

Health world views of post-soviet citizens

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Available online 7 July 2005

Abstract

The collapse of the Soviet Union has had an adverse impact on the lives of the peoples of Russia and Ukraine. This paper reports on qualitative case studies including interviews, focus groups and children's essays from Russia and Ukraine, on the topics of everyday understanding of health and the factors influencing it. The majority report poor health and difficult material circumstances. Their understandings of health and illness are multifactorial and include emotional as well as descriptive elements. Whilst the most frequently cited definition of health is of people with/without health problems, it is evident that health is seen positively, as more than the absence of debilitating illness. There is a strong emphasis on individual responsibility for health and evidence that people are thought to have a moral responsibility to strive to be healthy. However, there is also a strong awareness that the major factors which cause ill health are beyond their control. The findings provide additional support for the health lifestyles theory that has been developed to provide a sociological understanding of the mortality crisis in the former Soviet Union.

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Keywords: Lay health beliefs; Responsibility for health; Agency and structure; Health lifestyles; Russia; Ukraine

Introduction

In this paper we consider Russian and Ukrainian citizens' definitions of health and illness, their everyday understanding about responsibility for health and what they see as the main factors influencing their health. While qualitative research on these topics has been reported in the West (for recent reviews see e.g. Hughner & Klien, 2004; Lawton, 2003), there is no comparable research for Russia or Ukraine, and qualitative methods are a better medium than surveys for uncovering both the ways in which people express their negotiated, socially shared understandings and the complex compromises, inconsistencies and defensive attributions that form the real background to health choices. Under-

standing how people define health and illness, and their everyday knowledge and understanding of influences on health and illness in the face of the unprecedented disruption of biography they have experienced since 1990, will add substantially to our knowledge of how people make sense of/interpret the relationship between structure and agency, as well as contributing to our understanding of the influence of place (e.g. Popay et al., 2003a; Popay, Thomas, Williams, Gattrell, & Bostock, 2003b; Siegrist, 2000).

Socio-economic change, health lifestyle and health

The far-reaching social, political, and economic changes in Russia and Ukraine following the collapse of communism in 1991 have undoubtedly had a negative impact on the welfare of the populations (Abbott & Wallace, forthcoming; Alexander, 1997; Jeffries, 2004;

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Yanitsky, 2000). After 1989 there was an economic collapse in both countries, with GDP falling to 55 per cent of its 1989 value by 1998 in Russia and 38.7 per cent in Ukraine, although subsequently recovering to 67.6 per cent by 2001 in Russia and 44.8 per cent in Ukraine (EBRD, 2003). At the same time there has been a dramatic growth in economic inequalities, with the earnings Gini coefficient increasing between 1989 and 2001 from 0.271–0.521 in Russia and from 0.244–0.452 in Ukraine (World Bank, 2004). While life expectancy stagnated from the 1960 onwards, there was an unprecedented decline after 1989, most notably for men in mid-life. By 2001 male life expectancy was 59 years in Russia, a decline of 4.8 years compared to the 1989 figure, and 62.4 years in Ukraine, a decline of 3.6 years. For Russian women life expectancy was 72.3 years in 2001, a decline of 2.2 years and for Ukrainian women 73.6 years, a decline of 1.4 years (UNICEF, 2004). An increase in self-reported poor physical and psychosocial health as compared with the Communist era has also been reported, with women reporting poorer health than men (e.g. Adevi, Chellaraj, Goldstein, & Preker, 1997; Carlson, 2001; Dmitrieva, 2001).

Epidemiological research has uncovered key factors responsible for the unprecedented decline in health: factors associated with the economic transition (e.g. Brainerd, 1998; Carlson, 2004), adverse environmental factors (e.g. Feshback & Friendly, 1992; Morozova, 1994), stress consequent on the socio-economic changes (e.g. Bobak, Pikhart, Rose, Hertzman, & Marmot, 2000; Sigriest, 2000; Shilova, 1998) and health risk behaviour (e.g. Cockerham, 1999). The mortality crisis, and poor health more generally, is explained by poor diet and lack of recreational exercise and, for men, cigarette smoking and, especially, the high consumption and binge drinking of vodka (McKee, Shkolnikov, & Leon, 2001; Nemtsov, 2002; Shkolnikov, McKee, & Leon, 2001). Health risk behaviours are said to be combined with a tendency for individuals to rely on the state to care for them rather than being prepared to take responsibility for their own health (e.g. Dmitrieva, 2001; Field, 2000; Kharkhordin, 1999; Nazarova, 2000; Paluouo, 2000).

Building on Weber's (1978) distinction between life chances and life choices and Bourdeiu's (1984) notion of *habitus*, Cockerham (e.g. Cockerham 1999, 2005) has developed a sociological explanation for the mortality crisis—*healthy lifestyles theory*. He argues that health behaviours are culturally shared practices formed by socialisation and experience and shaped by material circumstances. Not only do structural factors (life chances) mitigate against Russians and Ukrainians adopting health lifestyles, but so do culturally embedded practices (drinking, smoking, poor diet and lack of recreational exercise) as well as a passive orientation to health developed under communism and encouraged by

the belief that health depends on the health-care system rather than on individual behaviour. The resultant habitus, it is argued, has produced a relatively enduring disposition for Russians and Ukrainians to lead unhealthy lifestyles, in a situation where there are limited opportunities for them to do otherwise (see, e.g. Cockerham, 1999; Cockerham, Hinote, Abbott, & Haerpfer, forthcoming).

Lay knowledge of health and illness

Sociological research not only challenges bio-medical definitions but also demonstrates the importance of understanding health as a complex multidimensional social phenomena (Blaxter, 1990; Bury, 2000), with lay understandings of health needing to be contextualised in people's lived experience (Blair, 1993). Lay understandings influence not only the ways in which people interpret their experience of health and illness but also the ways in which they act to promote their own health and that of their families (Blaxter and Paterson 1982; Cornwell, 1984; Graham, 1984). Two areas of lay knowledge that have been explored by sociologists are people's definitions of health and illness and their understanding of the factors that influence their health, including the extent to which they are aware of and understand the causes of health inequalities (Popay et al., 2003a).

Informants frequently define health both as a category or state and by reference to appearance, feelings and behaviour. Herzlich (1973), in an early study in France, categorised her informants into three groups — those who saw health negatively as the absence of illness, those who saw it as a reserve that persisted despite episodes of illness, and those who saw it positively, as normal physical and mental functioning. Blaxter (1990) provides a more extensive range of definitions: health as not being ill, being able to function, being physically fit, leading a healthy lifestyle, as a resource and as psychological stability. Informants' generic definitions of health often differ from how they describe what it means to them to be healthy, and when they are describing their own health they are more likely to refer to psychological feelings of well-being, as well as to the ability to cope (Cox, Blaxter, & Buckle, 1987). While middle-class informants in the West have been found to tend to have positive definitions of health, often including mental as well as physical well-being, working-class informants, in older studies, have defined health in functional terms as the ability to work (e.g. Calann, 1987; Cornwell, 1984; d'Houtard & Field, 1984; Pierret, 1993), and older people have seen it as a resource, the capacity to engage in everyday activities (Cox et al., 1987). Some reports have suggested that women tended to see health as the absence of illness while men define it as 'being fit and strong', physically energetic (Cox et al., 1987). However,

more qualitative research has found that men most frequently referred to health as absence of illness (Mullen, 1992) and that working-class women see themselves as healthy if they can carry on with their normal daily activities, even if they have to struggle to do so (Blaxter, 1997; Blaxter & Patterson, 1982; Cornwell, 1984; Pill & Stott, 1982, 1985).

When talking about responsibility for health, the causes of illness and explanations for health inequalities, informants have often moved between claiming individual responsibility and blaming external factors over which they have no control, with a strong emphasis on not giving in to illness (Blaxter, 1993; Cornwell, 1984; Pill & Stott, 1982, 1985; Pollock, 1993). Germs, heredity, the environment and the physical and emotional demands of work have often been cited as causes of ill-health over which individuals have no control. However, individual lifestyles are generally seen as the main factor in health and illness; poor diet, smoking, drinking alcohol, drugs and lack of exercise are all cited as major factors even when informants are talking about their own health. The small minority who refer to material and/or environmental factors are mainly middle-class (Blaxter, 1997). However, there is some evidence from responses to survey questions that working-class informants do understand the ways in which material deprivation impacts on their health, although they are reluctant to express this in more qualitative interviews (Popay et al., 2003a). Qualitative studies have also revealed how working-class people demonstrate their understanding of the structural causes of health inequalities and the ways in which material deprivation influences their health (Cornwell, 1984; Graham, 1987; Popay et al., 2003a; Popay & Williams, 1996). However, the strategies they adopt to cope with these are based on 'realistic' assessments of their life chances and the options available to them (Cornwell, 1984; Graham, 1987; Mullen, 1992; Pill & Stott, 1985), and may be health damaging.

The living conditions, lifestyle and health study

In this paper we draw on qualitative case studies carried out in 2003 in Russia and Ukraine—two very deprived regions (Archangelsk in Russia and Kherson in Ukraine), two less deprived regions (Samara in Russia and Lviv in Ukraine), and the Chernobyl region in both countries (which experienced the worst impact of the radiological contamination following the nuclear accident in April, 1986). Information on the project can be found on the Project website (<http://llh.ac.at>).

The qualitative case studies include:

- Fifty interviews with informants aged 25–50 yr in each case-study area in Russia and Ukraine and 30 in

the Chernobyl region in each country, with equal numbers of men and women; half the informants lived in rural areas and half in urban areas and roughly half had completed secondary education, with the rest split between those with higher education and those with incomplete secondary education.

- One focus group with men and one with women aged 30–50 yr in each case-study area.
- One mixed group of young men and women aged 18–25 yr in each area, except in Chernobyl, where, in place of focus groups, a sample of older secondary-school pupils were given an essay on the topic *Me: Yesterday, today and tomorrow*. Eighty-four usable essays were written.

The interviewers were sociologists employed as research assistants by partner universities in Russia, Ukraine, and Belarus and trained by us in qualitative interviewing and data analysis. The agendas for the interviews and the topics for the focus groups were discussed with the research assistants and covered living conditions, lifestyle and health. Informants were asked to describe their everyday lives, their diet, their smoking and drinking practices, their engagement in exercise, their use of the health services, the support they received from family and friends, and their non-work activities, so that we could gain insight into their everyday routinised practices and thereby uncover the taken-for-granted (Williams, 1995). (It was an advantage, for the conduct of the interviews, that most of the actual interviewers were naïve with respect to the specific literature on health and lifestyles, and thus not able even unwittingly to impose its conclusions on the data.) We maintained contact with the lead researchers during the fieldwork phase by email and made field visits. A training manual and guide to carrying out the research was produced in Russian and English after the first summer school (Wallace, Spencer, Basford, Dunn, & Chorostov, 2002).

The interviews (which were held in informants' homes) and focus groups were recorded and transcribed. The *Framework* system (O'Connor, Ritchie, & Spencer, 2003) was used for preliminary thematic coding and to categorise and summarise the individual interviews. This enabled the complex of knowledge, beliefs, meanings and routinised practices inherent in the accounts to emerge from the data. We worked with the Russian and Ukrainian research assistants on a sample of translated interviews to agree the main themes and construct an index. The research assistants then constructed the matrix charts for the individual interviews, summarising what each informant had said on each topic in the index, keeping as close as possible to the informants' own words and including illustrative quotes. The charts were then translated into English. We used as translators, at

research team meetings and for translating the charts, university research assistants who taught English to sociology students. This paper is based on an analysis of the interview charts, the complete translated focus group transcripts and our notes from our meetings with the research assistants.

Findings

Health and material circumstances of the population

When describing their own health, many of the informants gave quite long lists of health problems, with about two thirds mentioning at least one chronic condition, including high blood pressure, cardiovascular disease, diabetes, endemic goiter, cancer, stomach problem, intestinal disorder, and osteoporosis, with women generally reporting poorer overall health. Frequent reference was made to how few well people lived in their region:

There can't be any healthy people in modern Russia—70 percent of newborn children are unhealthy (man, Samara).

At my son's school there are 317 children and only four are healthy (woman Russian Chernobyl).

The young people in Chernobyl were not told the research was about health when they were asked to write the essays, yet most of them complained of poor health; as one young woman put it, "*I want to be healthy and I do not want my children to be as weak as I am*".

A vast majority of our informants thought that not only their health but also the economic situation had deteriorated in the previous 10 years. Even in the two less deprived regions, only a very few said that they had sufficient income to do more than buy essentials, and a noticeable minority claimed not even to be able to do that. Our research assistants commented on the extent to which informants kept returning to the problems of poverty and harsh economic conditions during interviews and in focus groups, even when the researchers were trying to get them to talk about other issues. They also expressed surprise at how hard the people they interviewed seemed to work, with many saying that they had no time for rest and relaxation as they struggled to do several jobs, grow produce at their dacha, carry out maintenance and repairs on their home and, in the case of women, do domestic work and childcare. An oft-repeated complaint was the withdrawal of holiday cards, which meant that they could no longer afford go on holiday to a resort and have a proper rest, and many complained that they needed to work at their dacha when they were on leave from work. Many of those who had plots of land (about half our

informants) said they relied on them for food, and in rural areas informants often had no other reliable source of 'income'.

Definitions of health and illness

Informants gave detailed and often complex accounts of their understanding of health and illness—much as has been reported for research carried out in Western Europe—often referring to mood, as well as behaviour and appearance, adding to their accounts as the interviews progressed. The most frequently cited indicator of health included in people's accounts was absence of illness (or in some cases serious illness), mentioned by nearly half our informants. Typical responses were:

Someone who does not feel ill (woman, Russian Chernobyl).

Someone who does not have any serious diseases (woman, Lviv).

I am a healthy person. There are illnesses I can't avoid but I can keep fit (woman, Archangelsk).

Nearly the same number of informants included references to psychological well-being, often talking about healthy people being happy and positive about life. As a Russian man living in Chernobyl put it, "*if a person is psychologically healthy he will be physically healthier*". A quarter of our informants talked about health as resource.

A healthy man should be able to easily walk 20 km and be able to lift with one hand a 50 kg sack of potatoes (man, Archangelsk).

A healthy person is able to do physical work, to chop firewood and dig soil at the dacha (woman, Lviv).

A similar number of respondents explicitly referred to various lifestyle practice—diet, smoking, drinking, exercise and rest and relaxation—as being related to health, but few explicitly said that a healthy person had a healthy lifestyle and from their accounts few had more than a superficial understanding of a healthy lifestyle as understood in health promotion in the West. Recognising healthy people by their appearance was mentioned by around a third of our informants, with men more likely to refer to physical build and women to complexion and condition of hair-

Average weight, colour of skin normal pink, hair is normal, nails are health (woman, Samara).

A healthy person has a sporty constitution (male, Samara).

Well-built, has a good constitution, and looks sporty (male, Lviv).

However some informants thought that looks could be deceptive; as one Russian woman in Chernobyl put it, a person walks and seems to be healthy but you talk to her and everything aches. This is like an apple that is red and attractive on the outside and rotten inside.

Many of our informants had complex understandings that they often developed and built on as the interviews progressed, rather than just seeing health as absence of illness, and some gave complex accounts even when first reporting their understanding. A male informant from Samara, for example, said:

A healthy person doesn't visit doctors because he has no reason to. He has no pain, no aches; he has a good appetite and is in high spirits. He regularly does some sport. He is on good terms with relatives and friends. However health is relative to age.

In a similar vein, a female informant from Lviv said:

A healthy person is rarely ill, does not have any chronic diseases—is always in a good mood, has a healthy complexion, good hair, and shining eyes and allocates time for work and rest.

However, a Russian man living in Chernobyl suggested an important caveat when he pointed out that “*completely healthy is an ideal to strive for but this ideal is unachievable*”.

Virtually all our informants thought that an unhealthy person has serious health problems, variously seen as having serious illnesses, being in constant pain, being in generally poor health, having a debilitating disease, being unhappy, looking sick and, in a small number of cases, having a mental health problem. Not being able to work was seen as a major sign that someone was ill—“*when I cannot work it means I am ill*” (woman, Chernobyl) and many respondents thought that people had a responsibility to fight illness and keep healthy. A male informant from Lviv encompassed the main definitions given by other informants in his description:

A sick man is a person who has some diseases, it handicaps a person, a person whose whole body hurts, and who is always in a bad mood. He is depressed, sad, he is closed in on himself, and his face expresses sadness and depression. He is not a sociable person, he is reserved, and he concentrates on himself—He is always complaining, talking about his health, and looking for sympathy. You can tell from his appearance, he is pale, stooping, and is coughing.

Lay accounts of responsibility for health and illness

In talking about their health and well-being, virtually all our informants said it was an individual responsibility—that they were responsible for looking after their own health—although not all of them thought they did so. Typically they said:

The only thing that influences my health is me—what I do (woman, Samara).

A person is personally responsible for their health (female focus group, Lviv).

Many suggested that people had a responsibility to fight to maintain their health:

If you don't want to fall ill you will not fall ill. A woman must fight for her health herself (woman, Russian Chernobyl).

Others, however, suggested that people had to look after their health because the state no longer did so:

The state does not take care of people's health, so a person has to be responsible for his or her health. If you want to be healthy you have to take care of yourself (man, Samara).

However, a noticeable minority of the informants did not think they take responsibility for their health—“*we don't have time to look after our health*” (male focus group, Lviv). Others felt they were not very responsible people:

I always wait until the very last minute, until it is really pressing. It means I am not a very responsible person (woman, Archangelsk).

A small minority did not want to be responsible for their health:

I don't have the time and I don't want to (woman, Kherson).

Not responsible—no chance (woman, Kherson).

or did not think they could look after their health:

people can do nothing (male focus group, Kherson).

There were three ways in which informants thought that people could act to look after their health: the ‘appropriate’ use of health services, striving to keep well and to get better when unwell, and leading a healthy lifestyle. Informants who talked about ‘appropriate use of the health service’ seemed to have a relatively passive orientation to health, but even they generally thought they had some responsibility:

I am responsible for going to the doctor when I am unwell (woman, Archangelsk).

I go to the doctor when I am ill so I will get well as quickly as possible (woman, Samara).

Even some of those who did not think they looked after their health thought they should take responsibility when they became ill:

I have the devil-may-care attitude to my health. I don't take any preventative measures. I start to do something only when I fall ill—when I fall ill I start to take care, to take tablets, to use folk remedies (man, Samara).

There was general agreement that people were responsible for looking after themselves when they were ill:

If you take care of yourself when you are ill your health will definitely get better (female focus group, Lviv).

Informants frequently made direct or indirect references to how they could or did look after their health by lifestyle choices:

A person must be responsible for health because dangerous habits influence our health (man, Kherson).

The way of life affects your health a lot, smoking, alcohol, drugs, and passive smoking (female focus group, Lviv).

However few were aware of any sources of information on healthy lifestyles, and the ways in which they talked about their own daily lifestyle practices suggests that few do in fact have healthy lifestyles—not even those who claimed to do so. Lifestyle seemed to be predominantly based on taken-for-granted practices that went unquestioned. Frequent reference was made to the importance of diet, including the need to eat protein and fresh fruit and vegetables, but there were few references to food thought to be unhealthy—“*It makes a difference if you eat fruit and vegetables every day*” (male, Archangelsk)—although not all agreed—“*I don't think that what I eat influences my health*” (man, Archangelsk). Informants' accounts of what they normally eat were of diets high in carbohydrate and fat, with bread and potatoes as staples. Having sufficient rest and relaxation, including an annual holiday at a resort, were thought to be important for health by a majority of informants, as was participating in physical exercise:

A person can be responsible for their health if they take part in sport and spend time outdoors (woman, Samara).

Many of our informants saw exercise as taking part in organised sport or using gyms, but a significant minority

said they did not need to do sport because they got sufficient exercise from their daily activities:

In order to improve health it is necessary to take physical exercise—working hard at the dacha is good for my health (Russian man, Chernobyl).

I think that working hard in the garden is excellent physical exercise (woman, Samara).

However not all informants agreed:

I don't think I need any help in this respect. I have normal complexion, a normal build—why do I need to go in for sport? (Man, Samara).

Cigarette smoking, which was seen as normal behaviour for men—with the majority having started while in senior school or when doing national service—was not frequently spoken of as being bad for health. One of the young men in Chernobyl did write in his essay,—“*I have a bad habit, it is smoking*”, and a female informant in Lviv stated explicitly what others hinted at—“*smoking is dangerous for health*”. A member of the male focus group in Lviv suggested, “*the government should ban tobacco adverts*”. A number of informants did, however, describe their successful and unsuccessful attempts to give up smoking—“*I would like to quit smoking but I cannot*” (Male, Lviv). A few referred to the negative health consequences of passive smoking.—“*I have started to smoke less because my children's health is important*” (man, Lviv). However not everyone saw smoking as a health risk, and some who recognised the health consequences, at least implicitly, did not want to give it up:

I don't think that smoking has damaged my health (man, Samara).

I enjoy it, we have a short life and cannot live without pleasure (man, Lviv).

Others thought that smoking helped them cope with the risk to their health posed by stress—*emotional stress*, “*I have a cigarette and I feel better*” (male, Lviv).

Alcohol was not generally seen as being damaging to health and a few informants even suggested it was good for health, although a number did make a distinction between moderate drinking and alcoholism, with the latter generally seen as a social rather than a health problem. Drinking was seen as a social activity and as a normal part of everyday life. While most informants said that they were moderate drinkers, many of the men referred to frequently drinking amounts of vodka that would be regarded as bingeing and as the interviews progressed it became evident that holidays and special occasions (when alcohol was consumed) happened very frequently. A male informant from Samara expressed the views of many of the informants when he said “*I enjoy it, we have a short life and cannot live without*

pleasure—alcohol brings joy into people's lives". However, some informants thought that people drink so that they can forget their problems:

Men drink because of hopelessness. Have a drink and forget (male focus group, Lviv).

Vodka is cheaper than spending money on pills (male focus group, Russian Chernobyl).

Even a knowledge of health risk did not necessarily influence attitudes: *"I don't care if heavy smoking and drinking affect my health"* (woman, Samara). A very small number explicitly denied any health influence: *"Smoking and drinking don't influence health. My grandfather smoked and drank and he lived to be nearly 100"* (Man Russian Chernobyl).

Informants' talk about their lives suggested a complex understanding of health that recognises the influence of factors over which they have little control. Virtually all respondents referred to four factors—pollution, stress, hard work, and poverty—but very few raised them when they were explicitly addressing the question of responsibility for health. In the focus groups there was a more immediate stress on external factors than in the individual interviews, and generally, more complaints about the economic and other problems they were experiencing, reflecting the ways in which Russians construct and reconstruct an identity of shared suffering through talk (Ries, 1997). The environment was seen as having a major negative influence on health in all the regions. A male respondent in Samara pointed out:

We live in an industrial city —there are lots of factories. The industry is very harmful—no one cares for the people's health. There is no proper treatment of sewage and other waste. The Volga is being polluted as an example, more and more every year.

The members of the youth focus groups in Ukraine agreed—environmental pollution is the major factor influencing health—and the members of the female focus group in the same region asked, *"if we say that our health depends on the environment, then what can we change?"* The informants in Archangelsk were especially concerned about the quality of the water, although industrial pollution was also seen as a problem. As one man put it, *"our water is a disaster; it affects our health to a great extent,"* while a female informant pointed out that *"we have to boil our water for 10 min otherwise it is dangerous to drink it"*. Informants living in urban areas were concerned about pollution from cars and other traffic, and in all the regions concerns were expressed about pollution from nuclear accidents, and especially so in the Chernobyl region:

Before Chernobyl I was never ill (male, Lviv).

Living in the contaminated zone influences my health negatively and if it weren't for Chernobyl we would feel healthier (Ukrainian man, Chernobyl region).

There were also frequent references to the negative impact of stress, working conditions, and unemployment. The male youth focus group in Kherson, for example, pointed to the influence on health of *"the lack of certainty"*, while a female informant from Lviv pointed to the impact of *"an uncertain life —constant stress situation every day because employment is not stable, the salary is not always paid and of course life is uncertain"*. The members of the female focus group in the same region pointed out that *"it's tough for us and people get very depressed"*, and a Russian man in Chernobyl argued that *"psychological health depends on living conditions, work stress, and family situation"*. Informants also pointed out that unhealthy lifestyles were a response to stress:

Alcohol consumption, drug consumption—all this is a consequence of the depression. I mean, people try to get rid of the stress—yes it is harmful, but if a person is in a constant state of stress—not enough rest—headache about how to feed the family—can we talk about health? (Male, Samara).

However a small minority rejected any negative impact of stress on health, and not everyone agreed that stress had increased.

They say it is a century of stress—but I don't agree with it—the people who lived long before us had stress (woman, Russian, Chernobyl).

Economic circumstances

What was most evident in the interviews and the focus groups was the way in which informants kept returning to their financial problems. Concerns about financial difficulties dominated the interviews, and the members of the focus groups constantly returned to the economic situation and its negative impact on their daily lives. Financial problems were seen as the overriding issue: *"when people have money all the problems will be solved"* (female focus group, Chernobyl Ukraine). A female informant in Lviv pointed to the sacrifices that women often make to look after their families:

I take care of everyone else but I cannot take care of myself because I do not earn enough—I cannot afford to buy food or clothes or go on holiday. I cannot lead a normal life.

Our research assistants told us:

The problem is poverty even in Chernobyl; the stress is on the inability to pay for heating, food, medicines, and the other necessities of everyday life.

The economic situation was also seen to impact adversely on health:

I can't afford to look after my health. I don't have the money (woman, Lviv).

The more money I get the more health I get (man, Samara).

Lack of money has an impact; we cannot afford to have enough rest after work, to buy healthy food, fruit and vegetables. We cannot afford to use the medical services (Female focus group, Kherson).

Informants frequently referred to their inability to live a healthy life because they could not afford to buy fruit and vegetables and other food items thought to be necessary for a healthy diet. A mother from Chernobyl told us:

My child is unwell because of lack of food, he sleeps constantly—he is very weak and I cannot provide him with the right diet.

A male informant from Archangelsk pointed out that “our wages do not allow us to have a normal diet”, while a female informant said, “I only have enough money to buy the most basic food”. The members of the male focus group pointed out that it was not the non-availability of fresh food (as had often been the case in the past) but being able to afford to buy it: “At the market place we have everything, oranges, bananas, but we can't buy. We have potatoes and nothing else.” Lack of money also precluded many of our informants from participating in sport and exercise—as one of our male informants from Samara put it, “I have no money for the gym” although some did point out that it was possible to take exercise without using sports facilities and others indicated that they got exercise walking to work, at work and/or looking after their plots.

Our informants complained about a decline in state-health care provision due, they said, to the economic crisis and their inability to afford the costs of state health-care or to buy medicines:

Financial situation—doctors, hospitals cannot provide adequate services and people cannot afford the costs of treatment (female focus group, Lviv).

In addition, many said they did not have time for rest and relaxation or to go on a holiday because of the demands of paid employment and having to look after their plots of land:

I think that my health is affected by hard everyday life, traveling to work and the work itself, poor nutrition, lack of normal sleep and stress—the impossibility of proper treatment. I cannot afford to go to a recreation centre (woman, Lviv).

There was general agreement amongst the participants in the focus groups, and amongst our individual informants when the whole interviews are considered, not only that people's health had declined since 1991 but that this was mainly due to the decline in living standards, although they also thought that the reduction in state spending on health care and the introduction of charges had had a negative impact. The young men in the focus group in Kherson, for example, pointed out that “living standards have drastically declined for the vast majority of the population”, and those from Lviv said, “the economic crisis is the cause of all the illness”. Others suggested that people were now less able to look after their health than in the past. A male informant from Lviv pointed out that:

During the past 10 years diet has become much worse. We used to be able to afford to eat all we wanted and as much as we needed.

The young men in the focus group in Kherson said, “A lot of people have become alcoholics due to unemployment”. There was virtually no evidence, however, that people had any awareness of the impact of inequalities on health. A rare exception was a male informant from Lviv who pointed out that:

Of course when you don't have enough money you start thinking about it you feel depressed and become more vulnerable to being sick—rich people are healthier but of course if they become ill they have equal chances with others, health cannot be brought.

Conclusions

Our informants had complex, multifactorial and often apparently contradictory understandings both of what health is and of responsibility for health. While many did see health negatively, as the absence of disease, they generally also had more positive images. ‘Looking healthy’ and ‘being happy’ were frequently seen as attributes of a healthy person, although they thought of themselves as being well if they could carry on with their daily activities. Conversely, the most frequently mentioned identifiers of unhealthy people were that they had diseases, serious illness or a chronic debilitating condition. Unhealthy people were also said to be identifiable by their appearance and their unhappiness. There is clearly a space between being healthy and being unhealthy—a space where most of our informants placed themselves—in which they are able to cope and to get on with their daily lives despite not always being fit and well, a ‘space’ in which people are expected to ‘fight’ to remain fit and healthy and feel morally obliged to be happy and ‘put a brave face on things’ what

Russians frequently refer to as normal health (Palosuo, 2003).

The vast majority of our informants thought that they themselves were responsible for their health, and many explicitly rejected any notion that they could rely on the health service to care for them if they became ill. We found little evidence of reliance on health services or of health being valued only as a resource to be exploited. Rather we found that, within the limits of their knowledge of what promotes health and the structural constraints on their agency, many of our informants were struggling to look after their own health and that of their families:

You can't give up a shower because the financial situation is bad. It depends on your character, on your struggle for life—we have to literally fight for our lives (female focus group, Kherson).

There was also an awareness of the things they could do to look after their health. Most recognised that diet was important, and many were aware of the health consequences of smoking and drugs, although few thought that alcohol was damaging to health and some men said that they smoked and drank vodka as a way of dealing with stress. However, the vast majority talked about eating food that was far from constituting a healthy diet, and, indeed, there appeared to be little knowledge of what constitutes a healthy diet beyond the importance of fresh fruit and vegetables. The majority of our male informants smoked and drank, and while few of the women smoked, they did drink alcohol. Drinking and smoking was seen as part of the normal way of life for men—deeply imbedded in taken-for-granted everyday practices. There was some evidence of a continuing reliance on the state to provide for the welfare of citizens in that, for example, most respondents said they did not engage in recreational exercise because the state no longer provided sports facilities—although a few pointed out that it did not cost anything to jog. There was also a general view that health was damaged by not being able to go on a holiday to the sea to have a proper rest, something the majority could no longer do because of the withdrawal of holiday cards and subsidised rail travel. (A few did point out that you could have a rest at home or by visiting relatives.)

There was awareness among our informants that they did not have the necessary resources to look after their health. In particular, they pointed to their inability to look after their health because of environmental pollution, stress, lack of time for rest and relaxation and, above all, their own and their country's financial situation. They recognised that their personal troubles were related to public issues and that their ability to take control over their lives was severely limited by structural factors over which they had little, if any, control. It is

evident that structural constraints preclude the majority of citizens' looking after their health, and while there is some evidence of a minority adopting healthy lifestyles, the majority are unable to do so. Daily lifestyle practices are also deeply embedded in the taken-for-granted—high levels of alcohol and cigarette smoking among men, and more generally a diet high in fat and carbohydrate and low in protein and fresh fruit and vegetables, are seen as normal and natural. Smoking and drinking have become habitual, part of the taken-for-granted everyday life, and are seen as both pleasurable, in a life that offers few pleasures, and as a way of coping with stress.

Health lifestyle practices are the complex outcome of the interaction of agency and structure, with agency informed by culturally shared, taken-for-granted practices. Even when structural changes led people to question aspects of life formerly taken for granted—in the case of post-soviet citizens, that they do not need to look after their health because the state will provide for them—their ability to exercise agency and look after their own health is limited by both structural factors over which they have no control and unquestioned, taken-for-granted daily practices.

Acknowledgements

This paper is based on work produced as part of the Livening conditions, Lifestyles and Health Project (LLH) funded by the EU under INCO–Copernicus. We acknowledge the work undertaken in carrying out the research on which this paper is based. We are especially grateful for the enthusiastic work of the research assistants who organised the qualitative interviews and ran the focus groups. Finally, we acknowledge the work of the translators without whom the project would not have been possible. Earlier versions of the paper were given at the All Russia Sociological Association Tenth Annual Conference in Moscow in 2003 and at the Sociology Staff Seminar at Glasgow Caledonian University in October 2004. We are grateful for the comments made by colleagues at these events. The authors alone remain responsible for the content of this paper.

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