

This article was downloaded by: [University of Aberdeen]

On: 27 May 2014, At: 14:22

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number:  
1072954 Registered office: Mortimer House, 37-41 Mortimer Street,  
London W1T 3JH, UK



## Journal of Communist Studies and Transition Politics

Publication details, including instructions for  
authors and subscription information:

<http://www.tandfonline.com/loi/fjcs20>

### Talking About Health and Well-Being in Post-Soviet Ukraine and Russia

Pamela Abbott & Claire Wallace

Published online: 16 May 2007.

To cite this article: Pamela Abbott & Claire Wallace (2007) Talking About Health and Well-Being in Post-Soviet Ukraine and Russia , Journal of Communist Studies and Transition Politics, 23:2, 181-202, DOI: [10.1080/13523270701317455](https://doi.org/10.1080/13523270701317455)

To link to this article: <http://dx.doi.org/10.1080/13523270701317455>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>

# Talking About Health and Well-Being in Post-Soviet Ukraine and Russia

---

PAMELA ABBOTT and CLAIRE WALLACE

---

Residents of Ukraine and Russia perceive their living conditions and health as very poor. This is coupled with concerns over access to social services and health care. There is a strong interaction between the poor quality of life after the economic and political collapse and the views of individual citizens about their ability to take responsibility for their health. The collapse of the former supportive system was a 'cultural trauma' that affected citizens' capacity for looking after their own health and well-being. In such a context of transition economies, the concept of agency is of limited explanatory value.

---

In this article we try to give voice to the citizens of post-Soviet Russia and Ukraine – letting them speak for themselves about the impact of the transition on their quality of life and health. Much of the published research on health and quality of life in post-Soviet societies has been on the Russian Federation

---

Pamela Abbott is Vice Rector Academic at the Kigali Institute of Education, Rwanda, and Director of the Caledonian Centre for Equality and Diversity at Glasgow Caledonian University, UK. She is at present working on an EU-funded research project on young people's experience of the transition in Moldova, and with Claire Wallace on a DFID-funded project on Girls into Science and Technology in Rwanda and an EU-funded project on Work–Life Balance in the enlarged European Union. Claire Wallace is Professor of Sociology at Aberdeen University, UK. As well as the projects on which she is jointly working with Pamela Abbott, she is currently researching migration in Central and Eastern Europe and is working on a number of projects related to social quality.

This article is based on work produced as part of the 'Living Conditions, Lifestyles and Health Project' (LLH) funded by the EU under INCO-Copernicus (contract ICA 20000-10031). Professor Christian Haerpfer, University of Aberdeen, UK, who at the time worked at the Institute for Advanced Studies, Vienna, Austria, directed the project. Professor David Rotman (Belarus State University, Minsk), Professor Valeriy Nikolayevskiy (Kharkov, Ukraine) and Professor Sergei Tumanov (Moscow State University, Russian Federation) coordinated the research, which was supervised by the authors of this article. We are grateful to the members of the LLH research team who participated in the collection and charting of data and the medical experts and citizens in Russia and Ukraine who participated in interviews and focus groups. The Ethics Committee of the University of Derby approved the qualitative study, and oral informed consent was obtained from all study participants at the beginning of the interviews. The authors alone remain responsible for the views expressed in this article and they do not necessarily reflect the views of the European Union.

Journal of Communist Studies and Transition Politics, Vol.23, No.2, June 2007, pp.181–202

ISSN 1352-3279 print/1743-9116 online

DOI: 10.1080/13523270701317455 © 2007 Taylor & Francis

and has been based only on quantitative survey data. In this essay we draw on the qualitative data from the 'Living Conditions, Lifestyle and Health' project to give a voice to the citizens of Russia and Ukraine, building on the reports we have previously made using both qualitative and quantitative data from the project.<sup>1</sup> The previous reports show that since 1991 the majority of the population of Ukraine and Russia have seen a decline in their well-being and their health, with a majority struggling to survive and men in particular engaging in high levels of cigarette smoking and 'binge drinking' of spirits. While women are significantly more likely than men to report poor physical and psycho-social health, there are few gender differences with respect to perceptions of quality of life more generally.<sup>2</sup> We argue not only that the transition has had a fundamentally negative impact on health and on quality of life, but also that the two are inextricably interrelated and mutually reinforcing. Qualitative data enable us to understand more fully the impact of the post-1991 changes on people's quality of life and their health and also the extent to which they feel able to exercise agency and take control of their lives.

The collapse of communism in the USSR in 1991 resulted in rapid and dislocating economic and social changes that have been little short of cataclysmic, and this has already been well documented.<sup>3</sup> The economic transition in Russia and Ukraine has been accompanied by economic crisis, exemplified in declining GDP, hyperinflation and cuts in state welfare spending. The social impact of transition can be seen, for example, in terms of increasing inequalities, and rising poverty, unemployment and violent crime.<sup>4</sup> One of the main objective indicators of the adverse impact on well-being is the unprecedented decline in life expectancy and the increase in poor self-reported physical and psycho-social health in comparison with the communist era. Male mortality increased dramatically after 1991, especially for men in mid-life; and, although it subsequently showed some improvement, it remains higher than before 1991 in both countries, with Russia having the highest male/female life expectancy gap in the world and Ukraine one of the highest.<sup>5</sup> Women live longer than men, but they report higher levels of psycho-social stress than men, poorer physical health and a higher incidence of limiting long-term illness.<sup>6</sup>

Sztompka,<sup>7</sup> in a sociological analysis of the transition, argues that post-Soviet societies are experiencing cultural trauma as a consequence of the rapid, comprehensive, unexpected and radical or fundamental change: they are societies in which there has been a breakdown of social trust and a loss of a sense of agency. Insecurity and uncertainty have become a normal experience of daily life for many citizens. The dislocation in the social structure has resulted in a breakdown in the normative patterns that define the expectation of actors, the patterns of social relationships among actors, and the embodied perceptions, habits and skills by which people produce and reproduce institutional and related structures. It is not only that structural change

means that people's life chances have been transformed (and, for many, for the worse), but so also have their understanding of how to make life choices and their ability actually to do so. Culturally shared templates are no longer appropriate for guiding behaviour in the changed socio-economic and cultural contexts. Cockerham and his colleagues<sup>8</sup> have argued with specific reference to health lifestyles not only that the socio-economic conditions in the countries of the former USSR make it difficult for citizens to exercise agency, but that the *habitus* inherited from Soviet times means that the majority of the population, and especially men, have unhealthy lifestyles. Informed by these analyses, we have previously demonstrated that, in order to understand the connection between the transition at a national level and specific problems (such as a decline in health) at the level of the individual and household, it is necessary to take into account the role of *agency* – the scope for households and individuals to act (or not act) within the context of structural changes.<sup>9</sup> A majority of the population of Russia and Ukraine report feeling insecure and unable to take control of their lives, and this has a major influence on their quality of life. The major factors affecting their cognitive evaluation of their satisfaction with life are economic, while the major influence on their mood – their happiness – is their health. Citizens feel unable to influence their economic situation or to take responsibility for improving their health.<sup>10</sup>

There are two competing explanations of the pathways linking individual response to the structural changes – the life choices that people are able to make and the agency they are able to exercise in the context of their changed structural life circumstances:

- i. *Social reward deficit theory* argues that the adverse socio-economic conditions have created a situation of demand and reward deficit, especially for middle-aged men, who have lost their core social roles. They are unable to develop appropriate psycho-social coping strategies; by contrast, women, who retained their core domestic roles, are still able to do so.<sup>11</sup>
- ii. *Health lifestyles theory* argues that the coping (or non-coping) strategies culturally available to men – smoking, drinking alcohol and binge drinking – are inherently life-threatening. The collective *habitus*<sup>12</sup> disposes men to engage in unhealthy lifestyles while disapproving of women doing so, accounting for the gender mortality gap.<sup>13</sup>

We have previously argued for a position, combining these perspectives, which points to lack of predictability and personal control, together with poor quality of life after the economic and political collapse, as important influences on stress and on behaviour.<sup>14</sup> Beyond this, a collapse in well-being and a daily struggle for survival are unlikely to lead to people putting

health lifestyles at the top of their priority list, and indeed will probably mean that they take what pleasure they can from life even if they know that what they do is health-damaging.<sup>15</sup> Men's actions – their heavy and binge drinking and excessive smoking – can be seen as a way of reasserting some measure of control and choice over their lives and lifestyles: a way of coping with stress, and one that is culturally available and 'scripted' for men but not for women. (One would then argue that control is not everything – that this is unsatisfactory as a coping stratagem because the physical harm done by the alcohol, especially when they begin to drink *samogon* ('hooch') and various types of industrial alcohol drink, outweighs any psychological benefit from the control over stress.) Beyond this it is important to note that the impact of lifestyles on health is cumulative; historically poor health lifestyles leave men vulnerable to heart attacks, while historical habits, especially related to alcohol consumption, mean that they are at risk of death from external accidents and violence. (Women, of course, also gain some protection from oestrogen until the menopause.) Thus, while men die, women survive, to struggle on with a poor quality of life and poor health. In this article we give a voice to the survivors – men and women in mid-life who have experienced the changes after 1991, and young people who have grown up in the post-1991 world.

### The 'Living Conditions Lifestyle and Health' Study

The 'Living Conditions, Lifestyles and Health' project is a multi-level study of how the health of the populations in Armenia, Belarus, Georgia, Kazakhstan, Moldova, Russia and Ukraine has been affected by a number of factors, including socio-economic conditions, cultural and ethnic factors, psychosocial factors and lifestyle generally. In this article we use the qualitative case-study data for Russia and Ukraine. We have sampled a region in each country that is very deprived and has poor health (Arkhangelsk in Russia and Kherson in Ukraine), one that is less deprived with better health (Samara in Russia and L'viv in Ukraine), and the Chernobyl-affected region in both countries (very deprived regions, although less so in Russia than Ukraine, with poor general health and experience of the worst impact of the radiological contamination following the accident at the nuclear reactor in April 1986). Further information on the project, including a number of reports and papers, can be found on the project's website.<sup>16</sup>

The qualitative case-study data used in this study were collected in late 2002 and the early months of 2003 and include various approaches.

- Qualitative agenda interviews, each lasting approximately one hour, were carried out with men and women aged 30 to 50. Fifty interviews were

carried out in each of two contrasting case-study areas in Russia and Ukraine and 30 in the Chernobyl region in each country. A quota system was employed for the selection: half of those interviewed were men and half women; half were from rural areas and half lived in urban areas, and roughly a quarter had higher education, a quarter incomplete secondary education, and half complete secondary or secondary and technical education. In total there were 260 interviews.

- Three focus groups were conducted in each case-study area in Russia and Ukraine (one with men and one with women aged 30–50 and one with young adults), and two (one with women and one with men aged 30–50) in the Chernobyl region in each country. In total, 16 focus groups were conducted, each comprising eight members (128 participants in total), deliberately selected to represent a range of ages and socio-economic backgrounds.
- There were interviews with 32 medical experts: a national expert in each country, two regional experts in each region and three local experts in each locality.
- The field notes of the research assistants and notes of the comments and observations they made at debriefing interviews during the course of fieldwork and at the post-fieldwork training sessions were also analysed.

The interviewers were all qualified sociologists employed as research assistants by partner universities in Russia, Ukraine and Belarus that had responsibility for coordinating the qualitative case studies. We trained the researchers in qualitative research methods, including interviewing and data analysis, at two summer schools. The agendas for the interviews and the topics for the focus groups were discussed and agreed at the first summer school and included social and economic situation as well as respondents' material and social circumstances and their understanding of health and illness. A training manual and guide to carrying out the research was produced in Russian and English after the first summer school.<sup>17</sup> We maintained contact with the lead researchers during the fieldwork phase by e-mail and made visits during the period when the fieldwork was being carried out. The interviews and focus groups were recorded and transcribed in Russian or Ukrainian, with a sample of the individual interviews and all the focus groups and expert interviews translated into English.

*Framework*<sup>18</sup> was used as the method for coding and categorizing data. We worked with the Russian and Ukrainian research assistants on a sample of interviews to agree the main themes and construct an index. The research assistants then constructed the matrix charts summarizing what each respondent had said in the individual interviews on each topic in the index, keeping as closely as possible to the informants' own words and including

illustrative quotations. The charts were then translated into English. We analysed the focus groups and expert interviews ourselves. As translators at research team meetings, and for translating the charts, we employed university research assistants who teach English to sociology students. This article is based on an analysis of the interview charts and the transcripts of focus group and expert interviews, supplemented by our notes from the debriefing sessions and other meetings with the research assistants.

## Findings

### *The Economic Situation*

The major impression given by the qualitative data is just how bad the majority of the people in the six regions think things are – how poor their quality of life is, and the range of chronic health problems they are experiencing. They talk repeatedly about the daily struggle for survival – poverty; poor health; unemployment; a decline in trust; a decline in close relationships with neighbours; an increase in selfishness; politicians who do not care about them; not being able to afford a good diet, clothes, or education for their children or to pay the charges for medical treatment; an increase in the consumption of alcohol and in cigarette smoking, including drinking and smoking by women and young people; and an increase in the use of hard drugs by the young. The present is compared unfavourably with the past. Young people are especially concerned about lack of employment opportunities and often report poor health. They also complain about the environment, the poor water supply, the unreliability of public utilities, including heating in the winter, the lack of street cleaning in the towns, pollution from cars and the impact of nuclear accidents (and not only in Chernobyl). Frequent mention is made of lack of time for rest and leisure, especially in the rural areas, and the inability to afford holidays. The last of these is a particular concern in Chernobyl because of the therapeutic value of spending time in a clean environment, and in Arkhangelsk because of the need to spend time in a warmer climate. Exceptions are few. A handful are relatively well-off, and others strive to cope and make do as best they can in difficult circumstances. However, the overwhelming view of the interviewees was that in general things had got worse since 1991 even if, in a very few cases, their own personal circumstances had not declined, and that they could do little to remedy the situation and had little expectation that things would improve. While the accounts of our informants, mainly aged 30–55 years, make evident the struggle they have in just surviving, they pointed out that in their view those hit hardest are pensioners and children (paradoxically, the groups where mortality has changed the least).



The perceptions of our informants were clearly shared by the medical experts we interviewed, who also pointed to the lack of investment in state health care, the difficulty of recruiting and retaining medical staff and the low salaries paid to health care professionals. The health care experts also pointed out that the main problems are economic. Health is mainly determined by factors other than the provision of health care – the environment, stress, unemployment, smoking, drinking, diet – and improvements in health and well-being will come only with economic improvement: ‘the main thing [to improve health] must be to improve the standard of living – it must be sufficient to satisfy the main needs of people. Then we could start talking about improving the state of health’ (Local medical expert, Kherson).

From our research assistants’ field notes we can see that they were struck by how hard everyone seemed to work – especially in rural areas – and surprised that the interviewees in Chernobyl looked so much older than their real age. When interviewing informants and running focus groups they found that people kept wanting to return to the economic situation and that even in Ukrainian Chernobyl they were more concerned about the economic situation and its impact on their health than the effects of the nuclear accident (although there was more concern about the consequences of the accident in Russian Chernobyl). They also thought that the respondents in the interviews underestimated the frequency with which they drank alcohol, the amount of alcohol they consumed and the amount of home-produced spirit (made both for personal consumption and for sale). They point to the quantity of alcohol available and suggest that someone must drink it, as well as reporting that in the rural areas they were told that they would have to hold the male focus groups early or the men would be drunk (indeed, on more than one occasion they had to exclude potential participants because of their state of inebriation). Again, the interviews and focus groups provide clear evidence that people’s initial responses to questions on alcohol consumption were conservative in terms of both the frequency of drinking and the amount consumed, and that there was reluctance to admit making or consuming (sometimes both) home-produced spirits. While women undoubtedly consume less alcohol than men, the discussion in the focus groups would suggest that women do drink more alcohol, and drink it more frequently, than they admit in the individual interviews. Again, the discussion in the focus groups suggest that alcohol consumption has increased significantly since 1991, as has the amount of drunkenness, although individual interviewees often claimed to have moderated their drinking. Our research assistants also noted that that, while women talked about their own health problems, men talked about health problems in general.

There is clearly a strong view that things have changed – for the worse – and that there was little that people could do to improve the situation. As the

members of the female focus group in Samara pointed out, 'We need to improve the economic situation before anything will change for the better'. There has been a loss of stability and certainty. Life was said to be a constant struggle and compared unfavourably with the past: life was seen to have been more stable and predictable before the transition: 'What pleasure are you talking about if you are working for next to nothing and even these minor sums are constantly delayed? There is no pleasure in any of this. If only I had a better alternative' (Female, middle education, L'viv).

The changes were seen to have been not just economic but also in the political system. In the changed system people do not know how to take responsibility for their lives – the previously shared templates are no longer seen to be an adequate guide. As a member of the male focus group in L'viv put it,

The transition to democracy brings about the problem of the loss of paternalism. That is, we used to know that the state would provide a flat, work and so on and now the state's guardianship has vanished. Now we are on our own. We must rely on ourselves – but we can't and we become depressed.

In similar vein, a member of the female focus group in Kherson pointed out that 'we used to have a normal life; we did not need for anything. And what do we have after ten years of independence? I am in such a state I just do not know what to do'.

There was also a general lack of certainty, of confidence. As one local medical expert in the Ukraine said:

[T]he constant instability in society and lack of confidence among the population . . . I remember that in my early years in the former Soviet Union I never woke up thinking that tomorrow I would not have enough to eat. There was no sword of Damocles, which forced me to think ahead and to think, what would I eat the next day? Today the overwhelming majority of the population lies under the sword of Damocles. And of course this constant psycho-emotional negative stress can't help having a negative effect.

The constant refrain was that living standards had deteriorated and the cost of everything risen and that employment opportunities were poor, especially for men and young people. The wages of those in employment were generally said to be low, wages were often not paid or paid late, people frequently had more than one job, and it was necessary, for survival, for all the adults in a household to have paid employment:

[W]e live on my salary. My husband works but his organization does not pay his salary. You can't live on one salary. We survive. We have a small kitchen garden. The prices are crazy and once you take away the payment for communal services from my salary, it is one-third, there is little left. (Female, higher education, Ukrainian Chernobyl)

People were not asking for much. They did not have high expectations – they want to be able to afford necessities. As one male informant with higher education in L'viv put it, 'The financial situation does not allow us to buy all the necessities – I cannot afford health treatment or clothes – the price of things goes up but our salaries stay the same'. People were also said to be working harder for less pay. Respondents over retirement age frequently indicated that they had to continue to work, and those who had vegetable gardens relied on them as an essential source of food. Although the living standard, on average, did seem to be marginally higher in L'viv and Samara and probably lowest in Ukrainian Chernobyl, the vast majority of all informants thought that things had grown worse economically since 1991 and that at best they were managing to survive. (Those living in the less-deprived regions did, however, have marginally higher expectations than those living in the more deprived ones.)

They said on a TV programme that the average wage in Russia is 1.5 to 2 thousand roubles. Our salary [farm workers] is 180 to 200 roubles and even then we don't get money – we are given food. (Male focus group, Russian Chernobyl)

People work from dawn to dusk to feed their families – money is the most important problem today ... my financial situation is not very good – I do not have any money for luxuries – our salaries are very low. In the past we could buy food, clothes, you could buy everything and you could even afford to save some money in those days. There is nothing like that any more. (Female focus group, Kherson)

I think that lack of money has an impact because most of our people experience economic hardship. They cannot afford to have enough rest and relaxation after their work; they cannot afford to buy the food they need for a healthy diet – they can't afford to have medical treatment. (Female focus group, L'viv)

Men, who are no longer able to support their families, have lost both their status and their traditional role as economic providers. They were said to have lost their purpose in life and to have become very depressed. According to a member of the female focus group in Kherson:

My husband is 51 years old and he looked after his family all his life. But for the last five years he has been unemployed; he has come down completely because of this lack of money. You know it is a constant problem. . . . He does not drink alcohol and he does not smoke. We lived the way people should live. Nowadays times are very tough for us because he has no job. (Female focus group, Kherson)

However, there was also clear evidence that women frequently put the needs of their families before their own, having paid employment, working on garden plots and doing all the domestic labour and childcare. As a member of the female focus group in Samara pointed out, 'I take care of everyone else but I can't take care of myself because my salary is not enough to buy food, buy clothes, and go on vacation or have a normal life'.

In the view of many interviewees, their poor economic situation was exacerbated by the fact that many services that had previously been provided free or been heavily subsidized now had to be paid for. This had a major negative impact on their welfare and their health. Five areas in particular were highlighted:

1. Concern was expressed about educating children, with having to provide books and the costs of higher education particularly highlighted.
2. The high cost of utilities and the poor service provided were mentioned by most. Informants in Samara and Arkhangelsk complained particularly bitterly about the inadequacy of the heating provided in the winter to the flats in the towns. A few of the better-off informants said that they had bought electric heaters, but the majority said that they could not afford to do this and that in any case they had difficulty in paying the community charge.
3. The closure of sports and recreational facilities and the imposition of charges for swimming pools and gyms was also heavily criticized. Most informants said that they could not afford the charges and many were critical of the ways in which facilities had not been maintained. The loss of sports facilities was seen to be an impediment to taking exercise by a significant number of informants, although others pointed out that they got exercise at work, walking to work, or working on their garden plots, and others said that they did exercises and a few pointed out that it costs nothing to jog or run.
4. A major concern for many of our respondents was the withdrawal of subsidized holidays and travel. They saw this as having a major negative impact on their well-being and health. There was a near universal view that a summer holiday every year was essential, preferably by the sea. However, the majority were now no longer able to have such a holiday every year, with most not having had one in the previous ten years and

seeing no prospect of having one in the near future. A male informant in Samara said, 'I dream about taking my children on holiday to the seaside but we cannot afford to do so'. While informants in all the regions commented on this, special concern was expressed in Chernobyl and Arkhangelsk. A few of the better-off informants did have holidays. Others living in towns said that they went to their *dacha* or visited relatives in the countryside; however, the majority of those living in urban areas did not see this as a holiday but as just more hard work.

5. The heaviest criticisms were of charges for health care, both legal and illegal. The vast majority of informants saw the withdrawal of a free, universal health care system as a direct attack on their welfare. They made a clear distinction between the newly imposed charges and demands for illegal payment, on the one hand, and *blat* (a gift or informal payment made as thanks for treatment received) on the other, and it was the first two of which they were most critical. As one of the Russian health care experts put it, 'illegal payments irritate patients most of all, and the money does not go towards the costs of providing care but straight into the pockets of the doctors'.

#### *Health and Health Services*

The health service was heavily criticized by many of our informants, who said that people had to look after themselves when they were ill because, for the majority who could not afford to pay for private care, the service was both inadequate and too expensive. The medical experts supported the view that the health care system had deteriorated since 1991 and that it was poorly resourced and poorly equipped. State health care was said to be poor, with a few exceptions; doctors did not care, equipment was old and inadequate, and even when check-ups and treatment were provided free the costs of medicines, aids and adaptations made acquiring them prohibitive:

Well, even if you experience some acute disease you can't just go to the doctors because they will prescribe a long list of medicines and your salary won't be enough to buy them. Therefore we provide ourselves with only the basic treatment – for instance, you can buy some pills to bring down your temperature, so you take the pills, but you can't afford any proper treatment. (Female focus group, Ukrainian Chernobyl)

A member of the female focus group in Samara expressed the view that 'doctors have forgotten their Hippocratic oath'. A member of the female focus group in Kherson summed up the general view when she said, 'We think with terror about the possibility that we will need to get medical help.

We don't have the money; there is no money to pay for treatment'. Interviewees recounted occasions when they had to purchase bandages and other medical supplies before the doctors or nurses would even examine them. One recounted a story of a doctor who refused even to look at a young boy who had been injured in a road accident because he had no money or identification on him; when the doctor went to write the death certificate the next day she realized that it was her own son. Informants did concede that, if you could afford to pay, the private health care facilities in the urban areas were good. This view was shared by the medical experts, who pointed out that medical facilities and treatment of the highest international standards were now available but that the vast majority of the population could not afford to make use of them. They also expressed concern that the more able, especially younger, doctors were being attracted to work in the private sector, creating even more problems for the state health care sector.

There was considerable concern in all the regions about the environment and the adverse impact a poor environment had on quality of life and health. While there was some debate in the focus groups in L'viv and Samara over whether the environment had deteriorated or improved, the general view was that it was poor and that this had an adverse impact on people's general well-being and health. In all regions concern was expressed about the quality of drinking water and the high cost of buying bottled water. In the towns there were concerns about pollution from cars and the lack of refuse collection and street cleaning. There was considerable disquiet, of course, about the impact of the nuclear accident at Chernobyl in affected regions of both Russia and Ukraine. There were also concerns about the environmental impact of the accident in both L'viv and Kherson in Ukraine. In Arkhangel'sk there were concerns about pollution from the accidents at the nuclear submarine base and from the crash of a space vehicle.

In all regions there was concern that people's health had deteriorated and that general health was poor. An informant in the male focus group in L'viv, for example, pointed out that 'The death rate for men has increased – fights, industrial accidents, and poor health because men worry because they can't support their families'. Beyond this, however, health was thought to be getting poorer. A member of the female focus group in Ukrainian Chernobyl, for example, said that

There is an increase in the number of strokes and cardio-vascular diseases. In the past people did not experience strokes until they were over 60; now 18-year-old people have strokes – the age at which people have strokes and heart attacks is getting younger.

Even the young people in the focus groups thought that health in general was poor. For example, an informant in the youth focus group in Kherson pointed

out that 'There are more diseases these days; the general condition of the people has deteriorated and we are depressed and don't know what to do'; while the members of the youth focus group in Arkhangel'sk agreed that 'The sickness rate is increasing due to the poor environment, shortage of heating, and the economic situation. Stress damages health and we have no money to improve our health'.

From the comments that people made about health in their region in general and their own health specifically, health is poorer in Chernobyl than in the other regions and best in Samara and L'viv, with people being old by the time they were 40 and few children even being healthy in Chernobyl. In the Chernobyl region the death rate from cancer was reported to be especially high, with respondents pointing out that they all knew people with cancer and had relatives who had died from the disease; the incidence of goitre also was reported to be high. Both of these illnesses are directly attributed to the nuclear accident. A local medical expert in the Chernobyl region pointed out that children have thyroid cancer, and 'we did not see it before, even when we looked at the statistics for the last 26 years'. However, even in the other regions few of our informants reported very good health. The medical experts agreed that the general health of the population was poor and that it had deteriorated since 1991. The comments of the medical experts also supported the view that health is considerably poorer in Chernobyl than in the other regions and that this is a combination of the effect of the nuclear accident and the adverse economic consequences of the post-1991 depression in an already poor area.

Few of the informants said they had excellent health, and women reported poorer health than men. Health generally declined with age. There was a general view that health was a problem only if it prevented you working and an expectation that health problems increased with age. Informants with a number of chronic health problems would nevertheless say that their health was 'OK' or 'average' if they could still work. Thus, people – especially women – with debilitating chronic health problems would define their health as 'not bad'. There was no doubt in people's minds that the decline in health was related to the changes since 1991 and especially to the economic situation. One of the local medical experts in Kherson in Ukraine summed up the views of many when he pointed out that 'the increase in high blood pressure and heart disease at ever younger ages must be blamed on social problems and lack of money'.

### *Taking Responsibility for Health*

In the face of the dramatic changes and difficult economic circumstances, people struggle to look after their own and their families' health and welfare. The vast majority of our informants thought it was their own

responsibility to look after their health and that if they did not do so then nobody else would. Contrary to the views of the Russian national medical expert, who said, 'In the Russian tradition they don't give a damn for health in the best cases; in the worst cases they think it is impossible to influence it', the vast majority of our respondents did think that they were responsible for looking after their health. For many this primarily meant self-medication and treatment when they were unwell, but there was a strong realization that a good diet was important for health, as was taking exercise and having rest and relaxation, not smoking cigarettes (or in some cases not smoking strong cigarettes) and drinking alcohol only in moderation. The problem was being able to act – to exercise agency, to change lifetime habits and deeply ingrained cultural beliefs – and lack of appropriate knowledge about health promotion. As we have already indicated, there was clear and strong distrust of the state health care system because of the charges imposed, the poor facilities and the perceived lack of care provided by the staff. The inability to afford holidays, the lack of time or money to enjoy rest and relaxation, the loss of a sporting culture and the poor environmental conditions were also seen as barriers to well-being and good health. Even where people were able to exercise more agency there were strong perceived cultural and financial barriers to their ability to promote their own and their families' health and welfare. For example, informants who pointed out that it did not have to cost money to engage in leisure-time exercise nevertheless conceded that many people did not have the time and energy to do so and that there was no tradition of jogging in their country, as there was in the United States.

Beyond leisure time, sport and rest and relaxation, three aspects of lifestyle have been seen as having a major impact on health, and especially on premature mortality in men: diet, tobacco consumption and alcohol. In the case of alcohol, the binge drinking of spirits has been seen as a particular problem in Russia and Ukraine. Our informants in both the qualitative interviews and the focus groups commented extensively on these aspects of their lifestyle, as did the medical experts. The main concerns raised regarding diet were the inability to buy sufficient food or at least to enjoy a balanced diet, the non-availability of fresh fruit and green vegetables during the winter and spring except at a price that none but the very wealthy could afford, and the radiological contamination of foodstuffs. A constant refrain was that in the past people had money but there was no food to spend it on; now the food is available in the shops but few can afford to purchase it: 'We used to have shortages and queues. Now everything is available but people cannot afford to purchase it, we cannot go to the market and afford to buy what we want' (Regional medical expert, Samara).

Four main factors seem to influence diet: the availability of foodstuffs, the means to purchase or otherwise obtain food, cultural preferences, and



knowledge about what constitutes a good or healthy diet. All these factors clearly influence the diet of our informants. All mentioned that foods were seasonal and that they eat more fresh fruit and green vegetables in the summer and the autumn. Few were able to afford to purchase fresh vegetables and fruit in the winter, and generally the food that was purchased was local – few could afford the imported food that was available in the shops. Most people relied on preserved and pickled fruit and vegetables in the winter, and on stored produce in rural areas where there were cellars. ‘It is clear that it changes with the season – especially vegetables and fruit. When winter comes the diet becomes more or less monotonous, we eat more macaroni, more potatoes, probably mostly potatoes’ (Female, medium education, L’viv).

Many – and not only those living in rural areas – relied totally or mainly on the food they could produce on their garden plots and, in the case of rural areas, subsidiary farms. There were frequent references to an inability to afford food, to have a varied diet, to give children sufficient quantities of fruit and in some cases actually to provide enough food so that they and their family were not hungry and lethargic because of poor nutrition:

Well, it happens sometimes if you make some money you can cook some soup or borsch for yourself. If you earn some money you can buy cabbage, potatoes, whatever – but sometimes you have no job and in that case you are hungry all day long. You just drink water, that is it! (Male, lower education, Kherson)

In the Chernobyl region it was quite evident that people knew what foods it was safe to eat and how to make food safe but that they ignored this most of the time because they needed to eat whatever food was available if they were not to go hungry. As a male member of the focus group in Russian Chernobyl pointed out, ‘you can buy clean food, but we can’t afford it – clean milk costs 20 roubles, other milk five roubles’.

It was evident that most people relied on a heavy carbohydrate diet, staples being bread, potatoes, macaroni and other starchy food; fat was also frequently mentioned, and it was evident that food was often fried: ‘People like fatty meat. They like food that is fatty’ (Local medical expert, Ukrainian Chernobyl). Dairy products were mentioned, although not affordable by the poorest unless they kept animals on a subsidiary farm. Meat was also seen as important (and fish in Arkhangelsk), but most in the poorer regions could afford to buy them only occasionally, and consumption was limited even in the more affluent areas: ‘People can’t even afford 100 grams of meat a day. We recommend that people with high cholesterol should not eat more than 170 grams of meat a day. They laugh at us; “we don’t even eat 100 grams a day”, they tell us’ (Local medical expert, Samara). A women in Russian

Chernobyl who described her diet as normal said 'We have a normal diet. Of course, I would like to be able to afford to buy fresh fish – the same with meat – but we have not got enough money. I would like to have more fresh fruit and vegetables in the winter'.

Beyond some feeling that fresh fruit and green vegetables were good for you because they provided vitamins and that a diet should include protein, there was little evidence that people had any clear ideas about good nutrition. Most were probably having too much difficulty getting enough food at all to worry about a balanced diet, but even the diet described by those who said they could purchase all the food they wanted seemed to be high in saturated fat and carbohydrate. The medical experts said that dietary preferences in their countries meant that people ate badly and that obesity and malnutrition were major problems, although they conceded that most people could not afford a healthy diet even if they wanted it – a view shared by our informants. As one of the participants in the female focus group in Kherson said, 'If you experience economic hardship, no matter how hard you try to be healthy there is nothing you can do about your diet'.

There was strong evidence in the interviews and the focus groups that levels of cigarette smoking among men were high and that most male and a majority of female informants drank alcohol at least occasionally; frequent reference was made to drinking on holidays and special occasions. The medical experts also thought that the consumption of alcohol and smoking had increased since 1991 and that significant amounts of alcohol were produced at home, both for personal consumption and for sale. One medical expert in Samara suggested that 'the population simply take to drink'. There was frequent reference to the fact that drinking and cigarette smoking had increased dramatically among women, and not just young women, since 1991: 'traditionally men smoked but women do as well now' (local medical expert, Samara). Concern was also expressed about the increase in smoking and drinking among young people – girls as well as boys – and also about a growing problem of addiction to hard and soft drugs: 'More young people have started to drink alcohol and smoke – all of them drink alcohol' (Regional medical expert, Ukrainian Chernobyl).

Men in the individual interviews mainly said that they drank vodka (a small number said that they drank *samogon*), with some drinking beer as well as – or occasionally instead of – spirits. Few men claimed not to drink, but most said that they did not drink frequently and that when they did they drank moderately. Women were slightly more likely than men to claim never to drink; those who did admit to drinking alcohol claimed to do so even less frequently than the men, and most said they drank wine for preference, although a few drank beer or vodka. Drinking was generally seen as a social activity: as one of the medical experts said, 'I am not good

company because I do not drink'. Frequent reference was made to the consumption of alcohol on holidays, with relatives and friends and, for some women, on their weekly visit to the bathhouse. A female informant in Kherson told us 'On a Friday I buy a bottle of vodka and go to the sauna with my friends. We drink beer and vodka'.

Few men or women admitted to home brewing or purchasing home-made alcohol, with most saying they purchased their drink in the shops. Young people were said to drink beer, and the members of our young people's focus groups agreed that this was the case. However, as interviews progressed and in the focus groups it was evident that consumption of alcohol was much higher and more frequent than respondents said initially. Informants who started by saying they drank infrequently or only on holidays would subsequently talk about consuming alcohol. The members of the focus groups referred to both the frequency and the amount of alcohol consumed by other people in their communities. They also pointed out that drunks are tolerated or even helped – although there was strong disapproval of alcoholism (defined as not being able to work or look after oneself or family because of dependence on alcohol): 'I realize very well what alcoholism is and what the consequences of becoming an alcoholic are – loss of job, degradation and so on – I mean, the results are very negative. I know that I don't want to become an alcoholic' (Male, higher education, Kherson). In Arkhangelsk, for example, the members of the male focus group said 'there is very heavy drinking – everybody drinks, young people, men, women and the elderly', while the female focus group in Samara pointed out that 'It is our Soviet tradition to drink'. An informant in Samara suggested that 'drinking is an essential spare-time activity, holidays, weekends. It is part of stress management and relations with friends, about having a good time'. Some informants did admit to making or consuming home-made spirit. The men in the focus group in Russian Chernobyl, for example asked: 'Why should we buy 100 grams of vodka when we can buy 200 grams of *samogon* for the same price. If you go to a private provider you can get more. It is cheaper.' It was also evident that the amount of spirit consumed in a typical drinking session was high and constituted binge drinking (more than 100 grams). Our informants did not see this as excessive – indeed, 100 grams of vodka was seen as a very modest amount to consume, and reference was made to drinking as much as half a bottle in one session.

Alcohol was seen as part of stress management – a way of coping with life. 'You have a drink and the headache is gone. So it is a kind of medicine and not harmful for a middle-aged person. I can drink alcohol – if something is wrong I go drinking' (Male, higher education, L'viv). There were few

references to harmful effects from drinking, although a small minority of informants said that they had had to stop because of specific health problems. Indeed, frequent reference was made to alcohol as beneficial. Male informants were concerned to emphasize that they were not alcoholics – that while they drank, and got drunk, they were not dependent on alcohol. Interestingly, there were few references to the cost of alcohol. Informants who said they had difficulty in feeding their families often said that they drank alcohol and made no reference to having difficulty in affording to buy it.

The same was also the case with cigarette smoking: there was little evidence that people had stopped smoking or reduced their consumption because of the cost. Some informants said they continued to smoke the strong Russian brands because they were cheaper, while others had switched to the lighter Western brands, often because they were thought to be healthier. There was much greater awareness of the harmful effects of cigarette smoking, although some informants denied any ill effects and others said they would consider giving up only if it affected their own health. A clear majority of men smoked and most women said that they did not, although it was said that more women (especially young women) were now smoking. Those who smoked had generally started while they were still at school or, in the case of men, during military service. Although many smokers made reference to having tried to stop smoking, few had succeeded; they said that it was a habit, an addiction, and they could not give it up. As with alcohol, frequent reference was made to smoking helping with stress management. As a woman from Archangel explained, ‘It [cigarette smoking] calms me down ... I smoke when I am nervous’.

### **Conclusion and Discussion**

Thus there was a clear view that there had been a general decline in the health and well-being of the population since 1991 and that unhealthy behaviour was often a means of coping with stress:

Of course everyone is going to say that people smoke, drink and take drugs, but again you have to mention the problem of stress. It is tough for us. People get very depressed. (Male focus group, Ukrainian Chernobyl)

All this drug consumption – yes it is harmful, but if a person is in a permanent state of stress and shock – if he is not even able to have enough rest, if he is constantly tired, if he has headaches about how to feed his family – can we talk about health after this? All this alcohol consumption is a consequence of the state of depression. People have to get rid of stress. (Female focus group, Kherson)

Smoking and drinking is cheaper than spending money on pills. (Male focus group Russian Chernobyl)

There was also a general view that the situation would improve only if the economic and political situation changed for the better:

A general improvement in the economic situation will certainly help improve health. People in our country have been under stress for many years. I watch – there are no smiling faces; everyone goes about looking sad and despondent. Everyone has problems – today’s economic situation demoralizes people. (Local medical expert, Samara)

The problem of health is not a medical one but rather a social one – the health of the people will improve when the living standard of the population increases generally. (Local medical expert, Arkhangelsk)

We carried out research on the main causes of morbidity – cardiovascular disease, cancer, and accidents. We came to a surprising conclusion. It is possible to prevent mortality in 82 per cent of cases for men and 68 per cent for women. Only 20 per cent of deaths for men and 17 per cent for women could have been prevented by better medical care. (National medical expert, Russia)

Neither social deficit and reward theory nor health lifestyles theory entirely accounts for what our informants said and experienced. There was some confirmation of the social deficit and reward theory position that men have lost their social role while women are still embedded in core domestic roles; certainly women talk much more about the daily need to plan and provide for their children than men do, while men are more likely to express depression or even despair over their inability to ‘provide for the family’ in a more abstract sense. Men’s concern with health also tends to be at a more abstract level than women’s, perhaps because women are domestically embedded in actively planning for other people’s health, while men position themselves more as observers than as actors. Both the informants themselves and the medical experts also talk about culturally available norms – including smoking and heavy drinking, but also a diet heavy in saturated fat and starch – which may be employed by both genders but appear to be more available, and more demanded, by men than by women, reflecting health lifestyles theory. Beyond both these explanations of differential health, however, the lived experience of both genders and all ages is one of struggling for bare subsistence and an acknowledgement of wider responsibilities that cannot be fulfilled in present circumstances. Health is important to them, and they have no sense of well-being in the absence of at least relatively adequate health, but survival has to take precedence even over the sense of

well-being. (This probably explains why health is often not high on the list of survey respondents' priorities; it may be important, but at the bottom of the economic order there are far more basic needs that are also not being met.)

The majority of our informants see daily life as a constant struggle, an unremitting fight for survival. Their sense of well-being had been seriously eroded and their health undermined. The old certainties and regularities in their daily lives have been replaced by uncertainty. Many of the templates that provided the framework for action are no longer available or appropriate in the changing social, political and economic circumstances. Many of the services previously taken for granted have been withdrawn or drastically reduced: guaranteed employment, free health care, subsidized holidays, free education, and adequate retirement pensions. Even when people are in employment, wages are paid late or not at all. Inflation has eroded the value of savings, and the wages of many of those who are paid have not kept pace with the increase in prices of goods and services and the withdrawal of subsidies. Many are unable to buy the basic essentials of daily living – food, heating and clothing – and few think that they have an adequate or good standard of living. They feel that they do not have control over major areas of their lives and that they cannot act to improve their circumstances and increase their sense of well-being. Most feel stressed, and the ways in which they describe their daily lives suggests an anomic society in the classical Durkheimian sense<sup>19</sup>: they are suffering from cultural trauma.

While daily life was said to be a fight for survival, a constant struggle, beyond this there was little hope for the future. People did not see things as likely to improve; there was no hope, and this increased people's despondency and sense of normlessness and helplessness:

Young people think, 'I won't have long. I will drink, smoke and take drugs. In any case my lifetime is short'. (Male focus group, Ukrainian Chernobyl)

When the standard of living was higher, a person could at least hope for the future. (Female focus group, Kherson)

One of the regional medical experts in Archangel summed up the situation thus:

A healthy economic situation would create opportunities in life without constant stress and worry – a general improvement in the political situation in the country would improve health. People don't have confidence in tomorrow – stability is necessary and then it will be possible to solve social problems.

Clearly, however, they do struggle on, and in doing so they cling to habitual ways of coping. Women tend to work harder and harder in struggling to provide for their families on reduced budgets, working long hours in paid employment as well as doing domestic labour and working on garden plots. Men, too, frequently work hard, but often they are unable to get employment, especially in the industrial and rural areas. Traditional or at least habitual ways of dealing with stress dominate – smoking and drinking. Clearly these are seen as essential for those who smoke and drink – probably more so than food or even looking after their families. There was virtually no reference to inability to afford cigarettes or alcohol in the interviews, although there were frequent references to being unable to afford an adequate diet, clothes and other basic essentials, as well as to the struggle of paying for utilities and an inability to afford holidays or to participate in sport. However, these ways of coping further undermine health, leaving women with a range of chronic health problems and in a permanent state of exhaustion, and pushing men into early graves.

This article has been concerned to document people's experiences in more affluent as well as in very deprived areas of two countries of the former Soviet Union. However, it also shows one of the consequences of moving from a command to a market economy: social and health services and facilities that were once seen as the responsibility of the state – and were provided – are now seen as the responsibility of the individual. The transition does not automatically bring with it the social infrastructure of countries with market economies – privately organized provision and sources of supply, available for money, with some kind of 'safety net' for those who fall outside the ability to cover the cost. This infrastructure has not yet been created, more than a decade after the change began. A major reason for this is that the socio-economic changes were accompanied by an economic collapse of such magnitude that virtually the whole population would fall into the 'safety net' category in a Western state, and so there is no incentive for private provision because no one could afford it. (Where such provision exists, most of our informants say it is beyond their economic reach; clean, safe food is available in the shops, but they cannot afford to buy it; holidays are available, but no one can afford to take one.) Contrary to what some of the literature asserts, we find that most of our informants do accept personal responsibility for their health, but they do not see how to exercise this responsibility in their present economic circumstances.

#### NOTES

1. P. Abbott, *Living Conditions, Lifestyle and Health in Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia and Ukraine: Social Trends 1990–1999* (Vienna: Institute for Advanced Studies, 2002). P. Abbott, 'Place, Control and Health in Post-Soviet Societies',



- paper presented to the International Congress of Sociology Convention, Beijing, July 2004; P. Abbott and R. Sapsford, 'Happiness and Satisfaction in Post-Soviet Russia and Ukraine', *Journal of Happiness Studies*, Vol.7 (2006), pp.251–87; W. Cockerham, B. Hinote, P. Abbott and C. Haerpfer, 'The Relationship between Stress and Health Lifestyles, and Gender in Belarus, Kazakhstan, Russia and Ukraine', paper presented to the British Sociological Association Annual Conference, York, April 2004.
2. Abbott and Sapsford, 'Happiness and Satisfaction'; P. Abbott and C. Wallace, 'Explaining Economic and Social Transition in Post-Soviet Russia, Ukraine and Russia: The Social Quality Approach', *European Journal of Social Quality* (forthcoming).
  3. See, for instance, J. Alexander, 'Surveying Attitudes in Russia: A Representation of Formlessness', *Communist and Post-Communist Studies*, Vol.30 (1997), pp.107–27; M. Burawoy, 'The Soviet Descent into Capitalism', *American Journal of Sociology*, Vol.102 (1997), pp.1430–44; M. Burawoy, P. Krotov and T. Lytkina, *Involution and Destitution: Russia's Gendered Transition to Capitalism* (Berkeley, CA: University of California, n.d.); O.N. Yanitsky, 'Sustainability and Risk: The Case of Russia', *Innovations*, Vol.13, No.3 (2000), pp.265–77.
  4. Abbott, *Living Conditions*.
  5. Abbott, 'Place, Control and Health'; Abbott and Wallace, 'Explaining Economic and Social Transition'; Cockerham et al., 'The Relationship'; L. Chenet, 'Gender and Socio-economic Inequalities in Mortality in Central and Eastern Europe', in E. Annandale and K. Hunt (eds.), *Gender Inequalities in Health* (Buckingham, UK: Open University Press, 2000).
  6. W. Cockerham, 'The Social Determinants of the Decline in Life Expectancy in Russia and Eastern Europe', *Journal of Health and Social Behaviour*, Vol.43 (1997), pp.42–55; W. Cockerham, *Health and Social Change in Russia and Eastern Europe* (London: Routledge, 1999); W. Cockerham, B. Hinote, P. Abbott and C. Haerpfer, 'Health Lifestyles in Ukraine', *Sozial und Preventiv Medizin*, Vol.50 (2005), pp.264–71; H. Paluoso, 'Health Related Lifestyles and Alienation in Moscow and Helsinki', *Social Science and Medicine*, Vol.51 (2000), pp.1325–41; H. Paluoso, A. Uutela, I. Zhuravleva and N. Lakomova, 'Social Patterning of Ill Health in Helsinki and Moscow', *Social Science and Medicine*, Vol.46 (1998), pp.1121–36.
  7. P. Sztompka, 'Cultural Trauma: The Other Face of Social Change', *European Journal of Social Theory*, Vol.3 (2002), pp.441–65; P. Sztompka, 'The Trauma of Social Change: A Case of Post-communist Societies', in J.C. Alexander, R. Eyerman, B. Giesen, N.J. Smelser and P. Sztompka (eds.), *Cultural Trauma and Collective Identity* (Berkeley, CA: University of California Press, 2004).
  8. See, for instance, Cockerham, 'The Social Determinants'; Cockerham, *Health and Social Change*; Cockerham et al., 'The Relationship'.
  9. Abbott and Wallace, 'Explaining Economic and Social Transition'.
  10. Abbott and Wallace, 'Explaining Economic and Social Transition'; Abbott and Sapsford, 'Happiness and Satisfaction'.
  11. J. Siegrist, 'Place, Social Exchange and Health: Proposed Sociological Framework', *Social Science and Medicine*, Vol.51 (2000), pp.1283–93; P. Watson, 'Explaining Rising Mortality among Men in Eastern Europe', *Social Science and Medicine*, Vol.41 (1995), pp.923–34.
  12. P. Bourdieu, *Distinction* (Cambridge, MA: Harvard University Press, 1984).
  13. Cockerham, 'The Social Determinants'; Cockerham, *Health and Social Change*; Cockerham et al., 'The Relationship'; G. Weidner and V.S. Cain, 'The Gender Gap in Heart Disease: Lessons From Eastern Europe', *American Journal of Public Health*, Vol.92 (2003), pp.768–70.
  14. Abbott, *Place, Control and Health*.
  15. J. Cornwell, *Hard-Earned Lives* (London: Tavistock, 1984).
  16. See <<http://llh.ac.at>>.
  17. C. Wallace, L. Spencer, L. Basford, K. Dunn and A. Chvorostov, *LLH Qualitative Manual for Regional Case Studies* (Vienna: Institute for Advanced Studies, 2002).
  18. W. O'Connor, J. Ritchie and L. Spencer, 'Principles of Qualitative Analysis', in J. Ritchie and J. Lewis (eds.), *Qualitative Research Practice* (London: Sage, 2003).
  19. Emile Durkheim, *Suicide. A Study in Sociology* (London: Routledge, 1952).