Tobacco Control and Public Health in Eastern Europe

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Tobacco and alcohol consumption in Post-Soviet Ukraine: qualitative findings from community consultations

Anastasiya Salnykova, Anna Vorobyova, Setareh Rouhani, Olena Hankivsky

BACKGROUND: This study focuses on a variety of social determinants of alcohol and tobacco consumption, which have been reported as an alarming epidemic in the post-Soviet Ukraine. Authors look at the intersections of social determinants of tobacco and alcohol use in Ukraine as perceived by the study participants, and their perception of structural effects of economic and cultural transition on the prevalence of these harmful lifestyles.

METHODS: This study is part of a mixed-methods research, informed by an intersectional framework, focusing on complex health and health care experiences of Ukrainians. This study uses findings from 21 community consultations in 11 regions, corresponding to Ukraine's diverse demographics, culture, and geography. At these consultations, participants discussed their health, experiences in seeking healthcare and provided recommendations for healthcare reforms.

RESULTS: The study identifies the important demographic factors like age, gender, SES, and place of residence, and how their intersections influence tobacco and alcohol consumption in Ukraine. People of lower SES have reportedly higher rates of consuming alcohol and tobacco, but younger individuals of low SES are most affected by these unhealthy lifestyles. The study also points to broader structural factors, such as stress, unemployment, poor law enforcement, poor social support, lack of health promotion, features of the built environment, and tobacco and alcohol availability, which affect the uptake of unhealthy behaviors.

CONCLUSIONS: The community consultations revealed people's perceptions about the complex nature of tobacco and alcohol consumption in the post-Soviet setting. People shared their concern about the vulnerability of certain social groups to using alcohol and tobacco, and their understanding of the detrimental effects these substances have on the health of these groups. This intersectionality-based study concludes that there is a need to look beyond individual demographics and consider how social factors intersecting between themselves, as well as individual demographic factors, affect outcomes.

KEYWORDS: tobacco; alcohol; drinking; smoking; Ukraine; social determinants of health; intersectionality; community consultations.

BACKGROUND

Tobacco and alcohol use are vastly spread in Ukraine and other post-Soviet countries, and their correlated dependencies have been well documented (Pomerleau et al., 2004; Stickley & Carlson, 2009). While a recent study focusing on self-reported tobacco use found a decline in adult smoking prevalence (Andreeva, 2012), the problem of tobacco and alcohol consumption is still persistent (Bakirov et al., 2013). According to the 2013 World Health Organization (WHO) *Report on Global Tobacco Epidemic*, the daily adult smoking prevalence in Ukraine was 25% in 2011. This figure is much higher than in developed countries such as Canada (13%) and the United Kingdom (14%) but comparable to most post-Soviet states, except for the Russian Federation where the daily adult smoking prevalence was as high as 34% (World Health Organization, 2013). Alcohol per capita (APC) consumption for Ukrainians over 15 years old is 13.9 liters (as compared to the global average of 6.2), and Ukraine is second in the world when it comes to alcohol-related deaths

(World Health Organization, 2014). In 2012, the government banned outdoor tobacco advertisement and smoking in public places (e.g. restaurants, bus stops) in response to some of the identified problems in Ukraine and as compliance with the Framework Convention on Tobacco Control that was ratified in 2006 (Verkhovna Rada of Ukraine Bill #4844, 2012).

And yet, with few exceptions such as Murphy et al. (2012), there is little information about the social determinants of alcohol and tobacco consumption in Ukraine and how they might be addressed. The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems existing to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (World Health Organization, 2014). This paper advances the understanding of such determinants by presenting findings from a mixed-methods research programme in Ukraine led by Olena Hankivsky in 2013 and informed by an intersectional framework (Hankivsky et al., 2012), focusing on complex and diverse health and health care experiences of Ukrainians. Specifically, the goal of this study was to investigate people's perspectives of health and health care and of the social situation in relation to these in order to better determine key areas of priority for future health policy and planning.

The paper outlines the intersections of various factors relating to tobacco and alcohol use from the perspective of study participants including the structural effects of economic and cultural transitions on the lives of the Ukrainian population using qualitative data from extensive community consultations across Ukraine. Unlike Abbott and Wallace (2007), who published a qualitative study on the first-hand health experiences among residents of three regions in Russia and Ukraine, the community consultations in our study capture the opinions of Ukrainians in a more in-depth manner, as the study has covered a much broader selection of regions and was run in both urban and rural settings.

Moreover, by exploring the problem of tobacco and alcohol consumption in Ukraine through an intersectionality framework, our research provides new insights into the diversity and causal complexities of tobacco and alcohol use patterns (e.g. older versus younger women of different SES backgrounds) and across different contextual settings (e.g. urban versus rural settings) as it is viewed by the study participants. To date these have not been reported in the literature or reflected in policy because the focus in alcohol and tobacco reporting in Ukraine, like in many other jurisdictions, has been on single factors (e.g. gender, socio-economic status) and only marginally engaged people's perspectives.

METHODS AND THEORETICAL FRAMEWORK

In 2012, our Canadian-Ukrainian research team conducted 21 community consultations involving 844 participants in 11 oblasts, reflecting Ukraine's different levels of economic development, demographics, culture, and geography. From each of the five sub-regions (East, North, Centre, West, South) two oblasts were selected: Dnipro ("Dnipropetrovsk" in 2012), Donetsk, Kyiv, Sumy, Cherkasy, Zhytomyr, Lviv, Vinnytsia, Kherson, Zaporizhzhia and Crimea. In each oblast, consultations were held in the urban oblast centre and either a village or a small town with population less than 17,000 (See Appendix A for more details on the locations of the consultations).

The selection of applying the community consultation methodology was modelled after a similar process held in Australia where health policy priorities were identified with the help of national public consultations (Commonwealth of Australia, 2010). Consistent with an intersectionality framework (Hankivsky & Cormier, 2009), this form of consultation fosters an increased desire, power and ownership among citizens to participate in decisions that affect them (Fishkin, 2009). It also aligns with the increasing need for policy development to be informed by input and perceptions of individual 'lived experiences' from those involved or affected (Lovan et al., 2004; Venkatesan & Abraham, 2010).

The norm of community inclusion and participation is well-recognized in the global health sector (World Health Organization, 1978; World Health Organization, 1996). Citizen participation is fundamental for effective and sustainable public health interventions (Brolan et al., 2014). There is solid evidence that community engagement interventions have a positive impact on health behaviours, health consequences, self-efficacy, and perceived social support outcomes across various conditions (O'Mara-Eves et al., 2013). As qualitative methodology prioritizes capturing the multi-dimensional, lived experiences of people in the full context

of their social lives, it is especially well suited for carrying out intersectionality-informed research and analysis (Hankivsky & Grace, 2014; Schultz & Mullings, 2006). Community-based or participatory action research is well aligned with intersectionality research since "it is informed by the experiences of the people and communities who are being considered, and is conducted in the environments in which interventions will be implemented, assuring 'real world' application of the research findings" (Rogers & Kelly, 2011: 402-404). Consultations are also effective processes for knowledge exchange, which is critical for policy change. For example, in Ukraine it is understood that policy change is undertaken by the government, but more recently it has been recognized that public perception and understandings of health issues must also be transformed in order for transformative change to be realized (World Bank, 2009; Swedish International Development Agency, 2003).

The purpose of the consultations was to provide a venue for Ukrainian citizens to discuss their health, experiences in seeking healthcare and providing recommendations for change in the healthcare system. Recruitment of participants was conducted by several NGO partners working towards gender equality and/or community development. Each NGO partner was instructed to recruit participants from three broad categories: health care consumers, health service providers, and local government representatives. Each of these three groups is involved in different aspects of health care in Ukraine, and their perceptions of the quality of provided services are important in the evaluation process. Participants were sent personal invitations by the NGO partners from their client networks, since only 35 to 50 people could have been accommodated to attend each consultation. In addition to including health care professionals and local officials, approximate age and gender parity were requested for each consultation, as well as representation of vulnerable populations (e.g., individuals with limited abilities). Overall, 822 individuals participated in these consultations. Despite attempts of gender parity, women accounted for two thirds of those in attendance, potentially identifying a gender-specific concern about health. Different age groups were similarly represented at each consultation. Additional demographic details of the study participants are presented in Appendix B.

The community consultations consisted of open-ended discussions in groups of 6-10 people and were moderated by facilitators trained by our research team. The questions that were discussed at each meeting (see Appendix C) were developed by our team upon the analysis of the quantitative portion of the research study (Omnibus survey conducted in 2011) and a literature review. The consultations took place in schools, community centres, libraries, museums, halls, or NGO offices, lasting 2-3 hours. They consisted of a brief information session regarding the purpose of the study followed by small group discussions. After an informal coffee break, key points and recommendations were presented by a participant from each table. At the end, participants were provided with a modest honorarium for their time.

Ethics approval was received from the respective ethics committees of the academic institutions where the principal investigator and two co-investigators are affiliated (Simon Fraser University, National University of Kyiv-Mohyla Academy, and the University of Alabama in Birmingham).

Each consultation was digitally recorded. Hand-written notes were also collected. Data analysis was conducted using the MaxQDA 11 qualitative software (VERBI – GmbH, MaxQDA 11). Three researchers were involved in coding the data. Two of them were present at community consultations as coordinators, note takers or facilitators. Each researcher was responsible for coding approximately one third of the consultation transcripts. Inter-coder consistency was verified, and divergence in codes' interpretations was eliminated to the best of our ability. The research team used an iterative and data-driven process of creating codes that were organized into themes representing frequently occurring patterned responses throughout the dataset. Each of the analysts took the following steps in the coding process:

1) Reading through the text;

2) Identifying repeatedly discussed topics and issues;

3) Assigning a code name to repeated topics/issues;

4) Linking each narrative to its respective code.

Codes were developed in collaboration by three analysts and the principal investigator. The team went through several coding trials to ensure the same segment of data was coded by all three researchers and verified for consistency of codes used in a group.

The conceptual framework underpinning the research was intersectionality. Coined by American critical legal race scholar Kimberlé Williams Crenshaw, intersectionality has deep historical roots in black feminist activism and scholarship (e.g. hooks, 1984; Bilge, 2009; Collins, 1990; Combahee River Collective, 1977; Crenshaw, 2011). In general, this perspective considers the combined impacts of interactive social locations (e.g., gender, race, age, geography, ability, class) and structural processes (e.g., racialization, patriarchy, capitalism, imperialism) in the creation and perpetuation of inequities. In general, intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations (e.g., 'race'/ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created (Hankivsky, 2012).

And although definitions of intersectionality can differ, there is a general consensus around a number of key tenants that are consistent (Hankivsky, 2012) with this type of approach. Namely, human lives are seen as such that cannot be reduced to single categories, the salience of any category or social location cannot be predetermined, and 'categories' are understood as not coherent but fluid in their meaning. Moreover, multi-level analyses that link individual experiences to broader structures and systems across time and space are key to understanding that privilege and oppression can be simultaneously experienced. Finally, self-reflexivity by researchers is essential for the 'doing' of intersectionality, and intersectionality-informed research, policy and practice must be oriented towards social justice. Intersectionality has gained significant traction across disciplines and methods (Cho et al., 2013; McCall, 2005; Hancock, 2007; Hancock, 2011; Hancock, 2013; Hankivsky & Grace, 2014; Grace, 2014; Rouhani, 2014; Hunting, 2014) and, in particular, in the context of health inequities research and policy (Bowleg, 2012; Weber & Castellow, 2012; Hankivsky, 2011; Hankivsky et al., 2010; Hankivsky & Cormier, 2009; Shultz & Mullings, 2006). In the context of health, intersectionality is seen to hold great potential for expanding on how determinants of health are understood and responded to.

Accordingly, we used an intersectionality-based analysis (Bowleg, 2008; Hancock, 2007) to analyze the content of the narratives we collected during the consultations. Intersectional codes were created for the narratives that described several demographic characteristics simultaneously, and how the combination of these characteristics was seen as predisposing a particular social group to certain health problems. For example, many participants talked about 'unemployment' as a general problem in the younger generation. Unemployment was also discussed as occurring among 'younger males' or 'youth in rural areas.' In this case, an intersectional code consisting of: "age + gender" and "age + place of residence" was created to deepen the analysis of perceived socio-demographic factors that were seen as affecting the health of the Ukrainian population. Both "explicit" and "implicit" intersectional content were considered while coding the data. "Explicit intersectional content" refers to multiple social locations directly present in the text as mentioned above. The "implicit intersectional content" is the discourse that explicitly mentions some social locations and experiences, to which researchers added information about the social structures in post-Soviet Ukraine. This method of implicit intersectional data was modeled after previous research on diverse populations using an intersectional approach (Bowleg, 2008). For example, when a participant shared their views on the hardships of young people living in rural areas, the intersection of age and place of residence was classified as explicit and coded as: "age + place of residence." In this example, the researcher also added a code for 'low socio-economic status' since rural residents in Ukraine generally experience higher levels of poverty and unemployment (Skryzhevska & Karacsonyi, 2012; Lekhan, Rudiy & Richardson, 2010). The new code: "age + place of residence + socio-economic status" in this example, was considered an implicit intersectional data.

RESULTS

In the following section, we present research findings according to key themes that emerged in our analysis: evolution of tobacco and alcohol consumption, intersections of individual and structural factors in the context of tobacco and alcohol use, and participant recommendations on how to address these problems.

Evolution of Tobacco and Alcohol Consumption in Post-Soviet Period

A large number of individuals in our study mentioned "alcohol addictions" among the most common "diseases" in Ukraine, and described tobacco and alcohol use as extremely widespread. This is illustrated by the following quotes: "*Everyone drinks…*" and "*people who smoke everywhere really bother me… this is like a national problem. When [I attend events] people smoke everywhere, it looks like a smoke room*". Moreover, in the view of participants, this problem is connected to poor health. Participants often related tobacco and alcohol consumption to structural factors and social determinants of health such as unemployment, stress, poor social support, and lack of healthy lifestyle social ads.

Consistently, participants from different regions of Ukraine reported that the situation with respect to tobacco and alcohol use/abuse has worsened in post-Soviet times. As one female doctor from Sumy noted: "*Alcoholism and drug addiction is rising and people with these problems are becoming younger and younger.*" One older man from Dzhankoj, a smoker himself, said: "*Our children, our grandchildren start smoking a lot earlier than in our generation…*" Two middle-aged participants from Lviv had the following exchange about social groups whose health was the weakest in their region: "*Elderly people sometimes have a better immune system now than young people*." – "*Of course, because they are from a different cultural system, they did not smoke or drink when they were young…*"

Participants also discussed concerns relating to beer consumption replacing vodka (or home-made "samohon") as the leading source of alcohol abuse. One participant summarized the problem as: "*All the problems are tried to be solved by drinking beer. I have never heard about beer alcoholics. But they do exist now*".

The findings point to the people's observation that both women and men suffer from addictions, which was a troubling development for many participants as illustrated in the following excerpt: "*Only men were alcoholics before, today women drink as well*." Interestingly, study participants reacted differently to gender-based use of tobacco and alcohol, perhaps reflecting some of the gendered norms and stereotypes in Ukrainian society (Hankivsky & Salnykova, *2012): "I feel so bad when I see young girls smoking and drinking beer*" (a middle-aged female from Lviv), and "*Forbid selling alcohol to women*".

Intersecting Factors of Tobacco and Alcohol Consumption

The participants often did not discuss gender as a single factor explaining unhealthy behaviors. Rather, they connected gender with age, socioeconomic status and place of residence that together contributed to the disproportionately distributed patterns of addictions across Ukraine's diverse society. For example, while addictions were mentioned in both cities and villages, rural residents connected tobacco and alcohol use to problems specific to rural life. To illustrate: residents of smaller towns and villages complained about the absence of recreation and leisure infrastructure for their youth. As a result, in the participants' view, children engage in health-jeopardizing behaviours, such as alcohol and tobacco consumption. As one participant from a village Halchyn explained: "*They build night clubs, cafes, internet clubs. But not a single stadium or playground for children was built in our village. And children have no place to go*". In the absence of such infrastructure, it is not surprising that as another participant observed "*A young person is going out at night and what else is there to do besides going to get a drink and a smoke with friends?*". Similarly, a middle-aged nurse from Okhrimivka talked about young people's unhealthy habits: "*I understand them, there is nothing to do these days in the village, we used to have different activities in community centres, for different people, for different tastes, now there is nothing. In the evening all they can do is get drunk, and that is it.*" The factor of "having nothing to do" was discussed as one of the main reasons for smoking and drinking among rural youth. The theme of "having nothing to do" also captures the following terms used by participants during consultations: "uselessness," "lack of meaning," and "no opportunities for self-actualization."

Age and its intersection with low SES and rural place of residence appeared as one of the strongest determining factors of unhealthy lifestyles, according to our participants. Many of the study participants connected smoking and drinking among young people to unemployment, which is directly related to SES. The pathways from unemployment to smoking and drinking seemed to be especially prominent among youth in villages: "*…because of unemployment our youth drinks alcohol, smokes and*

sometimes even takes drugs." Significantly, the tendency of both children and youth to engage in unhealthy behaviours was also discussed more broadly. For example, participants noted: "*Children in 4th grade try cigarettes*", and "*Now kids drink beer starting in primary school*." In addition to young age, the intersectional-analyses further identified that gender is also seen as a contributory factor. One middle-aged male participant from Lviv exposed this issue among young men: "*[in]…teenage years, when alcohol and smoking starts… their health deteriorates and not very many of them survive to the middle age*". Findings pertaining to discussions about young people in Ukraine revealed publicly perceived stigmatization for their lifestyle choices. The data analysis further indicated a higher degree of stigmatization with respect to young females. For example: young women were criticized more often than young men since people believe that the reproductive role of mothers is more important than that of fathers: "*We need to teach young girls that they should not drink beer or smoke. We need to teach them to give a natural birth.*"

Even when young age and rural location were not explicitly mentioned together by the participants, the intersectional analysis enabled us to identify children, young people, and village dwellers as the most frequently mentioned social groups with the worst health. Individual experiences are always embedded within structural factors and forces. Accordingly, participants noted the infrastructural and financial availability of tobacco and alcohol. One participant noted: "*we have two pubs but no gym*" commenting on the infrastructure of their village or town. As for affordability, a male student from Kherson has aptly formulated the problem that "*beer is cheaper than bottled water in our country*." The availability of harmful substances is also problematic as *"young people and even children can buy cigarettes and alcohol.*" A female public servant from Zvenyhorodka noted "*there are kiosks near schools, and our children run there to buy "sukharyky" and "chipsy"* [junk food in Ukrainian] *and light alcoholic beverages during school breaks*." Selling of alcohol and tobacco to persons under 18 years old is illegal in Ukraine, yet this practice is not well monitored, especially in small retail places within the cities and in village stores.

Significantly, the negative effects of socio-economic transition, including stress, were frequently mentioned as factors contributing to smoking and drinking. At the individual level, participants felt that failure to adjust to the new post-Soviet reality led some people to mental health problems and alcohol use, as illustrated by the following narrative from a mental health worker from Sumy: "*the main problems people have are psychological problems. That's why they become alcoholics. They don't have plans for the future. Don't have prospects*". Similarly, a female from Lviv shared: "*I think the main barrier is that our people are so depressed and so unsure in the coming day that we're all aggressive, we hate each other. It starts with the government, that they don't care about us, and it's also in our attitude towards each other. And that's why our young people smoke and drink so much, because there's no hope for the future.*" Macro-social changes during the transition and the new kinds of employment were singled out as stressors leading to unhealthy lifestyles. As one participant put it: "*People who own small businesses … live in constant stress because they always think about how to make enough money and often take away their stress by drinking*". Yet as evidenced by the following quote, the problem of stress is seen as relevant to the broader population as well: "*Social stress causes people to start smoking and drink*."

Lack of social and family support was also discussed at length, as evidenced by the following excerpts, as a factor in tobacco and alcohol consumption: "*Parents are indifferent to kids. They allow them to smoke and drink alcohol*", and "*parents do not provide a good role model to children regarding alcohol and tobacco consumption*," as they often smoke and drink as part of their meals or family celebrations. One middle-aged female participant from Lviv summed up the problem: "*But those kids have parents who give money for cigarettes. There are very few parents now who pay attention to their kids and talk to them and discuss their kids' difficulties with them, and those kids turn out fine.*"

The public perception in the community consultations across Ukraine unanimously revealed the problematic nature of poor law enforcement in post-Soviet states, and how it is seen to contribute to the spread of unhealthy behaviors through failure to enforce tobacco and alcohol restricting regulations. For example, one participant commented: "*they still drink in parks and everywhere. And even policemen do.*" Another followed: "*Police doesn't control the situation and pays no attention to the law's violation*." With respect to smoking, the situation was seen as

equally disturbing: "*even though it is forbidden to smoke at the bus stops, people keep smoking*." This explains why despite major steps that were introduced by the government to combat the issue of tobacco and alcohol use, the population-based findings from this study still describe these unhealthy behaviors as wide-spread and in need of attention.

Participants' Recommendations

Many of participant recommendations were consistent with some articles of the WHO Framework Convention on Tobacco Control. Some of the measures outlined in the Convention are tax and price policies to reduce tobacco consumption, a comprehensive tobacco advertising ban, mandatory labels disclosing health hazards on cigarette packages, and protection from smoke exposure (World Health Organization, 2003). While many such policies have already been introduced by the government of Ukraine since 2009, participants discussed how these measures require more effective enforcement. For example: "*There should be control over the sales of alcohol and tobacco to the underaged…*" As such, participants observed some dissonance between the government level actions on tobacco control and the effect these policies have at the general population level.

Although many participants suggested healthy lifestyle social ads in mass media, they were also concerned about the role media plays in popularizing unhealthy behaviours such as alcohol and tobacco use. As one person noted: "*Cigarettes and alcohol are advertised all over the place, and this is a big problem. I think it should be forbidden. They influence children's minds.*" Participants across all regions felt that the government should monitor and regulate what goes in the media and what is advertised to the public. As one individual suggested: "*Censorship of advertisement* [by the government]. *For instance, of tobacco and junk food*".

There was a strong consensus that the government should impose restrictions limiting the accessibility and affordability of tobacco and alcohol through regulations. One suggestion included: "*We need to fix the fact that alcohol and tobacco are so available and accessible. We need to either raise the price or make it really strict as to who can purchase it and when*". A smoker has shared that he "*would quit if the cigarette prices were the same as in Europe…*" Others proposed closing down and limiting access to bars, pubs, and nightclubs to the underaged. At the same time, some shared concerns regarding governments' lack of interest to monitor the issue of tobacco and alcohol availability. As one participant explained: "*I had some ideas and talked to some authorities but it went nowhere. I tried to talk to our police, wrote letters but it all came back to me*." Overall, people agreed that Ukraine desperately needed better implementation of existing regulations.

While restrictions and measures such as those mentioned above are important, they do not address the fundamental forces driving unhealthy behaviours in Ukraine. Not surprisingly, many participants discussed the need for more complex governmental programs to address the root causes – the complex interplay of determinants – driving tobacco and alcohol consumption. As one participant explained: "*Young people's addiction to smoking needs to be addressed on the widest government, educational and family levels. There should be a systematic campaign to address the needs of the young people that lead them to pick up smoking*". Participants suggested such comprehensive solutions to the problem of tobacco and alcohol consumption as creating employment and other opportunities for young people: "*Unemployment, nothing to do in leisure time – this is what causes our younger people to turn to drugs etc. And so we need to remove the first causes of these evils*". Recommendations also included the development of leisure infrastructure that would distract the youth from engaging in unhealthy behaviors.

Unique to this study, the lack of various forms of social support networks was extensively discussed as a factor in tobacco and alcohol addictions. Participants spoke broadly of the need to assist the young generations in making healthy choices with a healthy lifestyle promotion through government programs, schools, media, and families. Specifically, our participants suggested that schools should be more actively involved in promoting healthy lifestyles among the youth. Speaking of complex interventions in tobacco use among youth, one participant shared that: "*we need parental support on this*."

DISCUSSION

Our findings demonstrate a general concern about tobacco and alcohol consumption across the population. A recent study revealed that the residents of Ukraine show positive responsiveness towards tobacco control measures introduced in the country in the recent years. Ac-

cording to the 2005 national representative survey and the 2010 GATS survey, smoking prevalence among the adult population in Ukraine decreased from 37.4% to 25.5% (Andreeva, 2012). This change, however, was not reflected in the narratives of consultation participants, who strongly asserted that the situation has not improved across all regions and age groups. One of the possible explanations is that people's perceptions may lag behind reality. Also, the surveys analyzed the data from 2005 to 2010, which is a short time span, while participants of our study discussed the changes over the past twenty years. Therefore, our study participants may have commented on the trend that in the Soviet Union people smoke and drank less, while during the transition they started engaging in unhealthy behaviors more extensively. Compared to this major documented rise in tobacco consumption (Cockerham, 1999; Pomerleau et al., 2004), the recent decrease in smoking might be less noticeable.

Age has been extensively discussed as a factor in drinking and smoking in post-Soviet countries (Murphy et al., 2012; Stickley & Carlson, 2009, Pomerleau et al., 2004, Hinote et al., 2009). Consultation participants also discussed a new trend of tobacco and alcohol consumption in younger generations. This finding is consistent with the WHO *Health Behaviour in School-aged Children* (HBSC) study reporting that among the 15-year olds 13% of girls and 31% of boys in Ukraine smoked at least once a week (Currie et al., 2012). It is also consistent with Palipudi et al. (2012) whose worldwide study finds that the odds ratio for smoking prevalence was decreasing with an increase in age for Ukraine, as well as Russia and Uruguay, in contrast to other countries discussed in the study.

Given the fact that boys are so much more likely to engage in unhealthy lifestyles than girls in Ukraine (Currie et al., 2012), the *intersection* of young age and gender is a crucial factor to consider in developing tobacco control measures. While our participants discussed that both boys and girls were affected by increasing rates of alcohol and tobacco consumption, they expressed greater concern about girls engaging in such behaviours compared to boys. Due to existing gender stereotypes in Ukraine (Hankivsky & Salnykova, 2012) that stigmatize females with addictions to a larger extent than males, young boys may be less encouraged to participate in smoking reduction programs.

Personal decisions about health and healthy lifestyle choices are embedded in structural opportunities and features of the built environment. Our study highlighted how problematic this is in the context of post-Soviet Ukraine as study participants viewed leisure infrastructures to be either unavailable, in poor condition, or not affordable. Therefore, any future smoking cessation program should consider introducing a simultaneous improvement with affordable leisure infrastructures.

Further, the concept of "having nothing to do" was discussed as one of many reasons for smoking and drinking among youth. This concept has not been previously explored in the literature (Murphy et al., 2012) and requires further research. In the current study, the participants referred to this concept as a lack of ideas, but more importantly a lack of infrastructure and social possibilities to engage in both labor and leisure activities. The "nothing to do" problem is also related to the issue of unemployment, and Murphy et al. (2012) found a significant association between unemployment and alcohol consumption, especially among men. Our results further this finding by highlighting the intersection of age, gender, and place of residence as one of the most influential factors in tobacco and alcohol consumption in Ukraine. It stands that, according to the views of the study participants, young unemployed males from rural locations are the most vulnerable social group with respect to engaging in tobacco and alcohol use in Ukraine.

Our findings are also consistent with previous research that found SES to be associated with tobacco and alcohol prevalence in post-Soviet countries (Murphy et al., 2012; Roberts et al., 2013; Pomerleau et al., 2004; Stickley and Carlson, 2009). The pattern of tobacco consumption in developed countries shows that individuals of lower SES are more likely to smoke (Katainen, 2010). The trend of decreasing odds of tobacco use with increasing wealth and level of knowledge was significant for Ukraine and a number of other states in a worldwide study by Palipudi et al. (2012). Relatedly, the global experience shows that individuals of lower SES are less responsive to tobacco control measures. Yet a recent study demonstrated that this tendency may not hold in Ukraine, where smoking prevalence declined among all socioeconomic groups since the implementation of tobacco control measures in 2009 (Andreeva, 2012).

However, in our study, *the intersection* of age and low SES was most frequently seen by participants as a factor of harmful lifestyles. This conclusion parallels findings from the HBSC survey reporting boys and adolescents with low family affluence to be more vulnerable to alcohol and tobacco use (Currie et al., 2012). Moreover, the intersection of age and low SES was compounded by rural place of residence, as a strong factor in adopting unhealthy lifestyles. Young unemployed males from villages and small towns were mentioned very often as a demographic group most susceptible to tobacco and alcohol use. There is also some evidence in the literature to suggest a relationship between place of residence and uptake of unhealthy behaviors. For example, a German study has concluded that alcohol consumption was significantly higher in rural areas. And the mechanism they discuss is similar to what we find in our study – fewer opportunities for healthy leisure activities in rural areas (Donath et al., 2011).

The unique and most important contributions stemming from our community consultations were the findings that advanced understandings of the broader structures and factors affecting the Ukrainian population's health, and also drew connections on how these were inextricably connected in the view of our participants. Transition, unemployment, poverty, political uncertainty, and poor public infrastructure were commonly named as interconnected factors of poor health. Abbott and Wallace (2007) previously highlighted the detrimental effects of transition on the health experiences of populations in post-Soviet countries. Our participants discussed at length how the economic transition, which resulted in rampant unemployment and broader uncertainty about life, negatively affects – in their view – their health and ability to seek timely care. The complex nature of the economic and political turmoil affects – in the participants' opinion – the tobacco and alcohol use especially among the younger generation that was growing up in the post-Soviet years. Among the youth, it is the unemployed young males predominantly from rural locations that seem to be the most vulnerable to alcohol and tobacco abuse according to our participants.

To our knowledge, this study was the first to undertake health-related community consultations of such magnitude in Ukraine. This study was based on a diverse sample of Ukrainian citizens across all major regions, including the areas that have undergone the pilot healthcare reform. Purposeful sampling was also employed to ensure that vulnerable, marginalized groups in Ukraine are captured in the study. While previous qualitative and quantitative research in Ukraine and similar post-Soviet countries have examined critical health issues and healthcare experiences of individuals, this study was a step forward in comparison to previous research.

One of the limitations of this study was the lack of sufficient and consistent demographic data of participants collected during the consultations. Our intersectionality-informed analysis has been limited in analyzing the intersectional content due to this shortcoming in data collection. However, many individuals provided detailed demographic responses in their assessment of health and experiences with the healthcare system to adequately enable the researchers to both explicitly and implicitly analyze the data. Additionally, this study explored the perceptions of individuals, and as a result, causal relationships between determinants of health and health outcomes cannot be ascertained. The collected data from this study informs important areas of research and provides insights that can be further investigated with additional research methods. For example, the importance of leisure infrastructure was named among the priority policy interventions by our study participants, yet the robust effects of such measures need to be clarified by future studies using different research methods.

CONCLUSIONS

Given the social and economic turmoil following the collapse of the Soviet Union and the political unrest that started in 2013 and continues to garner international attention, there is a need to take an intersectional look beyond demographics to understand the role of structural factors that influence the uptake of unhealthy behaviors. This paper is an attempt to conduct more contextualized research. The study demonstrates that the population of Ukraine attributes many serious health problems to the use of alcohol and tobacco. Findings revealed that Ukrainian people perceive the complex, intersecting relationship between place of residence, gender, age, SES and unhealthy behaviors, where younger individuals of lower SES are found to be the social group most affected by tobacco and alcohol abuse. These qualitative findings provide insights into the public's perception of the key issues faced in post-Soviet Ukraine as well as an opportunity to explore how social factors and features of the built environment (e.g. place of residence, and

availability of infrastructure) may affect health outcomes. This study enabled us to underscore the need to address complex roots and to engage actors from multiple spheres of society, including the general population that directly experiences and observes these phenomena. Future studies should use a mixed-methods approach to optimize results using both qualitative and quantitative methods. Effective policy measures should consider these underlying factors, incorporate them into national policies on the control of tobacco and alcohol use, as well as improve the enforcement of existing related laws.

ABOUT THE AUTHORS

Anastasiya Salnykova, PhD, is affiliated to the Institute for Intersectionality Research and Policy, Canada, and Lviv School of Public Health, Ukraine;
ORCID 0000-0001-8739-8784
Email: salnykova@alumni.ubc.ca

Anna Vorobyova, MA, is affiliated to the Institute for Intersectionality Research and Policy, Canada, and Lviv School of Public Health, Ukraine;
Email: avorobyo@sfu.ca

Setareh Rouhani, MSc, is affiliated to University of Ottawa, Canada
Email: srouh057@uottawa.ca

Olena Hankivsky, PhD, is affiliated to Simon Fraser University, Institute for Intersectionality Research and Policy, Canada, and Lviv School of Public Health, Ukraine;
Email: oah@sfu.ca

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REFERENCES

Abbott, P., & Wallace, C. (2007). Talking about health and well-being in post-Soviet Ukraine and Russia. *Journal of Communist Studies and Transition Politics*, 23(2), 181-202.

Andreeva, T., & Krasovsky, K.S. (2007). Changes in smoking prevalence in Ukraine in 2001–5, *Tobacco Control*, 16(3), 202–206.

Andreeva, T. (2012). Differences by gender and education in responding to tobacco control measures implemented in Ukraine since 2005. *Tobacco Control and Public Health in Eastern Europe*, 2(2), 111-121. doi: 10.6084/m9.figshare.105433.

Bakirov, V., Danilenko, I., Kizilova, K., & Kuzina, I. (2013). General condition and social seterminants of health of the population of Ukraine. In: P. Brigadin, M. MacKee, D. Rothman, A. Khvorostov & C. *Haerpfer, eds. Health of Populations and Social Transformations in the Post-Soviet States*. Minsk, 325-351.

Bilge, S. (2009). Smuggling intersectionality into the study of masculinity: some methodological challenges. Paper Presented at *Feminist Research Methods International Conference* at Stockholm University, February 4-6, 2009.

Bowleg, L. (2008). When black + lesbian + woman does not equal black lesbian woman: the methodological challenges of qualitative and quantitative intersectionality research, *Sex Roles*, 59, 312-325. doi: 10.1007/s11199-008-9400-z.

Bowleg, L. (2012). 'The problem with the phrase women and minorities: intersectionality - an important theoretical framework for public health'. *American Journal of Public Health*, 102(7), 1267-1273. doi: 10.2105/AJPH.2012.300750.

Brolan C. E., Hussain S., Friedman E. A., Ruano A. L., Mulumba M., Rusike I., Beiersmann C., & Hill P. S. (2014). Community participation in formulating the post-2015 health and development goal agenda: reflections of a multi-country research collaboration. *International Journal of Equity in Health*, 13(66). doi: 10.1186/s12939-014-0066-6.

Cho, S., Crenshaw, K.W., & McCall, L. (2013). 'Toward a field of intersectionality studies: theory, applications, and praxis'. *Signs* 38 (4): 785-810.

Cockerham, W.C. (1999). Health and social change in Russia and Eastern Europe. London: Routledge.

Collins, P. H. (1990). *Black feminist thought: knowledge, consciousness, and the politics of empowerment* (New York: Routledge).

Combahee River Collective. (1995). 'Combahee River Collective statement' (original work published 1977). In B. Guy-Sheftall (ed.), Words of fire: an anthology of African American feminist thought (New York: New Press): 232-240.

Commonwealth of Australia (2010). National male health policy: building on the strength of australian men. Available from http://www.health.gov.au/internet/main/publishing.nsf/Content/7935AC78159969D4CA257BF0001C6B07/$File/MainDocument.pdf

Crenshaw, K. (2011). 'Postscript'. In H. Lutz, M. T. H. Vivar and L. Supik (eds.), Framing intersectionality: debates on a multi-faceted concept in gender studies. (London: Ashgate).

Currie, C., Zanotti, C., Morgan, A., Currie, D., De Looze, M., Roberts, C., et al. (2012). *Social determinants of health and well-being among young people. Health behaviour in school-aged children (HBSC) study: international report from the 2009/2010 survey*. Health Policy for Children and Adolescents, No. 6. Copenhagen: WHO Regional Office for Europe.

Donath, C., Gräßel, E., Baier, D. Pfeiffer, C., Karagülle, D., Bleich, S., & Hillemacher, T. (2011). Alcohol consumption and binge drinking in adolescents: comparison of different migration backgrounds and rural vs. urban residence-a representative study. *BMC Public Health*, 11, 84.

Fishkin, J. S. (2009). *When the people speak: deliberative democracy and public consultation*. New York: Oxford University Press.

Grace, D. (2014). Intersectionality-informed mixed methods research: A primer. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.

Hancock, A.M. (2007). 'When multiplication doesn't equal quick addition: examining intersectionality as a research paradigm'. Perspectives on Politics 5(1): 63-79.

Hancock, A.M. (2011). *Solidarity politics for millennials: a guide to ending the oppression olympics*. (New York: Palgrave Macmillan).

Hancock, A.M. (2013). Empirical intersectionality: a tale of two approaches. UC Irvine Law Review 3.

Hankivsky, O. (ed.) (2011). *Health inequities in Canada: intersectional frameworks and practices* (Vancouver, BC: University of British Columbia Press).

Hankivsky, O. (ed.) (2012). *An intersectionality-based policy analysis framework* (Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University).

Hankivsky, O., & Grace, D. (2014). "Understanding and emphasizing difference and intersectionality in mixed and multimethods research". In The Oxford Handbook of Mixed and Multimethods Research. Hesse-Biber, S.N. and Johnson, R.B., Eds. Oxford University Press.

Hankivsky, O., & Cormier, R. (2009). *Intersectionality and women's health research: a primer* (Vancouver, BC: Women's Health Research Network).

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). 'Exploring the promises of intersectionality for advancing women's health research'. *International Journal for Equity in Health* 9(5): 1-15.

Hankivsky, O. (2014). *Intersectionality 101*. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.

Hankivsky, O., & Salnykova, A. (eds.) (2012). Gender, politics, and society in Ukraine. University of Toronto Press.

Hinote B.P., Cockerham W.C., & Abbott, P. (2009). The specter of post-communism: women and alcohol in eight post-Soviet states, 68(7): 1254-62.

hooks, b. (1984). *Feminist theory: from margin to center* (Boston: South End Press).

Hunting, G. (2014). Qualitative intersectionality-informed research: A primer. Institute for Intersectionality Research and Policy, Simon Fraser University.

Katainen, A. (2010). Social class differences in the accounts of smoking – striving for distinction? *Sociology of Health & Illness*, 32(7): 1087-1101.

Lekhan, V., Rudiy, V., & Richardson, E. (2010). Ukraine health system review. *Health Systems in Transition*, 12: 1-183.

Lovan, W. R., Murray, M., & Schaeffer, R. (2004). Participatory governance in a changing world. In W.R. Lovan, M. Murray, and R. Schaeffer (Eds.), *Participatory Governance: Planning, Conflict Mediation and Public Decision Making in Civil Society* (pp. 1-22). Aldershot: Ashgate.

McCall, L. (2005). The Complexity of Intersectionality. *Signs* 30(3): 1771-1800.

Murphy, A., Roberts, B., Stickley, A., & McKeem M. (2012). Social factors associated with alcohol consumption in the former Soviet Union: a systematic review. *Alcohol and Alcoholism*, 47:6, 711–718.

O'Mara-Eves A., Brunton G., McDaid D., Oliver S., Kavanagh J., & Jamal F. (2013). Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. *Public Health Research*, 1(4).

Palipudi K.M., Gupta P.C., Sinha D.N., Andes L.J., Asma S., et al. (2012) Social determinants of health and tobacco use in thirteen low and middle income countries: evidence from global adult tobacco survey. *PLoS ONE*, 7(3).

Pomerleau J, Gilmore A, McKee M, Rose R, Haerpfer C.W. et al. (2004). Determinants of smoking in eight countries of the former Soviet Union: results from the living conditions, lifestyles and health study, *Addiction*, 99 (12): 1577-85.

Roberts, B., Gilmore, A., Stickley, A., Kizilova, K., Prohoda, V., Rotman, D., et al. (2013). Prevalence and psychosocial determinants of nicotine dependence in nine countries of the former Soviet Union. *Nicotine & Tobacco Research*, 15:1, 271–276.

Rogers, J., & Kelly, U. A. (2011). Feminist intersectionality: bringing social justice to health disparities research. *Nursing Ethics* 18(3): 397-407.

Rouhani, R. (2014). Intersectionality-informed quantitative research: A primer. Institute for Intersectionality Research and Policy, Simon Fraser University.

Schulz, A. J., & Mullings, L. (2006). *Gender, race, class, and health: intersectional approaches* (San Francisco, CA: Jossey-Bass).

Skryzhevska, Y., & Karacsonyi, D. (2012). Rural population in Ukraine: assessing reality, looking for revitalization. *Hungarian Geographical Bulletin* 61: 49-78.

Stickley, A., & Carlson, P. (2009). The social and economic determinants of smoking in Moscow, Russian. *Scandinavian Journal of Public Health*, 37 (6): 632-9.

Swedish International Development Agency (SIDA). (2003). *Gender issues in Ukraine: challenges and opportunities*. Kyiv: SIDA.

Venkatesan, C., & Abraham, K. K. (2010). *"If we involve, will they contribute?": involvement of people living with HIV in policy and program decision-making. A qualitative situation assessment of greater involvement of people living with and affected by HIV/AIDS (GIPA) in five indian states.* India: Indian Network for People Living with HIV/AIDS.

VERBI – GmbH, MaxQDA (Version 11) (2014). The Art of Qualitative Data Analysis. Available from: www/maxqda/com

Verkhovna Rada of Ukraine, 2012, Bill #4844. “On introducing changes to some laws of Ukraine improving certain articles about limitations of smoking in public places” (Pro vnesennia zmin do dejakyx zakoniv Ukrainy schodo vdoskonalennia okremyx polozhen’ pro obmezhennia misc’ kurinnia tiutiunovykh vyrobiv – in Ukrainian).

Weber, L., & Castellow, J. (2012). ‘Feminist research and activism to promote health equity’. In Sharlene *Hesse-Biber, (ed.) Handbook of Feminist Research: Theory and Praxis. 2nd ed*. (Thousand Oaks, CA: Sage Publications): 434-454.

World Bank. (2009). An avoidable tragedy: combating Ukraine's health crisis - lessons from Europe. Available from: http://documents.worldbank.org/curated/en/686961468171870399/An-avoidable-tragedy-combating-Ukraines-health-crisis-lessons-from-Europe

World Health Organization. (1978). Declaration of Alma-Ata. Available from: http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf

World Health Organization. (1996). Ottawa charter for health promotion. Available from: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

World Health Organization. (2003). The framework convention on tobacco control. Available from: http://www.who.int/fctc/text_download/en/

World Health Organization. (2013). WHO report on the global tobacco epidemic, 2013 Enforcing bans on tobacco advertising, promotion and sponsorship. Available from: http://www.who.int/tobacco/global_report/2013/en/

World Health Organization. (2014). Social determinants of health: key concepts. Available from: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

APPENDICES

APPENDIX A

List of community consultation locations:

Kherson and Hola Prystan' (a small town)

Sumy and Trostianets (a small town)

Dnipro and Pryvovchans'ke (a village)

Kyiv and Korolivka (a village)

Vinnytsia and Busha (a village)

Donetsk and Starobeshevo (a small town)

Simferopol and Dzhankoj (a small town)

Zhytomyr and Halchyn (a village)

Okhrimivka (a village in Zaporizka oblast)

Lviv and Bania Lysovetska (a village)

Cherkasy and Zvenyhorodka (a small town)

APPENDIX B

GENDER

Women	263
Men	581

AGE

Middle age (30-65)	550
Retired	101
Young	149
Unidentified	44

OCCUPATION

Manager	13
Unemployed	48
Librarian	24
Nurse	29
Doctor	75
Secretary	3
Teacher	71
Principal	2
Technician	8
Engineer	6
Retired on Disability	4
Retired	95
Driver	5
Feldsher	3
Student	77
Economist	1
Preschool teacher	10
Sales	13
Designer	1
Local official	50
Tourism	4
IT	2
Marketing	1
Journalist	9
Professor	9
Security	10
Photographer	1
NGO	55
Social worker	27
Business owner	51
Accountant	9
Priest	1
Police	4
Sailor	1
Artists	2
Midwife	1
Janitor	8
Seamstress	2
Biologist	1
Bartender	1
Head nurse	1
Gas technician	2
Stay at home Mom	8
Chef\Cook\Chocolatier	5
Advertisement	1
Community centre	5
HR	2
Railway worker	1
Tractor driver	1
Insurance company	4
Lab worker (hospital)	1
Undisclosed	28
Hospital economist	1
Construction	1
Musician	2
Veterinary	2
Sanitary epidemic services	1
Business council	1
Editor	1
Waitress	1
Hairdresser	2
Union	1
Plumber	2
Post office	1
Dance school	1
Teacher at a school for blind	1
Undisclosed	28
Lab worker (hospital)	1
Masseuse	1
Insurance Company	4
Medical statistician	3
Electrician	1
Bank teller	1
Dance school	1
Undisclosed	28
Lawyer	5

APPENDIX C

Community Consultation Questions

1. What do you think are the main problems or issues affecting life in [your region] of Ukraine?

2. How would you describe the health of people in your community?

• What do you think affects people's health here?

• What do you think are the main health problems

• Who in your community do you think experiences poor health and why)?

3. What are the main barriers in your community for accessing health care?

4. How would you describe the health care system and services that you are able to access?

5. Which three things would you change (if you could) to improve people's health in your region and in your community?

6. Is there anything else you would like to share with us?

7. For rural communities: What are the main differences between urban and rural communities when it comes to health?