

CRS Report for Congress

Received through the CRS Web

Health in Russia and Other Soviet Successor States: Context and Issues for Congress

May 21, 2001

Jim Nichol
Analyst in Foreign Affairs
Foreign Affairs, Defense, and Trade Division

Lois McHugh
Analyst in International Relations
Foreign Affairs, Defense, and Trade Division

Health in Russia and Other Soviet Successor States: Context and Issues for Congress

Summary

Health issues in the New Independent States (NIS) of the former Soviet Union have received increased U.S. attention in recent years. As part of this concern, a January 2000 U.S. National Intelligence Estimate (NIE) highlighted global threats posed to U.S. citizens and interests by increasing tuberculosis, hepatitis, HIV/AIDS, and other infectious diseases outside U.S. borders. While mostly focusing on disease threats emanating from Africa and Asia, the NIE also highlighted the NIS as an emerging concern. It warned that increased political, military, social, and economic disorder in the NIS could be worsened by the spread of disease, thereby setting back NIS democratic and free market reforms, and that such instability might further complicate U.S. arms control cooperation and efforts to contain the proliferation of weapons of mass destruction. In addition, the NIE cautioned that NIS militaries could face increased ill-health, harming the national security of the states in which they are deployed, their effectiveness in international peacekeeping could be diminished, and the troops could become agents for the spread of diseases among U.S. and other peacekeepers, troops involved in international exercises and training, and among civilian populations.

Congressional concerns about health conditions in the NIS have been reflected in legislative language and other actions, but the major foci of U.S. policy have remained democratic and economic reforms and arms control. U.S. health aid has hovered at about 5-7% of all U.S. foreign assistance to the NIS in recent years, not greatly increasing or decreasing, and cumulative U.S. aid obligations for FY1992-FY2000 for health programs in the NIS are about 5% of about \$16.5 billion for all programs. While this aid is overshadowed by other U.S. aid priorities, many policymakers and analysts have increasingly argued that health aid buttresses other assistance.

The Foreign Operations Appropriations for FY2001 (P.L. 106-429) provides not less than \$45 million for child survival, environmental health, and combating infectious diseases, and for related activities in the NIS. It also includes funds for healthcare and environmental health epidemiology in Ukraine and for expanding primary healthcare in Ukraine, Georgia, and Russia. Nonetheless, since FY1999, the dollar amounts of U.S. health assistance to the countries of the NIS have increased only to Tajikistan and declined for most other countries.

This report provides an overview of health conditions in the NIS, U.S. aid efforts in recent years, and issues which Congress might consider in providing health assistance to the NIS.

Contents

Introduction	1
Overview of U.S. Policy	1
Health in the NIS:	
Context and Current Developments	4
Selected Health Indicators	7
Childhood and Maternal Mortality Rates	7
The Increase in Infectious Diseases	8
Drug Addiction	9
Alcoholism and Smoking	10
Water-Borne Disease	11
Non-Medical indicators	11
Refugees and Displaced Persons	11
Orphans	12
U.S. and International Health Aid	12
International Assistance Efforts	16
Issues for Congress	17
How Significant are NIS Health Issues to U.S. Interests?	17
How Much Health Assistance Should the United States Provide to the NIS?	18

List of Tables

Table 1. U.S. Health Aid to the NIS	21
Table 2. Health Spending and Life Expectancy	22
Table 3. Tuberculosis, HIV/AIDS, STD Rates and Drug Users in the NIS	23
Table 4. Refugees and Internally Displaced Persons	24
Table 5. Abortion Rates and Contraceptive Use	25

Health in Russia and Other Soviet Successor States: Context and Issues for Congress

Introduction

During the Soviet era, health information was closely guarded and government health statistics highly suspect. The Soviet government proclaimed the high quality of its socialized healthcare system. Soviet data showed numbers of hospital beds and doctors per capita as among the highest in the world and life spans comparable to those in other developed countries. As became more apparent after the Soviet collapse, such data were often incomplete or falsified and covered up substantial and growing health problems.

The New Independent States (NIS) of the former Soviet Union¹ faced problems sustaining the huge, expensive, and ineffective healthcare systems they inherited. Health conditions seemed to deteriorate during the 1990s, as measured by life expectancy at birth, infant and maternal mortality, drug addiction, rates of infectious disease, and other measures. On some measures, these states now face health challenges common to developing countries, and these challenges are increasingly braking their economic and democratic reforms, according to many observers.

Data on health and healthcare in the NIS are poor, but some general conditions and trends may be discerned. Besides healthcare quality and access, factors affecting health touched on but not analyzed in detail in this report include poverty rates, conflict, living and working conditions, and the environment.

Overview of U.S. Policy

Although health issues in the NIS have been a lower priority in U.S. assistance and relations than arms control and economic and democratic reforms, they have been a matter of U.S. concern since the early 1990s and have received increased attention in recent years. U.S. health assistance to the NIS began even before the collapse of the Soviet Union with a public-private medical aid program to distribute pharmaceuticals and medical supplies to the Soviet republics. Later, the Bush and Clinton administrations led international efforts to address NIS needs, including health needs. The 1992 Freedom Support Act (P.L. 102-511), the major authorization

¹The NIS generally include the Western NIS (Belarus, Moldova, Russia, and Ukraine), the South Caucasian NIS (Armenia, Azerbaijan, and Georgia), and the Central Asian NIS (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan).

for NIS aid, included the provision of medicine and medical supplies and equipment and other aid to create quality healthcare and family planning services as priorities of U.S. assistance.² In the early 1990s, however, U.S. and Western donors lacked a clear picture of health conditions in the NIS (largely because of the mostly sanguine picture painted by Soviet health officials), and donors tended to assume that a short-term aid infusion would put NIS health systems “back on their feet” in no time. As health conditions became clearer, it was apparent that the NIS faced massive health problems.

The Clinton Administration’s increased attention to global disease threats to U.S. citizens and interests included a January 2000 U.S. National Intelligence Estimate (NIE) on the implications for U.S. national security of rising infectious disease outside U.S. borders. According to the NIE, the infectious disease burden will add to political, military, social, and economic disorder in the NIS and could set back democratic and free market reforms. Such instability might further complicate U.S. arms control cooperation and efforts to contain the proliferation of weapons of mass destruction. The NIE cautioned that NIS militaries already face increased ill health, harming the national security of the states and the effectiveness of the armies in international peacekeeping, and making the troops agents for the further spread of diseases among U.S. and other peacekeepers, among U.S. and other troops involved in international exercises and training, and among civilian populations.³

The January 2000 NIE and other Clinton Administration efforts to highlight global disease as threatening U.S. interests were controversial. The Republican Party’s 2000 campaign platform was critical of the NIE, stating that it had added “disease . . . to an undiminished set of existing American responsibilities” in the world, and asserted instead that “a Republican president will identify and pursue vital American national interests.” However, the platform also supported U.S. assistance for urgent humanitarian needs and for combating HIV/AIDS internationally.⁴ Richard Armitage, now Deputy Secretary of State, stated during the presidential campaign that “it is the height of insincerity to suggest that AIDS is at the top of our national security list.”⁵ However, he argued in later confirmation hearings that the new foreign affairs request would increase funding for HIV/AIDS, other infectious diseases, and child survival, showing that the Administration was not “walking away” from these

²Silk Road Act language in P.L.106-113, signed into law in November 1999, also authorized enhanced policy and aid to support humanitarian needs in the South Caucasus and Central Asia, including the provision of medicines and medical equipment.

³U.S. National Intelligence Council, *The Global Infectious Disease Threat and Its Implications for the United States*, NIE 99-17D, January 2000. Russian troops serve in seven U.N. and Organization for Security and Cooperation in Europe missions, are “peacekeepers” in Georgia, are stationed in Armenia, Georgia, Moldova, and Tajikistan, and serve as advisors in India, Cuba, Peru, and Syria. See *Johnson’s List*, March 13, 2001.

⁴Republican National Convention. *The Republican Party Platform 2000*, July 31, 2000; Council on Foreign Relations, Interview with Benjamin Gilman, August 3, 2000.

⁵*Washington Post*, February 14, 2001, p. A23.

issues.⁶ Secretary Powell testified in March 2001 that increased foreign affairs expenditures for child survival and diseases were a high priority of the Bush Administration, noting that HIV/AIDS is “spreading into the [new] countries of the [former] Soviet Union,” and terming HIV/AIDS a national security concern.⁷

U.S. policymaking on health issues in the NIS in the new Administration broadly involves the State Department’s Office of the Coordinator for Assistance to the NIS, the Special Advisor for the NIS, and USAID, the Department of Health and Human Services (DHHS), and other agencies. The Coordinator for Assistance plays a major role in integrating policy and implementation goals. USAID, the lead agency in implementing healthcare aid programs in the NIS, has seconded the argument of the January 2000 NIE that healthcare support helps ensure the success of other U.S. aid for democratization, economic reforms, and the security of the NIS.

Some policymaking and coordinating efforts dealing with health aid are being revamped by the new Administration. The new Administration eliminated an office dealing with international health from the structure of the National Security Council, a move criticized by a Clinton Administration official who argued that U.S. national security is enhanced by assistance to prevent a nuclear-armed Russia and other countries from “imploding” from an HIV/AIDS epidemic.⁸ The Bush Administration also discontinued the U.S.-Russian Joint Commission on Economic and Technological Cooperation and the U.S.-Ukraine Joint Commission, both of which had addressed health and other cooperation. The Bush Administration has stated that while these commissions will not be retained, health and other bilateral concerns will be discussed “in other fora and other organizations” on a regular basis. Among these, the Administration reportedly plans to address the international HIV/AIDS threat by creating a high-level interagency task force and by adding a State Department role to activities of the Office of National AIDS Policy.⁹

Congress has become increasingly concerned about the rising global threat of infectious diseases, including HIV/AIDS, TB, and malaria, and has authorized and appropriated funds to reflect that concern.¹⁰ Though primary attention in Congress is focused currently on the threat these diseases pose in Africa, and much of the increased funding is directed to African programs, there is some increased attention to health problems in the NIS and other regions. Members of the House Banking Committee (H.Rept.106-548), in reporting the Global AIDS and Tuberculosis Relief Act of 2000 (P.L. 106-264), cited the January 2000 NIE to the effect that increases in HIV/AIDS are threatening Africa, Asia, and the NIS. On the appropriations side,

⁶ Senate Foreign Relations Committee, *Nomination for Deputy Secretary of State*, March 15, 2001.

⁷ Senate Foreign Relations Committee, March 8, 2001; Senate Budget Committee, March 14, 2001.

⁸ Tom Malinowski, Senior Director for Speechwriting in the National Security Council. *Washington Post*, February 9, 2001, p. A29.

⁹ *Washington Post*, April 9, 2001, p. A2.

¹⁰ For information on health aid legislation in the 106th Congress, see CRS Report RL30793, *Health in Developing Countries: The U.S. Response*.

Foreign Operations Appropriations for FY2001 (P.L. 106-429) allocated \$963 million for the Child Survival and Disease Programs Fund, including funds to combat HIV/AIDS, polio, and other infectious diseases. A small amount (\$6 million) for the first time was made available to the NIS from this Fund. P.L.106-429 provided not less than \$45 million for NIS child survival, environmental health, and to combat infectious diseases, and for related activities. This included not less than \$1 million for healthcare and environmental health epidemiology in Ukraine, including the study of birth defects, and not less than \$1.5 million to meet the health and other needs of NIS victims of trafficking in persons. Infectious diseases of Congressional concern in the NIS included HIV/AIDS and tuberculosis. While limiting aid to Russia if it continues to cooperate with Iran on nuclear and missile technology matters, P.L.106-429 excluded aid for combating infectious diseases and for partnerships between U.S. and Russian hospitals from this limitation.

Congress has generally appeared to support health assistance that amounts to about 5 to 7 percent of overall aid to the NIS (see Table 1 at the end of the report). This aid has been dwarfed by that provided for democratization and economic reforms and arms control. U.S. aid obligations for FY1992-FY2000 for health programs in the NIS are about 5% of about \$16.5 billion for all programs for the NIS. Among recent action, in February 2001, Representative Curt Weldon led a bipartisan congressional delegation to visit legislators and medical officials in Russia, Ukraine, and Moldova, which included discussions of healthcare needs and U.S. assistance.¹¹

Health in the NIS: Context and Current Developments

As part of the legacy of the former Soviet Union, the NIS inherited a large centralized healthcare apparatus that provided good care for some medical conditions but relied on outdated practices to treat many illnesses. The health of Soviet citizens lagged behind that of U.S. and other Western populations in terms of access to many new medical procedures and medicines and even in terms of prosaic measures such as the number of hospitals and clinics with plumbing and heat. The healthcare system emphasized a large number of specialized medical facilities with large staffs and prolonged hospitalizations, rather than primary and preventive care, including regular check-ups. The healthcare system was isolated from changing world standards of treatment of diseases like TB, it followed secretive practices that prevented the operation of a competent disease surveillance system, and it suffered from a lack of medical supplies and equipment outside of the major medical centers. The creation of the NIS exacerbated problems by creating international borders between healthcare suppliers and customers and requiring re-negotiation of business relations that are still not satisfactory.

Despite this shared legacy, the NIS emerged from the Soviet collapse with varying health situations. Some of the NIS had better healthcare facilities than others, and some had healthier populations at the beginning of the 1990s. A few had

¹¹*Congressional Record*, February 28, 2001, p. H485-H493.

suppliers of medical equipment or pharmaceuticals. Many observers have viewed Central Asia's population as having suffered the most from inadequate healthcare during the Soviet period. The Western NIS had older populations than the Central Asian states at the time of the Soviet collapse, reflecting differences in fertility and mortality, providing age-related health challenges. Environmental catastrophe affected health in several regions, including the Chernobyl area (radiation fallout in Ukraine and Belarus), Chelyabinsk area (radiation contamination in Russia and Kazakhstan), and the Aral Sea area (desertification in Kazakhstan and Uzbekistan).¹² The NIS also differed in their rates of economic decline during the 1990s, and in such related issues as healthcare funding, the diets of the people, and living conditions, which affected infant survival and life expectancies. Conflicts in the NIS also damaged health, leading to casualties, injuries, orphans, and displaced persons who suffered physically and psychologically.

Health challenges in all the NIS loom larger because of the very low percentages of gross domestic product (GDP) they devote to healthcare. Table 2 shows GDP per capita in the NIS and the percent going to health. Health spending levels are low in the NIS in comparison to the more than 8% on average spent in European Union (EU) countries. In most of the NIS, government budgets (as opposed to private or out-of-pocket spending) provide the bulk of funding for healthcare, but private spending accounts for over one-half of spending in Armenia and over 80% in Georgia, indicating heavy private burdens in these states. Given the low spending for healthcare, the population's ability to obtain healthcare when needed ranged from 50-70% in the Western NIS to only 40-50% in the Central Asian NIS, according to one estimate.¹³

In the post-Soviet era, demographers have been able to scrutinize previously suppressed health data and conduct analyses that suggest that some aspects of the health crisis in Russia and other NIS can be traced back to the 1960s. A major indicator of overall health, life expectancy, peaked in the 1960s and began a downward trend in Russia and other republics of the former Soviet Union by the late 1960s, perhaps caused by an increase in alcoholism, violence, tobacco use, and poor diet. Another peak occurred in the mid-1980s (mostly attributed to government restrictions on alcohol consumption), followed by a decline that deepened after the Soviet breakup, though life expectancy in most NIS began to rise again after the mid-1990s. Nonetheless, life expectancy remains lower than in most European states. Life expectancy for males in the NIS in 2001 is 60.7 years (See table 2). This compares unfavorably to 75.1 years for Western European males, and 74.4 years for U.S. males.¹⁴

¹²Christopher Murray and Jose Bobadilla, in *Premature Death in the New Independent States*, Washington, D.C., National Research Council, 1997, pp. 184-219. Other notable overviews include Murray Feshbach and Alfred Friendly, Jr., *Ecocide in the USSR*, New York, Basic Books, 1992; and Laurie Garrett, *Betrayal of Trust*, New York, Hyperion, 2000.

¹³U.S. Department of Defense. Defense Intelligence Agency. Armed Forces Medical Intelligence Center (AFMIC), as reported in the January 2000 NIE.

¹⁴Russia's demographic problems, however, are attributable not only to declining health, but also to population dynamics, including the ripple effects of World War II and evolving family (continued...)

Some policymakers and analysts have warned that adverse health trends in Russia – “unprecedented for an urban, literate society in the 21st century” – are limiting its economic potential and “reducing its influence on the international stage,” and may even raise the specter of political disintegration and the subsequent establishment of authoritarian rule hostile to Western interests.¹⁵ Causes of bad health in Russia include cardiovascular disease, untreated chronic illnesses (high blood pressure, diabetes, high cholesterol), alcoholism (contributing to homicide, vehicular accidents, and suicide), drug abuse, and infectious disease. The threat of large increases in HIV/AIDS, hepatitis, and TB could further depress life expectancy.

Russia has not implemented systematic healthcare reforms. Hospitals and clinics remain largely government-owned, though there are private physicians and a private health insurance industry. Compulsory payroll contributions for healthcare began in 1993, but basic public health issues involving sanitation, pharmaceuticals, vaccinations, ambulances, and the distribution of medical staff countrywide remain unresolved. While Russian policy and U.S. aid programs have emphasized the theoretical economic benefits of decentralization of healthcare to the regions, some health experts have argued that decentralization has harmed healthcare, at least in the short term, in part because many public health issues are not fully addressable at the regional level.¹⁶ Perhaps reversing what some observers have termed a policy of governmental “malign neglect” of health issues, Russian President Vladimir Putin in his April 2001 state-of-the-nation address criticized the lack of fundamental reforms of the Soviet-era healthcare system, the lack of federal and local budgetary support for healthcare, inadequate functioning of the insurance system, and the widespread demand by state hospitals and doctors for illicit under-the-table payments.

The collapse of healthcare in Central Asia has been reflected in decreasing life spans, continuing high abortion rates, high infant and maternal mortality rates, and increases in cardiovascular/circulatory, parasitic, infectious, and respiratory diseases. While the spread of TB and hepatitis in Central Asia is most worrisome, the U.N. Secretary General has pointed to rising HIV/AIDS rates in Kazakhstan and elsewhere in Central Asia as a global concern.¹⁷ Poor sanitation and increasing drug abuse, tobacco and alcohol use, malnutrition, diet deficiencies, and tainted blood supplies

¹⁴(...continued)

planning attitudes. See U.S. Department of Commerce. Bureau of the Census. Ward Kingkade, *Population Trends: Russia*, International Brief IB/96-2, February 1997; George Demko, Grigory Ioffe, and Zhanna Zayonchkovskaya, eds., *Population Under Duress*, Boulder, CO: Westview Press, 1999, pp. 9, 24-27, 48, 55-56.

¹⁵Nicholas Eberstadt, Kennan Institute, February 5, 2001; Demko, p. 63; Murray Feshbach, *Washington Quarterly*, Winter 2001, p. 16-18.

¹⁶Diane Duffy in Vicki L. Hesli and Margaret H. Mills, eds., *Medical Issues and Health Care Reform in Russia*, Lewiston, N.Y., Edwin Mellon Press, 1999, pp. 47-48, 52-53; United Nations. World Health Organization. *Highlights on Health in the Russian Federation*, November 1999, p. 23.

¹⁷United Nations General Assembly, *Review of the Problem of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome in All its Aspects*, Report of the Secretary-General, A/55/779, February 16, 2001, pp. 5, 13-14.

contribute to declining health. Kyrgyzstan has made the most progress in healthcare reforms (though its fragile economy places them at risk), and Tajikistan the least. The health consequences of poor quality healthcare seriously constrain economic development in the region, according to USAID.¹⁸

Selected Health Indicators

By looking at how a country measures up in certain categories of health over time, it is possible to get a picture of the health situation in that country. Unfortunately, another legacy of the Soviet healthcare system is the lack of reliable health statistics and an unreliable system for collecting them. The Soviet Union did not follow U.N. World Health Organization (WHO) methods for birth and death statistics and the NIS are only slowly moving to implement them. Both factors make it difficult to compare health indicators across the NIS and with other countries. In order to make comparisons, this report uses statistics from the United Nations. Although these also rely on government provided information, the various U.N. agencies adjust them with their own estimates. Nonetheless, the statistics used in this paper should be used only as a general view of the situation in and among the NIS and should not be assumed to be directly comparable to U.S. or European health statistics.

Most observers agree that the early 1990s saw major declines in health in virtually all NIS in terms of such measures as infant mortality, alcoholism, and cardiovascular disease. From 1995 onward, as NIS economies began to stabilize, there were improvements (or slowing declines) in these health conditions. Concerning other problems, such as infectious diseases, tobacco use, and drug addiction, the situation has become worse. By most measures, health in the NIS in 2001 continues to lag behind that in most developed countries.

Childhood and Maternal Mortality Rates. Table 2 shows mortality rates for children under five years of age. According to USAID, increasing mortality rates in the NIS among children under five years old are telling signs of the deterioration of healthcare and the plight of many families suffering from poverty and malnutrition.¹⁹ USAID estimates that mortality rates for children under five years of age increased in all the NIS over the period 1990-1997, the worst record in all its geographic bureaus.²⁰ Health surveys conducted by Kazakh medical institutes suggest that infant mortality is much higher in the late 1990s than implied in government data, raising the implication that in poorer Central Asian states, infant

¹⁸USAID, *Infectious Disease Assessment*, pp. 1-2; USAID, *Health Program Review: Central Asia: September-November 1999*, p. 2; Kevin Rushing, USAID Central Asian Republics Desk Officer, *Paper*, Panel on Public Health and Environmental Issues, Harvard Colloquium on International Affairs, March 11, 2000.

¹⁹ Infant mortality is generally used to determine the overall health of a country. However, because most of the NIS still use the Soviet system of measuring infant mortality, which undercounts deaths by as much as 50 percent, this report uses under 5 years of age mortality statistics.

²⁰USAID *Economic Strategy in Central Asia*, November 10, 1999, p. 9; USAID's *Assistance Strategy for Central Asia 2001-2005*, July 2000, p. 56; *Broadening the Benefits of Reform*, p. 11, from U.S. Census Bureau data.

mortality rates may also have increased. In Tajikistan, malnutrition has contributed to an “alarming” degree of stunted, underweight, and wasting children, according to a Save the Children NGO report.²¹ Maternal mortality rates are much higher in the NIS than in many other European countries (see Table 5). Causes include poor nutrition, lack of maternal care, and extremely high rates of abortion, compared to the United States and most of Europe. High rates of abortion and maternal mortality are being reduced in several NIS by education and access to other contraceptive methods (Table 5).

Childhood vaccination rates in the NIS declined dangerously in the late 1980s and early 1990s, contributing to a diphtheria epidemic in the early 1990s. By the mid-1990s, this epidemic accounted for 90% of worldwide cases. Ukraine, Russia, and Tajikistan were hardest hit. USAID collaborated with WHO in delivering vaccines and the United States later advocated international donor assistance for childhood immunizations. By the latter 1990s, diphtheria cases had declined greatly, as had some other childhood diseases thanks to these efforts.

The Increase in Infectious Diseases. The sharp deterioration of the health infrastructure due to economic conditions has contributed to a dramatic increase in infectious disease cases. Increasing levels of infectious diseases such as TB, HIV/AIDS, and malaria have raised great concerns from the international community. The U.N. Program on HIV/AIDS (UNAIDS) and the WHO “Stop TB” program provide statistics for all the NIS which are considered reliable. Comparable statistics for other infectious diseases are not available. Table 3 shows the number of new cases of TB and the numbers living with HIV/AIDS.

Tuberculosis. TB, including drug-resistant TB, appears to be increasing in most of the NIS because of poor living conditions and inadequate treatment. Drug-resistant TB can be extremely costly to treat, further burdening already strained healthcare finances in the NIS. WHO ranks Russia among the top ten countries worldwide in terms of new cases of TB, and at the bottom among twenty-three countries with high TB rates in use of an effective TB treatment termed the Directly Observed Treatment Short-course (DOTS). WHO and the Russian Health Ministry have begun to implement a five-year plan for DOTS coverage in Russia that would reach about one-half of the population. Rates of drug-resistant TB have increased dramatically, especially in 1998 when then-President Boris Yeltsin announced an amnesty that released tens of thousands of prisoners with TB into the general population. The Russian Health Ministry also has announced that Chechnya and surrounding areas with high numbers of displaced persons have become a major locus of drug-resistant TB.

TB rates in all the NIS except Armenia are higher than in the rest of Europe. The highest numbers of new cases besides Russia are in Kazakhstan, Ukraine, and Uzbekistan. TB and hepatitis now account for 5% of deaths in Kazakhstan and Kyrgyzstan, although USAID’s support for DOTS in Kazakhstan may have

²¹USAID, Rushing; U.S. Save the Children, *Not By Bread Alone: Household Livelihood Security in Rural and Urban Tajikistan*, June 2000, p. 34.

contributed to a significant decline in TB from 1998 to 1999, for the first time since rates climbed in 1990.

HIV/AIDS. U.N. Secretary General Kofi Annan in February 2001 highlighted the NIS as a major risk zone for the increase in HIV/AIDS, warning that the NIS present “an extremely steep increase in the number of new infections,” which is one “of the most dramatic trends in the worldwide AIDS epidemic.” Although the actual numbers are small, compared to Africa and parts of Asia and Latin America, the NIS has the fastest rate of growth of HIV/AIDS infection in the world. The Secretary General argued that a window of opportunity “still exists for effective targeted interventions, particularly among injecting drug users” if the NIS governments show commitment.²²

During the 1990s, the NIS witnessed growth in injecting drug use, prostitution, and population mobility that spread HIV/AIDS, but many of the governments are slow to recognize the growing HIV/AIDS threat. HIV/AIDS infection rates in Ukraine are the highest among the NIS and the highest in Europe, according to the UNAIDS. The number of confirmed cases in Russia has tripled in the last year. Official statistics in Russia record 80,000 cases of HIV/AIDS, but UNAIDS estimates some 130,000 Russians were infected in 1999, and that two times that number, 300,000, were probably infected in 2000. Russian AIDS official Vadim Pokrovsky has asserted that “in fact, half a million Russians are infected,” with cases fueled by an HIV “epidemic” among injecting drug users (IDUs). The incidence of HIV/AIDS in Russia as a percent of its population, he suggests, could match U.S. levels this year, and up to 700,000 Russians could die from AIDS within 10-12 years if remedial efforts are not taken.²³

Central Asia’s inadequate health care system and growing injecting drug use leave it vulnerable to an explosive increase in HIV/AIDS cases, according to some assessments. UNAIDS official Henning Mikkelsen has suggested that Central Asia “may well be on the verge of a major public health and socioeconomic development disaster, in terms of large scale epidemics of HIV/AIDS,” because of rising drug use. Sexually Transmitted Disease (STD) rates in Kyrgyzstan, Kazakhstan, Belarus, and Moldova are high, another indication that HIV/AIDS infections will also rise if unchecked.

Drug Addiction. All of the NIS face increased injecting drug use (see Table 3), with the greatest estimated increases in Russia, Ukraine, Turkmenistan, and Uzbekistan. In all of the NIS, demand reduction efforts are inadequate, according to the U.S. State Department’s *International Narcotics Control Strategy Report*, because of inadequate budgets, inadequate treatment services in rural areas, and a lack of focus on drug use prevention by officials.

²²United Nations General Assembly, *Review of the Problem of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome in All its Aspects*, Report of the Secretary-General, A/55/779, February 16, 2001, pp. 5, 13-14.

²³Andrei Shukshin, *Reuters*, March 13, 2001; *Agence France-Presse*, January 9, 2001; *FBIS*, February 3, 2001.

Drug treatment is poor or lacking in most of the NIS, and where available, mainly entails involuntary confinement after arrest. Treatment consists of detoxification with little or no follow-up rehabilitation efforts. The 1998 Russian narcotics law provides for the involuntary commitment of drug users who come to the attention of the authorities, which many observers criticize as preventing most addicts from seeking treatment. International HIV/AIDS expert Kasia Malinowska-Sempruch suggests that there may be 200,000 drug addicts in Kazakhstan and 120,000 in Tajikistan. In Central Asia, she states, drug treatment is “so scarce as to be virtually nonexistent,” and drug users avoid seeking treatment out of fear of arrest by authorities. Laws are mostly aimed at interdiction and punishment of drug traffickers and users. In major cities in Tajikistan and Kyrgyzstan, heroin is cheaper to buy than vodka, according to the nongovernmental Open Society Institute, threatening to lead to much higher future drug addiction rates in these NIS.²⁴ An Uzbek law “on narcotic substances and psychotropic agents” took effect in 2000 that authorizes compulsory blood testing for suspected drug use and involuntary commitment that, like the Russian law, inhibit addicts from seeking treatment. Turkmenistan claims that it has the most progressive drug treatment program in the NIS, consisting of six drug treatment centers where addicts can seek voluntary and confidential treatment, but these centers cannot serve the entire population. Religious and non-governmental organizations have opened several drug rehabilitation centers throughout Ukraine.

High-level attention to the drug problem in Russia was demonstrated on March 13, 2001, when Premier Mikhail Kasyanov convened a government commission to study increasing drug abuse and HIV/AIDS cases among youth. Revealing the inaccuracy of official drug abuse figures, Kasyanov stated that the official number of drug addicts, 450,000 as of January 2001, was a fraction of the real number. He warned that Russia had changed from a drug transit country to a consumption country, and that organized crime was increasingly involved in the drug market. Recognizing that a comprehensive counternarcotics strategy must be adopted that embraces demand reduction and rehabilitation as well as law enforcement, Russian officials have met with the U.S. Office of National Drug Control and Prevention to discuss how to set up an analogous agency.

Alcoholism and Smoking. Alcohol consumption in Russia and many other NIS remains much higher than in most of the world. Russian observers have stressed that alcoholism is linked to other causes of increased mortality in Russia, including traffic accidents and injuries (homicides and suicides). Alcohol consumption in Russia declined briefly in the mid-1980s as a result of a sobriety campaign, but rose thereafter.²⁵ In 1993, there was a large increase in male alcohol poisoning in Russia,

²⁴Matthew Curtis, *Eurasianet*, February 21, 2001 and March 2, 2001; Open Society Institute, International Harm Reduction Project, *Uncovering the Dangers of Drug Use in Kazakhstan, Kyrgyzstan and Tajikistan*; Peak Options Consulting, for the Open Society Institute, *Summary of Fact Finding Mission to Kyrgyzstan*, March 1, 2001.

²⁵Vladimir Treml, in Herlemann, pp. 151-162. According to Russian analysts Vladimir Shkolnikov and Alexander Nemtsov, “in the period from 1988-1992, the biggest share of the increase in Russian mortality was attributable to alcohol consumption.” *Premature Death*
(continued...)

along with increases in male homicide and suicide and in circulatory and respiratory diseases. According to many observers, deaths from alcoholism in Russia have increased recently.²⁶

According to the WHO, smoking in most of the NIS continued to increase during the 1990s. In Russia, the majority of adult males smoke, while in the EU countries, rates of smoking are declining. Smoking has been linked to high percentages of male deaths among those aged 35-69 in Russia, Kazakhstan, Ukraine, Armenia, and Belarus, substantially higher than in the United States.²⁷

Water-Borne Disease. Deteriorating water and sewer systems (often water and sewer pipes are co-located), in conjunction with other causes such as injecting drug use, are linked to large increases in the incidence of hepatitis, cholera, and typhoid fever throughout the NIS. Russian media reported that hundreds of people in towns near Moscow contracted hepatitis type-A in January 2001 from contaminated drinking water. Russian health authorities also warned in early 2001 of the spread of cholera as well as intestinal diseases in Chechnya, because sewer systems are nonfunctional in Grozny. Poor sanitation and hygiene lead to yearly outbreaks of hepatitis-A at the beginning of school in Turkmenistan and Uzbekistan. Hundreds of typhoid fever cases in southern Tajikistan were reported by the Tajik media during the winter of 2000-2001, attributed to poor drinking water. Increasing cases of malaria and encephalitis in Tajikistan associated with mosquito-infested drainage systems are also of growing concern.²⁸

Non-Medical indicators

Increasing numbers of people in the NIS belong to subgroups that face special health needs, including orphans, refugees, and the internally displaced.

Refugees and Displaced Persons. NIS health conditions have been impacted by the large number of persons forced from their homes by warfare and discrimination since the breakup of the Soviet Union. The U.N. High Commissioner for Refugees has estimated that during the 1990's as many as nine million people left their homes in the NIS. These included refugees who fled their country's warfare, those displaced within their own country by war or returned from exile to find their

²⁵(...continued)

in *the New Independent States*, pp. 232-233.

²⁶*Premature Death in the New Independent States*, pp. 240-241, 256; Feshbach, *Washington Quarterly*, p. 19.

²⁷United Nations. World Health Organization. *Highlights on Health in the Russian Federation*, November 1999, p. 19; *Premature Death in the New Independent States*, pp. 274, 275-286, 287-313.

²⁸For healthcare problems in Chechnya and Ingushetia, see Bill Frelick, *Refugee Reports*, Special Issue 2001, p. 2; *Humanitarian Situation of Refugees and Internally Displaced Persons from Chechnya*, Committee on Migration, PACE, Doc.8944, January 23, 2001; U.N. World Health Organization, *North Caucasus Briefing/Update Activity Report*, February 4, 2001.

homes and communities destroyed, and those forced to leave their homes, denied citizenship or declared aliens in their homeland under new residence or citizenship laws. Lack of routine health care and immunization, poor food and sanitation, exposure to disease, and violence against vulnerable groups all result in declines in health among those living in crowded refugee camps or makeshift housing.

Major humanitarian emergencies caused by conflict have occurred in Armenia, Azerbaijan, Georgia, Russia, and Tajikistan. During the 1990s, conflict resulted in the exile or displacement of some 300,000 Armenians, over 500,000 Azerbaijanis, 325,000 Georgians, and 450,000 Chechens and other Russian residents, according to the U.N. High Commissioner for Refugees²⁹. Major populations that relocated because of changes in ethnic status in the new republics included ethnic Russians returning to Russia (3 million between 1992 and 1996), and Tatars returning to Ukraine (250,000 between 1988-1999). While aid agencies responded to the health needs of the refugees and some of the displaced, for the most part, their health remains precarious since the political causes of their displacement have not been resolved, and they have limited access to health services and to a better life. Table 4 shows the current estimates of refugees and displaced in the NIS.

Orphans. According to UNICEF, the numbers of children aged 0-3 years placed in orphanages greatly increased in all the Western NIS and in Kazakhstan over the period 1991-1998, from an average of 165 children per 100,000 population in 1991 to an average of 304 children in 1998 for these NIS. The number of such children in 1998 in other NIS was substantially lower, about 39 per 100,000. While numbers of institutionalized children have been growing, declining public funding has led to increasingly poorer care. The orphanages in the NIS, unlike in most of Europe, often include children with birth defects, mental disabilities, and chronic health conditions. USAID and international NGOs have increasingly provided assistance, including urgent and other healthcare. The numbers of homeless and street children in Russia and other NIS reportedly also have expanded, and these children are helped only on an *ad hoc* basis by existing healthcare programs and most international aid.³⁰

U.S. and International Health Aid

Soon after the Soviet collapse, USAID focused on healthcare reforms in the NIS as one of its objectives. It developed the Hospital Partnership Program, to be carried out by a newly created American International Health Alliance (AIHA), as its major public-private vehicle for aid efforts focusing on educational activities and professional exchanges by U.S. medical volunteers. A related Health Reform Project by USAID launched in 1993 focused on the reorganization of healthcare institutions

²⁹United Nations. High Commissioner for Refugees. *The State of the World's Refugees 2000*, p.185-209.

³⁰United Nations. United Nations Children's Fund. *Young People in Changing Societies*, 2000, p. 153. On conditions in Russia and recommendations to international aid donors, see Human Rights Watch, *Cruelty and Neglect in Russian Orphanages*, December 1998.

and financing in the NIS, to “increase economic efficiencies, quality of care, access, and provider choices in the NIS through market-oriented reforms.” These changes have faced obstacles in Russia and other NIS, including Soviet-era healthcare establishments and officials that balk at change and skyrocketing poverty rates, which have placed fee-for-service healthcare out of reach for many people.³¹ However, the changes are seen by USAID as essential to the ability of the healthcare systems to modernize and function on their own without ongoing international donor assistance.

The Clinton Administration asked Congress in 1997 to begin supporting a new “Partnership for Freedom” initiative as part of boosted NIS assistance that would emphasize grass-roots economic and social reforms, including health. Additional aid was sought for hospital and health facility partnerships, Defense Department-supplied hospital equipment and supplies, programs to combat infectious diseases, and efforts to bolster clean water supplies, childhood survival, and maternal health.³² Rationales for the initiative included that it countered negative social impacts of the economic transition in the NIS and that it “shows that Americans indeed care.”³³ The request for a large boost in NIS aid was not supported by Congress, but many of the programmatic emphases, including health aid, were endorsed.³⁴

Building on the “Partnership for Freedom” initiative, USAID in 1998-1999 increasingly emphasized social needs in the NIS. USAID came to argue that economic reforms in the NIS had not always contributed to the growth of middle classes, but also helped create “a new class of chronically poor,” who lost the meager state benefits they received under communism. While democratization and economic reforms remained U.S. objectives, USAID stressed that without adequate healthcare and other social services, populations in the NIS would lose faith in the reform process, and economic productivity, restructuring, and reforms would be harmed. USAID stated that it would increasingly take social issues into account in designing and implementing programs, so that “the broadest possible spectrum of [NIS] citizens...have the opportunity to enjoy the benefits of reform.”³⁵

³¹Edward Burger, Jr., in *Russia's Torn Safety Nets*, ed. by Mark Field and Judyth Twigg, New York, St. Martin's Press, 2000, pp. 291-292; About AIHA, see [<http://www.aiha.com>]. Burger criticizes the Health Reform Project as “clearly out of phase with the political and economic realities of the time in Russia.”

³²Spurring these emphases, conferees on Foreign Operations Appropriations for FY1997 (H.Rept. 104-863) had criticized the Administration for not including health and environmental health as NIS aid priorities, and had urged that the treatment of childhood illnesses in Ukraine related to Chernobyl supercede other aid objectives. See CRS Report RL30148, *U.S. Assistance to the Soviet Union and Its Successor States*, p. 29.

³³U.S. House of Representatives. International Relations Committee. *Statement of Richard Morningstar*, March 26, 1998.

³⁴CRS Report RL30418, *U.S. Assistance to the Soviet Union and Its Successor States 1991-1999*, pp. 29-32.

³⁵USAID, *Budget Justification FY2001, Annex III, Europe and Eurasia*, p. 9. See also USAID, *Broadening the Benefits of Reform in Central and Eastern Europe and the New Independent States: A Social transition Strategy for USAID*, Bureau for Europe and Eurasia,

In keeping with the new emphasis, USAID’s assistance activities were divided into three broad strategic areas, economic, democratic, and social transition. The objectives of social transition assistance include improving NIS health and other social benefits and services. USAID healthcare goals include helping the NIS to draw up healthcare and insurance legislation and policy focusing on community-based primary health care; to improve the cost-effectiveness of healthcare budgets; to improve the quality of healthcare; to educate citizens about their personal healthcare rights and obligations; and to reduce environmental and occupational health risks.

USAID provides the bulk of U.S. health aid to the NIS, though some has also been provided by the Defense, Health and Human Services, and Energy Departments (see text box on this page). Table 1 shows the amount of health aid to the NIS provided by USAID in FY1999-FY2001. U.S. assistance obligated FY1992-FY2000 for health was less than 5% of total aid obligations to the NIS of \$16.5 billion, indicating the relatively low priority of such aid, though recent years have indicated a fairly steady U.S. aid commitment amounting to about 5-7% of NIS aid. In recent years, Russia, Ukraine, Kazakhstan, Uzbekistan, and Armenia have received the largest amounts of health aid, partly reflecting broad U.S. policy interests in these states.

Within each NIS, the percentages of U.S. aid devoted to health as opposed to other programs have been highest in the Central Asian states in recent years (usually more than 10%), reflecting heightened U.S. concerns about urgent health needs and poor healthcare situations in these states or low levels of aid overall.

U.S. government health aid to the NIS has been supplemented by large-scale private donations of medical goods and expertise worth about \$1.5 billion during FY1992-FY2000, including those provided through the NIS Health Partnerships program, implemented by AIHA (private donations that do not use U.S. subsidized transport are not included in this total). The AIHA leverages USAID funding to foster cooperation between U.S. hospitals and healthcare providers and NIS medical

Cumulative Obligations FY1992-FY2000 for Health and Related Programs (Freedom Support Act and Other Funds)	
<i>(million dollars)</i>	
USAID Healthcare Improvement	346.87
Presidential Medical Initiative	5.0
Operation Provide Hope transport costs	195.0*
Defense Department Excess Defense	
Articles: Hospitals and Related	225.8
Peace Corps Health Education	26.0**
DHHS Biotechnology Engagement Prog.	11.38
<i>Subtotal U.S. Government Health Aid</i>	<i>810.05</i>
Coordinator’s Office privately-donated cargoes	1,500*
<i>Total</i>	<i>2,310.05</i>

Sources: State Department, Freedom Support Act FY2000 Annual Report; Background Paper on State Department-Directed Humanitarian Assistance to the NIS, January 11, 2001; Conversation with Coordinator’s Office, April 17, 2001; The Peace Corps, Congressional Budget Presentation, FY2002.

*Health-related; Estimate by the Coordinator’s Office
 **Estimated: a program breakdown by health activities in the NIS is not available, but the Peace Corps reports that about 20% of global projects involve health.

³⁵(...continued)
 February 2000, pp. 8-9, 23-24.

facilities and experts. Twenty-eight primary healthcare initiatives have been launched by AIHA in Armenia, Azerbaijan, Moldova, Russia and Ukraine, and an emergency medical services partnership in Uzbekistan. Operation Provide Hope, an interagency program launched in 1992, provides U.S. funded transport services for private donations of medical goods. The combination of U.S. public and private health-related assistance amounts to about 12% of total aid obligated in FY1992-FY2000.

USAID programs include small-scale demonstration projects in various regions of the NIS that it is hoped NIS governments will replicate nationwide. USAID has maintained that its performance measures show that its health programs are having some impact in the NIS. While heralding these impacts, USAID nonetheless cautions that more assistance is needed, since “systemic trends in the region remain disturbing” because of rising rates of HIV/AIDS, tuberculosis, and multi-drug resistance tuberculosis, and inadequate improvements in healthcare systems. Progress has been made in lowering the high rates of abortion in the NIS, for instance, but abortion rates are still among “the highest in the world.”³⁶

To promote access to quality health care in Russia, the Quality Assurance Project funded by USAID helped to improve the outcomes of primary care treatment. In partnership with the American College of Physicians, information was provided to Russian physicians on the treatment of hypertension, cardiovascular disease, diabetes, and TB. In addition, an Evidence Center in Primary Care Medicine was created at the Moscow Medical Academy, and training sessions were held for physicians from Russia and other NIS on substance abuse prevention. In FY2000, the USAID’s Women and Infants’ Health Project in Russia carried out training on post-abortion care and STD counseling; training on breast-feeding and newborn care; and surveys on mother and child health indicators.³⁷

Among other recent U.S. agency health-related programs, the Energy Department allocated \$3 million per year beginning in FY1999 for studies on radiation health in the NIS. The DHHS’s Biotechnology Engagement Program and the U.S. Department of Agriculture’s Collaborative Biotechnical Research Program are supporting the redirection of former Soviet biological warfare scientists to peaceful research, with a focus on healthcare (such as the control of tuberculosis, hepatitis, HIV/AIDS and other infectious diseases). In addition, some activities of the Moscow and Kiev Science Centers, funded by the State Department, deal with biomedical research by NIS scientists. With major U.S. backing, a Civilian Research and Development Foundation NGO was set up in 1995, including a Biomedical and Behavioral Sciences Program that carries out collaborative medical research, funded by the U.S. State, Defense, and Commerce Departments NIH, and others.

Peace Corps health-related programs in the NIS have included preventive health education programs in Armenia, Kazakhstan, and Moldova, community health development programs in Turkmenistan and Uzbekistan, and environmental education

³⁶*Broadening the Benefits of Reform*, pp. 8, 38; *FSA Annual Report FY2000*.

³⁷See also Centers for Disease Control and Prevention, Office of Global Health, and the Agency for Toxic Substances and Disease Registry, *Working with Partners to Improve Global Health: A Strategy for CDC and ATSDR*, September 2000.

in Kazakhstan, Russia, and Ukraine. The Defense Department has donated military hospitals under the Excess Defense Articles program and has provided follow-on equipment packages and training worth \$225.8 million to all the NIS during FY1992-FY2000 except Tajikistan and Turkmenistan.³⁸

International Assistance Efforts. International organizations with health programs in the NIS include the World Health Organization(WHO), the U.N. Fund for Population Activities, UNICEF, U.N. Development Program and the World Bank. With the increased effort to curb the spread of HIV/AIDS, and the establishment of UNAIDS, a consortium of seven U.N. agencies, health programs have become a growing part of the activities of the U.N. International Drug Control Program and UNESCO (U.N. Educational, Scientific, and Cultural Organization) as well. The European Union's TACIS program also addresses health issues.

WHO's European office in 2000-2001 provided small amounts of aid to Armenia, Azerbaijan, Kyrgyzstan, Moldova and Tajikistan (\$463,000), Russia (\$200,000), and other NIS (\$130,000). The programs focus on communicable diseases, non-communicable diseases and health promotion, health policy, health care reform, women's and children's health, and environment and health. Each country has a WHO special representative. WHO also has technical assistance programs in the NIS countries funded both by the WHO regular budget and by voluntary donations from members. In the 2000-2001 biennium, the proposed funding was \$3.4 million from regular budget funds and \$5.3 million from voluntary contributions.³⁹ The NIS are also included in European regional programs and some WHO global initiative projects funded directly by WHO's regional office for Europe.

Coordinated U.N. interagency HIV/AIDS programs in all the NIS have been operating since the early to mid-1990s. Most of these countries also have active private voluntary organization partners and programs run by bilateral aid agencies such as USAID. The projects address the populations currently most likely to spread HIV/AIDS (injecting drug users, prostitutes, and men who have sex with men), education for young people and schoolchildren, vulnerable groups (prisoners, street children, refugees, ethnic minorities), care for people living with HIV/AIDS and for their human rights, condom distribution, blood safety programs, prevention and treatment of STDs, disease surveillance, and public service information on HIV/AIDS. Program totals for 1997 for the entire region, including governmental and nongovernmental sources, were over \$18 million and covered several years according to a UNAIDS survey in 1999⁴⁰ About two-thirds of the funds went to Russia. Additional millions were available for region wide programs. A December 2000 donors' meeting on HIV/AIDS in Russia included a promised loan of \$150 million for TB and HIV/AIDS from the World Bank covering several years. Some

³⁸*Peace Corps, Congressional Budget Presentation, FY2002; Background Paper on State Department-Directed Humanitarian Assistance to the NIS*, January 11, 2001.

³⁹See [http://www.who.int/wha-1998/EB_WHA/english/new/ANG_navigat.htm] .

⁴⁰Snapshot of external support for national responses to the epidemic of HIV/AIDS in Central and Eastern Europe (including Central Asia) as reported by co-sponsors, bilateral agencies and NGOs. UNAIDS. October 1999.

Russian health officials are concerned that loan will be more expensive because it will require the use of Western pharmaceuticals and procedures instead of cheaper domestic products. Critics of the current Russian health system argue that Russian medical leaders are refusing to adopt better western methods of addressing diseases such as TB and HIV/AIDS.⁴¹

UNICEF has health and nutrition programs in all the NIS. Program totals in 1999 ranged from a high of \$882,000 in Russia to a low of \$152,000 in Belarus, according to UNICEF. The U.N. Population Fund also has programs in all the NIS. The average annual UNFPA funding level since 1998 ranges from \$100 million in Belarus to \$785 million in Kazakhstan.

The TACIS program is the major technical assistance program of the European Union for the NIS. Its most recent report, covering 1999, indicates that 427.6 million Euros (about \$380.6 million in current dollars) committed to the NIS for developmental or technical assistance programs. Support for health sector reform is mentioned as one TACIS emphasis, but the report listed only two health projects, private financing of health services in Russia and Uzbekistan.⁴²

Issues for Congress

How Significant are NIS Health Issues to U.S. Interests?

Though the debate over whether infectious disease is an important national security concern is not over, the Administration, Congress and most Americans agree that the uncontrolled spread of infectious disease and especially HIV/AIDS is a danger to Americans, both in the United States and abroad. Current U.S. aid to the NIS emphasizes arms control and security, suggesting that these are far more important to U.S. national security. While the rapid growth in HIV/AIDS cases, large numbers of drug resistant TB cases, and outbreaks of infectious diseases are worrisome, the rates of infection are not as great in the NIS as in some areas of Africa and Asia and arguably do not pose as severe a near-term threat to U.S. interests. Should the United States reprogram some recently focused U.S. policy initiatives and assistance to troubled regions in Africa and Asia and shift aid to the NIS? Or is it likely that health problems will be resolved by the NIS themselves as their economies improve?

The U.S. military views the rise of infectious and other diseases in the NIS and the poor quality of healthcare as factors endangering U.S. troops during military training, exchanges, exercises and operations involving the NIS. The diphtheria epidemic in Russia in the early 1990s, for instance, was traced to Soviet troops returning from Afghanistan and infected troops rotated out of Tajikistan. On the other hand, the U.S. military is always concerned about protecting personnel from disease. NIS military

⁴¹*The Washington Post*, May 8, 2001.

⁴²Commission of the European Communities. Report from the Commission. *The TACIS Programme Annual Report 1999*. Brussels, December 20, 2000. COM (2000) 835 final.

personnel are no more dangerous than the personnel of other countries with large health problems.

Another serious concern is that the health crisis undermines U.S. economic and political transition policies in the NIS. Adverse health trends in Russia may be a drag on economic reforms that are conducive to U.S. investments, foster civil unrest, encourage a countervailing political authoritarianism, and perhaps lead to a more internationally belligerent, nuclear-armed Russia.⁴³ Even small increases in health aid may pay big dividends in lowering disease rates and ameliorating social discontent in the NIS. Some call for much larger commitments to meet pressing health needs in the NIS, perhaps by shifting aid from democratization and economic reform programs. On the other hand, as Table 2 indicates, governments of the NIS are spending a very small percentage of their budgets on health. Without government commitments to health, U.S. assistance is likely to do little to improve the NIS health status.

U.S. security interests may be served by bolstering the health of the NIS militaries and the general populations. Declining health in the NIS militaries can harm their abilities to combat terrorism and drug trafficking and otherwise to defend the territorial integrity of the NIS. If the NIS militaries are less capable of carrying out these missions, then U.S. border and security aid (recently boosted by the Administration and Congress), may be less effective than anticipated, according to this argument. Also, terrorist groups may be able to gain more adherents where failing healthcare systems create disaffected populations. U.S. health aid has been considered by several NIS militaries as a major benefit of military-to-military cooperation, according to U.S. defense officials.

However, money alone will not resolve health problems in the NIS. Health problems are often caused by sanitation system failures and environmental degradation – such as radiation hazards in Kazakhstan’s Semipalatinsk nuclear testing site or the evaporation of the Aral Sea – that will require large-scale remediation support. Health problems caused by alcohol abuse, drug abuse, and malnutrition have societal roots which must be addressed.

How Much Health Assistance Should the United States Provide to the NIS?

Congress and the Clinton Administration clashed for several years over the level of aid to provide for the countries of the NIS. Current U.S. health aid to the NIS comprises between 5 and 7 percent of total aid to the region. Due to cuts in the overall aid program since FY1999, however, the actual amount of health aid has increased only to Tajikistan. One way to address the need for more assistance would be to increase the percent of foreign aid devoted to health in the NIS or to establish Congressional guidelines for the amount of aid to be provided for health assistance. FY2001 was the first year Congress included the NIS in the Child Survival and Disease account, where most health money is provided. Until this year, health programs in the NIS were entirely funded through the Freedom Support Act, where health programs competed with many other programs. Either of these changes would

⁴³Nicholas Eberstadt, Kennan Institute, February 5, 2001.

require a change in U.S. policy which currently focuses on democratization and economic reforms and arms control. Also, there may be a need to consider longer-term health aid commitments, particularly if U.S. assistance focuses more on healthcare institution-building and reform efforts that aim to bolster the ability of the NIS to meet their own needs.

A second possible change in health aid to the NIS would be to alter the distribution of aid among the countries of the NIS. Table 1 shows the distribution of USAID's bilateral health funds to the NIS in recent years. The largest aid amounts have gone to Armenia, Kazakhstan, Russia, Ukraine and Uzbekistan. Much less health assistance has been provided to Azerbaijan, Belarus, Moldova, Tajikistan, and Turkmenistan. These latter countries have the highest rates of under five mortality and are among the lowest in ranking of health system performance in the NIS, according to the World Health Organization.

Before changing the distribution or amount of health aid provided, policymakers must consider whether U.S. health assistance should be targeted to the most needy NIS, to the closest or most strategic U.S. friends, or to the most democratic and market-oriented NIS. Such determinations are complicated by the added desirability of targeting U.S. aid to NIS where the governments are receptive, honest, and efficient at carrying out healthcare reforms, but these conditions are not currently met in any of the NIS.⁴⁴ In Russia and other NIS, many critics charge, the governments are inefficient, highly corrupt, and not focused on health budgets, policies, and stewardship.⁴⁵ In such conditions, U.S. and international medical assistance to the NIS risks being undermined or redirected for political purposes. In some cases, NIS governments have blocked medical as well as other humanitarian aid to civilians for political and military purposes (such as in Chechnya), using it as a weapon to bring populations and separatist movements into line. To help circumvent problems with governments, some suggest that U.S. health aid should focus more on high-quality indigenous health-related non-governmental organizations in the NIS, to ensure that aid is used properly and to strengthen long-term self-help capabilities, while others caution that in most of the NIS, such local NGOs are still hard to find. Some in Congress have raised concerns that U.S. funding for health-related research by former biological warfare scientists, aimed at keeping them employed in peaceful endeavors and retraining them, may be misused by NIS governments to maintain the warfare skills of the scientists.⁴⁶

⁴⁴Gro Harlem Brundtland, Director-General of WHO, has argued that governments should not only provide adequate budgetary support and policies facilitating public and private healthcare, but also proper "stewardship" to maximize healthcare performance dollar for dollar. U.N. WHO, *The World Health Report 2000*, pp. viii-ix, 119-141, 200-203.

⁴⁵Nicholas Eberstadt, Kennan Institute, February 5, 2001, argues that the Russian leadership has failed, compared to other societies facing economic turmoil, to provide adequate healthcare, partly because of an undemanding Russian public. Ukrainian demographer Valentyna Steshenko has been critical that "neither the public in Ukraine nor their leadership" focus on "the preservation and improvement of public health as one of the nation's most important priorities." *FBIS*, January 24, 2001.

⁴⁶U.S. General Accounting Office, *Biological Weapons: Effort to Reduce Former Soviet* (continued...)

In most but not all cases, U.S. health assistance has been exempt from restrictions on aid to particular countries. USAID family planning programs in the NIS must comply with policy promoting maternal health and the provision of modern contraception methods that counteract the inordinately high rates of abortion throughout the region. Likewise, with HIV/AIDS spreading throughout the NIS primarily through injecting drug users, U.S. programs to curb the spread of the disease must comply with restrictions on U.S. drug assistance programs. (For details on NIS aid issues, see CRS Issue Brief IB95077, *The Former Soviet Union and U.S. Foreign Assistance*, updated regularly.)

Many in Congress suggest that other industrialized countries should bear a greater share of NIS health assistance. These countries may not have the same U.S. legislative restrictions, allowing them to address these problems in a different manner. Although information on bilateral assistance to the NIS is sketchy, TACIS, the major aid program of the European Community, devoted very little of its budget to health programs. On the other hand, U.S. advocacy of greater Western involvement has in the past acted to spur European donors.

⁴⁶(...continued)

Threat Offers Benefits, Poses New Risks, NSIAD-00-138, April 28, 2000; House Committee on Armed Services, *National Defense Authorization Act for FY2001*, H.Rept. 106-616, May 12, 2000, pp. 421, 422-423.

Table 1. U.S. Health Aid to the NIS

Country	USAID FY1998 Health Funding (\$ millions)	USAID FY1999 Health Funding (\$ millions)	USAID FY2000 Health Funding (\$ millions)	USAID FY2001 Planning for Health (\$ millions)
Armenia	1.98	4.6	4.6	4.6
Azerbaijan	0.0	2.5	2.87	1.5
Belarus	0.4	0.6	0.35	0.0
Georgia	3.55	5.3	4.04	3.705
Kazakhstan	4.28	7.05	5.1	5.71
Kyrgyzstan	2.28	2.43	3.0	2.3
Moldova	0.6	1.0	0.03	0.45
Russia	6.79	11.77	11.2	11.32
Tajikistan	0.45	0.8	1.0	1.5
Turkmenistan	0.65	2.15	1.3	0.9
Ukraine	9.55	8.8	4.26	5.095
Uzbekistan	2.48	7.26	4.6	5.0
Regional	2.34	4.75	3.06	5.133
<i>Total</i>	35.35	59.01	45.06	45.09
<i>As Percent of NIS Funding</i>	4.59%	6.97%	5.39%	5.58%

Sources: USAID, Budgets for Health Care Programs in Eurasia

Table 2. Health Spending and Life Expectancy

Country	GDP Per Capita 1999	Health Spending as % of GDP	Life Expectancy 1999 Male	Life Expectancy 1999 Female	Under-5 Mortality Rate/1,000 1998
Armenia	\$485.5	7.9%	72.3	77.1	18.4
Azerbaijan	\$498.5	2.9%	67.8	75.3	33.2
Belarus	\$777.0	5.9%	62.4	74.6	14.3
Georgia	\$517.0	4.4%	69.4	76.7	17.5
Kazakhstan	\$1,058.0	3.9%	58.8	69.9	28.9
Kyrgyzstan	\$263.8	4.0%	61.6	69.0	40.7
Moldova	\$271.0	8.3%	64.8	71.9	22.2
Russia	\$1,249.0	5.4%	62.7	74.0	20.3
Tajikistan	\$176.0	7.6%	65.1	70.1	--
Turkmenistan	\$381.7	4.3%	61.0	65.3	60.0
Ukraine	\$619.5	5.6%	64.4	74.4	17.3
Uzbekistan	\$304.2	4.2%	65.8	71.2	38.0

Sources: Estimated GDP data are from the European Bank for Reconstruction and Development, *Transition Report 2000*. Health spending (based on 1997 data) and life expectancy data are from the U.N. World Health Organization, *World Health Report 2000*. Data for under-five mortality are from UNICEF MONEE on-line report [<http://www.eurochild.gla.ac.uk/documents/monee/welcom.htm>].

Table 3. Tuberculosis, HIV/AIDS, STD Rates and Drug Users in the NIS

Country	New TB Cases Reported in 1998	Living with HIV/AIDS, End of 1999		Number Diagnosed for the First Time with Syphilis or Gonorrhea, Rate per 100,000 in 1998	Estimated Number of Drug Abusers
		Adults	Children (0-14)		
Armenia	1,381	<500	<100	39.8	10,000
Azerbaijan	4,672	<500	<100	21.1	13,500
Belarus	6,150	14,000	<100	261.5	5,000
Georgia	4,876	<500	<100	79.75	20-25,000
Kazakhstan	20,623	3,500	<100	238.8	37,408
Kyrgyzstan	5,706	<100	<100	353.5	--
Moldova	2,625	4,500	<100	260.0	5,000
Russia	121,434	130,000	1,800	336.5	2 million+
Tajikistan	2,448	<100	<100	32.3	--
Turkmenistan	3,839	<100	<100	80.1	250-300,000
Ukraine	31,318	230,000	7,500	194.7	100,000+
Uzbekistan	14,558	<100	<100	75.0	200,000

Sources: U.N. World Health Organization. *Global Tuberculosis Control: WHO Report 2000*. Geneva, 2000; for HIV/AIDS, see UNAIDS, *Report on the Global Epidemic*, June 2000; for STDs, see U.N. Children's Fund. *Young People in Changing Societies. The MONEE Project*. CEE/CIS/Baltics Regional Monitoring Report No. 7, 2000.

Table 4. Refugees and Internally Displaced Persons
(as of December 31, 1999)

Country	Refugees	Displaced/Forced Migrants
Armenia	296,200	--
Azerbaijan	221,600	569,600
Belarus	260	16,400
Georgia	5,200	281,000
Kazakhstan	14,800	25,200
Kyrgyzstan	10,800	6,800
Moldova	10	--
Russia	80,100	1,408,200
Tajikistan	4,500	8,400
Turkmenistan	18,500	--
Ukraine	2,700	260,000
Uzbekistan	1,000	--

Source: U.N. High Commissioner for Refugees. *State of the World's Refugees 2000*. Information as of Dec. 31, 1999.

Table 5. Abortion Rates and Contraceptive Use

Country	Maternal Mortality/ 100,000*	Abortion Rates (abortions per 100 live births)*		Contraceptive Use: All Methods**	
	1998	1989	1998	Year	Percent
Armenia	25.5	34.7	46.5	1990	21.6%
Azerbaijan	41.1	21.5	20.1	1990	17.2%
Belarus	28.1	163.5	152.2	1995	50.4%
Georgia	34.2	75.6	44.9	1990	17.1%
Kazakhstan	54.9	77.5	67.1	1999	66.1%
Kyrgyzstan	35.5	66.3	27.0	1997	59.5%
Moldova	36.3	97.3	80.4	1997	73.7%
Russia	44.0	204.9	182.8	1994	66.8%
Tajikistan	58.2	20.1	19.1	1990	20.8%
Turkmenistan	16.3	31.3	25.7	1990	19.8%
Ukraine	27.2	153.2	125.3	1990	23.4%
Uzbekistan	9.6	27.8	13.5	1996	55.6%

Sources: * UNICEF MONEE Regional Monitoring Report No. 7.

** U.S. Bureau of the Census. International Data Base.