't have to pay anything under the counter.

Other informants were convinced that they would get better treatment, if they had been able to pay a little extra.

Viktor (28) was married a few months previously. With only one, but relatively high income, his household was among the mid-income groups in our survey. Just before his wedding he had an accident, and injured his hand.

– I think the health care services in Apatity are very bad. When I went to the clinic after the accident I had to wait there for two hours, with blood running. As if they had forgotten about me. They didn't explain why – just told me to sit and wait.

He lifted his hand to show us one of his fingers is crooked.

– The doctors say it will grow OK – that there is nothing more they can do.

But Viktor did not believe them. He thought that if he could afford to pay for it himself, they could have straightened the finger out – or would have done a better job in the first place. He didn't have to pay anything for the plaster cast

or X-rays, not even for medicines. He was not certain if his job paid for it, or whether it was free. He had some kind of insurance at work, and this might have covered it – he has a friend who had to pay for X-rays recently.

Like Viktor, we cannot know if it would have helped to pay some extra money on the day he injured his hand, but his belief that it would is clearly supported by stories like those of Anya and Nikolay. Even if the doctors did their best on that day, it is hard to believe that they did. The results of the treatment disappointed him, and he knew that better-off people choose to pay in order to get better treatment.

Even though payment for services does not seem to be very common in Apatity yet, the advent of such potentially damage the performance and integrity of the health services in the long run. This might lead to increased pressure from health care staff for informal payments, reducing the time health personnel spend on official activities, and placing those who are not able to pay at the back of the queue. And, as stories like those of Nikolay and Anya get out, public dissatisfaction with official services will increase, because people will assume they will not get the best possible treatment, even when this is not true.

Knowing what you are entitled to, and getting it

Viktor's story also illustrates the lack of control people in Apatity have over what services they are entitled to receive for free and when they have to pay. In addition to coverage from the medical insurance fund, Viktor had additional medical insurance through his job. Still he did not know what services he was entitled to, and had to accept what they offered him (even though he is not satisfied). This was in striking contrast to Tatyana and her husband, who both have higher education and extensive networks. However, in spite of their resourcefulness, Tatyana tells a story of many years of fighting with health care institutions, in order to get the services they are entitled to.

Tatyana's 11-year old son had been ill for almost four years when we spoke to her. What started out with hospitalisation for bronchitis and an infection in a foot continued with an eye illness and the onset of a gradual blindness. She told a story of many years of fighting against the health care institutions. Her conclusion was clear:

– The medical services have become so much worse – you don't get what you are entitled to anymore. If you don't fight for your rights yourself, and you don't have financial resources, nobody will help you. If it hadn't been for the contacts

my oldest son has in St Petersburg, the help we got from the trade unions [where she knew the head of the local branch], and support from my work and relatives – I don't know what would have happened... I just think about those people that do not have the same resources that we have....

Tatyana's main complaint against the health institutions is that they did not send her boy to the right specialists, they left it up to the parents to find the children's eye clinic in St Petersburg that now seemed to be able to cure the boy. After months of hospital stays and specialist consultations in Apatity and Murmansk, the boy was still without a diagnosis. In the end the doctors gave up, and said there was nothing more they could do. The only thing Tatyana and her husband could do, they said, was to try to find a specialised institute outside of Murmansk oblast'. When they asked for suggestions or recommendations for where to go, the doctors in Murmansk could not help.

They spent their next holiday in St Petersburg, where their oldest son lives. They didn't know where to go, so they opened the Yellow Pages and started calling around to a number of specialists and hospitals. With some of the specialists, it would take six months before an appointment became available. However, making use of networks and contacts they were able to get in sooner. This is only possible through connections, Tatyana argued, or if you can pay some extra money. In the end they found a children's eye clinic, where they were accepted immediately. It turned out to be a clinic that is supposed to cover the needs of citizens living in all of the northern and north-western provinces; the clinic to which the child should have been referred in the first place, according to Tatyana. She and her husband refuse to believe that the eye specialists in Murmansk did not know about this clinic, and argue that they were not sent there in the first place for financial reasons. Any treatment rendered by specialised clinics in St Petersburg to a person living in the Murmansk would be invoiced to the Murmansk medical fund. According to Tatyana, the medical authorities in Murmansk want to avoid using specialists in other provinces to avoid such expenses. What provoked Tatyana the most is that since they did not know this in the beginning, they might just as well have found a clinic in Moscow or another city at the start. They would then have had to cover all expenses themselves. And it is hard for her to accept that it took so long before the specialists in St Petersburg got a chance to look at the child. According to the specialists in St Petersburg, some of the damage to the child's eyesight could have been avoided if they had been contacted earlier.

But the difficulties were not over just because they found the clinic in St Petersburg. The medical fund would only cover expenses for services that are not

available in Murmansk. Thus, for tests and diagnosis that could be done in Murmansk, they were supposed to bring the child back to Murmansk. Due to the large distances and high travelling costs, they decided to cover the cost of such tests themselves. One of the diagnostic tests cost 1 600 roubles. In addition, they had to pay for medicines and travel. An ordinary monthly income for the family is about 5 000 roubles. But, Tatyana said, if you want your child to get well, and everybody wants that, you pay the money. Luckily, they had friends and relatives to help them out economically, and she and her husband took additional jobs to help cover the costs.

Ira (48) tells a similar story. She and her husband both have higher education, but as Ira has been without work for a long time, their economic situation is relatively tight:

– When my daughter was ill some time ago, the specialists in Murmansk couldn't figure out what was wrong with her. They did not believe that she was ill, and sent us back to Apatity. Then we travelled to St Petersburg, where a doctor immediately diagnosed her illness, and prescribed effective treatment. We had to pay for the consultation and treatment ourselves. Luckily we got financial help from some friends.

We have to be open to the possible explanation that the hospitals in St Petersburg do not offer better diagnoses than the ones offered in Murmansk, but that, since they are able to demand outside funding from Murmansk CMI fund or private contributions, they exploit the parents who will try everything to ensure their children's health. However, the stories of Tatyana and Ira indicate that getting access to specialised hospitals and services outside Murmansk takes a lot of time and energy, as well as financial resources and/or networks. This might be a negative side effect of the decentralised system of financing and administration.

Cost of medicines

Although services largely are free, payment for medication is usually drawn from household budgets. For those in hospital, medicines are free when they are available. But hospitals are often short of medicines and, according to doctors and administrators, the medicines provided by the hospital are the cheapest sort. If patients can afford it, they recommend that they buy other, more efficient medicines themselves.

A survey conducted in Russia by Boston University in early 1998 found that household spending on health care in 1997 was equivalent to public spending – that is 3.5% of gross domestic product. Of the private expenditure, 57% was used on pharmaceuticals, and 42% on medical services. Very little (less than 1%) was spent on voluntary medical insurance (OECD 2001).

Children and invalids get medicines for free, but apart from this, both rich and poor have to pay for medication if the hospital does not have medicines available. During our interviews with patients that were in, or had recently been in hospital, we were not able to see a pattern about when they had to pay for medicine and when not. Thus, the unemployed and low-income households have no place to go for subsidised or free medication. In surveys the unemployed and members of low-income households in general tend to have lower self-rated health than members of better-off households, and are thus more often in need of medical services and medication. Some of the groups with the strongest need for medication are therefore the ones least likely to be able to afford them.

Several of our respondents said they had had to choose between buying medicines or medical treatment on one hand, and food for the family on the other. They usually chose to abstain from treatment. In most cases, they were referring to treatment for colds, operation against far-sightedness or other minor health conditions. However, one of our respondents was at home ill with pneumonia, having been sent home from the hospital because he could not afford penicillin.

One in 20 visits the polyclinic every day

One of the more striking findings of our study is the extensive use of, and general trust in, health care institutions among all social groups. The most frequent users are clearly families with children in urban areas. All urban families with children of school-going age had visited the hospital or polyclinic several times in the previous year for children's illness, in addition to a number of visits by various specialists to schools and nursery schools. Other respondents were in frequent contact with health institutions as well. If we include visits to the *feldsher* in the village, all of our respondents had had at least one visit to a health care institution in the year prior to our study, some several times a month. Many respondents felt it is necessary to visit a doctor for almost any symptom or illness. Even those who know they will not be able to buy any medicines or pay for treatment will contact a doctor to get a diagnosis, even for an ordinary cold.

Marina (26) is the sole supporter of four children and was struggling to make ends meet.

– I visited the polyclinic this winter. I had a cold. The doctors suggested I should drink some herbal tea and take some medicine. If the cold is bad enough they will send you for a massage, but if you are not able to buy anything they cannot help you. No, I didn't buy the medicine or tea he suggested, I had some old medicines from when the children were ill and I used those instead.

Marina knew the only thing the doctor would do was to diagnose that she had a cold, which she had already diagnosed herself, and suggest medicines and massages she couldn't afford or at least, would consider a priority. Even so, she still went to the polyclinic, as this is what she felt one does when one has a cold.

As Table 6 illustrates, in 1998 2.14% of the population in Apatity visited the polyclinic per shift. As there are usually two shifts per day in the polyclinic, almost 5% of the population visit the polyclinic each working day according to official figures. In addition, there are enough hospital beds for 0.7% of the population. These figures are much higher than what we find in the western parts of the Barents region.

Table 6: Indicators of health care development* in the Murmansk region and the city of Apatity

	1990		1995		1998	
	Murmansk region	Apatity**	Murmansk region	Apatity	Murmansk region	Apatity
Number of doctors per 10 000 inhabitants	49.3	66.9	44.2	52.3	44.0	51.7
Number of nurses per 10 000 inhabitants	152.6	203.2	130.5	216.4	129.8	219.5
Number of hospital beds per 10 000 inhabitants	112.9	85.3	107.4	73.3	105.6	70.5
Capacity of the polyclinics, number of visits during one shift per 10 000 inhabitants	168.9	170.8	208.8	267.3	213.0	214.8

Source: Murmansk Regional Committee of State Statistics & Russian Agency of Statistics (1998)

* This does not include the medical institutions of FSB and the Ministry of Defense.

* Statistics for 1990 include Polyarnye Zory.

The number of somatic beds per inhabitant, for example, is 2–3 times higher in Murmansk region and Apatity than in the Nordic countries.

Rules that determine budget allocations strongly emphasise in-patient care. In the last years of the 1990s, about 70% of available resources were spent on hospital care. Relative to the average in OECD countries, the average length of stay in a hospital is high. (OECD 2001).

From 1999, the local government of Apatity has attempted to reform the local health care system, to reduce the number of beds for overnight stays, and to develop a department for day-care/polyclinics (Mamchenkov, 2000), and in terms of hospital capacity Apatity is below the regional average. However, people who are used to the widespread use of hospitalisation find it difficult to understand it when the rules change.

Ijulja (40) was going to the hospital with her one-year old son at least twice a month. He had a bad cough that he seemed to be unable to get rid of. Once the child coughed very badly in the night and they called for the ambulance. But when the ambulance personnel came, they did not want to take the child with them. They just gave him some medicine and left again. Ijulia was very upset about this. There was no danger to the child's life, and she was never afraid that there was, but with a bad cough like that she felt that the child belonged in the hospital. She referred to this incident again later in the interview – arguing how offensive it was that the ambulance did not want to take the child to hospital.

Several of the nurses and doctors we talked with said that it is a major problem that poor people try to get into hospital in order to get food for free. Some poor pensioners are allowed to stay in spite of not having a serious medical condition, while other groups are not allowed to take up hospital beds unnecessarily. It is difficult to determine whether this influences the help people get, but we do not believe it helps the quality of health care if health care personnel expect that certain groups of people come to hospital pretending they are ill.

Misha (22) had recently spent three months in hospital after a complicated operation. He could not praise the nurses in the hospital enough for the care and empathy he received during his stay. But not everybody got the same treatment as he did.

– Do they treat people differently? How differently... there are all kinds of people in the hospital. I wouldn't say they treated anybody badly – after all their work is not very well paid.

Do they even treat the alcoholics nicely, we asked, and without hesitation he exclaimed:

– No – there are these low-caste people that refuse to take injections and make a lot of fuss – and they are not treated well. These low-caste people pretend to be ill so that they can come into hospital and get food. They have one separate room for this kind of person, and others – working people – get to stay in another room.

In spite of their relatively frequent use of health care institutions, many argued that they believe in self-cure, and preferred to heal themselves rather than to visit the health care institutions. One of the leading doctors in the hospital even argued that the ‘Russian tradition of self cure’ is a problem, because many patients only come to hospital when their illnesses are advanced and there is little that the doctors can do. To us it seemed like a paradox that a country with one of the highest number of medical personnel and health consultations per capita in the world, and a thorough system of health checks in schools and workplaces, has a problem with patients not seeking medical attention soon enough.

When being strong becomes a problem

Women and children need vegetables, men just need a job

As we established in beginning of this report, men die very young in Russia, mainly from lifestyle-related diseases and accidents. Among Russian males, we find one of the world's highest liquor consumptions and smoking prevalence. The Russian diet is also one of the worst in the world in terms of cholesterol and saturated fat. In addition some undernutrition, even hunger, occurs among the poor and unemployed. Many workers are exposed to low workplace security, while psychological stress and alienation leads to self-destructive behaviour and suicide. The list of health hazards is long, and it may not be difficult to understand why this country has such high death rates. The challenge lies in understanding *why* these hazards are so widespread in Russia.

Through our fieldwork in Apatity and surrounding areas, we could not help but be touched by the strength displayed by people and by their ability to endure almost anything. Suffering, coping and strength are central topics in both classical and modern Russian literature, and they are also recurring topics in this report. To the extent you can talk about a typical Russian mentality, it could be said it is based on a strong admiration of strength – not necessarily physical strength, but perhaps more importantly, mental strength; the ability to cope and endure. While it is acceptable, even expected, that children, women and the elderly display some weakness, adult men are expected to be strong all the time. We contend that this ideal, or more specifically the way the strength ideal becomes translated into health behaviour, has become one of the major health risks in Russia, *because, at some point living a healthy life implies admitting to being vulnerable.*

Let us briefly summarise some of the areas where the strength ideal is translated into risky health behaviour among our respondents:

First of all, there seem to be a perception that as long as they get enough energy, strong men do not need a varied diet with vegetables and fruits. When deciding what food to prepare for the family, women would often say they would like to buy more vegetables and fruits, but would prioritise buying meat 'for their husbands'. Several men stated that they did not like vegetables, and therefore did not eat them. There is no lack of knowledge about the nutritional advantages of

vegetables. Everybody knows that fruits and vegetables are supposed to be good for health. However, vegetables are seen as something children and sick people need. For an ordinary strong man, the most important dietary component is perceived to be meat.

Secondly, it is a widespread belief that strong men do not develop alcohol dependency. There is a general understanding that many drink much now because times are tough, but it is expected that once things 'go back to normal', most of them will stop drinking. To refer to strength in connection with addictive behaviour is not unique to Russians, but the explicit reference to strength not only among the addicts themselves, but among people from all parts of society, including health care personnel, is quite exceptional. As a result of this, alcohol dependency is not seen as a serious problem in itself, and it is not seen as a threat to 'the ordinary strong man'. A man who cannot 'pull himself together' and stop drinking is perceived as weak.

Furthermore, it seems that people believe that a strong man is less vulnerable to the dangers of both alcohol and tobacco. Most respondents (both men and women) would see it as more worrying that women drink and smoke, even though women generally drink and smoke much less than men do, and have much lower mortality rates. Smoking or using alcohol is thus not perceived as a risk to your health if you are strong enough.

Thirdly, 'strong men' are not concerned about high risk at work. Men are supposed to be able to support their family, so if they do not have an academic education, they often prefer well-paid high-risk jobs in heavy industry. In spite of a high awareness of health hazards, nobody wants to change jobs just because of the risks involved. Among the unemployed men we talked to, nobody could imagine saying no to a job because it was too dangerous. Even though they know that accidents happen regularly, it seems like many believe they are not at risk themselves; accidents were thought to happen only to people who make mistakes.

These results and others, combine to form a worrying pattern – it seems generally accepted that 'a strong man' does not need to live a healthy life. The male strength ideal is presented as a type of genetic strength – it is something you *are*, not something you get. Thus limiting your alcohol consumption and eating more vegetables becomes an indication of weakness, rather than an indication of strength.

These individual attitudes are echoed in health care institutions and among health care personnel. Those in need of care and advice on healthy living are mainly perceived to be children and invalids, and also to some extent the uneducated and resource-poor. The strong and successful (the wealthy and employed) are assumed to live a healthy life by definition. Adult males who are neither employed nor successful, escape the attention of health care workers and administrators. They seem to be the unworthy needy – people who are supposed to be able to take care

of themselves, but prove that they are not able to do so. Adult males thus seem to fall into one of two categories; the strong who can help themselves, or the weak who cannot be helped.

Laws, information and knowledge

Health care workers acknowledge that preventative health care is important (as we may expect them to do in a study on lifestyles and health), but argue that it is not the responsibility of medicine. Among doctors and nurses, the focus is almost exclusively on treatment of illness, and perhaps teaching people about hygiene.

One of the leading policymakers in Apatity said:

– Lifestyle-related diseases are caused by inheritance, way of living, bad habits, social problems, ecological problems and lack of physical activity. People do not seem to understand that their health is in their own hands. They do not think much about their health and do not appreciate a healthy life. The lifestyle-related diseases are so linked to the people's own efforts and there is not much that medicine can do. As little as 10% of illnesses can be cured by medical treatment. The only thing health care institutions can do is to influence people's lifestyles by giving more information about hygiene, how diseases arise and can be detected at an earlier stage. But because of the difficult social situation, people do not absorb information any more. Very few read the medical information in newspapers. It has also become more difficult to print such information, as we have to pay for advertisements. The main threat to the health situation in the future is the low living standard and lack of money for preventative health care.

The challenges in reducing non-communicable diseases associated with lifestyle are different to those associated with communicable diseases. While infectious diseases could be fought through a 'positive' modernistic approach, introducing modern medicine, feeding of children and 'modern' standards of personal and domestic cleanliness, fighting non-communicable diseases implies deprivation of the 'fruits of modernisation', such as tobacco, animal products and sugar in diet, alcohol and the use of machines to avoid excessive muscular exertion. Experience from other countries has shown that, in order to reduce the risk of these lifestyle-related diseases, it is important to increase people's awareness of risks, and increase knowledge of what constitutes a healthy diet. Many countries have used legislation or economic incentives to improve general health, through limiting smoking in public buildings and the work environment, raising the cost of tobacco, alcohol and animal fat and subsidising physical exercise, vegetables and other healthy dietary

components. Laws have proven helpful to reduce risks, for instance through increasing the use of seatbelts, or improving working conditions. Sometimes laws, education and persuasion combine to encourage diminishing risk for instance through health warnings on tobacco packages, and bans on tobacco advertisements. (WHO 2002)

The majority of the Russians do not have a problem with getting sufficient dietary energy. However, our survey indicates that there is a substantial lack of knowledge and awareness, among both health care workers and ordinary people, about healthy diets, and in particular about the potential harm of excess animal fats and the acceptability and health benefits of vegetable protein.

Health care workers and administrators expressed worry that low-income families eat too little meat and too few dairy products, and live mainly on 'potatoes, dark bread and pasta'. Quite naturally, many people miss the luxury components of their diet – if they did not have to think about money, they say they would buy white bread, meat and sweets for the children. A diet with varied and tasty food might be important for people's quality of life, and we will not argue that luxury food components are not important or relevant. However, in nutritional terms there is a strong indication that the diet of the relatively poor, comprising dark bread (not white), less meat and fewer sweets and cakes is potentially better than the diet of the more affluent. There is a risk that a future increase in people's income will make sugar, meat and animal fats more important components in people's diets, leading to overweight and diabetes, and a further increased risk of cardiovascular disease.

A number of respondents from households with a relatively well-balanced diet believe that what they eat is bad for their health, and this introduces an extra element of stress in their daily lives. More knowledge about correct nutrition and advice on how to make healthy food choices may lead not only to a healthier population, but might remove some of the worries for relatively large groups of the population at the same time.

High-risk groups are overlooked.

We started out by saying that the media, administrators and health care personnel argue that poverty is the main threat to health in Russia. We do not deny that the poor in Russia face a number of challenges to living a healthy life. However, it is our belief that by focusing exclusively on poverty and on the traditionally weak groups, there is a risk of overlooking two other major risk groups in the Russian society – the traditionally strong groups of the more affluent and adult men in general.

In Russia little or no attention is paid to the nutritional challenges of the more affluent. In Western countries, campaigns to change people's eating habits, the

introduction of low-fat dairy products, reduction in meat consumption and increased intake of fruits and vegetables led to reduced cardio-vascular mortality in the last decades of the 20th century. For this change to take place in Russia, campaigns are necessary here too. However, more importantly, health care personnel need stronger awareness of risk factors and about healthy diets, so they can give advice to everybody about how to live a healthier life, not only those who come from the poorest households.

Most importantly, there is a need to focus on adult males in the age group 30–55, the group that all statistics indicate runs the largest health risks in Russia today. This report shows that the risks are abundant: high alcohol consumption, smoking, stress, high-risk jobs, and unhealthy food. If the goal is to reduce mortality figures for this group, the focus must be on the problems they are facing as well.

In our study we did not meet many who talked about hunger, but those who did were largely unemployed men living alone. The Russian government, international organisations and NGOs run several food security programmes in Russia. However, the major target groups for these programmes are children, and sometimes the disabled and the elderly as well. Young men generally have nowhere to go for help. As we find in most cultures in the world, young men are expected to manage on their own. However, in a country with high unemployment, limited unemployment benefits, and very limited possibilities for growing or gathering food, managing on your own may be difficult, even for the young and strong men.

In order to reverse the high mortality trend for this group, it is necessary to accept that traditionally strong groups of society are vulnerable as well.

References

- Bateson, Gregory. 1972. *Step to an ecology of mind*. New York: Ballantine.
- Chenet L, McKee M, Leon D, Shkolnikov V, Vassin S. 1998. *Alcohol and cardiovascular mortality in Moscow; new evidence of a causal association*. J Epidemiol Community Health 1998 52: 772-774..
- Cockerham, William C. 1997. "The Social Determinants of the Decline in Life Expectancy in Russia and Eastern Europe" in *Journal of Health and Social Behavior* 38:117-30.
- DaVanzo Julie & Grammich, Clifford 2001. *Dire demographics: Population trends in the Russian Federation*. Santa Monica, California: Rand.
- Doak, Colleen, Adair, Linda, Monteiro, Carlos & Popkin, BM. 2000. Overweight and underweight co-exists in Brazil, China, and Russia. *Journal of Nutrition*, 130:2965–80.
- Döbrösy, L. 1994. *Prevention in primary care*. Copenhagen: World Health Organisation Europe. (Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme report.)
- Durkheim, Emile. 1997. *Suicide: A study in sociology*. New York: Free Press.
- Economic Research Service. 1997. International agriculture and trade: Newly independent states and the Baltics, in *International agriculture and trade* (March 1997) Washington, DC: US Department of Agriculture.
- Evdokimov, Juri A. 1999. *Zdravokhraneniye Kol'skogo Severa – analiz sostoyaniya i zadachi na 1999–2000 gody* (Health care in the Kola North - analysis of the situation and tasks for 1999–2000).
- Glazunov, I. S. (red.) 1996. *Issledovanie potrebnostey dlya organizatsii effektivnoy profilaktiki serdetsbno-sosudistych i drugikh neinfektsionnikh zabolevaniy, ikh faktorov riska i ukreplenii zdarov'ya v Rossii*. Moscow, 1996.
- Goskomstat 1996 *Statisticheskii Ezhegodnik*. Moscow: Goskomstat

- Goskomstat. 2000. *Sotsial'noe polozhenie i orovyen' zhizni naseleniya Rossii*. Moscow: Goskomstat.
- Horton, Susan 2001. *The nutritional and epidemiological transitions*. Paper presented at the Sustainable Food Security for All by 2020 conference, 4–6 September 2001, Bonn, Germany.
- Kleinman, Arthur 1980. *Patients and Healers in the Context of Culture* University of California Press, Berkeley, LA.
- Kopp, Maria S; Skrabski, Arpad & Szedmak, Sandor. 2000. Psychosocial risk factors, inequality and self-rated morbidity in a changing society. *Social Science & Medicine*, 51:1351–61.
- Lopez, Alan D. 1999. Male mortality remains on the rise worldwide. *Global Health & Environment Monitor*, 7(2), Fall. /Center for Communications, Health and the Environment (CECHE), Washington DC/ (www.ceche.org/publications/monitor/vol-7/mnfall99.pdf)
- Mamchenkov V. 2000. “Zdravoohranenie v Apatitakh” [Health care in Apatity]. *Kirovskiy Rabochiy*, 7(18), February.
- Martinchik, AN, Baturin, AK & Helsing, E. 1997. “Nutrition monitoring of Russian schoolchildren in a period of economic change: A World Health Organization multicenter survey, 1992–1995”. *American Journal of Clinical Nutrition*, 65.
- Murmansk Regional Committee of State Statistics. 2001. Goroda i rayony Murmanskoy oblasti/ [Towns and districts of the Murmansk region]. Murmansk.
- Nordic Medico-Statistical Committee. 1998. *Health statistic indicators for the Barents Euro-Arctic Region*. Copenhagen.
- OECD (Organisation for Economic Cooperation and Development). 2001. *The social crisis in the Russian Federation*. OECD Centre for Co-operation with Non-Members. Paris: OECD.
- Palosuo, Hannele. 2000. “Health-related lifestyles and alienation in Moscow and Helsinki”. *Social Science & Medicine*, 51:1325–41.
- Persson, LG, Lindstrom, K, Lingfors, H, Bengtsson, C & Lissner, L. 1998. “Cardiovascular risk during early adult life: Risk markers among participants in ‘Live for Life’ health promotion programme in Sweden”. *Journal of Epidemiology and Community Health*, 52:425–32.

- Popkin, Barry. 1996. *Childhood obesity is a worldwide epidemic*. The American Society for Clinical Nutrition. www.faseb.org/ascn/nov96pr.htm
- Powells, John. 1991. *Changing lifestyles and health*. Background paper for Technical Discussions at 43rd Session of Regional Committee, September, 1991, World Health Organization, Regional Office for the Western Pacific, Manila, Philippines.
- Seeman, M. 1959. "On the meaning of alienation". *American Sociological Review*, 24:789–91.
- Tkatchenko E, McKee M, and Tsouros A.D. (2000) "Public Health in Russia: the view from the inside". *Health Policy Plan* 15(2) p164-169.
- UNDP (United Nations Development Programme) Russia. 2000. "*The Arkhangelsk Declaration*": *Promoting healthy nutrition in the Russian Federation*, Newsletter 6/2000. www.undp.ru/eng/Newsletter
- Unicef. 2002. *The state of the world's children 2002*. New York: Unicef.
- Weber 1948 "Class, Status, Party", in *From Max Weber*, Gerth H and Mills C.W. (eds), London: Routledge
- WHO Europe (World Health Organisation Regional Office for Europe) 1999. *Highlights on health in the Russian Federation*. Copenhagen: WHO Epidemiology, Statistics and Health Information Unit. www.euro.who.int/document/e72504.pdf
- WHO Europe (World Health Organisation Regional Office for Europe) 2001/2002. *Country information*. www.euro.who.int/countryinformation
- WHO (World Health Organisation). 2000. *MONICA population survey data book*. Geneva: WHO.
- WHO (World Health Organisation). 2002. *The world health report*. Geneva: WHO.
- WHOSIS (World Health Organisation Statistical Information System). 2002. *WHOSIS*. www3.who.int/whosis
- Zaridze, David. 1999. "Russian men face the worst health prospects in the world". *Global Health & Environment Monitor*, 7(2), Fall. /Center for Communications, Health and the Environment (CECHE), Washington DC

Trying to be strong

Trying to be strong portrays the health challenges and problems that individuals face in the Russian North. The analysis focuses on lifestyles, with particular emphasis on how people think and act in relation to risk factors such as diets, alcohol, smoking, stress, and workplace security. The analysis is based on interviews with more than 50 ordinary Russian citizens, health care workers and representatives from public administration in the city of Apatity and a nearby village in Murmansk oblast'.

The background for this study was the low life expectancy and high mortality from non-communicable diseases that we find in Russia today, where the mortality figures for middle-aged men are particularly worrying. **Trying to be strong** shows how an ideal of being strong often is translated into potentially harmful health behaviour, in particular among adult men. At the same time, the health challenges of adult men are often overlooked, also among health care workers and administrators. We argue that in order to reverse the high mortality trend for this group, it is necessary to focus on the challenges that these groups are facing. We also have to acknowledge that these traditionally strong groups of society may be vulnerable as well.

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