

Reform in Eastern Europe: Assessing its Impact on Parallel HIV, TB and STD Epidemics.

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Introduction

This paper begins with some definitions.

Eastern Europe is taken for the purpose of this paper to include those countries to the east of the former East Germany, Austria and Italy and west of the Ural mountains and north of Greece and Turkey. The Russian Federation is included although it stretches as far as the Pacific. There are problems accessing consistent data for a number of the former Soviet Union countries and so the examples are taken where data are available.¹

Reform is defined in the Collins English Dictionary as "to improve (an existing institution, law, practice etc) by alteration or correction of abuses or as an improvement or change for the better especially as a result of correction of legal or political abuses or malpractice"².

Since 1989 the countries of Eastern Europe have undergone a period of unparalleled change. The change began with political liberalisation, which resulted in the creation of new governments and countries. However, this has been happening concurrent with economic decline and a collapse of many social services. It is not at all certain that the majority of citizens of East Europe would regard this as "reform". It is more accurate to describe events past and current as **transition**.

The Structure of Eastern Europe pre-1988 and causes of change

Prior to the changes of 1989 the Eastern European countries had a number of features in common.

- Politically all were ruled through a communist party and opposition was not tolerated.
- Economically the countries operated as "planned economies" where production was controlled and all the resources were allocated through state planning.
- Socially citizens swapped a high degree of control over their lives for a number of certainties - they were assured of employment, health care, education and housing, and when they became too old to work the state would provide a pension and other care.

¹ The note in the 1997 World Development Report states, "Estimates for the economies of the former Soviet Union are preliminary, their classification will be kept under review".

² Collins English Dictionary. Third Edition, HarperCollins. Glasgow 1992.

From the perspective of the ordinary citizen the benefits of this planned system were considerable. In addition to the social benefits alluded to above, during the 1950's, 60's and 70's there was steady economic growth and incomes were relatively equally distributed. Up to the 1970's the health status of the East European countries was comparable to that of the West, indeed in the 1970's life expectancy was higher in East Germany than in West Germany.

Although the changes that swept through Eastern Europe during the 1980s were driven by politics, under-pinning them lay a severe economic crisis. The problem was that the economies were dependent on central control, and it became apparent that planning was intrinsically inefficient. The planners could not get enough information (which is provided by prices in a market economy). The emphasis was on heavy industry and servicing a military machine to respond to the perceived threat posed by the West. The result was growing shortages of consumer goods, and deterioration in the quality of manufactured goods, for example Soviet manufactured cars cost a third of similar western models in Finland.³ At the same time there were few incentives for workers to be more productive or innovative as they were guaranteed employment, and there was no encouragement of entrepreneurship.

In this context change was inevitable. The result was that by mid 1990's all the countries of Eastern Europe (apart from those torn by strife) had moved towards some form of political liberalisation, generally with one-person one-vote elections. There was a fragmentation of some of the countries, Czechoslovakia split into the constituent countries of the Czech and Slovak republics, Yugoslavia "Balkanised" and is still doing so. The Soviet Union's western Soviets became independent as Latvia, Lithuania, Estonia, Belarus, Ukraine and Moldova.

Economic and Social Changes Since 1990

It is hard to grasp the extent to which the economies of many of the East European countries have collapsed. As is shown in Table 1 and on Figure 1, Eastern Europe may be divided into those countries that have experience economic growth (or at least economic stability) and those which have seen economic deterioration. The successes include Poland, and the Czech and Slovak Republics. The worst affected are Moldova and Ukraine where the 1999 per capita incomes were 24 per cent and 44 per cent per cent of the 1991 figures respectively.

Table 1. GNP Per Capita Trends in Selected East European Countries.

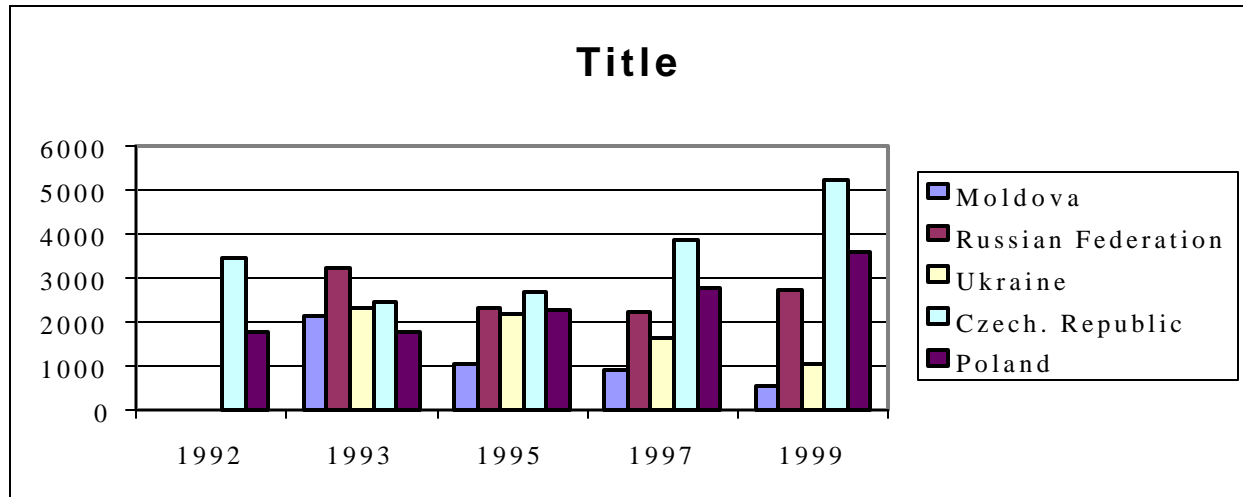
	1991	1993	1995	1997	1999
Countries experiencing economic decline					
Belarus		3110	2870	2070	2150
Bulgaria	2320	1840	1140	1330	1140
Estonia		3830	3080	2860	3330
Latvia		3410	2010	2270	2430
Lithuania		2710	1320	1900	2230
Moldova		2170	1060	920	540
Russian Federation		3220	2340	2240	2740
Ukraine		2340	2210	1630	1040
Countries experiencing economic growth or stability					
Czech. Republic	3450	2470	2710	3870	5200

³ World Bank, World Development Report 1996. From Plan to Market, Oxford University Press, New York 1996.

Hungary	2590	2720	3350	4120	4430
Poland	1790	1790	2260	2790	3590
Romania		1390	1140	1480	1420
Slovak Republic			1950	2950	3700

Source: World Bank, World Development Reports for 1991, 1993, 1995, 1997 and 1999, all published by Oxford University Press, New York.

Figure 1



There has been an increase in poverty. In 1999 it was estimated that the population living in poverty varied from a low of 4 per cent in Hungary, to a high of 66 per cent in Moldova. This is shown in Table 2. Unemployment figures hide the reality that in a number of the countries many workers are only partly employed and even when they do work wage may be months or years in arrears. For example in Ukraine it was estimated that by 1995 unemployment had risen from 14.4 per cent to 21.3 per cent. However an incomplete working week was routine for an additional 4.6 per cent. In addition 23.3 per cent received wage lower than the low income level – when they received wages. By June 1997 it was estimated that 5 per cent of the GDP was owed in back pay (30.5 per cent of the total wage bill).ⁱ

Table 2 Population below the Income Poverty Line (\$14.40 a day 1985 PPP\$)⁴

Belarus	22
Bulgaria	15
Estonia	37
Hungary	4
Latvia	22
Lithuania	30
Moldova	66
Poland	20
Romania	59
Russian Fed.	50
Ukraine	63

Source: United Nations Development Programme, World Development Report 1999, Oxford University press, New York 1999.

The social changes lead to the citizens gaining personal freedoms but losing the certainties of employment, a monthly salary and other social benefits. In general the quality of life has

⁴ The figures are for the period from 1989-1995 and poverty is measured at 50 per cent of the mean adjusted disposable personal income.

deteriorated for the majority of citizens of Belarus, Bulgaria, Estonia, Latvia, Lithuania, Moldova, the Russian Federation and Ukraine no matter how one measures it. Furthermore in the successful countries there are signs of growing income inequality as is shown on Table 3.

Table 3. Income Inequality, Percentage share of income distribution lowest and highest 20 percentages

COUNTRY	1991		1993		1995		1997		1999	
	lowest	highest	lowest	highest	lowest	highest	lowest	highest	lowest	highest
Bulgaria					8.4	39.3	8.3	39.3	8.3	39.3
Estonia							6.6	46.3	6.6	46.3
Hungary	10.9	32.4	10.9	34.4	10.9	34.4	9.5	36.6	9.7	38.1
Poland	9.7	35.2	9.2	36.1	9.2	36.1	9.3	36.6	9.3	36.6

The Changing Health Status in Eastern Europe

As would be expected with economic decline the health status of those citizens experiencing this decline is suffering. The most obvious measure is life expectancy where there has been a steady deterioration in a number of countries. This is shown on Table 4 below.

Compile

Table 4. Changing Life Expectancy in Selected East European Countries.

	1991	1993	1995	1997	1999
Countries experiencing economic decline					
Belarus					
Bulgaria					
Estonia					
Latvia					
Lithuania					
Moldova					
Russian Fed.					
Ukraine					
Countries experiencing economic growth or stability					
Czech. Rep.					
Hungary					
Poland					
Romania					
Slovak Rep.					

Source: ????

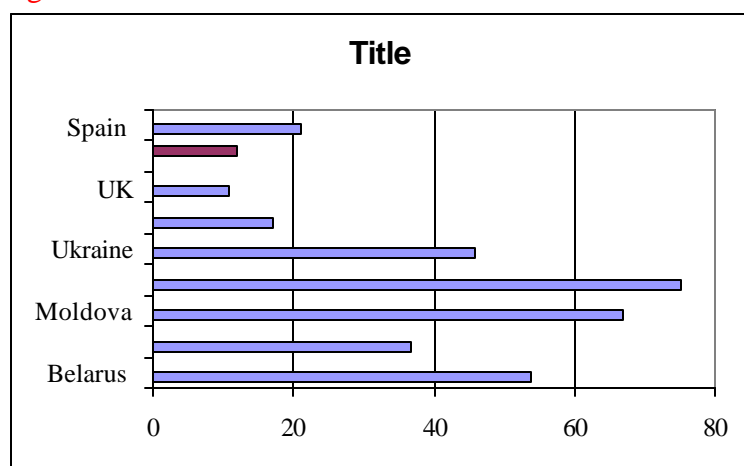
World Bank, World Development Reports for 1991, 1993, 1995, 1997 and 1999, all published by Oxford University Press, New York.

However there are other indicators of changing health status. In particular TB case rates per 100 000 are high and rising as is shown in Figure 2

Graph the following TB rate per 100 000

Belarus	53.9
Bulgaria	36.8
Moldova	66.8
Russian Fed.	75.1
Ukraine	45.7
Austria	17.1
UK	10.7
Ireland	11.9
Spain	21

Figure 2



Source: UNDP, Human Development Report 1999, Oxford University Press, New York, 1999

The trends and patterns of the HIV/AIDS epidemic have been well documented.ⁱⁱ What is apparent is that there has been a dramatic upsurge in infections in eastern Europe. Up to 1995 it appeared that these countries had avoided the HIV epidemic, and the very good surveillance meant that public health officials and others were confident of this. For example in Ukraine during the initial period of the epidemic (from 1987 to 1994) there was mass HIV testing. Over 39 million (39 226 9860) tests were carried out. These were performed on all blood donors, pregnant women, sexual partners of HIV-positive persons, social and professional contacts of HIV-positive people, hospitalised patients, military personnel, people who were abroad for more than three months, “promiscuous persons”, patients with STIs, prisoners, men who had sex with men, and drug addicts. Of the 39 million tests only 398 were positive, and the majority of these (215) were in foreigners (see Table 5). It is clear that Ukraine was not experiencing an epidemic of HIV but rather was there were sporadic occurrences, mainly among non-Ukrainians.

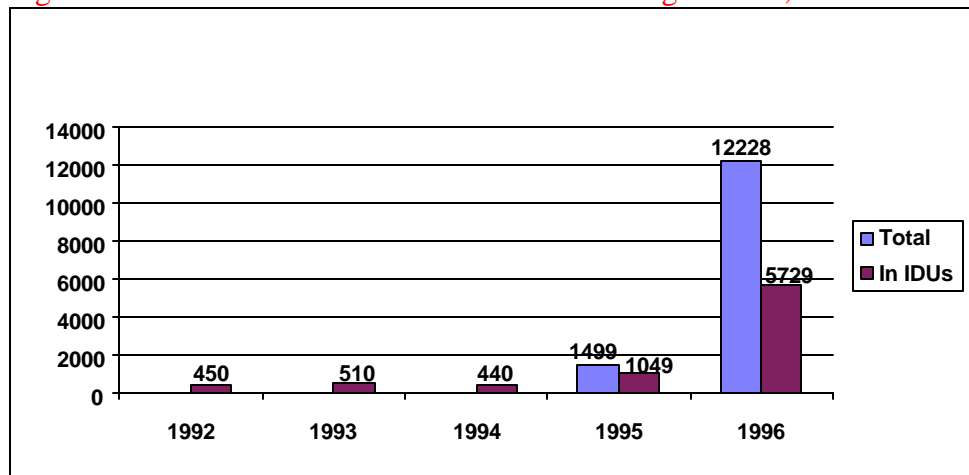
Table 5 HIV Positivity by Transmission Category 1987-94, 1995 and 1996*

Transmission group	1987 to 1994		1995		1996*
	Number	Percentage	Number	Percentage	Number
Ukrainians	183	46	1480	99.4	5400
Of whom Homo/bisexual men	25	6.3	2	0.1	
IVDUs	3	0.8	1021	68.6	
Blood Transfusion	5	1.3	0	0	
Heterosexual	103	25.5	304	20.4	

Nosocomial	10	2.5	0	0	
Perinatal	8	2	8	0.5	
Breast milk	2	0.5	0	0	
Undetermined	27	6.8	145	9.7	
Foreigners	215	54	9	0.6	22
Total	398		1489		5400
* Breakdown by transmission group was not available when the table was prepared.					
Source: Hamers, 1997, Table 2					

Since 1994 the epidemic has been located among the IVDU' population, where the spread of HIV has been most rapid. In Ukraine in 1996, there were 51,681 drug users registered with the Narcology Dispensaries of the Ministry of Health and 63,450 registered with the police. It is estimated that there were at least ten times as many (650,000) and 85 per cent use drugs intravenously. In the worst affected regions, up to 18 per cent IVDU's are already infected. This is shown on Figure 3.

Figure 3 Rate of Increase of detected HIV among IVDUS, Ukraine 1992 - 1996



Data on STD's, other than HIV, are puzzling. The number of syphilis cases rose from 5,229 in 1991 to 77,345 in 1995, but gonorrhoea cases fell, from 54,319 cases in 1994 to 38,167 in 1996. It is thought that people with gonorrhoea increasingly seek treatment privately, thus avoiding the stigma of visiting State facilities while syphilis is more serious, so patients go to government facilities.

The pattern of infection is that among the western newly independent states and the Russian Federation the epidemic is mainly among IVDU and has spread rapidly. In the Baltic state the epidemic is small and is mainly among men who have sex with men, but there is an emerging epidemic among drug users. There are few cases in the Central European countries except Poland, but here the epidemic appears to have stabilised and it is mainly among MSM's.

Table 6 HIV infection as at 31/12/97 in Selected East European Countries.

	HIV infection cumulative	Cumulative HIV infections per 100 000	IVDU as a % of HIV+ pop.
Countries experiencing economic decline			
Belarus	1787	17.3	85
Bulgaria	217	2.6	2
Estonia		74	4.9
Latvia	88	3.5	7

Lithuania	83	2.2	31
Moldova	471	10.8	77
Russian Federation.	7024	4.7	50
Ukraine	27671	53.7	49
Countries experiencing economic growth or stability			
Czech. Republic	311	6.5	9
Hungary	677	6.6	8
Poland	4990	12.9	65
Romania	499	Na	0
Slovak Republic	80	1.5	4

Source: Dehne Karl L., Khodakevich Lev, Hamers Françoise F., and Swartlander Bernhard, The HIV/AIDS epidemic in eastern Europe: recent patterns and trends and their implications for policy-making., AIDS, 1999, 13:741-749

Assessing Susceptibility to AIDS and STDs

Describing the deterioration of the economies of Eastern Europe and the concomitant increase in diseases is an academic exercise. What is needed for policy is to understand why diseases are on the increase; which sectors of society are more or less susceptible; and what can be done about it. Information about the level of drug use is hard to come by, but it is generally accepted that it is high and growing.

The sexual behaviour of East Europeans does not differ markedly from their western neighbours. The admittedly un-academic Durex Global Sex Survey included Russia. It showed that 43 percent of Russians admitted to being in more than one relationship at the same time (Britain 42 per cent, Germany 40 per cent and the USA 50 per cent, global average 37). Russians start their sexual lives later than most at 18 years, (Britain 16.7, Germany 17.4 and the USA 16.3, global average 17.6). They do however report have sex more frequently than most at 131 time per annum , (Britain 112, Germany 112 and the USA 138, global average 106).ⁱⁱⁱ

In earlier work Barnett and Whiteside developed a methodology for assessing susceptibility to infection and vulnerability to the impact of disease.^{iv} This argument stated that the susceptibility and vulnerability to the epidemic needed to be assessed separately. This was applied to Ukraine in a study sponsored by the British Council.^v

Methodology: Susceptibility and Vulnerability to HIV and AIDS

It is clear that in most of Eastern Europe the epidemic is being driven by IVDUs. If the epidemic is to spread beyond the drug users into the broader population, a key question to address is the likelihood and rate of “bridging”. If bridging occurs, the result will be sharply increased morbidity and mortality in the most economically active section of the population.

One of the main problems in assessing in which sectors of the economy and society the epidemic is likely to be located, and where the impact is most likely to be felt, is the lack of analytical tools. Epidemiologists and public health specialists are well aware of the concepts of risk. However, for non-specialists to understand the implications of an HIV/AIDS epidemic, they need to go beyond this idea. This is especially so if the non-medical audience is to be shown the potential consequence

of the disease and the need and ways to respond. The approach is to use the two concepts of susceptibility and vulnerability.⁵

These two concepts may be defined as follows:

Susceptibility describes those factors determining the rate at which the epidemic is propagated.

Such factors may be physical (as in the case of the development of a new road), environmental (such as a drought which results in unusual population movements), cultural (a particular sexual practice or belief), economic (increased unequal distribution of income), or social (operation of labour and associated housing markets in urban areas). This concept may be operationalised at any level, being applicable at the aggregate level of an entire "society" or country, or at the level of a social group such as a friendship network or a household. It may also be applied at the level of meso-entities such as an organisation or manufacturing enterprise.

A society or other social or economic entity in which factors combine to increase the chances of infection may be described as a *risk environment*. In such an environment (for example in a group of IV drug users), any activity in which body fluids are exchanged is a risky activity. Thus, it is not the activity alone which is risky; rather it is the environment that makes particular activities risky. When infection is spread widely in the general population, then an entire society may be said to have made the transition to becoming a risk environment. It will be apparent from what follows that this may already be the case in parts of Eastern Europe.

Vulnerability describes those features of a social or economic entity that make it more or less likely that excess morbidity and mortality associated with disease will have deleterious impacts upon that unit. An important component of this concept is the medium and long term impact of death and illness on social and economic life.

Once again, this concept may be applied at a number of levels. To offer some examples, a household with only one wage-earner aged 25 is more vulnerable than one in which there are two or more wage-earners, one of whom is more than 50 years old. An industrial process plant which depends upon one or two key pieces of equipment with very specialised operatives who are expensive to train, whose training takes place over a long period and who are therefore in short supply, will be more vulnerable than one in which large amounts of unskilled labour are all involved in the same or similar processes.

These two concepts enable us to speak of the *relative* vulnerability and susceptibility of whatever scale of unit we are concerned with. This could be geographic - Odessa and Kyiv or the whole Ukraine as compared to Poland or the Czech Republic; sectoral - the fishing industry or the coal mines; social - IVDUs or housewives; or occupational -civil servants or truck-drivers. Relative susceptibility will affect the gradient and the peak of the epidemic in a specific population or population sub-group, while relative vulnerability will describe the degree to which a social or economic entity is likely to be adversely affected by excess morbidity and/or mortality in the population over a period of time.

Some of these relative levels of susceptibility and vulnerability may be expressed in quantitative terms (as in the case of rates of rural-urban migration - which may be an important factor in relative susceptibility). Others may be expressed in qualitative terms (such as the enhanced rates of infection associated with particular balances of power between men and women and the ways that these affect sexual partner choice or lack of choice).

⁵ This concept has been developed in research work in Europe, India and Africa and tested over a number of years with multinational participants at the Planning for HIV/AIDS workshops run in Norwich and Jaipur by Barnett and Whiteside.

The concept of vulnerability refers to a complex of effects. These include:

- (a) the likelihood that raised morbidity and mortality will have adverse effects as illustrated above.
- (b) those features of a social or economic entity which make it more or less likely that it will be able to respond to or cope effectively with raised mortality or morbidity and for how long. Examples might include:

Thus a society, community or group might be described as *susceptible* to infection by a disease, but *vulnerable* to its effects. The processes which determine susceptibility and vulnerability are complex and incompletely understood.

However, experience from other epidemics suggests that among the key factors which determine susceptibility at the level both of a society in general and of social sub-groups are: aggregate income, income inequality, the degree of social control or the ability to mobilise resources, the level of social order, the extent of population movement, sudden and unpredictable political and economic change, sexual attitudes, behaviours and practices, general level of health in the society (in particular rates of STIs).

Determinants of vulnerability appear to revolve around factors such as: dependency ratios, labour and skill shortages in production or social and economic maintenance processes, pressure on social reproductive activities, the depth of resource availability, the degree to which social effort to cope with the effects of excess death and illness can be mobilised. The latter factor is of considerable importance and appears to be related to the response capacity of both the state and the non-state and non-household sector (sometimes referred to by the term ‘civil society’).

The Macro - Environment for HIV Spread and AIDS Impact - Transition and its effects on Economy and Society

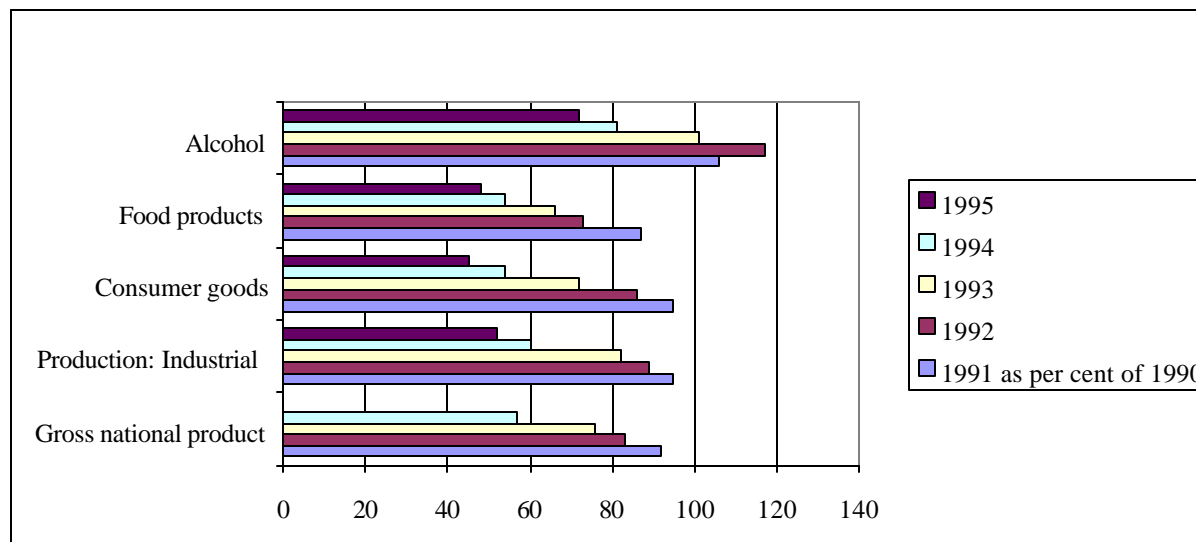
HIV spread and AIDS impact do not happen in a vacuum. They have to be seen in the economic and social context. As discussed above one of the main features of countries experiencing an epidemic is economic turmoil and contraction. Ukraine provides a good example of this. Since independence in 1991 the economy has been in crisis. Ukraine inherited a deteriorating and structurally unbalanced economy. Under Soviet rule, three quarters of Ukraine’s production was tied to the military industrial complex and heavy industry and only one quarter was directed to the manufacture of consumer goods. The economic situation has serious implications for the wealth and income levels of the citizens. Perhaps the greatest impact has been apparent in the provision of services, which were often provided by the state under the Soviet system. The progressive removal of these income subsidies is a major factor in declining living standards. The economic crisis has not only created an environment for the spread of HIV, but is leading to a reduced capacity to respond.

Table 7 Macroeconomic Indicators in Ukraine 1990-1995.

	1991	1992	1993	1994	1995
	<i>as per cent of 1990</i>				
Gross national product	92	83	76	57	-
National income produced	87	71	58	43	-
National income: consumption and accumulation	95	79	61	46	-
Consumption	95	86	60	56	-
Accumulation	96	62	60	26	-
Production: Industrial	95	89	82	60	52
Gross agricultural	86.8	79.6	80.8	67.5	65.1

Consumer goods	95	86	72	54	45
Food products	87	73	66	54	48
Non-food items	103	98	74	46	32
Alcohol	106	117	101	81	72
Per capita GDP in US dollars	2143	1909	1940	912	-
Source: Ukraine Health Initiative Report Draft. October 1997, no page number.					

Figure 4 **Macroeconomic Indicators in Ukraine 1990-1995**



Since independence the national output has declined every year, the consequence being fewer goods, jobs and resources for the population, a decline in the government income base and a growth in the need for social services.

Income and Expenditure

Households and wage-earners have seen their real incomes decline precipitously. More than one third of the population has an income below the official level entitling a family to subsidies for housing, public utilities and social assistance. It is common for wage-earners to face delays of several months in the payment of their wages or to be paid in kind .

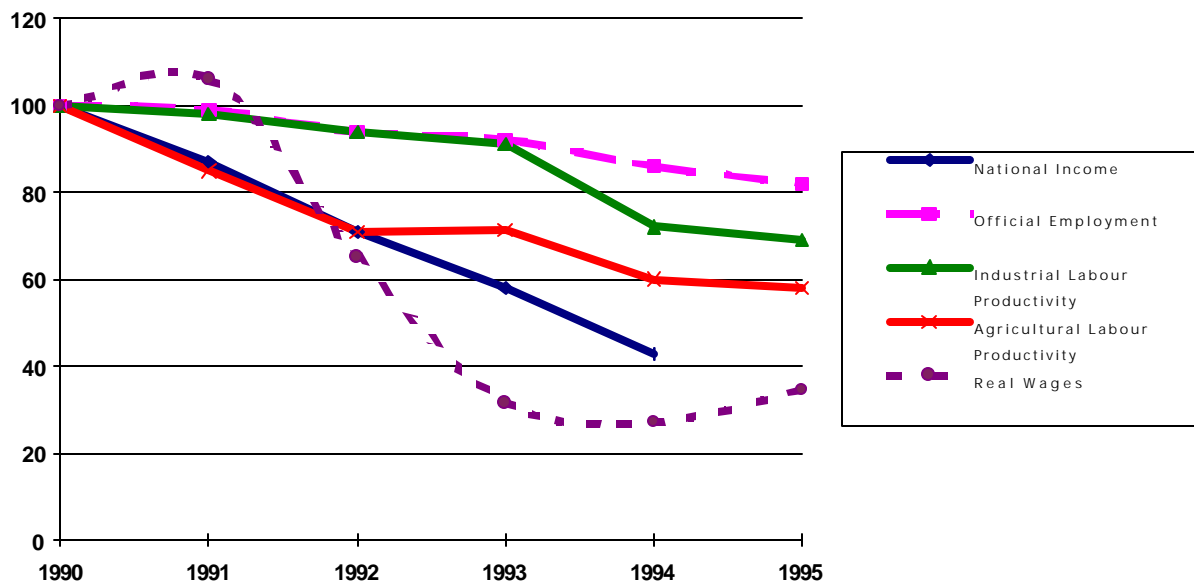
Living standards falling below subsistence levels are indicated by the sharp increase in the percentage of household income spent on food. This leaves less money for other expenditure including housing, leisure and, particularly important, in the face of HIV, the associated TB, and other diseases, medical care. Ukraine's population is becoming less well-nourished and less healthy, increasing both their susceptibility and their vulnerability.

In normal circumstances the state would provide a safety net through social assistance and services. However the availability of state-provided services has been reduced and the quality has fallen. In some cases unofficial and informal user fees have been introduced. The result is that households and individuals are being forced to adopt new means of making a living, some of which making them susceptible to HIV infection. The extreme example is of young women entering the sex industry, but it might include female traders crossing international borders – a few of whom apparently trade sexual favours for assistance in evading customs dues. At the same time lack of employment may force others into crime or self-destructive behaviour such as alcohol or drug use, which again increases susceptibility.

The decline in household incomes will also have an impact on vulnerability, as households become less able to cope with the demands that the AIDS epidemic may place on them. There is also the question of the impact on groups such as the elderly, who might have expected some support from their extended families. This is already reduced and AIDS can only exacerbate the situation.

Economically polarisation is, as mentioned above a common feature of Eastern Europe. In other societies this has been observed to lead to the creation of a market for sex. Men tend to be wealthier and buy sexual favours from poorer people - generally women. The exception to the generally impoverished state of Ukrainian society is the small group of entrepreneurs (some of whom make up the richer segment referred to above). It is to these people, and their foreign counterparts, that the government looks for the economic growth. The AIDS epidemic may have significance for this assumption.

Figure 5 National Income, Official Employment, Labour Productivity in Industry and Agriculture, and Real Wages 1991-1995 as a per cent of 1990.



Source: Ukraine Health Initiative Report, Draft, October 1997, no page numbers

Eastern Europe as a risk environment

The break up of the Soviet Union had acute social, political and economic implications for the newly independent CIS states in particular. The Soviet system was highly centralised and controlled via four main mechanisms, the party, the internal security apparatuses, the official trade unions and the administration. Entitlements to social, economic and cultural goods were largely administered within this structure. To a considerable degree, this was also true of personal identity, expression and morality (at least at the public level).

The acute economic decline which has followed independence has resulted in negative growth rates, while unemployment and underemployment (characterised by short- and part-time working) have become widespread. In some cases, this crisis of employment is geographically concentrated. For example, in areas of heavy industry, entire communities have seen their economic base disappear. Given the known association between high unemployment, alcohol abuse, domestic violence, IV drug use, increased migration and possible increased rates of sexual partner change, together with movement by some women into regular or occasional commercial sex work as a survival strategy, there may be specific regions and communities which are particularly susceptible to increased disease incidence.

For many people, the only way to survive has been through entering the “shadow economy”, which is by its nature unregulated, unaccounted and often involves activities which are at the very least on the border-line of what is considered legal.

Factors Contributing To Susceptibility

The absence of civil society

The term “civil society” is used to describe those social institutions and activities which are located between the intimacy of the household and the expressly public arena of the state apparatus. Under the Soviet system, such areas of life were hampered in their development by a combination of official suspicion and obstruction. It was also the case that official mechanisms often existed to meet these social, economic and cultural needs and aspirations for many sections of the population. With the political and economic changes which are in train, there is a marked gap in provision. Material survival is increasingly the business of the individual and the household.

What the “absence of civil society” means in practice is that this is a period of great uncertainty. At the political level conditions are uncertain, and the same is obviously true at the level of economic life. This may be described as a crisis of legitimacy, meaning that people are not clear as to what it is reasonable to expect of each other, what are “correct” or “acceptable” values and how and where (in terms of social space) to organise to achieve the goals that they desire. There is a lack of skills and capacity to manage the kinds of activity which contribute to an effective civil society. The non-government or “third sector” requires a wide range of skills and capabilities and has to compete for these in the general labour market. It is less able to offer wages which are equal to those in the developing private sector, and often faces problems of funding sustainability as well as having to adjust its goals to fit with those of (usually) external funding sources (such as the Soros Foundation or the UN system). Labour market competition, skill shortages, funding problems and uncertainty about working methods all contribute to a general difficulty of innovation in an uncertain situation.

In the context of susceptibility, the importance of this is that individuals and households are forced to explore whatever ways become available to them in order to achieve their economic, political and cultural goals. The only solution in such circumstances is to recourse to a world of individual and household. In such circumstances, and in marked contrast to Soviet society and to “Western” and some other societies such as India where there are highly developed civil societies, the degree of social control is weak. Experience from a number of other epidemics suggests that this is a key factor in increased susceptibility.

Gender relations

This term refers to all areas of social, economic and cultural life in which the relations between men and women are of significance. Its concerns are thus very broad and of considerable importance, when looking at the relative susceptibility to infection of whole populations and population sub-groups. It concerns the context within which sexual relations occur and the factors influencing those relations. In particular, the control which women have over their own sexuality; the degree of choice they have over whether, when and how they have sexual relations. This is important in a situation where the danger is of increased epidemic spread into the general population.

Evidence suggests that women are disadvantaged in Eastern Europe. According to the Ukraine Health Report, 70 per cent of women reported humiliation in the home; 60 per cent discrimination in the workplace; and 50 per cent, sexual harassment. More generally, according to the *Health 1996* survey (UHI Report, 1997, section 9, no age number), “only 41.97 per cent of women are fully satisfied with their family (interpersonal) relations at home (37.7 in urban areas, 40.6 in rural areas) and only 45.5 per cent of women (40 per cent urban, 43 per cent rural) indicated that they were

satisfied with their sexual life. Marriage and family life, including sexuality, obviously leaves much to be desired in Ukraine for most women. The rising divorce rate (currently about 50 per cent of marriages) confirms these sociological research findings.” What this means for men is currently unexplored or unrecorded. It is not unlikely that their response to all the social and economic pressures, and in particular to unemployment, may be to take refuge in alcohol abuse, violence and a search for alternative sexual partners with consequent implications for susceptibility.

In housing conditions, where accommodation is cramped and often shared with relatives, it is not surprising that personal relationships are often strained, particularly when this is combined with excessive and possibly increasing alcohol consumption, unemployment and other problems. Increased pressure upon and uncertainty regarding housing associated with breakdown of the system of central allocation and control can only add to these pressures upon domestic relationships.

In addition to these elements, there are others to be taken into consideration. Eastern Europe does not have a tradition of equality between men and women - even after decades of Soviet rule. Indeed the Soviet system reinforced certain already existing forms of gender inequality and established others.

In the current period of rapid social and economic change, people report a transition in sexual attitudes and behaviours to more “liberal” Western norms. Breakdown of the Soviet system of surveillance of private behaviours, and increased population mobility in search of livelihoods both allow for increased sexual expression. But this is taking place in a society where knowledge of sexual health among both men and women is quite limited and where a common form of contraception is abortion.

Against this background, the absence of an effective civil society (which might for example provide personal counselling services), cramped and sometimes uncertain living situations, involvement in the shadow economy, un- and under-employment, poverty, women’s involvement in trading activities, labour migration, the opening up of certain forms of sexual liberation, all combine to make gender relations in the domestic sphere more stressed, more uncertain, and more open to negotiation and disagreement. In the non-domestic sphere the same is also the case.

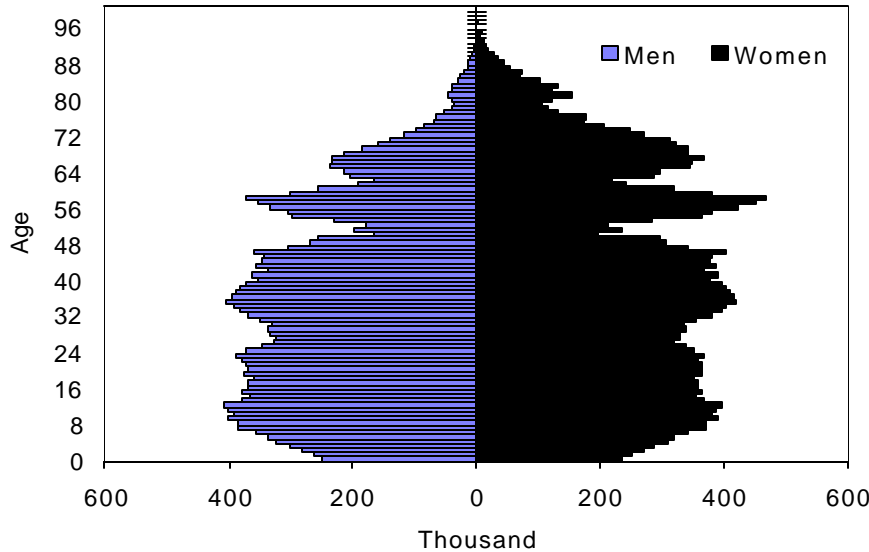
In the employment sector, the labour market is certainly going to reflect these gender inequalities existing in society more widely. These will also disadvantage women and force more of them into livelihood strategies, which are likely to include a sexual element or expose them to working conditions in which they may be open to sexual harassment or exploitation. Taken together, economic changes, the absence of effective civil society, and changing and uncertain gender relations are all likely to contribute to increased susceptibility in Ukraine.

Social and Economic Vulnerability

Population Structure

A key factor in the ability of any society to cope with increased illness and death is its human resources. In much of Eastern Europe countries face particular problems in this respect because of the age structure of the population and the resulting unfavourable dependency ratio. Ukraine provides an extreme example as is shown on Figure 6.

Figure 6 Age-Gender Pyramid, Ukraine, 1996



Source: Ukraine Health Initiative Report Draft. October 1997, no page number.

How will vulnerability manifest itself?

The vulnerability of society revolves around the burden which illness and death will place upon social and economic productive and *reproductive* capacities in an ageing society. Social reproductive activity refers to those social and economic activities which are largely unremunerated (such as child care, household management, care of the elderly and other dependants) and which do not enter into any conventional definition of economic activity. These reproductive activities are often done by women and create the conditions whereby much else in a society becomes possible.

Increased dependency ratios in households (and there are already large numbers of one-parent households) with resulting constraints on care of the very young and the very old (in a population which is ageing dramatically) do pose serious challenges for the future, even without an HIV/AIDS epidemic. These “care-dependent” sectors of Ukrainian life are where the impact will be felt. Some of these effects are outlined in the following sections.

Orphans

Consideration must be given to the increased numbers of orphans resulting from the epidemic. Satisfactory estimates of this will depend on the assumptions we make as to likely numbers of infections and AIDS cases.

The Elderly Dependent

Care of the elderly in an already ageing population with an unfavourable dependency ratio is going to require thought and long term policy decisions. Any changes currently being considered in health care provision in Ukraine will impact upon these excess orphans and solitary old people, and they will be among those population groups least able to make effective demands upon a system which is dependent upon private insurance provision.

The “New Entrepreneurs”

Life in a period of dramatic transition is risky for everybody. However, as is becoming apparent, not all are as clever or as fortunate in their risk-taking. Or perhaps some take greater risks and reap

larger rewards. Entrepreneurial ability is rarely in great supply, and it might be argued that those who are now entering the new middle-class are among the most successful. Neither is it correct to assume that entrepreneurs are only to be found in the economic sphere. Entrepreneurship is essentially a creative activity in which individuals are able to see opportunities for achieving goals. Thus there are entrepreneurs in politics, the arts and in the "third sector". In a society making the transition to capitalism, these people may be seen as a social investment. They are also, because of their increased income or because of their life style and attitudes, among those most likely to be at risk of HIV infection. Increased illness and death in this group will affect the development of this component of the the Eastern European countries.

It is not possible to explore this issue with any data. However, it is an area which should be researched both in relation to questions of targeted interventions to prevent infection, and also in terms of the potential social and economic loss in the event that they are a group which is particularly affected by increased rates of illness and death.

Household Vulnerability

More poor people will be affected than those who are better off because there are more poor people in the society. Thus more poor households will be affected and will be particularly vulnerable to the impact of death and illness.

In some respects, urban poverty is more frequent and deeper than rural poverty (World Bank, 1996, 19) but this is in part a statistical and definitional artefact. It reflects the importance of self-provisioning in rural households. In practice, the nature of poverty differs between urban and rural locations. The former are food-poor, the latter are more likely to be cash and service poor. Both types of poverty result in household vulnerability. As well as urban rural differences in poverty there are also national and regional differences.

Community Vulnerability

Some areas of part of Eastern Europe are experiencing levels of unemployment and effective de-industrialisation which are extreme even by current standards. Such communities, which are already particularly vulnerable because of their position in the economic restructuring process, may exhibit a particular vulnerability to the impact of the epidemic. With few resources to fall back on they will find it most difficult to cope. The danger here is that a long-term process of drug use, epidemic spread into an already poor and disheartened general population, and increased illness and death will lead to communities in which infection increases even more rapidly than would otherwise be the case.

Conclusion

The health status of the population of Eastern Europe had ceased to improve before the momentous events of 1989 and 1990. The life expectancy had stabilised and in some cases begun to decline. As Wilkinson notes "indeed, looking at the trends in life expectancy in Eastern Europe, one has a strong impression that if we know why health failed to improve after the early 1970s, we would also know the underlying causes of the uprising of 1989. Something went wrong in those societies in the early 1970s and health is probably the clearest indicate of it" ^{vi}

The social fabric of much of Eastern Europe had begun to deteriorate in the 1960s. the causes, well described by Wilkinson, are complex and it is the results that concern us. The population became alienated from activity in the public sphere - effectively social cohesion, which was expressed as

social control, broke down. It was not replaced with civil society and there was growing inequality. This treated a fertile field for the spread of diseases.

In 1989 the health of many East Europeans was already beginning to deteriorate. One feature of this was spiralling STD and TB rates. It is into this environment that HIV has been introduced and it seems that in some countries at least, all the factors are in place of this too to explode. What may be learnt from this paper and the differences in the HIV epidemic before say the Czech Republic and Ukraine, is that it is not only economic reform which will determine the future. There is a strong argument for seeing economic 'reform' as practiced in many countries as a contributor to the HIV, TB and STD epidemics. Social reform is essential, and this means addressing fundamental inequalities.

ⁱ United Nations Development Programme, 1997 Ukraine Human Development Report, Kyiv, 1997

ⁱⁱ See for example Dehne Karl L., Khodakevich Lev, Hamers Francoise F., and Swartlander Bernhard, The HIV/AIDS epidemic in eastern Europe: recent patterns and trends and their implications for policy-making., *AIDS*, 1999, 13:741-749

ⁱⁱⁱ durex Global Sex Su

rvey 1998, www.durex.com

^{iv} Barnett Tony and Whiteside Alan, AIDS and development (exact title) European Journal of Development Research, Forthcoming.

^v The social and economic impact of HIV/AIDS in Ukraine by Tony Barnett, Alan Whiteside, Lev Khodakevich, Yuri Kruglov and Valentyna Steshenko.

^{vi} Richard G Wilkinson, "Unhealthy Societies: The afflictions if Inequality", Routledge, London and New York, 1996).