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**The Social and Economic Situation in
Countries of the FSU
Case Studies of Ukraine, Russia & Moldova**

**HIGHLIGHTS OF THE
INTERNATIONAL LITERATURE
and Source Documents**

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Introduction

The past 12 years have been years of turmoil in the republics of the Former Soviet Union, beginning with the dissolution of the FSU in 1991 and the transition from centralized to market economies. The negative impact on the populations of various republics was further exacerbated by the Russian economic crises of 1993 and 1998. Together, these changes have contributed to dramatic declines in standards of living over this period.

This review describes some of the impacts of this situation on the people living in Ukraine, Russia and Moldova. It is based on the most up-to-date data available from international comparative databases and on the literature in English and Russian from the major international organizations (such as World Bank, various divisions of the United Nations, World Health Organization, and International Monetary Fund) and from important sources – governmental and non-governmental – within the countries.

All of the information in this report is directly based on statements made or direct quotes from the literature. We have not exercised any independent review of these statements. However, we have only included information that seemed to be consistent with the reports from various sources and was not directly contradicted by any of the sources.

It covers a range of topics, from overall economic growth, to poverty and nutrition, and to key social support mechanisms, such as the health and pension systems. There is a particular emphasis on the situation of the elderly. We have attempted to provide a general overview and each of the topics covered could certainly be examined in greater depth.

While we feel we have already covered the bulk of the major literature, this is definitely still a work in progress.

Ukraine

Comparative Economic and Social Indicators

In 2002, the standard of living in the Ukraine is well below that which prevailed in 1989, prior to the transition. Real GDP declined in the 1990s so that in 1997 it was 37.4% of the level in 1989. Due to the resumption of economic growth in the last several years, by 2002 it rose to 46.5%, of the level in 1989. Parallel to this decline, real average wages (adjusted for inflation) declined throughout the 1990s to 48.9% of their 1989 level in 2000 and improved to 59.1% in 2001 with the spurt of economic growth in that year, which is continuing. In 2003 there has been new crisis with the emergence of poor harvests and grain shortages that have led to dramatic increases in prices of basic staples, such as vegetables and bread. It is still unclear how long this situation will persist. In 2002, the per capita GDP, adjusted for purchasing power, was \$5,344 compared with \$35,158 in the United States.

One indicator of the health and social situation is life expectancy. This has been increasing rapidly in the 1990s throughout the West and most of the developing world. By contrast, in Ukraine, life expectancy fell significantly between 1990 and 2002. In 2002, it was 60.9 for males and 72.1 for females, well below the levels for developed countries and many developing countries.

Sources:

UNICEF, Social Monitor [Brookdale data base]
World Health Organization, World Health Report [Brookdale data base]
U.S. Bureau of the Census, International Data Base (1996-2050) [Brookdale data base]
Economist Intelligence Unit, July 2003

General Standards of Living and Poverty

"The economic decline in the 1990s has had a serious and long-term impact on the income and the well-being of the Ukrainian people." A 2001 survey found that 80% of the population expects to experience ongoing financial difficulties. In two separate surveys conducted in 2000, respondents reported incomes insufficient to purchase enough food, housing, healthcare and clothing. [In the 2000 National Survey] "respondents assessed the sufficiency of their income to satisfy basic needs: 73% of them do not have enough food, 80% cannot pay for housing, 89% cannot receive medical services and buy medicines, 93% cannot buy enough clothes. While they prefer to expend income on food, their ability to satisfy other needs decreases, and the level of dissatisfaction with the ability to pay for housing, clothes and healthcare is higher."

Sources:

UNDP Prosperity Program April 2002, p. 3

"The life expectancy at birth has declined marginally between 1992 and 2000. The estimated level of GDP per capita in 2000 was \$700, which is more than 60% less than what it was a decade ago. The economic decline in the 1990s has had a serious and long-term impact on the income and the well-being of the Ukrainian people. "

Yatsenko, USAID Mission, 2001, p. 1

"According to the survey jointly conducted by the State Statistic Committee of Ukraine and ILO in the Fall of 2000, only 18.9% of the polled people found their financial

situation good or adequate. The remaining 81.1% foresaw they would be living in financial scarcity. "

Kalachova, State Statistics Committee of Ukraine, 2001, p. 3

"The majority of respondents [in the People's Basic Security in Ukraine Survey conducted in 2000] said that [their income] was not sufficient to cover the priority needs: food, housing, healthcare, clothing. ... Pensioners and unemployed feel least secured."

Novikova, National Academy of Science of Ukraine, 2001, p. 9

"Analyzing the assessment of respondents of sufficiency of their income to satisfy the first needs, we may say that 73% of them cannot have enough food, 80% cannot pay for housing, 89% cannot receive medical service and buy medicines, 93% cannot buy enough clothes. While they prefer to expend income on food, their ability to satisfy other needs decreases, and the level of dissatisfaction with the ability to pay for housing, clothes and healthcare is higher" [based on a poll conducted October-November 2000; part of the ILO Target Social and Economic Safety Program].

Poverty remains very high. The National Survey in 2000 found that over half of the population lived below 85% of the poverty level and three quarters live below 127% of the poverty level. Moreover, the United Nations Development Program identified 16% of the population in 2000 as extremely poor. There are high levels of distrust in government social security agencies and reportedly growing social unrest. "Ukraine is experiencing the creation of chronic "inherited" poverty, when children from poor families are predetermined to remain poor in adult ages."

Sources:

Novikova, National Academy of Science of Ukraine, 2001, p. 12

"The 75% of respondents have the average per capita household income up to UAH 150.00, among whom 53% - up to UAH 100.00. This means that more than the half of respondents have an average per capita income lower than the official poverty level – UAH 118.00. "

UNDP Prosperity Program April 2002, p. 3

"The poverty assessment indicates that in 2000, 45% of the population lives on less than \$1 a day and the number rises to 70% when the \$2 a day yardstick is used. Nearly 16% of the population is termed as extremely poor, living on less than 60% of the median equivalent expenditures. The people have also faced the erosion of social benefits and services, largely due to cuts in public expenditures and introduction of policies of gradual cost recovery in the social services."

Kalachova, State Statistics Committee of Ukraine, 2001, p. 4

"People have little trust in the government agencies dealing with social security: almost half of the respondents (49.4%) do not trust these government agencies."

Kvryan, Ukrainian Ministry of Labour and Social Policy, 2001, p. 24

"Today poverty is turning into one of the most important factors of the social tension and unrest in the society, the rapid decline in birth rates, the growing rates of emigration, including illegal emigrants, the high morbidity and mortality rates and the accelerated depopulation processes. Ukraine is experiencing the creation of chronic "inherited" poverty, when children from poor families are predetermined to remain poor in adult ages.... Therefore, poverty today may turn into the problem of the future."

The rate of poverty among those age 60 and older is variously estimated to be 40% overall in 2000-2001 and 93% among pensioners. The rate is estimated to be 88%

among those 50 to 60 years of age. Older adults reduced their expenditures on food and consumer goods at the end of the 1990s and reportedly receive fewer and poorer quality services. Furthermore, pensioners and those just before retirement age are very worried about their future financial situation and access to medical care.

Sources:

HelpAge International 2001; based on 2000-2001 estimates, p. 32

"The period since the end of Soviet rule in 1991 has been one of austerity for older Ukrainians, who make up nearly a quarter of Ukraine's total population of 50 million. They have fewer, poorer quality services. They have experienced a sharp reduction in financial security.

Male deaths in the Second World War, coupled with lower male life expectancy, have led to an imbalance between numbers of older women and older men, with nearly twice as many women aged 60 and over as men. Older Ukrainian women form a substantial and often isolated group. The 'oldest old' of both sexes – those over 75 – are set to rise from 5 to 8.7 percent of the population by 2026."

Yatsenko, USAID Mission, 2001, p. 1

Over 90% of Ukrainian pensioners are poor.

Novikova, National Academy of Science of Ukraine, 2001, p. 14

"In the older age groups the feeling of poverty is growing. Among respondents at the age from 50 to 60 years, the specific weight of poor people is 88%, and it is higher in the oldest age group – 93%."

Bezrukov and Foight, United Nations, 2000, AARP AgeLine Abstract

"Old-age pensions have fallen from about 40 percent of an average wage in 1985-1986 to just 15.7 percent of an average wage in 1995. As a result, expenditures on food and consumer goods by older adults have declined, though housing opportunities have increased slightly, due largely to public assistance and subsidies."

Kalachova, State Statistics Committee of Ukraine, 2001, p. 4

The level of dissatisfaction continues to grow among people of pre-retirement and retirement age. "Almost 82% are very worried about their financial and healthcare service situation in old age. 81.1% and 76.4% accordingly are expecting poor financial situation and inadequate healthcare in old age."

Despite recent economic growth since 2000, employment may not provide an escape from poverty, at least in the near term, as 70% of poor families already have at least one adult worker. In 2000, 25% of workers received wages lower than the poverty level; many industries pay wages lower than the official minimum wage. Moreover, positive economic growth was accompanied in some years (such as in 2000) by declining domestic consumption and real wages.

Sources:

Kyryan, Ukrainian Ministry of Labour and Social Policy, 2001, p. 24

"In contrast to many countries, the available job does not mean a guarantee of at least minimum prosperity. About 70% of all poor families has one adult worker.

About ¼ of workers received a wage which is lower than the poverty level and 72% of them – less than the minimum subsistence level, that was estimated in 2000 in the amount of UAH 270.1 per capita and in 2001 – UAH 311.3 per capita.

The positive changes in the national economy that happened in 2000 are accompanied by the further constriction of domestic consumption and a decrease in real wages by 0.9%. It was usual in many industries to pay wages which are lower than the minimum official wage."

Health Services

Expenditures on health care declined significantly during the transition years and reportedly had a disproportionate effect on older adults. In a 2000 survey, lack of access to acceptable health care services was reported by those living in rural areas (91%) and in urban areas (76%). "About 90 per cent reported that their income was inadequate to cover their healthcare needs."

Sources:

UNICEF, Social Monitor 2002, p. 74

Table 6.10 Public expenditures on health (as percent of GDP)

Bezrukov and Foight, United Nations, 2000, AARP AgeLine Abstract

"Expenditures on health care and social welfare have declined significantly [from 1986 to 1995] and have had a disproportionate effect on older adults."

Standing and Zsoldos, International Labour Organization, 2001, pp. 3, 36

" [In a 2000 survey, researchers found that] "Most Ukrainians felt that they do not have access to acceptable health care services in their neighborhood: 82 per cent of women and 79 per cent of men." (p. 3)

"The positive correlation between financial and health status was clear. "about 90 per cent reported that [their income] was inadequate to cover their healthcare needs" (p. 36).

[By the mid 1990's] "Ukraine had seen the development of a two-tier system of health care in which the poor suffer disproportionately from poor-quality treatment, shortages of necessary medicine and indifferent medical practitioners. Patients had to provide all medical supplies, including cotton, bandages, needles, anesthetics and antibiotics. For hospital stays, patients had to bring their own bed linens and food and arrange to have family members at the patient's bedside around the clock." [Even more recently it was reported that] "doctors commonly supplement their salaries by charging for operations and maternity care, and drugs are often available only privately."

Sources:

The World Bank, Wanner and Dudwick, 2003, p. 285

"As in education, a two-tier system was developing in health care in which the poor suffered disproportionately from poor-quality treatment, shortages of necessary medicine, and indifference on the part of medical practitioners....Patients had to provide all medical supplies, including cotton, bandages, needles, anesthetics and antibiotics. For hospital stays, patients had to bring their own bed linens and food and arrange to have family members at the patient's bedside around the clock. "

Economist Intelligence Unit, July 2003, p. 19

"Doctors commonly supplement their salaries by charging for operations and maternity care, and drugs are often available only privately."

Against the backdrop of poor health care are indications of urgent healthcare needs. "Poor health is a feature of Ukrainian society, in addition to the pervasive long-term effects of the Chernobyl accident of 1986.... According to data [gathered from the People's Security Survey conducted in 2000], a high proportion of adults suffer from health problems – including 48-52% of pensioners."

Sources:

Standing and Zsoldos, International Labour Organization, 2001, pp. 2-4

"There is no doubt that poor health is a feature of Ukrainian society, in addition to the pervasive long-term effects of the Chernobyl accident of 1986. (p.2) According to the data, a high proportion of adults were suffer from health problems...." (p. 3)
Figure 1: Respondents suffering from a chronic illness by work status and gender (p. 4)

Nutrition/Food

Insufficient agricultural and meat production and the declining purchasing capacity of the population over the 1990s threatened Ukraine's food security levels. As a result, the caloric intake in the late 1990s was estimated by the State Statistical Committee of Ukraine to be about 70% of what is considered necessary. "Consumption of meat has fallen by about 50% [between 1990 and 1996], fruit by over 20%, eggs by 40% and fish by 75%.... Nutritional deficiencies have become widespread, as Ukrainians have cut their consumption of expensive vitamin- and protein-rich foods in favor of cheaper bread and potatoes, in response to a sharp drop in incomes."

Sources:

National Security and Defense, 2001, p. 3

"The level at which the basic needs of Ukraine's population are met in terms of agricultural production remains insufficient. In grain production, Ukraine is behind not just developed European countries (Austria, Denmark, Spain.) but also its former COMECON partners – Bulgaria, Poland, Romania and Hungary.

Per capita meat production fell 2.5 times (from 84 kg in 1990 to 33.6 in 2000) over the last decade – one of the worst indicators in Europe: and many other basic indicators in the agro-industrial complex also declined. As a result, at the end of the 1990s, Ukraine's food security level was close to a critically dangerous level by FAO criteria.

According to the State Statistical Committee of Ukraine, the caloric content of nutrition received by the populace in the late 1990s was about 70% of what is considered necessary. It is worth noting that the insufficient volume of agriculture production is not the only cause of the decline in the level of Ukraine's food security – the quality of nutrition is not least dependent on the purchasing capacity of the population, which is critically low. "

The Economist Intelligence Unit, July 2003, p. 19

"Consumption of meat has fallen by about 50% since 1990, fruit by over 20%, eggs by 40% and fish by 75%.... Nutritional deficiencies have become widespread, as Ukrainians

have cut their consumption of expensive vitamin-and protein-rich foods in favor of cheaper bread and potatoes, in response to a sharp drop in incomes."

In a 1996 study, the poorest – disproportionately pensioners – "cite hunger as the worst aspect of their lives. After purchasing bread, these households barely had any money left. Many existed on bread, milk and tea." In a 2000 survey, very large majorities reported that their household incomes were insufficient to cover food needs. Among those most severely affected were pensioners – 82% of whom reported that their incomes did not cover their food needs.

Sources:

The World Bank, Wanner and Dudwick, 2003, p. 265

" [In interviews conducted between October 1995 and March 1996] The destitute cited hunger as the worst aspect of their lives. After purchasing bread, these households barely had any money left. Many existed on bread, milk and tea. Household and utility charges, medicine, clothing, and other necessities were entirely unaffordable. The destitute tended to be pensioners and young single people without a social support network."

Standing and Zsoldos, International Labour Organization, 2001, p. 35-36

"Most people in Ukraine reported that their household income was insufficient to cover their food needs, and this applied to three-quarters of all industrial workers, 82% of pensioners, 65.8% of agricultural workers, 64.1% of students, 70.8% of private service workers, 83.7% of the unemployed and 72.2% of those working in the public service sector. In all cases, even higher proportions said their incomes were insufficient for their housing needs, and about 90% reported that it was inadequate to cover their healthcare needs. This is chronic income insecurity."

Elderly: Pension Levels

The value of pensions declined "from about 40 percent of an average wage in 1985-1986 to just 15.7 percent of an average wage in 1995." Declining pension values and the eradication of savings precipitated by bank failures and hyperinflation between 1992 and 1994 have all contributed to very high poverty rates among the elderly.

Sources:

Bezrukov and Foight, United Nations, 2000, AARP AgeLine Abstract

"Old-age pensions have fallen from about 40 percent of an average wage in 1985-1986 to just 15.7 percent of an average wage in 1995."

Yatsenko, USAID Mission, 2001, pp. 1, 7

"The current pension system does not ensure the important linkage between the contributions made and benefits paid. The pension contributions stay high compared to the inadequately low pension benefits" (p. 1).

" [P]eople invest in private pension plans if they are confident in appropriate management of their assets and receiving pension benefits upon retirement. The previous years of bitter experience gave Ukrainians the grounds to doubt the reliability of private pension plans. In addition, many large banks bankrupted, and the hyperinflation of 1992-1994 erased all savings" (p. 7).

The ongoing pension crisis was precipitated not only by the economic crises of the 1990s but also by the large number of pensioners relative to workers, black market activities,

and ongoing public distrust in pension reform. "The old system of social insurance has effectively gone bankrupt," so that, without pension reform, assessments are that Ukraine's 14 million pensioners will continue to face extreme poverty.

Sources:

Yatsenko, USAID Mission, 2001, p. 1

"Along with the economic crises of 1990s, the aging population of Ukraine per se causes the fundamental problem for the pension system: an ever decreasing number of working people will have to support more and more pensioners in future."

Dubrogonov, 2000, AARP AgeLine Abstract

" [There are] problems associated with pension reform in Ukraine associated with the large informal ("black market" or underground) economy in the post-Soviet era.... Together with a decline in output in the formal sector and rising unemployment, informalization has become one of the main reasons for the severe crisis in the Ukrainian pay-as-you-go pension system. Analyses indicate that public trust in pension reform plays a crucial role in its success and in economic development in general."

Oxford Analytica, 2001

"The old system of social insurance has effectively gone bankrupt, and no new social protection programmes have been established. Without pension reform, many of Ukraine's 14 million pensioners are doomed to extreme poverty, especially in view of the decline in the birth rate and increasing mortality rates among the population of employable age."

Bezrukov and Foight, United Nations, 2000, AARP AgeLine Abstract

"The position of older adults in Ukraine – especially in regard to income and housing security- will depend on the success of current government reform proposals."

Russia

Comparative Economic and Social Indicators

In 2002, the standard of living in Russia is well below that which prevailed in 1989, prior to the transition. Real GDP declined throughout the 1990s and in 1997 was 58% of the level in 1989 and fell further in the major financial collapse of 1998. Due to the resumption of economic growth since 1999, by 2002 it rose to 64.3% of the level in 1989. Parallel to this decline, real average wages (adjusted for inflation) were 45.9% of their 1989 level in 1995 and recovered to 52.7% in 2001. In 2002, the per capita GDP, adjusted for purchasing power, was \$7,926 compared with \$35,158 in the United States.

One indicator of the health and social situation is life expectancy. This has been increasing rapidly in the 1990s throughout the West and most of the developing world. By contrast, in Russia, life expectancy in 2002 was significantly below that of 1990. In 2002, it was only 62.3 for males and 73.0 for females, well below the levels for developed countries and many developing countries.

Sources:

UNICEF, Social Monitor [Brookdale data base]

World Health Organization [Brookdale data base]

U.S. Bureau of the Census, International Data Base (1996-2050) [Brookdale data base]

General Standards of Living and Poverty

Poverty rates rose significantly over the transition years; there are various estimates of the change. The Russian Bureau of Statistics reports that poverty increased from 10-12% in 1990 to 25%-33% in 2000. There have been some declines since 1989, but poverty remains high. The poor are predominantly single women over age 65 and two-parent families, previously part of the middle class, with one or two children.

Sources:

Oxford Analytica, 2000

"The proportion of the Russian population living in poverty is estimated at 25-33%, compared with 10-12% in 1990. Poverty is defined as living on less than the subsistence minimum (SM), with the official poverty line based on the cost of the consumer basket. In September, Goskomstat set the SM at 695.5 roubles per month (24.9 dollars)."

UNICEF, Social Monitor 2002, p. 4

"While poverty has declined in Russia since 1998, it still affects 3 in 10 young children in that country."

World Bank, Grootaert and Braithwaite, 1998, pp. 48-49

"In Russia, out of all poor individuals, approximately 60 percent live in families with children, while slightly more than 40 percent live in childless homes....For single Russian females, the poverty rate was high but so too was the share (60 percent) aged 65 or older."

Rimashevskaya, Russian Academy of Sciences, 2000, p. 2

"40-60% of the poor consist of two-parent families with one or two children in their prime working years. These "new poor" are people who were previously considered middle class."

Poverty rates vary by population groups. The elderly are disproportionately poor (two-thirds in 1998-99), as are one-parent families (more than half in 1998-99). In general, rural areas have higher rates of poverty than urban areas. For example, the poverty rate in the Russian Far East is more than four times the rate in Moscow. The North Caucasus and North-European parts of Russia have the highest concentrations of poverty.

Sources:

Rimashevskaya, Russian Academy of Sciences, 2000, p. 2

More than half of one-parent families and two-thirds of pensioners are under the poverty level.

The regions with the highest concentration of poverty include the North Caucasus and North-European part of Russia.

Food and Agricultural Organization of the United Nations, May 1999

Structurally, the level of the poor is higher in the rural than in the urban areas (e.g., 15% in Moscow, 60-70% in the Far East).

The income gap between the wealthy and the poor in Russia is estimated to be higher than in any other Eastern European country.

Sources:

Oxford Analytica, 2000

"The income levels enjoyed by the wealthiest sections of the population are more than 14 times higher than those of the poorest. This is estimated to be the largest income gap in all of the East European transition economies."

A very small percentage of the poor who are eligible to receive benefits actually receive them. The poor report widespread dissatisfaction with nutrition and housing conditions.

Sources:

Ovcharova, I.E.T., 2001, p. 28

"25% of the population is officially eligible for benefits due to poverty; however, only 5-6% actually receive such benefits."

Food and Agricultural Organization of the United Nations, May 1999

"The poor show overall dissatisfaction with nutrition (94%), housing conditions (74%), provision with modern home equipment (86%)."

Health Services

The quality of the health care system declined dramatically over the 10 years following the collapse of the Soviet Union. Since 1992, government medical spending has been cut by 75%. According to the World Bank, 54% of health bills within Russia's public system are now paid out of patients' pockets.

Sources:

Webster, Lancet, 2003, p. 498

"Although the Russian constitution still guarantees universal access to medical care, health-care quality has declined dramatically since the Soviet collapse in 1991.... Since 1992, government medical spending has been cut by 75%. According to the World Bank, 54% of health bills within Russia's public system are now paid out of patients' pockets."

Currently, only about 4% of GDP is going to health services and a 2003 government report concluded that the health insurance fund received only about one fifth of the funds it actually needs.

Sources:

Lancet Editorial, 1999, p. 337

"Despite the desire to provide free care for all, the health service received only about 4% of the GDP, compared with 8 - 9% in most market economies.... With the country in such political and economic turmoil, funding is likely to remain inadequate, and the effect the changes will have on access to health care remains to be seen. "

Webster, The Lancet, 2003, p. 498

" [A Jan 2003] report from the Kremlin's Government Control Directorate (GKU), concluded that because Russia's health insurance fund receives only a fifth of the funds required to adequately sustain the system, patients are denied 'equal access to free medical services guaranteed by the state.'"

Even before the economic crises of the 1990s, the Russian health care system was operating well below optimal levels. "Facilities were old, many without running water and health care personnel were paid as much as a third below the national average." Poor training and heavy patient loads also contributed to improper diagnoses. "The last decade has seen the virtual collapse of Russia's health care system. Although Soviet-era conditions were poor, with long waits, brusque bureaucracy and uneven standards of care, today's problems are more fundamental. Public hospitals and clinics lack the most basic medicines and equipment and are nearly overwhelmed by an increasingly sick population. Despite successful reform efforts in a few localities and the heroic efforts of dedicated doctors to improvise their way around the shortages, the overall statistics are grim."

Sources:

Wines, New York Times, 2000, Late Edition – Final, Section A, Page 1, Column 2

"Russia's health care system is ancient (one in 10 hospitals was built before 1914), ill equipped (one in five hospitals have no running water), huge and inefficient (12,000 hospitals and 20,000 clinics). Doctors and nurses are astonishingly underpaid, as much as a third below the national average, as of December 2000. The best leave for better jobs. Those who stay battle a lack of money, medicine and equipment it. "

The New York Times, Editorial, January 2, 2001

"The last decade has seen the virtual collapse of Russia's health care system. Although Soviet-era conditions were poor, with long waits, brusque bureaucracy and uneven standards of care, today's problems are more fundamental. Public hospitals and clinics lack the most basic medicines and equipment and are nearly overwhelmed by an increasingly sick population. Despite successful reform efforts in a few localities and the heroic efforts of dedicated doctors to improvise their way around the shortages, the overall statistics are grim."

Maclean's Toronto, 1993, p. 29

"With the collapse of the Russian economy, the grim state of the health care system has become shockingly clear. A government study (published Fall 1992) showed that 40% of Russia's hospitals lacked hot water, 18% had no sewage systems and 12% had no water at all. Much of hospital equipment is obsolete and broken and supplies are poorly stocked. Ambulances are often unavailable because drivers use them as unlicensed taxis."

Kessler, Employee Benefits Journal 1998, start page 18

"A main and overriding issue [in 1998] is the inability to receive proper diagnoses; the first doctors that a patient sees are usually very poorly trained and overworked in terms of patient load. If diagnosis is done correctly, the next major hurdle is adequate and correct treatment. Drugs are in very short supply, and patients often must seek them out themselves or use what is available."

The impact of the antiquated system, as well as declining government expenditures, may be seen along a number of dimensions, including, for example, declining life expectancy and rising incidence of Tuberculosis and other infectious diseases.

Sources:

Maclean's Toronto, 1993, p. 29

"As the medical system crumbles, overall levels of health among Russians are declining as well. Doctors are paid the equivalent of \$16-30 per month."

UNICEF Social Monitor 2002, pp. 9-10

"The case of Russia is of particular concern, with recent signs of a significant climb in mortality among adult men and women ... aged 20-24 between 1996 and 2000. The increases that occurred after 1997 mean that the mortality rates in this age group in 2000 were higher in Russia than in any other country in the region and higher than at any stage since 1989."

Lancet Editorial, 1999, p. 337

"In today's Russia, control of infectious diseases, such as diphtheria, multidrug-resistant tuberculosis, and sexually transmitted diseases, is a struggle; infant mortality is three to four times, and maternal mortality is five to ten times, those of other industrialized countries; and life expectancy has plunged. In the 1960s Russia was the second strongest industrial power in the world, yet now life-expectancy for Russian men (57.6 years) is lower than the average for developing countries (64 years). For both men and women, increasing death rates at 30-60 years of age account for most of the fall in life-expectancy, and heavy alcohol consumption is a major contributing factor. The downturns in health have been especially striking in the 1990s."

The New York Times, Editorial, January 2, 2001

"The last decade has seen the virtual collapse of Russia's health care system. Although Soviet-era conditions were poor, with long waits, brusque bureaucracy and uneven standards of care, today's problems are more fundamental. Public hospitals and clinics lack the most basic medicines and equipment and are nearly overwhelmed by an increasingly sick population. Despite successful reform efforts in a few localities and the heroic efforts of dedicated doctors to improvise their way around the shortages, the overall statistics are grim. Male life expectancy has declined to just 59.9 years, compared with 74.1 years in the United States. Russia's death rate now surpasses its birth rate. Once tamed infectious diseases, including tuberculosis, diphtheria and polio, are again spreading at worrisome rates. On top of this, many Russians have responded to economic hardships with self-destructive forays into alcoholism and violence."

While the overall level of health care is low, the poor fare even worse. Even though Russia still theoretically guarantees universal access to medical care, those with wealth and/or connections fare better. In 1997, only 1% of the population could afford insurance and special clinics, and in 1998, 1% of the medical service expenditures went to the poorest population groups, while 46% went to the wealthiest. The homeless, among the poorest, cannot receive outpatient medical care without documentation of address; between 1999 and 2003 nearly 1,700 homeless people in Moscow died of hypothermia.

Sources:

Rusinova and Brown, 2003, Abstract

"Those with connections and better knowledge of the state medical system are able to interact more effectively with physicians, take greater advantage of supposedly free services, and thereby gain access to the best care.

The brunt of the inadequacies of impoverished and inefficient state medicine is born by those who lack both the skills to "work" the system and the resources to pay for private care outside it. This reinforces the long-standing cultural predisposition to delay treatment until health problems become more difficult and costly to manage."

Possehl, Hospitals and Health Networks, 1997, start page 42

"The Russian state health care system, which is supposed to provide equal care for all, is among the last vestiges of Communism. In 1997, Russia's health system was in the process of developing a 2nd tier that depended on the patronage of the wealthy, and the quality of care can differ greatly. A visit to a Western-style clinic costs more than the average Russian's monthly wage.

In 1997, the number of Russians who could afford insurance and special clinics was limited to 1% of the population. The other 146 million contended with a much grimmer reality, with both the state system and general health status facing serious challenges: Outside major cities, the situation is desperate, with scarcity of medication and beds. In the Russian Far East, doctors went on a hunger strike because they had not been paid."

Rimashevskaya, Russian Academy of Sciences, 2000, p. 3

"In 1998 only 1% of all medical services expenditures go to the poorest population groups, while 46.4% go to the wealthiest population groups."

Ford, Lancet, 2003, p. 887

"As of Feb 25, 2003, 360 people have died of hypothermia since winter began, bringing the total number of deaths on Moscow's streets in the past 4 years to 1697.

Despite constant lobbying over the past decade, there are no outpatient medical services available for homeless people, and hospital services are expensive and only available for people without documents in emergencies."

The costs of medicines and medical devices are unaffordable for many. A 2002 survey indicates that 12-16% of sick people cannot afford needed medicines. The situation is severe for the elderly who are most in need of medicines. Various reports indicate that at least 20,000 cancer patients die annually because they cannot afford medicine and that 200,000 diabetics are unable to get insulin. In addition, those with disabilities face additional high costs; for example, an artificial limb reportedly costs \$2,000 today.

Sources:

Maksimova, Moscow: Per Se, 2002, p. 139

"According to surveys of physicians 80-90% of physicians surveyed for the 2002 study report that they discuss the cost of drugs with their patients. This generally results in the prescription of a cheaper, less effective drug than the optimal choice, which may lead to complications. Despite physicians' efforts to accommodate patients' limited purchasing power, surveys show that 12-16% of sick people are still unable to buy the drugs prescribed for them.

[G]roups that have most need of medicine – in particular, the elderly – are least able to afford it.... Matters would be worse yet if not for the fact that 15% of the population have privileged access to medicines."

Wines, The New York Times, 2000, Late Edition – Final, Section A, Page 1, Column 2

"By a 1999 estimate, at least 20,000 cancer patients die annually because they cannot afford medicine. By another, some 200,000 diabetics are unable to get insulin, even though the government guarantees a free supply, because local and regional governments cannot afford to buy it."

Blagov, Global Information Network, 2003, p. 1

"The disabled encounter particularly severe difficulties in the winter. Russian cities are not easy for anyone in a wheelchair; facilities such as ramps, wheelchair accessible toilets and special parking for the handicapped are rare. Artificial limbs, once distributed for free in Soviet days, now cost about \$2,000 – prohibitively expensive for most people."

As in the Ukraine, the condition of the health care system must be evaluated against the backdrop of environmental problems (two-thirds of the population live in areas in which air pollution levels exceed health and safety standards), high disease and mortality rates (documented earlier) and high disability rates.

Sources:

WHO Country Highlights, 1999

More than two-thirds of the population live in areas affected by air pollution at levels exceeding health and safety standards in force.

Blagov, Global Information Network, 2003, p. 1

"There are an estimated 10.8 million people listed as disabled in Russia – about one in every 14. [Labor Minister Alexander Pochinok said] that the figure could reach 15 million over the next few years. "

Nutrition/Food

The impact of the economic crises in the 1990s, both on incomes and the social/health service system, has resulted in a serious deterioration of the Russian population's nutrition patterns. An estimated 40% of the Russian population was receiving insufficient nutrition at the end of the 1990s. Population of some Russian regions suffers from faster growth of food prices as compared to incomes. These include regions in which price increases exceeded income increases by at least 30% between 1995 and 1999 (three regions in Central Russia, three in Southwest or South Siberia, two in the Far East and one in North Russia and the Caucasus).

Sources:

Baturin, I.E.T., 2001, p. 33

"The economic instability in Russia during the reform years entailed serious deterioration of population's nutrition patterns."

Ovcharova, I.E.T., 2001, p. 21

"The drop of household incomes during years of transition has greatly undermined food security of most Russian families."

Serova, I.E.T., 2001, p. 14

"Population of some Russian regions suffers from faster growth of food prices as compared to incomes."

Rimashevskaya, Russian Academy of Sciences, 2000, p. 2

"About 60 million people are living in very hard conditions and are receiving insufficient nutrition."

One source indicates that milk and dairy product consumption declined by 43% and meat consumption by 36% between 1990 and 1998. Another source reports a 21% decline in dairy consumption and a 15% decline in meat consumption over the same period. In 1996 the average daily caloric consumption was 30% lower than recommended by the World Health Organization and on par, at the end of the 1990s, with developing countries having problems with food supply.

Sources:

Ovcharova, I.E.T., 2001, p. 21

"The average per capita consumption of food items declined as follows:
Milk and dairy products – from 386 kg in 1990 to 253 kg in 1995 and to 219 kg in 1998; Meat consumption – from 69 kg in 1990 to 52 kg in 1995 and to 44 kg in 1998.

The consumption of the food items declined: milk and dairy products from 278 kg in average per capita in 1995 to 219 kg in 1998; meat consumption – from 52 kg in average per capita in 1995 to 44 kg in 1998.

The caloric intake dropped to the level of developing countries having problems with food supply. "

World Health Organization, Country Highlights, 1999

"In 1996, average daily calorie consumption per head was approximately 30% lower than the level recommended by WHO, and the diet of all population groups contains an inadequate amount of B group vitamins."

Rimashevskaya, Russian Academy of Sciences, 2000, p. 2

"Long-term poverty led to 10% of urban families and 5% of rural families suffering from insufficient calorie intake and 20-40% experienced protein hunger in 1996."

In 2001 reported that a majority of Russians suffer from a variety of nutritional deficits including vitamins, minerals and protein. Vitamin A sufficiency decreased from 70% in 1989 to 57% in 1996 and Calcium from 80% to 56%.

Sources:

Baturin, I.E.T., 2001, p. 35

"Russians suffer from vitamin and mineral deficits, including: Vitamin A – sufficiency decreased from 70% in 1989 to 57% in 1996. Calcium – sufficiency decreased from 80% in 1989 to 56% in 1996."

Incidence of malnutrition is highest among the poor, with various studies reporting malnutrition among impoverished groups and arguing that it is a serious issue of concern. A study relying on 1996 data indicates that urban families were twice as likely to suffer from insufficient caloric intake as rural families. Specific outcomes have also been reported, ranging from a reduced body mass index among men in lower income groups to a deterioration of children's anthropometric status. Undernourishment is reported to be a new feature of poverty in Russia, which in the past was more likely to be characterized by poor housing conditions and inadequate clothing.

Sources:

Ovcharova, I.E.T., 2001, p. 32

"Poorer population groups are most affected demonstrating medical signs of malnutrition."

Rimashevskaya, Russian Academy of Sciences, 2000, p. 2

"Long-term poverty led to 10% of urban families and 5% of rural families suffering from insufficient caloric intake and 20-40% experienced protein hunger in 1996."

Baturin, I.E.T., 2001, p. 41-42

"Breast-feeding period has been decreasing, and children's health and their anthropometric status has also deteriorated. Malnutrition in low-income families is a serious issue of concern."

Elderly: Pension Levels

Over the 1990s, large and systematic deficits occurred in all social funds, including the pension fund. The pension fund was also drawn upon for non-mandated uses, further contributing to its insolvency. "As a result, the system is chronically unable to cover the broad field of social risks that have brought about its low efficiency, crisis and actual bankruptcy."

Sources:

Oxford Analytica, 2000

"In 1997, enterprise arrears accounted for 51% of total obligations to the Pension Fund, 40% to the Social Welfare Fund, 120% to the Health Insurance Fund and 174% to the Unemployment Insurance Fund. Moreover, the federal and local administrations often gain access to the funds' resources (especially the Pension Fund) for opaque and non-mandated uses (eg, to reduce pension or wage arrears temporarily ahead of local elections). As a result, the system is chronically unable to cover the broad field of social risks that have brought about its low efficiency, crisis and actual bankruptcy in the first place."

In 1998 pensions were the only source of income for 2/3 of elderly households and yet, between 1992 and 1998, average pension values declined from 117% of the poverty level in 1992 to 70% of the poverty level in 2000. In 2000, pensions "did not provide sufficient income to bring half the country's population above the poverty level."

Sources:

Tchernina, Ageing and Society, 2002, AARP AgeLine Abstract

"In the decade since the collapse of the Soviet centrally planned welfare state, poverty has affected a rising number of older persons in Russia. Most have seen their savings annihilated and their pensions devalued, and all have had to face the degradation of medical care and personal social services."

Ovcharova, I.E.T., 2001

"Minimal pension as percentage of the poverty level declined from 85% in 1992 to 67% in 1998 to 49% in 2000. Average pension as percentage of the poverty level declined from 117% in 1992 to 115% in 1998 and to 70% in 2000."

Rimashevskaya, Russian Academy of Sciences, 2000, p. 3

"The largest transformation of the social service system occurred in the pension system. As a result, today pensions do not provide sufficient income to bring half of the population's elderly above the poverty level."

"The elderly have arguably suffered the most during Russia's uneasy transition to a market economy. Too old to find new ways of earning money in the post-Soviet economy, most of the country's elderly are forced to survive on their pensions alone, which, at an average of \$45, do not even meet the official subsistence wage of \$60 a month. The problem is especially dire in Moscow, where living expenses can soar to nearly three times that amount.... Living on so little money reduces the life of a pensioner to a kind of grim mathematical equation. Monthly expenses may include \$10 for housing and utility costs, \$3 for a garden plot outside of Moscow; at least \$3.50 must be set aside every month for medicine. After that, just 55 rubles (\$1.70) remain to spend each day on food and other small necessities."

Sources:

Mereu, Russia Political Weekly, 2002

"The elderly have arguably suffered the most during Russia's uneasy transition to a market economy. Too old to find new ways of earning money in the post-Soviet economy, most of the country's elderly are forced to survive on their pensions alone, which, at an average of \$45, do not even meet the official subsistence wage of \$60 a month. The problem is especially dire in Moscow, where living expenses can soar to nearly three times that amount.

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Moldova

Comparative Economic and Social Indicators

In 2002, the standard of living in Moldova is well below that which prevailed in 1989, prior to the transition. Real GDP declined throughout the 1990s and in 2000 was 32.6% of the level in 1989. Due to the resumption of economic growth in recent years, by 2002 it rose to 38.4% of the level in 1989. Parallel to this decline, real average wages (adjusted for inflation) were 35.8% of their 1989 level in 2000 and have then somewhat increased. In 2002, the per capita GDP, adjusted for purchasing power, was \$1,432 compared with \$35,158 in the United States

One indicator of the health and social situation is life expectancy. This has been increasing rapidly in the 1990s throughout the West and most of the developing world. By contrast, in Moldova, life expectancy fell significantly between 1990 and 2002. In 2002, it was only 60.4 for males and 69.3 for females, well below the levels for developed countries and many developing countries.

Sources:

UNICEF, Social Monitor 2002 [Brookdale data base]

World Health Organization [Brookdale data base]

U.S. Bureau of the Census, International Data Base (1996-2050) [Brookdale data base]

General Standards of Living and Poverty

The transition from a centralized to a market economy has contributed to increasing economic insecurity. "In Soviet times, all people of working age worked, and older people received pension payments. Although formal wage payments were low, there were significant non-wage benefits, as well as price controls and subsidies on consumer goods."

Moldova, one of the poorest republics of the Former Soviet Union (FSU), is closely tied to the Russian economy and was therefore severely impacted by the economic collapse of the Soviet Union and the Russian economic crisis in the third quarter of 1998. Poverty rates increased to an estimated 62% and unemployment rates to an estimated 28% of the labor force in the late 1990s. Even among the employed, the poverty rate was 22%. After the 1998 crisis, poverty, which had most affected rural populations, also affected the previously non-poor in urban areas.

Sources:

World Bank, Poverty Assessment Summaries, Moldova, 2000, pp. 6, 9.

"In Soviet times, all people of working age worked, and older people received pension payments. Although formal wage payments were low, there were significant non-wage benefits, as well as price controls and subsidies on consumer goods. Only those totally cut off from the formal labor market were considered to be in need of special interventions. Poverty was regarded as a social pathology, and these 'excess' cases included alcoholics, the handicapped, vagrants or the elderly infirm. The Moldovan social protection system is still oriented towards this old philosophy" (p. 9).

"Official unemployment rates are very low, but greatly underestimate the true number of those out of work. Registered unemployment is about 23,000 workers, but if workers who are on forced or unpaid leaves, the official unemployment rate rises to over 12% of the

labor force. Data from the household survey presents a more serious picture- the rate of unemployment and unpaid leave is closer to 28% of the labor force.

Being officially employed or not has a very small effect on whether a person is poor. Those with jobs have about a 22% chance of being poor, while the unemployed have about a 28% chance of being poor because salaries are often extremely low and are often delayed by several months. The unemployed rely on trade, seasonal employment and transfers from family members" (p. 6).

World Bank, Murrugarra and Signoret, 2003, pp. 2, 42

"Moldova is one of the poorest countries in Europe and was severely affected by the Russian crisis. Incidence of poverty increased by about 10% (from 52% to 62%)" (p. 2).

"Poverty in Moldova had been concentrated in rural areas, but after the crisis, non-poor in urban areas were also severely affected" (p. 42).

World Bank, DeSoto and Dudwick, 2003, pp. 339-340

"In urban and rural areas alike in Moldova, many houses had no gas or water connections. Many families could not afford coal to heat their houses for the winter. Throughout the country, access to potable water was a problem, and in villages, water was supplied exclusively from wells, with hours waiting on line to get it. For the poorest, including the elderly, life has become a struggle to survive."

Health Services

The healthcare system was severely affected during the transition years, particularly during the Russian crisis in 1998. Between 1997 and 2000, government spending on health care declined from 6% to 2.9% of GDP – the equivalent of a 46% decline in average per capita health expenditures. The population's utilization of health care services, particularly of primary care, was similarly affected: outpatient visits declined by 30%. By the end of the 1990s many could no longer afford basic medicines.

Sources:

World Bank, Murrugarra and Signoret, 2003, pp. 28-29, 35

" [Moldova's extensive healthcare system] presented a major burden to the government in face of a decade of difficult transition and of a major regional crisis. The response has been one of major restructurings and expenditure cuts.... According to official statistics, in 1999, after the Russian Crisis, public fiscal expenditure on health was ...2.9% of GDP. This same figure ...in 1997 [was] 6% of GDP" (p. 28).

"Health expenditures in Moldova during the period after the Russian Crisis drop on average by 7.4 lei per capita (a proportional drop of 47%)" (p. 29).

"Before the crisis, 33.5% visited at least once a health clinic or a hospital per month. And most households visited clinics (31.9%) compared to hospitals (5.2%). For the period after the crisis, the percentage of households that had visited either a clinic or a hospital decreased almost 7 percentage points, from 33.5% to 26.8%. Most of this decrease comes from a decreased utilization of clinics. Clinic utilization dropped by 6 percentage points.... (p. 35).

UNICEF, Social Monitor 2002, p. 74.

Table 6. 10. Public expenditures on health

exclusively on pensions for income are especially vulnerable." In a 2000-2001 survey of those aged 65 to 90, "over a third were receiving help from relatives or humanitarian organizations."

Sources:

HelpAge International, 2001, p. 26

"Since [independence in 1991] the real value of pensions – on which 85 percent of older Moldovans depend – has fallen dramatically, and there has been a near collapse in social security systems. Over 80 percent percent of older people now live below the poverty level, many working informally to supplement their incomes. The rolling back of state subsidies has brought a sharp rise in their cost of living, while protracted delays in the payment of benefits have added to the stress of budgeting on inadequate income.

A recent survey of 1,500 people aged 65-90 was conducted by a Moldavan non-governmental organization, Second Breath, showed incomes were desperately low. Pensions ranged from US\$5 to US\$14 a month, and were paid three to nine months late. Over a third of those surveyed were receiving financial help from relatives or humanitarian organizations."

World Bank, Poverty Assessment Summaries, Moldova, 2000, pp. 4, 10

"Some sections of the elderly are, indeed, extremely poor. Those living alone, or depending exclusively on their pensions for support, may be extremely vulnerable" (p. 4).

"Most pensioners (especially those in rural areas) receive pensions anywhere from a few weeks to nine months late. Moreover, distribution and access to assistance differs a great deal between city and village" (p. 10).

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SPENCER FOREMAN, M.D.
President

January 15, 2004

MONTEFIORE



Hon. Judah Gribetz
Special Master
Holocaust Victim Assets Litigation
New York, NY

Dear Mr. Gribetz:

I write as an experienced physician and hospital executive who for the past eight years has made annual field visits to the countries of the Former Soviet Union as a member of the Board of Directors of the American Jewish Joint Distribution Committee (JDC) to observe conditions affecting their Jewish populations, particularly the elderly, a very large proportion of whom are Holocaust survivors, and to assess the JDC's efforts to provide assistance to them. In the performance of these evaluations I work as a volunteer professional bringing my medical expertise and more than 30 years experience as a hospital and health systems chief executive.

My first trip, in 1996, was to Kiev, Moscow and St. Petersburg. The following year, I returned to Ukraine and visited Belarus. In addition to observing conditions in the major cities (Kiev and Minsk), I traveled into smaller towns and villages. In 1998, I made my third visit to Ukraine starting in Kharkov and then into the countryside. In 1999 I returned to St. Petersburg and then went to Tbilisi and Gori in Georgia. In 2000 I visited Almaty in Kazakhstan and Biskek in the Kirgiz Republic. In 2001 I made my first trip to Kishinev, Beltsy and various villages and town in Moldova. In 2002 I went to Chelyabinsk in the Ural region of Russia; and in 2003 I returned to Kishinev and to Moscow.

Initially, the focus of my visits was entirely on the needs of the elderly Jewish population. On each trip I visited Hased welfare centers, talked with professional and voluntary staff, observed a wide range of programs that provide food, medical care and other services and made home visits to the elderly. I visited hospitals, polyclinics, pharmacies and long term care facilities (where they existed). I met with government officials, local volunteers, community service workers, rabbis and representatives of non-governmental organizations.

These visits revealed enormous problems. While the economic conditions created by the collapse of the Soviet Union (1991) and the Russian currency crisis that followed (1998), which reverberated throughout the FSU, were difficult for everyone, they were devastating for the elderly, who subsisted then and now on meager pensions. Under the Soviet system of government supported prices, pensions were adequate to sustain life at a bearable level; but in the new economic environment where prices are allowed to climb and pensions do not, all pensioners are poor, and some are desperately poor, without adequate food, housing, heat, clothing and social supports. Medical care is a particular problem. Diagnostic testing, specialty services and all but the most urgent hospital care are unavailable to those unable to pay for them, a group that includes virtually all of the Jewish elderly, and even when admitted to a hospital as an emergency out of pocket payment must be made for pharmaceuticals and medical equipment used

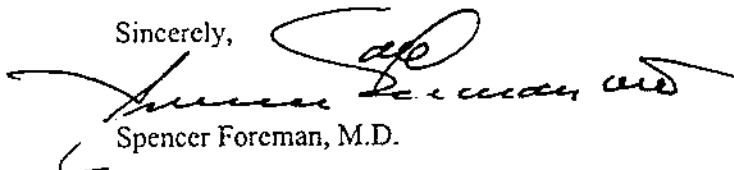
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during the hospitalization! Prescription medications are either unavailable or unaffordable for the average pensioner. Effective care is further strictured by the primitiveness of hospital and polyclinic facilities and by the scarcity of medical equipment, even the most basic items. While limited hospital care is available for trauma and acute medical problems, elderly patients with serious conditions such as stroke are often just sent home to linger bedridden or to die. A patient with fractured hip, who in the West would be treated with a surgically inserted hip prosthesis and sent home in three days, is treated with traction for weeks then sent home, often with a non-union of the fracture, never to walk again. With the exception of a few major centers in Moscow and St Petersburg and selected places available only to those who can pay, the services most people receive are at best comparable to those available in the U.S. in the 1950s, and they are in striking contrast to the high-quality care and advanced technologies to which elderly patients in the U.S. and Israel have access on a routine basis and for which, with a few exceptions, governmental or private payment is available.

The JDC has responded to the needs of elderly Jews with remarkable solutions, utilizing extensive networks of multi-functional Hesed centers to provide food packages, hot meals, medical care, home repairs and other needed services. The only problem is that there are not enough resources to reach everyone in need.

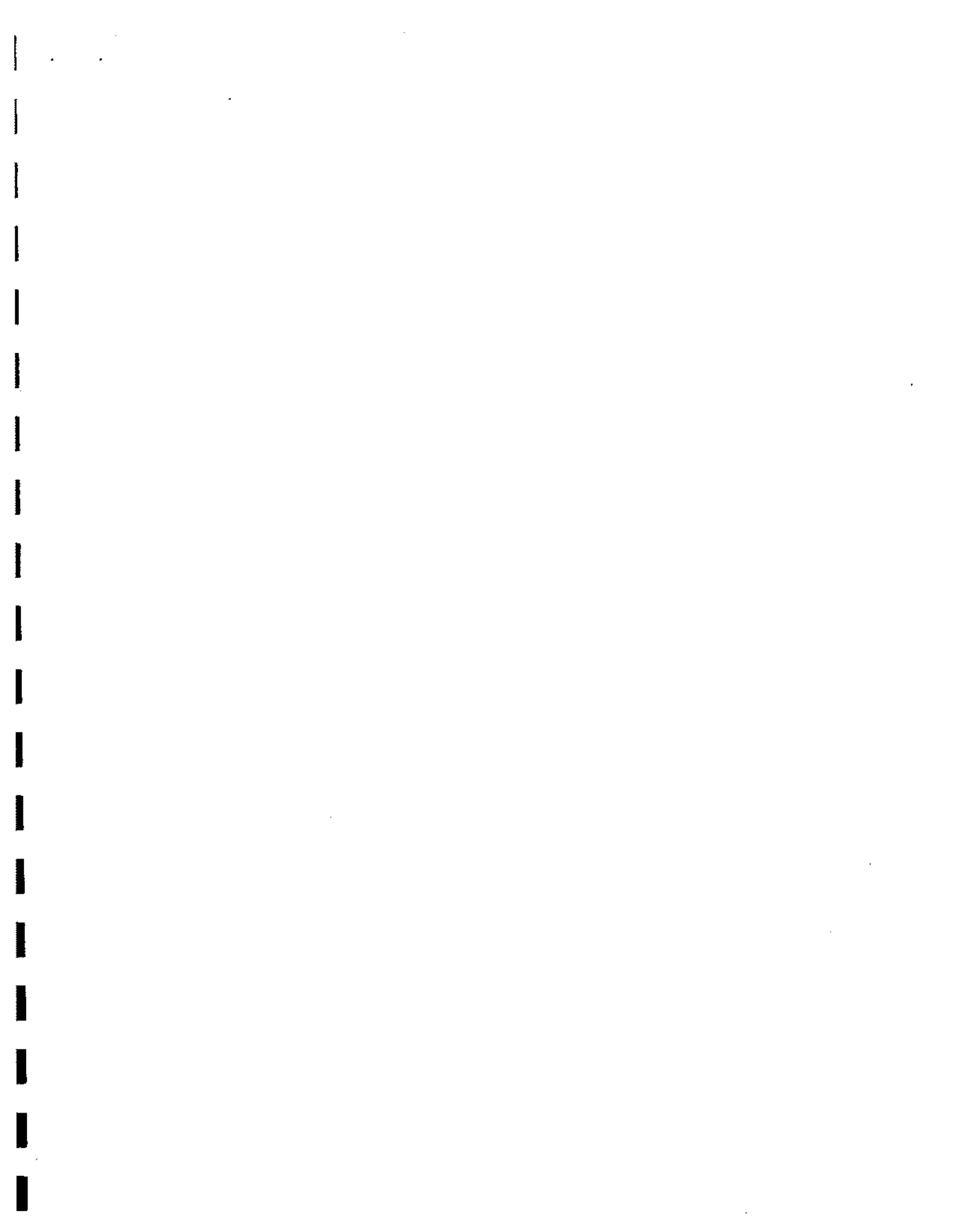
In my more recent trips to the FSU, although I have turned my attention to the conditions affecting Jewish children I have continued to evaluate the situation of the general community. For the elderly, nothing has changed since my earliest trips *with the exception of the assistance that is provided under the auspices of the JDC*. If this help were to disappear, the elderly Jewish population would again be left to face life without its barest necessities. Indeed, some few would starve; while many others would suffer from intermittent hunger and general food insecurity with attendant nutritional deficiencies. Without JDC's medical services, medical equipment and pharmacy programs many would undergo a worsening of their chronic and acute medical conditions. Without its home care and social services support the elderly would live in isolation desperately lacking support services and winter fuel and have no alternative sources of assistance. The JDC has achieved astonishing progress in improving the living conditions of elderly Jews in the FSU. Its efforts merit continued support and expansion to reach even greater numbers of those in need.

Sincerely,



Spencer Foreman, M.D.

SF/sf





Jewish Healthcare International

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January 2004

To Whom It May Concern:

Jewish Healthcare International (JHI) is a non-profit organization that works to enhance the quality of healthcare services provided to communities in need throughout the world, by sending volunteers to train local healthcare professionals. In the Former Soviet Union (FSU), JHI works at several sites based on the overwhelming needs of the Jewish communities there, particularly the needs of elderly Holocaust survivors. Many of JHI's programs are accomplished through a partnership with the American Jewish Joint Distribution Committee ("The Joint"). This partnership enhances and maximizes the work of both organizations.

In the FSU, the elderly are suffering. This is one of the few regions of the world where the life expectancy age is actually declining. This deteriorating state of health has two main causes: first, the overall quality of healthcare is quite low; second, and more significant, is that most citizens do not have sufficient access to the healthcare services that exist.

Due to the current economic and political situation in the FSU, governments are unable to provide sufficient funding to adequately support the public health system that, in theory, should provide free medical services to the entire population. Although free diagnostic and treatment services exist, access to these services is quite limited. In order to get adequate medical care, especially for more serious conditions, most find it necessary to pay for their healthcare needs. Many of the people within the Jewish community are living far below poverty standards, and are unable to pay for special medical care. They are completely reliant on the state's "free" medical services, and they are forced to wait, often indefinitely, because access to medical services is so limited.

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Jewish Healthcare International

Thousands of elderly Jews (mainly Holocaust survivors) at the sites included in this document are homebound due to health problems, an inability to manipulate stairs, extreme weather conditions, fear and lack of assistance. They often live in substandard apartments, plagued by lack of gas and electricity, frequent power failures, shared bathroom facilities and unresponsive landlords. They are lonely and often suffer from extreme depression. They are often malnourished and debilitated. Their medications are not taken properly, thus exacerbating their medical problems.

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Enclosed please find information about the Jewish community, the medical community and the overall state of healthcare services at six of JHI's sites in the Former Soviet Union. Each document includes a summary of the needs of the community, some of the services available, some of the medical institutions accessible to the Jewish community and comments from healthcare professionals who have participated in past JHI missions.

Sincerely,

Stephen Kutner M.D.,F.A.C.S.
Medical Director
Jewish Healthcare International

JEWISH HEALTHCARE INTERNATIONAL (JHI)

What is JHI?

Jewish Healthcare International (JHI) is a nonprofit organization supported by the Jewish Federations of Atlanta, Chicago, Greensboro, New York, Minneapolis, Pittsburgh and Tidewater; Israeli medical institutions with the support of American Jewish Joint Distribution Committee (JDC), The Jewish Agency (JAFI) and Israel's Health and Foreign Ministries; and other organizations, foundations and individuals.

What is the vision of JHI?

The vision of JHI is to be the central Jewish address for Israeli and North American healthcare professionals who wish to volunteer and provide medical or dental support to Jewish communities at risk in the former Soviet Union, Eastern Europe and other countries. In this way, we hope to foster closer ties between the Israeli, American, and host country medical communities while providing critical healthcare services to communities in need.

What is the mission of JHI?

Our mission is to enhance the healthcare services to Jewish communities in need throughout the world by utilizing teams of healthcare professional volunteers from Israel and the North America. We provide ongoing services by sending these teams to areas in need on a regular basis. In addition, JHI works to provide medical and pharmaceutical supplies needed to enhance the quality of medical and dental services offered.

How does JHI accomplish its mission?

JHI provides, through its volunteers, a variety of medical services and support to healthcare experts and on-site healthcare providers in five host country communities: Kiev, Ukraine; Kishinev, Moldova; Minsk, Belarus; Odessa, Ukraine; and Riga, Latvia. JHI participants teach medical techniques and procedures to local physicians, present lectures and seminars, and serve as consultants on numerous medical issues. All JHI teams include healthcare experts from the North America and Israel. In addition to building relationships with each other, mission participants meet and work with medical experts and leadership from the host community.

How do JHI missions work?

Each JHI mission is seven days long (plus travel). The program varies from community to community, however many of the activities are standard. Mission participants screen patients in consultation with local professionals on a one to one basis, they visit homebound patients and gain insight into the problems associated with the large numbers of homebound, and they lecture in seminars organized by our JHI coordinators. These seminars are attended by healthcare professionals from both the Jewish and secular communities and come from as far as two hundred miles away. Lectures may also be given in the local Medical and Nursing schools, local hospitals, and state Academies of Post-Graduate Education.

In addition to the medical component of the mission, participants visit the rich cultural and historic sites of the community and share with the community the Jewish renaissance taking

place in that area of the world. A JHI mission is an exciting professional and personal experience. Participants come back having helped to improve the quality of healthcare for the entire community and personally enriched by their experiences and by the people they met.

JHI Accomplishments

JHI was founded in July 1999, and over the past four years has sent close to 300 healthcare professionals (about half American, half Israeli), on 58 missions, to eight different sites in the Former Soviet Union. Mission participants have visited 198 homebound Jewish patients in their homes, and additional 1,560 individual patients received second opinion consultations. JHI mission participants have delivered 593 lectures, that have been attended by over 22,800 local healthcare professionals, who in turn, have provided a higher quality of care to hundreds of thousands of patients. JHI has donated over \$500,000 worth of medications and equipment. In addition, as a result of providing lectures and donations of medication and equipment, hundreds of Jewish patients have received free care at collaborating hospitals, and many more have benefited from priority access to an increasingly higher level of care at these institutions.

In addition to medical accomplishments, JHI has strengthened the bond between American and Israeli mission participants, breaking down stereotypes and building a core of Jewish healthcare professionals dedicated to Tikun Olam. Furthermore, mission participants return with a greater understanding of the worldwide and their own local Jewish communities and a greater commitment to the state of Israel.



Jewish Healthcare International

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Kiev, Ukraine

Kiev, the capital of Ukraine, is the largest city in the country. It is considered "the cradle of the Slavic civilization." About 70-100,000 Jews live in Kiev and 15,000 in periphery cities. Approximately 35% are elderly (over the age of 60). The population in the periphery is primarily elderly, and is more impoverished and at greater risk.

Pensions and other benefits range from \$4/month for post delivery women to about \$30/month for retirees. Even though medical care is supposed to be provided by the state, the care is inadequate and medicine is unavailable. The Jewish life expectancy is declining at a rate of 13:1, i.e., 13 Jews die for each one born.

Several Jewish organizations and programs are working to bridge the gap and provide services for elderly at-risk populations. The services listed below are provided to the Kiev Jewish community.

- The Kiev Jewish Welfare Center, Hesed Avot ("Hesed"), was founded in the early 1990s. It serves about 35,000 clients, 1,500 of whom are homebound. The Hesed programs cover three primary areas: food, social and cultural activities, and medical support. Hot meals are served to about 1500 clients each day at 10 soup kitchens and 7 restaurants. Meals on Wheels provide 650 kosher meals every week and food packages are delivered to 8,000 clients each month and to some four times each year to celebrate holidays. Warm Houses (social meetings in someone's home) also serve meals twice each week and provide comfort in a social atmosphere. There are about 400 social workers (home-care workers) that care for the 1,500 homebound clients. They receive training at the Institute for Communal Workers, which is run by the Joint. The workers are obligated to attend training sessions at the Institute four times a year. They develop skills related to activities of daily living and do not provide any medical treatment or have any medical responsibility or authority. A Hesed or regional district doctor occasionally is called in when the home-care worker has a medical concern. The medical needs and services necessary for the homebound are not adequately addressed with this system. No nursing services are available in this program.
- The Hesed medical program started five years ago and now has 35 volunteers for Kiev and 10 for the periphery. These multi-specialty volunteers serve about 17,000 clients in Kiev and 4,000 in the periphery. They work in a very small



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area with limited equipment; they are seniors and also receive a small stipend from the Hesed. Hesed volunteer doctors cannot provide direct services. They are able to refer clients for a second opinion to the hospitals affiliated with the Hesed. There is a waiting list for patients who need hospitalization. They fill prescriptions, free of charge, at the Hesed pharmacy but there is limited supply because of the Ukraine government's restrictions on overseas humanitarian donations. There is a small emergency fund available for extreme cases.

- A Hesed mobile van does some outreach that includes limited medical triage.

The Hesed serves as a liaison between the Jewish community and the local medical community. On a JHI site evaluation of Kiev in September 2001, a group of JHI healthcare professionals from the United States and Israel visited several medical sites in Kiev:

- Institute of Gerontology of Academy of Medical Sciences of the Ukraine: This facility has a Jewish director. The Institute has many units that primarily provide services for neurological and post-stroke patients. The facility seems to have equipment that is quite old; however, there was one area with more modern equipment. The Institute of Gerontology currently provides access and care to the Hesed. The Institute is very interested in a continuation of its excellent relationship through the introduction of teaching seminars, donation of equipment, and upgrading of different services.
- Hospital No. 8 and Medicom: Hospital No. 8, with 1100 beds and many different departments, is very old and has limited resources. The ophthalmology department does not provide inpatient service. It had very old equipment with limited services. Medicom is a private organization with space in Hospital No. 8. It has a contract with the Hesed to provide services to Hesed clients at a discounted price. Its professionals conduct home visits to demonstrate quality care practices for Hesed consultants and home-care workers. In Hospital No. 8, Medicom has 15 inpatient beds for surgery and gynecology, emergency care, ambulance services, neurological pediatric and general medicine. (The average length of stay for Medicom's patients is 5 days, whereas in community hospitals the average length of stay is 16 days.) Medicom will soon move to a larger facility that will provide 35 beds and additional services. In the new facility, Medicom is planning a new first stage ophthalmology unit for diagnostic examinations. Medicom seems very receptive to developing a collaboration with JHI for expansion of facilities and upgrading expertise.
- Hospital No.4: This is a very busy city hospital with over 600 beds covering the specialties of medicine, surgery, neurology, orthopedics, hepatology, gastroenterology, urology and infectious disease. There is also an intensive care unit for about 8 patients. The facility is about 10 years old with very, old



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equipment that is poorly maintained. We had an opportunity to visit the urology, medicine and surgery departments and intensive care departments. The medical, urological, and surgical procedures and equipment dated back 30 years and were supported by limited resources and expertise. The intensive care department had many recycled durable goods, syringes, and minimum support equipment. The hospital is very receptive to collaborating with us; however, the possibilities are very limited within the framework of its poor infrastructure. In addition, the Hesed and others in the Jewish community are reluctant to be admitted for care.

JHI mission participants who visited Kiev had the following comments about their visit:

"...about programming in Kiev...it is my opinion the focus needs to be on public health type programs designed to educate physicians and patients on health maintenance and disease prevention. Such areas as immunization practices, and nutrition would add to the care of Jews through the Hesed programs. The training of home workers on simple interventions and changes in food packages could further the health of the elderly. Focused educational sessions for certain physician groups would also be valuable as long as they were tailored to the limited technology available to these physicians."

Diagnosis and particularly pre-operational diagnosis suffers from a lack of appropriate diagnostic equipment.

Medicinal treatment in some of the eye diseases, especially glaucoma, is lacking because new expensive medicines are largely unavailable.

According to my estimation, the community is in need of 200 to 400 eye surgeries a year, mostly cataract extractions.

Kishinev, Moldova

Moldova is a small, densely populated country situated on the western rim of the Former Soviet Union. Although Moldova is endowed with rich agricultural land, and temperate climate, it is the poorest country in Europe. Moldova's Jewish population is estimated at 40,000: 25,000 live in the capital city of Kishinev, and 15,000 live in some 50 towns and villages. The elderly number 35% of the Jewish population in Kishinev, rising to 50-70% in some of the smaller towns and villages.

Pensions for the elderly are approximately \$35/month.

Several Jewish organizations and programs are working to bridge the gap and provide services for elderly at-risk populations. The services listed below are provided to the Kishinev Jewish community.



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- Opened in October 1995, the Hesed Yehuda Jewish Welfare Center ("Hesed") provides diverse assistance to the elderly and lonely, to the sick and disabled, and especially to fascist ghetto survivors and Holocaust survivors. Hesed provides hot meals at canteens to over 300 people per week, meeting their physical, social and emotional needs. An additional 200 bedridden and homebound clients receive hot meals at home from Meals-on-Wheels. Food packages are distributed once a month to 2,500 clients. Diabetics receive special packages composed of the corresponding assortment of food products. Hesed also provides for the medical needs of their clients. Forty highly qualified volunteer doctors of various specialties provide over 10,000 consultations annually both at the doctor's office in the Hesed and in the clients' homes. Over 400 homebound clients are visited regularly visits by homecare workers. Annually, about 400 clients borrow over 900 units of auxiliary rehabilitation equipment including wheelchairs, canes, walkers, crutches, bed sore prevention mattresses, special devices for bed-adjusting and bed-lifting, etc. The Hesed also provides its clients with discounted or free medications both at local pharmacies as well as the Hesed Pharmacy. Hesed on Wheels serves over 200 people in an outreach program aimed to provide distant periphery clients with the same range of services that are available in the central location.

In their effort to obtain care for members of the Jewish community, Hesed has relationships with several medical institutions. JHI is working with Hesed and the Moldovan Ministry of Health to enhance these relationships in order to provide better access for the Jewish community:

- Polyclinic #11 is a local polyclinic with a relatively low quality of care. It provides basic care for clients referred by Hesed
- The Republican Diagnostic Center has relatively good quality equipment, however, its staff is not always trained in the best use of the equipment. Hesed will pay for some tests for its clients at this facility.
- The Republican Hospital is a very large hospital with a professional staff, but relatively low quality of care. Hesed has a relationship with the hospital and refers clients there.
- City Hospital #3 has an ophthalmology department, to which Project Vision donated a laser in hopes of facilitating access for Hesed referrals. The hospital staff had difficulty maintaining the laser and the relationship produced minimal results.

JHI mission participants who visited Kishinev had the following comments about their visit:



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The equipment and solutions used in the nephrology and dialysis ward were old and outdated.

Moldova was at least 20-25 years behind on medical technology and medicines that were available to the people.

I made home visits to 2 women with bad arthritis. One was 84, had no living relatives, and had not left her small third floor apt in 4 years. Another woman was from Moscow, just celebrated her 50th wedding anniversary with her husband, had bad arthritis resulting from tuberculosis of the spine which she developed while in Moscow during the 2 years of German Seize in WW2, and had not left her 5th floor flat in 10 years. I could not believe that fact. But she was a vibrant intelligent woman and lives for each day. The average elderly aged pension is \$10 a week- the cost of living is \$60 to \$80 a week. Somehow these people survive.

The Hesed helps people get wood, coal, and gas for heating during the cold winters. In Moldova all medicines have to be bought so Hesed helps get medicines for the people. People have to pay for all lab and x-rays - with a 50% discount for the elderly and disabled. Thus people forgo medicines and doctor's visits just to survive on what little they have." They are 20 years behind in equipment and medical care.

Physicians get \$25 a month - they work 2 or 3 jobs to survive. I spoke to many physicians - they really are dedicated. They have 11 years of high school, then 6 years of med school and the equivalent in internship and residency and then to practice for \$25 when the cost of living is \$60 or more a month.

Minsk, Belarus

Belarus has a population of 10 million people. Minsk has two million residents, of whom 35,000 are Jews. More than 35% of Minsk's Jewish population is elderly. The country is divided into six regions. Each resident receives health services in the region in which s/he lives.

Belarus has a state-run health system; 90% of healthcare costs are supposed to be paid by the government. Due to budget deficits, only a limited number of diagnostic and treatment procedures can be performed, leaving many without adequate care. Serious health issues include the infant mortality rate (11 out of every 1000 infants), an increase in the number of thyroid cancer patients, due to the leak at Chernobyl (estimates are that two million people are suffering as a result of Chernobyl), cardiology problems, tuberculosis (54 out of every 100,000 have tuberculosis) and AIDS. In times of emergency, there is often a lack of medication and equipment such as ultrasound, MRI, etc. Lack of human resources also poses a challenge: for



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every 10,000 residents, there are six family doctors and 150 hospital beds. For every 30,000 people there is one cardiologist.

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Jewish organizations and programs are working to bridge the gap and provide services for elderly at-risk populations. The services listed below are provided to the Minsk Jewish community.

- Hesed Rachamim ("Hesed") has 60 paid employees, over 300 volunteers, a salaried doctor and a salaried pharmacist. There are 130 salaried home caregivers. The Hesed has 7,500 clients, 500 of whom are in outlying areas. 600 people receive help at home, 200 eat in canteens every day and 400 receive food at home. 4,000 people receive food packages. Hesed has 12 volunteer doctors: a cardiologist, neurologist, family doctor, urologist, ophthalmologist, surgeon, oncologist and others, all of whom give second opinions. Medications are expensive and Hesed's clients cannot purchase them without assistance. Hesed is in contact with two pharmacies, one private and one state-run. For those aged 70 and above, the State pays 50% of the medication costs, with Hesed paying the remaining 50%.

In the capital city of Minsk there are 10 hospitals, some are general and some focus on one particular specialty. The average hospitalization stay is 14 days as opposed to four days in Israel. Patients are required to travel great distances in order to obtain care at specialty hospitals, and then must stay there throughout the entire course of their treatment. This is both inefficient and expensive.

- Hospital #1 (Cardiology) has 850 beds. 400 catheterizations are performed each year, far fewer than those needed, and patients have to wait a number of months for the procedure. The State provides only 150 pacemakers per year, once again, far less than the need. JHI teaches at this hospital and Hesed clients receive immediate referral and treatment.
- The Oncology Department of the hospital has 430 beds, 150 doctors and 20 outpatient beds for chemotherapy. In the years following the Chernobyl leak, there was a dramatic increase in the number of thyroid cancer patients. This has stabilized over the last few years. There is virtually no involvement in prevention. A mammogram is performed only if there is an indication of cancer and after age 40. There is no hospice for cancer patients. JHI teaches at this hospital and Hesed clients receive immediate referral and treatment.
- Hospital #9 (Neurology) was founded in 1967; it has 1,250 beds, serves 30,000 patients annually and performs 11,000 operations per year. It has an annual budget of \$15 million. JHI teaches at this hospital and Hesed clients receive immediate referral and treatment.
- Hospital #2 has 600 beds and departments for oncology, cardiology, urology, hematology, pulmonary diseases, gastroenterology and geriatrics. Hesed has



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contact with Hospital #2, which has 30 beds in its Geriatric Department. Hesed pays for 12 of these beds (The cost of one day's hospitalization is \$3 per person). The waiting list for this department is one to two weeks. Two volunteers from Hesed come to the department to help. Hesed assisted the department in purchasing a wheelchair, sheets and other equipment. JHI teaches at this hospital and Hesed clients receive immediate referral and treatment.

- The SUDGHOK Center was established with the help of doctors from Seoul, South Korea and is involved in alternative medicine. 107 patients were treated at the Center in 1995-96. There is an agreement between the Center and Hesed, whereby 50 patients from Hesed were treated at the Center. 100 volunteers from Hesed received instruction at the Center.

JHI mission participants who visited Minsk had the following comments about their visit:

"Interaction with Hesed, its administration, volunteers, physicians and others was very productive, and included Minsk as well as Vitebsk. I believe that the mere fact of our presence and desire to come and share our knowledge and care for the patients is a tremendous positive influence on the life of the Jewish community, and Hesed in particular. Further development of this relationship and maintaining contacts not only during the missions themselves, but also in general will be critical."

"We visited an elderly Jewish woman bed-ridden with breast cancer. She was the lone survivor of her family and was solely nurtured and supported by the Hesed homecare program."

"Minsk is a poor city where people frequently live on \$50 per month. A high priority for the people is clothes and for the most part they appeared well dressed. With the exception of the Jewish people who we came in contact with, the people appeared depressed with little response to our questions and little curiosity. In Belarus, the cost of medication is great, and surgical correction of medical problems was preferred to medical treatment."

"A patient must pay for instruments (such as urinary catheter) before he or she will be treated. There are lithotriptors in Belarus, but not enough to handle the amount of stone disease in the country."

"The apartments where the local people live are varied. I visited some that were very run down, in buildings that were built right after WWII. They don't use electricity during the day because it costs too much so the hallways and stairwells were pitch dark. The sun never shown the whole time we were there, which made it



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even harder to see in some of the buildings. We met one woman who lives in a one-room apartment with her husband and 3 children. The parents sleep on the floor and the kids on cots. We also noticed that people wear the same clothes for days at a time.”

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Odessa, Ukraine

Odessa is located on the Black Sea, on the southern coast of the Ukraine. The Jewish population is approximately 43,000, or 3.5% of the city's population. The region includes smaller centers of Jewish population, with an estimated additional population of 39,000. Elderly make up 35% of the Jewish population.

Both pensions and salaries are very low. Medical care is no longer free, and the elderly often have to choose between paying for medication or heating fuel.

Several Jewish organizations and programs are working to bridge the gap and provide services for elderly at-risk populations. The services listed below are provided to the Odessa Jewish community:

- Gmilus Hesed (“Hesed”), a welfare organization established in 1994, cares for over 10,000 elderly, needy Jews. In addition to a wide variety of social services, Hesed operates a “primary care” clinic in a small space with little equipment. Volunteer physicians and medical personnel staff the clinic. They suffer from a lack of training and physical resources, such as medications, durable goods and basic tools for consultation work on site. Hesed also runs Help Pharmacy. Hesed tries to supply drugs to the most needy clients and discounts to those who have some means to pay. Quality and quantity of medications are both significant issues.
- Migdal Community Center is supported by the Hesed and houses a variety of activities for all ages. It serves as a point of entry into the Jewish community and often a referral agency for those in need.

In their effort to obtain care for members of the Jewish community, Hesed has relationships with several medical institutions:

- The Municipal Dental Clinic provides different standards of care for patients depending on their status: private pay vs. free care. Hesed clients often receive free or discounted care.
- Disabled Veterans Hospital regularly accepts Hesed clients in exchange for medicine and equipment donations. Hesed has a contact to provide Meals-On-Wheels to this hospital. The quality of care is low but the food is good.



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- Filatov Ophthalmology Center received a laser donation from JHI and regularly accepts clients for both surgery and treatment. The Center has a good reputation, however the facility is crowded and in need of repair.
- The Municipal Cardiology Center is in the process of developing a relationship with Hesed and JHI, similar to that established at the Filatov Ophthalmology Center. The Cardiology Center presently accepts Hesed clients on a regular basis, but this enhanced relationship will provide for a higher level of care.

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JHI mission participants who visited Odessa had the following comments about their visit:

"I worked with a doctor in a single chair office in the remote polyclinic where he sees Jewish patients referred to him by Hesed. His office is missing basic setups, x-ray machine, evacuation/ suction system, sterilization materials and equipment. There are no assistants and the doctor has to do paperwork and preparation himself that make treatment complicated and inefficient.

I did not see curettes or other instruments for calculus removal, no patient education materials. I observed dental treatment but did not see once that a doctor would give oral hygiene instructions to the patients.

The visit (to two geriatric psychiatry wards) helped to confirm the very distressing state of psychiatric hospitalization for these patients. The separate pavilions for the men and women were in desperate physical condition. The individual rooms were overcrowded, with no "private space" but even more basically, the facilities were not heated, patients in bed (in the middle of the afternoon) were covered with threadbare blankets, other patients were poorly dressed and many complained of hunger. The staff appeared completely overwhelmed and unable to manage the patients and their needs.

The home visits we made demonstrated the desperate plight many of the Jews in Odessa and a brief glimpse at the wonderful work being accomplished by the Hesed program and its dedicated workers. In the far room of the apartment the daughter, 54 years old, with severe mental retardation, sits on the corner of a plastic covered mattress surrounded by pieces of paper that she tears up as her only form of activity. At the entrance to the room there is a covered area that serves as the woman's toilet. According to the mother the daughter was well until age 12 and then, for the next 12 years she was in an institution. At age 24 she was taken home and she has lived with her mother ever since. The mother has rejected all suggestions to re-institutionalize her daughter – basically noting, "She is all I have". The home care worker is scheduled to care for the daughter three times a week, involving showering and other personal care, but noted that she is available as needed. In addition, Hesed services provide food and additional direct assistance. Here too we



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saw another example of the vital, life saving involvement of the Hesed caregivers and service provision.

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Riga, Latvia

Historically, Riga was a center for Jewish thought and culture. This is due in part to the unique geography of the region, with the Baltic States, and Riga in particular, serving as a bridge between Russia and Europe. During World War II and the German occupation, nearly the entire Jewish population of Riga (approximately 50,000 to 100,000) was exterminated. Furthermore, during the Soviet era, a decline in Jewish identity was imposed and most Jewish institutions were closed.

Since gaining independence from the Soviet Union in 1991, there has been a resurgence of Jewish community in Riga. Community life was revived, the first Jewish school in the former Soviet Union was established, and the Jewish hospital was reinstated to the community. However, due to economic hardship in the entire region, the turbulent transition from the previous Soviet regime, and demographics, there are enormous obstacles that impede this rebirth of the Jewish community. Moreover, the small Jewish community that remains is for the most part elderly without family or family support systems.

There are some 30,000 Jews living today in the Baltic republics, the majority of whom live in Riga. Approximately 50% of the Jewish community is elderly.

Several. The services listed below are provided to the Riga Jewish community:

- Wizo Rachamim, the local Jewish Social Welfare organization, distributes 2000 food packages a month. About 100 people receive "Meals on Wheels," and about 100 people eat at canteens. There are two family physicians who work at Wizo Rachamim four times a week, primarily offering second opinion consultations. Wizo Rahamim pays them a stipend. If there is a need for a specialist, they get assistance from the Jewish hospital. Services offered are blood pressure monitoring, ECG and stethoscope checks etc. There is a pharmacy operating on premises that distributes medications (most are purchased in Riga.)
- Riga has a Jewish hospital, the only one of its kind in Europe. It was established in 1924. In 1940, when Russia conquered Riga, the hospital was nationalized. After the war the hospital served as a Government hospital until 1992. After independence, the Jewish community requested that the hospital be returned to them. On September 1, 1992, the hospital was reopened as a Bikur Holim Jewish Hospital. Bikur Holim has 200 beds. It is made up of the following departments: internal medicine (50 beds), intensive care (6 beds), surgery (30 beds), cardiology, hospice, outpatient clinic, diagnostic center, clinical laboratory,

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radiology and dentistry. They have recently received a CT machine. Since this is a Jewish hospital, it offers other services as well: 25 people arrive every day to receive a hot meal in the hospital's kitchen. The hospital will treat a Jewish person even if he cannot pay for the treatment. It seems that the local Jews and other minorities prefer to be treated at Bikur Holim because they often feel discriminated against at other hospitals. The hospital employs 27 Jewish doctors out of the 45 doctors working there (60%). The government covers 55% of the hospital budget. The rest (45%) comes from the patients themselves. The hospital needs new technologies in the field of medicine, training in these technologies, and medications. The hospital enjoys relationships with other hospitals in Riga and JHI volunteers often represent Bikur Holim at seminars and training events.

JHI mission participants who visited Riga had the following comments about their visit:

"There are essentially two resources for eye care in Riga---the city hospital system, and private care. The city hospitals are government-sponsored facilities (10 in all) offering most standard medical and surgical services. Only two of the facilities offer ophthalmology. I had the opportunity to visit one of the centers (Hospital #7). There is also a "private practice" sector for ophthalmology care in Riga. This sector appears to be where the best technology and delivery of eye care is available but few people have access to this resource due to their financial status. I did not have the opportunity to visit with any of the private ophthalmologists. There is a medical school in Riga with an ophthalmology residency. Based on my meeting with two recent graduates, the residents appear to be well trained. However, they cannot find jobs upon graduation and, when they find employment, they are in situations in which they must work with sub-standard equipment and inadequate facilities."

"There were many of the problems that I have seen in the former Soviet Union, some of which were mitigated by Latvian circumstances. Many of the elderly Jewish people were caught by the transition from the Soviet to the free market system. They live in isolation, far from the city center. Their pensions barely cover rent and food. Medications that had previously been a benefit under the Soviet system are no longer covered and many people can no longer afford them. Cheap medications that were previously imported from the Soviet Union are no longer available and have been replaced by more expensive western medications.

The overcrowding of the rooms (in the hospice) makes it easy to transmit infection from one bed to another. There is also no privacy in the rooms, so whatever personal care is given, is easily viewed by the 5 other roommates.



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The most dismal aspect of the environment is the odor of the ward. This is due to lack of ventilation in the hospital combined with the urine-soaked, cloth-covered mattresses that act as a sponge for the patient. While the staff tried to improve conditions with opening windows in the hallways, Baltic winters do not allow this form of ventilation in the separate wards. There was a general feeling of hopelessness in the faces of the patients. There were no diversions to break up their days; the staff were too harried to spend time with the patients. Except for a few exceptions, the majority of the patients appeared waiting to die."

St. Petersburg, Russia

Approximately 100,000 Jews live in St. Petersburg, one third of whom are over the age of 65. The social security benefits received by this population are very low; the average pension per person is approximately \$40.00 per month. Patients have to pay for treatment and medications themselves. The situation is made worse by the fact that the price of medicines is as high as in Western countries. Life expectancy rates are in constant decline. Moreover, the social services, which had been provided by the state during the communist era, are no longer available.

Several Jewish organizations and programs are working to bridge the gap and provide services for elderly at-risk populations. The services listed below are provided to the St. Petersburg Jewish community.

- The Hesed in St. Petersburg, Hesed Abraham ("Hesed"), was founded in 1993. It has approximately 42,000 clients. There are a large number of homebound. Almost all of the elderly Jews receive assistance from the Hesed. Hesed programs cover a wide spectrum of people, needs, services and issues, such as health, education, support, nutrition, etc. 1185 people receive a hot meal every day at Hesed's local canteen; 661 enjoy 'hot meals on wheels,' which they receive in their homes. The Hesed also supplies food packages. 1525 people receive assistance from a home care worker in their homes. The Hesed supplies many useful medical and non-medical appliances such as: wheelchairs, walking aids, hearing aids (approx. 600/year), glasses (over 3000/year), warm winter clothing (donated to 5000 people/year). Hesed also supplies medication to 5000 people each year and medical consultation to 3000 people each year. In addition, the Hesed runs a social and cultural club that offers concerts, "Kabalat Shabbat" on Friday evenings and Hebrew and English lessons. Hesed also has a day center for the elderly that accommodates people from 10 different areas of town, providing meals, exercise, social, and cultural programs.
- The Hesed Medical Program tries to bridge the gap between the services promised by National Insurance and those actually provided. Hesed has 50 volunteer doctors from 17 different specialties. Hesed's primary medical



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services focus on consultation and referral; however, it does own and operate an EKG machine and a small, poorly equipped ophthalmologic room. (In the last year over 1200 people have been screened) In the last year, as many as 400 people received medical consultation in Hesed. Moreover, 500 people received medical consultations in their homes and 1200 received first-aid.

- William Rosenwald Institute for Communal and Welfare Workers was founded by the Joint in 1994 and serves as the center for the development and training of welfare workers from across the FSU. To date, they have trained over 4000 welfare workers, Hesed managers, volunteers, community leaders and others. The Institute has advanced learning facilities, publishes on many topics and is involved in research. It has branches in Kiev, Minsk, Odessa, Kishinev, Dnepropetrovsk and Krasnoirsk.

According to an official of Social and Health Matters, the city has severe problems in the areas of drug abuse and serving a large, rapidly aging population. There is a great need for more geriatric hospitals. On a JHI site evaluation of St. Petersburg in July 2001, a group of JHI healthcare professionals from the United States and Israel visited several medical sites in St. Petersburg:

- The Medical Academy of Postgraduate Studies (MAPS) has a hospital with 200 beds and the following departments: cardiology, internal medicine, intensive care, operating rooms, catheterization rooms and more. The patients are hospitalized for an average of 5-7 days. The conditions and equipment in the building are on a reasonably high level. The Academy has a floor with lecture rooms; there is one lecture room with 80 seats and a large hall that can seat 300 people. They also have facilities for tele-conferencing.
- The "Fyodorov" Ophthalmology Clinic is a private clinic with 300 workers, including 35 medical doctors. The clinic is for elective procedures and is clean and impressive. Emergency and trauma cases are not treated here. It has 5 departments: three surgical, one laser, and one diagnostic. Most diagnoses are for cataracts and glaucoma. 120 people are operated on every day in their 5 operating rooms. The patients stay in the clinic for two nights: the night before and following the operation.
- Hospital #20 is spread out over a number of locations, and has 360 beds. It has eight operating rooms and one emergency unit with six beds. Its areas of specialty include: surgery, neurology, neuro-surgery, internal medicine, cardiology, gastroenterology and ENT. There is also a hospice under construction. The external clinic serves approximately 45,000 clients. A general practitioner has an average caseload of approximately 2500 patients. 7500 victims of Chernobyl have been treated here and are examined routinely. The hospital has 750 staff members, including 120 doctors. Half of the hospital's



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budget comes from insurance companies and the city provides the other half. The patients do not pay for treatment. The average hospitalization period is 11.4 days. The hospital has ties with different countries; for example, the ENT is in contact with a French organization.

- Hospital #2 has 1500 beds and six main areas of care: neuro-surgery, ophthalmology (300), cardio-surgery, back and spine, plastics and pulmonology. It has 32 operating rooms, which seem to be well equipped, clean and sterile. The hospital provides trauma and emergency care. However, the German equipment is old and there is no budget to replace it. It also has professional ties with Germany and the USA (through an organization called 'Heart to Heart'). During our visit there were only 1000 patients in the hospital, in contrast to the usual number of between 1400 to 1500 patients. This relatively low number was due to summer vacation. This hospital is considered as one of the best in the city and has been operating for 6 years.

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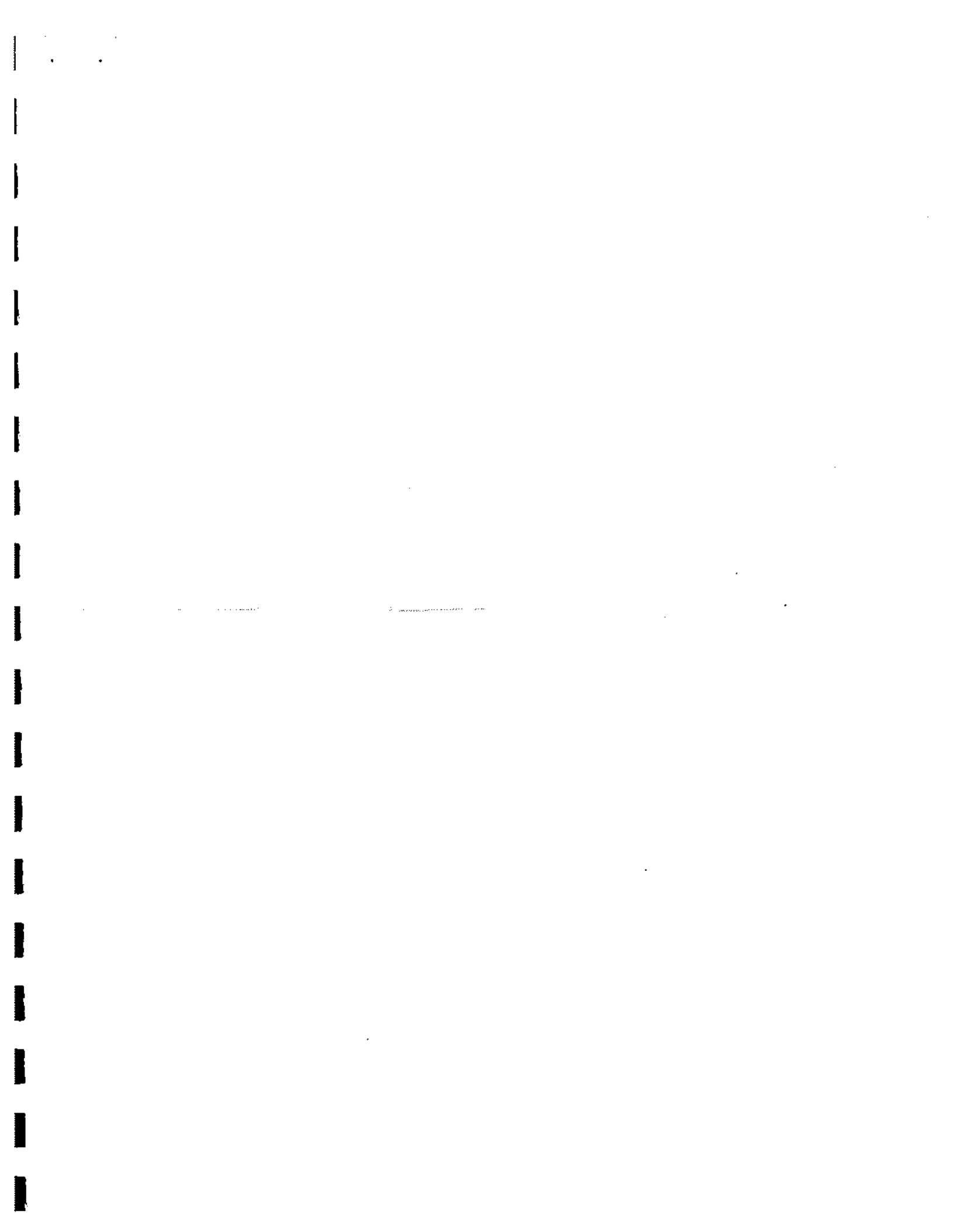
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International Jewish Healthcare Organization

Medical Status Report

From reports from JDC offices in the FSU:

Currently, the part of the elderly among the Jewish population of the region is estimated from 35% to 40%. It is predicted that by 2015 the number of elderly will grow by 3.5%. The ratio of elderly to children and teenagers will be 3 to 1 (three times more elderly). The high level of illness and death among the able-bodied population does not only reduce the labor forces but also will result in the growing number of widows, orphans, single-parent families and lonely elderly.

The Ural region (where Yekaterinburg, Russia is located) is considered to be one of the most ecologically damaged regions. The level of air and water pollution is one of the highest in Russia. The high concentration of harmful industries in the region has led to a high sickness rate among all age groups. As a result, people become Hesed (welfare) clients at an earlier age.

Free provisions in medical institutions are basically no longer available. Those who need hospitalization must supply medicine, supplies, linen and food. Prices for medicine are constantly growing; medicine is a considerable part of the monthly expenses for elderly. The demand for social services far exceeds the current governmental capacities to provide the elderly with such services.

Most elderly rely solely on pensions to support themselves.

Minimum pension:	\$24.20
Monthly average pension:	\$41.50
Monthly average salary:	\$128.00

Most of IJHO's missions go to people in the periphery. In the Ural region, this is one of the priorities for the JDC Ural office. Living conditions are much worse in these areas. There are no basic conveniences. Running water and sewage are non-existent. Homes generally lack central heating. They are heated with coal or wood on the kitchen stoves. Coal and wood are scarce and expensive. Salaries are delayed for months. Pensions are lower than in the big cities. Supplies of food and medicine are conducted with difficulties. Most of the young and able-bodied people move to the big cities, often leaving the elderly without any support.

From IJHO Missions:

Some of the major medical problems found among the elderly in Yekaterinburg, Russia during a site evaluation in October 2002 were: diabetes, hip fractures, strokes, post-coronary, oncology, blindness, arthritis, Parkinson's, and Alzheimer's. The homecare workers requested help in

traumatology (complications after hip fractures, skin sores) and rehabilitation methods from the "west." The major causes of deaths reported during a site evaluation to Belarus are due to heart disease and cancer.

Most hospitals are lacking sufficient medical equipment. On many of our trips, the comments heard from the doctors are "I have more medication in my medical cabinet at home than there is in this entire hospital!" Prof. Mervyn Gotsman, former chief of cardiology at Hadassah Medical Hospital in Jerusalem, following his visit to Belarus in May 2003, reported, "The staff lacks modern drugs and equipment, and the patient monitors are switched off in the ICU. The units were donated and there are no spare parts to replace the worn out television screens. There are ten basic drugs in the drug cupboard." In an interview with Gotsman from the Jerusalem Post, from September 2003, he says, "The level of cardiology in the local hospitals is from the 1970 era.... Many departments have a pitiful lack of up-to-date equipment."

There is often only one computer with very slow Internet access to updated knowledge in a hospital. Gotsman continues to report, "A cardiologist I met in Vitebsk had a computer with Internet facilities, so he could get some medical information. But the number of hours he's allowed to use it is very limited. A partial Iron Curtain still exists in Belarus, so the population is content and doesn't make excessive demands on the strained services."

During this mission, Dr. Vadim Pikovsky, an Israeli dentist from the Ministry of Health, shares, "Almost 100% of medical health serviced in Belarus is provided by governmental health care system and financed from governmental budget, which is limited enough. This fact influences the level of medical equipment, assortment and amount of medicines in hospitals and polyclinics. Medical staff in health care system is not exposed to international medical literature. Reasons for this: low awareness for this, lacking English and low budget. Some of the medical equipment is not modern and some of the treatment is not based on evidence-based medicine."

Dr. Eli Kooby, a dentist from Israel's Ministry of Health, following his visit to Belarus in May 2003, reports, "Money can buy better [dental] equipment, materials and range of treatments. [A main issue] which need[s] our attention are the elderly population, which in the present situation might have both problems of affordability and accessibility of services." He continues, "The materials used for fillings and the way of application are not in the standards of modern dentistry. This could result in high rate of secondary caries and deterioration of the treatments."

During a mission to Yekaterinburg in May 2003, we sent two geriatricians and a nurse specialized in geriatrics. They lectured on:

- Depression in elderly
- Acute stroke
- Treatment of Parkinson's Disease
- General introduction to geriatric medicine
- Organization of care for the elderly in hospitals

- Rehabilitation of the frail elderly
- Dementia peculiarities

The geriatric field in Yekaterinburg has only recently begun to develop. The locals lack finances to open a geriatric hospital; so the geriatric departments have been opened in the psychiatric hospitals. Gila Hershcowitz, a geriatric nurse from Israel explained how, due to this situation, an elderly person who breaks her hip would end up in a psychiatric ward. She will then slowly debilitate both physically and mentally (amongst the psychiatric patients) to the end of her days.

During IJHO's missions, the medical professionals visit pharmacies, homes, hospitals, and the Jewish community. The impressions in this report are from those who have visited the FSU during these missions.

INTERNATIONAL JEWISH HEALTHCARE ORGANIZATION

2002 - 2003

IJHO (International Jewish Healthcare Organization) is an exclusive and innovative non-profit Jewish organization of medical professionals from Israel and the Diaspora who jointly volunteer to aid people around the world.

Why:

Help upgrade the quality of medical services given to the needy Jewish and non-Jewish communities and health services around the world particularly throughout the former Soviet Union and Eastern Europe.

Create a platform to facilitate dialogue and the development of professional and personal ties between Jewish professionals from Israel and the Diaspora.

Strengthen and enhance ties between Israel and Jewish communities around the world.

How do we work:

Joint delegations including Jewish volunteers health care professionals from Israel and the Diaspora visit various cities throughout the former Soviet Union and Eastern Europe.

Prior to the departure of each delegation, the volunteering teams meet in Israel for a two-day interactive preparation, team building and integration workshop.

What do we do:

Each delegation stays on site for seven days to:

- Give seminars and lectures to local Jews and non-Jews health care professionals and paraprofessionals (physicians, nurses, home caregivers).
- Run training sessions on medical techniques in order to enhance and upgrade the level of medical care.
- Provide basic medicine and medical equipment as requested.
- Offer an additional medical opinion to local patients.

The overriding value of the fieldwork is that medical professionals and local healthcare providers experience a Jewish reunion and a return to their roots while strengthening global Jewish ties and their appreciation for heritage and tradition.

Partners:

- **Israel:** JDC, the Ministry of Foreign Affairs, the Ministry of Health, Hadassah, General Health Services.
- **Diaspora:** Hadassah International, Australian Jewish Medical Aid Abroad, The British Chapter, World Jewish Relief, UKJAID.
- **Partners Underway:** Jewish health organizations in France, England, Canada and Jewish Federations in the USA.

Organizational structure:

- Heading the project in Israel is Mr. Gaby Blauer.
- The medical director in Israel is Dr. Shimon Scharf.

Status Report:

Since August 1999:

- 60 medical personnel from Israel and 60 from the Diaspora have participated in 27 separate delegations which included:
11 delegations to Odessa (Ukraine), 9 delegations to Kishinev (Moldava),
4 delegations to Minsk (Belorussia), 2 delegations to Riga (Latvia), and one delegation to Sofia (Bulgaria)

Assessment surveys were conducted in Bucharest (Romania), St. Petersburg (Russia), and Kiev (Ukraine).

The medical professionals who took part in the various delegations came from a wide range of medical specialties, amongst them: Geriatrics, Cardiology, Oncology, Urology, Nephrology, Neurology, Pediatrics, Gynecology, Psychiatry, Family Medicine, Gastroenterology, Internal Medicine, Ent, Ophthalmology, Dentistry, Occupational therapy, Medical and Nursing Administration, Rehabilitation, Community Nursing and Hospice care.

Activity planned for 2002 – 2003:

Simultaneous departure are scheduled every spring (May) and autumn (October) to the following locations:

Yekaterinburg (Russia)

Sofia (Bulgaria)

Minsk and its periphery (Belarus)

- By request of the Ministry of Foreign Affairs, emergency delegations will leave on behalf of IJHO to help crisis situations throughout the world.
- The possibility of extending the project to additional cities will be examined.
- The possibility of including professionals such as social workers, community center directors, school principals, directors of institutions and educators is being considered.

Quotes from previous participates on the project

“The trip was an unforgettable personal experience...it achieved all the expected goals...” – Prof. M.S. Gotsman, Israel

“I have felt more Jewish during the week in Odessa than in all my life in israel” – Dr. Vadim Pikovsky, Israel

“The mission proved to be a moving experience and I felt it gave more to me than I gave to it...” - Prof. Frederick Ehrlich, Australia

“The orientation in Israel was great. It had a good mix of lectures and social events and was useful to get a better idea of the goals of the project” – Dr. Burton Appel, USA

Interested to participate in one of the scheduled delegations?

We are looking forward to enlarging our data base of volunteer Jewish health care professionals from Israel and the Diaspora who are interested in participating in one of our missions.

If you are interested, please send us your CV and we will contact you according to the requests we receive from the field.

Please feel free to contact us on any relevant issue regarding the project.

How to contact us?

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January 4, 2004 Sunday

SECTION: MAIN; BRIEF; Pg. 1A

LENGTH: 1332 words

HEADLINE: Local Jews aid peers in former U.S.S.R.

BYLINE: BY RICK LINSK; Pioneer Press

BODY:

EDITORS NOTE:Reporter Rick Linsk traveled to Ukraine and Israel in November as a member of the Twin Cities Harry Kay Leadership Institute. The institute is a joint project of the United Jewish Fund and Council of St. Paul and the Minneapolis Jewish Federation.

KOROSTYSHEV, Ukraine -- Bella Guler was 16 when the Nazis rolled into her hometown in Ukraine. She was also a Jew, which made her a target of the German killing machine.

The Germans were so close at one point, Guler had to jump out a window to elude them. She made it to a railway station and lay face down while German bombs rained down all around her. She fled hundreds of miles east by train to Kazakhstan, nearly starving to death while waiting out World War II. After the war, she came back to this village west of Kiev.

Today, at age 78, Guler is one of a dwindling number of Jews in Korostyshev. Aged, frail and poor, they are completely dependent on social-service agencies. Those agencies are largely funded by charitable donations from Jews in North America, including the Twin Cities.

"She doesn't know what she would do without you," a translator told a delegation that visited recently from the St. Paul and Minneapolis Jewish communities.

The Soviet Union's demise in 1991 was a victory for religious freedom generally and especially for Jews. Newly independent Ukraine and other former Soviet republics have been host to a rebirth of Judaism among young people. But for many, freedom came at a price: economies left in disarray, and pensions unable to cover rising prices. Hundreds of thousands of elderly people in the former superpower were left suddenly destitute.

The long-suffering Jewish population, however, had a friend overseas: the far-flung American Jewish **Joint Distribution Committee**. Acting on a central principle -- "All Jews are responsible for one another" -- the **JDC** is sustaining the needy while simultaneously laying the foundation to rebuild Jewish communities across the former Soviet Union.

"We definitely feel a responsibility not to leave these people in the last years of their lives, but to support them and help them live in dignity," said Amos Lev-Ran, the **JDC's** missions director in the former Soviet Union.

A VAST MISSION

It is a cold, raw day in early November as the Twin Cities group steps off a tour bus in Korostyshev, about 50 miles west of the far more cosmopolitan Kiev, and only an hour's drive from the site of the 1986 Chernobyl nuclear disaster.

Some of the houses look like tumbledown shacks, with outhouses and tin roofs. It is a bleak place, seemingly frozen in the past.

The brief visit here is part of a four-day itinerary in Ukraine, followed by six days in Israel. The trip was sponsored by the Minneapolis Jewish Federation and the United Jewish Fund and Council of St. Paul. Two dozen community leaders are here to witness the impact of the charitable contributions they raise at home.

In Ukraine, the group primarily sees the work of the **JDC**, the venerable refugee relief agency that has evolved into a provider of social programs and a catalyst for Jewish cultural and religious renewal. The organization is active in many little-known corners of the globe, but its mission in the former Soviet Union is arguably the most challenging. An estimated 450,000 elderly Jews still live in the former Soviet Union, many of them spread out over vast distances.

The **JDC's** services reach more than 2,780 cities, towns and villages across 11 time zones, channeled mainly through welfare centers known as **Heseds**, after the Hebrew word for kindness. In 2002, the **Heseds** provided more than 3 million hot meals in communal dining rooms, delivered 3.4 million "meals on wheels" and distributed 1.5 million food packages.

SURVIVAL AND TEARS

Jews have lived in Ukraine for centuries. By 1939, one census estimated their numbers at more than 1.5 million. In the 19th century, communities like Korostyshev were chronicled by Yiddish writer Sholom Aleichem in the tales that would someday be turned into "Fiddler on the Roof."

This long history, however, is scarred by a tradition of anti-Semitism, including massacres. A particular low point was the Germans' slaughter of 33,000 Jews over two days in 1941 at Babi Yar, near Kiev.

Life in newly independent Ukraine is not free of tension, but is undoubtedly more bearable.

Since 1996, the Jews of Korostyshev have been sustained by the **Hesed** center in nearby Zhitomir. Sofia Zaytceva, the facility's director, explains there were once 10,000 Jews here, nearly half the total population. There was a Jewish school, eight synagogues and a collective farm.

Today, the town has just 10,000 residents. Only 66, spread out through the town, are Jews.

The Minnesota visitors split into smaller groups to go see them, accompanied by **Hesed** staff, Jewish college students who also are helping as translators, and the **JDC's** Lev-Ran.

By the rickety door of her one-room hovel, one group of seven meets Bella Guler.

Guler, who is blind, greets them with a firm, warm handshake. Come in, come in, she says in Russian. The visitors, some of whom can trace their roots to this region, arrange themselves on chairs. Guler sits on her bed, which doubles as a couch. Her hair is gray and wispy, her face lined and sad.

She leans on a cane and answers questions. First, it is polite conversation. She still celebrates the Jewish holidays, she says. Yom Kippur, yes. The Sabbath -- yes, yes.

Then, her voice rising, she recalls the catastrophe of World War II. The words tumble out, almost too fast for the translator.

Before she fled the Nazis, she lived in her birthplace of Baranovka, a small town in this region. In 1943, while she was in Kazakhstan, her father was killed in the war. She came to Korostyshev after the war, because her mother's sister was living here.

The same year, in 1945, she met her husband, Boris Krupnik, who had lost a leg in the war. He repaired roofs, and Guler worked as a cashier. Boris died 20 years ago.

Their son and his wife, both ill, live in Kiev. Guler has no grandchildren.

"She doesn't remember anything good from her life," the translator said.

Life after the breakup of the former Soviet Union has been hard for many older people, regardless of ethnic or religious background. But Jews like Guler suffered additionally because of the destruction and erosion of their community, and the lack of extended family. On the other hand, as someone persecuted by the Germans during the war, she does get a pension of \$26 per month. Otherwise her support is from the money raised by Jews in North America.

Guler's home has no running water. The walls are cracked and peeling. But the **Hesed** does enough repairs to keep it livable, and it is surprisingly warm inside.

The **Hesed** also meets Guler's medical and clothing needs. The welfare center picks up many of the elderly here and takes them to Zhitomir once a week for a bath and hot meal, but Guler is mostly homebound.

Guler once had a chance to join her 80-year-old brother, who lives in Israel, but she was ill and unable to go. She has diabetes, heart troubles and other ailments. Now, she said, it is too late to leave. She will pass the years with her helpers here, and with the occasional visitors who come from America.

All too soon, it is time for those visitors to leave. Lingering, they share hugs and tears with the old woman. "Spah-SEE-bah," she says. "Spahseebah. Spahseebah." Thank you. Thank you. Thank you. Afterward, back on their bus, the Twin Cities visitors said they would never forget the encounters.

Weeks later, the memories remained vivid. Amy R. Weiss, director of communications for the Minnesota AIDS Project and one of those who visited Bella Guler, could still feel the freshly established bond. "Even now, when I close my eyes, I can feel the surprising warmth of her home and feel her hand grasping mine when we hugged goodbye."

Rick Linsk can be reached at 651-228-5371.

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The Jerusalem Post

October 17, 2003, Friday

SECTION: FEATURES; Pg. 26

LENGTH: 2174 words

HEADLINE: Acts of kindness

BYLINE: Melissa Radler

HIGHLIGHT:

Hesed organizations and volunteers in the FSU are making life easier for poverty-stricken Jewish seniors. Two boxes at end of text.

BODY:

Rosa Zaitseva was 26 and pregnant when the Nazis first arrested her. Between 1941, when she attempted to flee Kiev ahead of advancing German forces, and 1944, when she was liberated by the Soviets, Zaitseva hid with her husband's relatives, languished in a ghetto, and fled to the forest, where soldiers shot at her from the trees. Her husband joined the partisans and disappeared, she gave birth to their daughter in a barn, and briefly changed her name to Nina to sound less Jewish.

After the war, she returned to Kiev to find her apartment destroyed, and married a cousin who was injured during the war and died in 1968. Their only son died 17 years ago, and Zaitseva's daughter, who lives in Russia, has been ill since birth.

Today, Zaitseva, 88, lives alone on the sixth floor of a rickety, Soviet-era building with pitch-black elevators and unkempt hallways. Her pension is \$ 30 per month. She is not recognized by the German government as a Holocaust survivor; in August 2000, the Conference on Jewish Material Claims Against Germany turned down her request for assistance because she hadn't been imprisoned for at least six months in a concentration camp, prison camp, or forced labor battalion, and didn't spend at least 18 months in a ghetto, in hiding, or as a child under a false identity.

Zaitseva, it seems, had fallen through the cracks.

When the Soviet Union fell, the Communist system that the elderly had come to rely on also collapsed. In Ukraine, Jews old enough to have lived through the war, or the evacuation of some 300,000 Jewish Ukrainians to eastern Russia and Central Asia, were particularly hard-hit. Unlike those in the West, Soviet survivors never received compensation, their unique physical and psychological problems were never addressed. In addition, some 40 percent of elderly Jews are childless, and those with children are often alone due to the high emigration rates to Israel, the US, and Germany.

Ten years ago, Igor Kogan visited a small village where, he heard, 15 Jewish families lived. He found the Jews, all elderly, walking around in rubber boots with no socks - in the middle of the winter.

"These people survived ghettos, and were dying during peacetime," Kogan said.

Stepping into Zaitseva's two-room apartment is a surprise, however: it is comfortable and neat. Food packages and medicines are delivered on a regular basis, and a full-time homecare worker named Luba comes by to cook, clean, and provide companionship. Zaitseva owns a small black-and-white TV made by local volunteers. She can't walk anymore, so Luba's husband built a remote control.

Zaitseva's \$ 30 monthly pension covers just a fraction of her needs, but in the unlikely event she receives compensation from Germany, she says she will give it away.

"Personally, I don't need anything," she says. "I would help my daughter. I would help the village that hid me during the war, and I would help **Hesed**."

In 1993, the **Joint Distribution Committee (JDC)** opened its first **Hesed** center to provide welfare and social services to the hundreds of thousands of poverty-stricken Jews in the FSU. Today, 174 centers, serving 250,000 Jews, are operating in nearly 2,800 communities in the region. In Ukraine, the **JDC** runs 54 **Hesed** centers, providing such services as homecare, food packages, medical equipment loans, soup kitchens, haircuts, laundry, and community activities. **Hesed** centers rely heavily on volunteers - **Hesed Avot Azriel** in Kiev, for example, serves 15,000 people with 190 staffers and 750 volunteers.

The FSU's attitude toward charity has changed: Back in the 1950 edition of the Great Soviet Encyclopedia, charity was "aid hypocritically rendered by representatives of the ruling class in an exploiter society to a part of the poor population in order to deceive the workers and divert them from the class struggle."

While most survivors don't receive direct aid from Germany or the various restitution funds, two thirds of the **JDC's** 2003 welfare budget, or about \$ 40 million, is from the Claims Conference's sale of heirless East German property. The conference currently allocates 80% of sale proceeds to Jewish victims of Nazi persecution, saving 20% for **Holocaust** research, education, and documentation.

The \$ 40m. also includes monies from Swiss banks and insurance claims settlements. While a 10-year plan for distributing the money is in place, Claims Conference officials note that the funding is finite. **Hesed** spends an average of \$ 250 on services for each survivor annually, says the executive vice president of the **JDC's** New York office, Steven Schwager, compared to tens of thousands spent on survivors in assisted-living facilities the US and Israel.

"Twenty dollars a month for these people is the difference between life and death," he said.

Just 6,000 FSU survivors out of an estimated 135,000 in the region receive monthly pensions of 250 DM - quadruple the average Ukrainian pension - through the 1998 Central and East European Fund. "Evacuees" or those who fled their homes ahead of the Nazis to eastern Russia or Central Asia, are ineligible for pensions in the FSU, even though many lost their homes and families. Some 60,000 survivors and evacuees who have left the FSU, however, receive monthly pensions of 500 DM through the Article 2 Fund, and 276,410 survivors and evacuees who no longer live in the FSU have received one-time Hardship Fund payments of 5,000 DM.

In other words, FSU survivors - who constitute one of the poorest, most vulnerable survivor populations - are also the least likely to receive restitution, unless they pack up and leave.

The Claims Conference, said chief operating officer Greg Schneider, is currently pressing the German government to agree to a one-time payment for survivors and evacuees who opt to stay in the FSU.

Funds for **Hesed** programs also come from federations and family foundations. In September, the International Fellowship of Christians and Jews announced a \$ 1m. donation for services to the elderly. Schwager notes, however, that it has become more difficult to raise money from US Jews.

"I find it hard to believe that there is not enough money in the Jewish world to take care of these people," says Schwager.

While the level of service in Ukraine is still far below what the elderly in western countries enjoy, Zaitseva, who has no family or friends outside the FSU to point out the inequities, is thrilled with what **Hesed** provides for her.

Sitting on her day bed with the **JDC's** regional representative for central and western Ukraine, Volodya Glozman, Zaitseva laughs when Glozman says, "May you live to be 120."

"No way," she replies. "I'm very tired of myself, but **Hesed** never lets me pass away."

(BOX #1) Anti-Semitism in Ukraine

When Eudokia Perel-Guralnick received a one-time restitution payment from Germany, she decided to use the money to commemorate her late husband, a **Holocaust** survivor. A month after Perel-Guralnick dedicated a memorial gravestone in Kalinovka, it was destroyed.

Perel-Guralnick, 71, seemed taken aback when asked if she considered the attack to be anti-Semitic. The local press described the attackers as kids and the attack as vandalism. "Maybe they were drunk," she said.

Other gravestones were destroyed around the same time in Kalinovka. All were in the Jewish cemetery.

While the attack was certainly in keeping with Ukraine's notorious past, the response by local officials illustrates Ukraine's potential 60 years after the **Holocaust** and 12 years after declaring independence from the Soviet Union: the government immediately rebuilt the Perel-Guralnick gravestone.

"State anti-Semitism doesn't really exist anymore in the way it existed in the Soviet days," said Ukraine's chief rabbi, Ya'akov Dov Bleich.

While the government's official rejection of anti-Jewish attacks is a giant step forward for Ukraine, Mark Levin, the executive director of NCSJ (Advocates on behalf of Jews in Russia, Ukraine, the Baltic States, and Eurasia), warned that the hatreds of the past remain close to the surface.

"We're dealing with a part of the world that has a very long history with this issue. It is ingrained very deeply in Ukrainian society and it's going to take a long time to see popular anti-Semitism eradicated," he said.

Jews interviewed last month in Ukraine gave a mixed assessment of their country's progress toward a more tolerant, pluralistic society. Some 56 anti-Semitic attacks have been recorded since January 2002, according to the Coordination Forum for Countering Anti-Semitism. Over the summer, noted the Forum's Web site, a Chabad rabbi was severely beaten in Kiev by three young men shouting anti-Jewish epithets; a Jewish youngster wearing a shirt with Hebrew letters was roughed up by a group of skinheads; and two Ukrainian parliament members blamed Jews for Stalin's "starvation terrorism" in the 1930s.

In July, the executive director of the United Jewish Communities of Ukraine, Edward Dolinsky, warned delegates at the Organization for Security and Cooperation (OSCE) conference on anti-Semitism that anti-Jewish sentiment is returning to the country after a decade-long hiatus. A recently-published Ukrainian book that has gained popularity in some circles is titled Ghidy, or Yid, he said.

"From 1989 up to one year ago, I was very optimistic about Jewish life here," said Dolinsky. "A year ago, I understood I would have to spend a lot of time in my life fighting racism, intolerance, and anti-Semitism."

(BOX #2) The righteous few

When the Nazis invaded her village in 1941, Polina Osadchuck-Buchko had a strange dream. The retired Russian literature teacher dreamt she was crossing a river at night, in stormy weather, and that when she reached the other side, calm ensued.

"She believed she'd live through the war," her daughter, Galina, says in an attempt to explain why her mother risked her well-being to save a Jewish teenager, Boris Samojluck, during three years of Nazi occupation. As her daughter speaks, Polina, now 91 and deaf, calls out the name of the German officer who hunted down Jews and executed anti-Nazi sympathizers in Ivcha. To this day, Galina explains, his name is a curse in the village.

In September, **Hesed** Emunah, the welfare center run by the **Joint Distribution Committee** in the nearby city of Vinnitsa, paid its first visit to Ivcha, a small Ukrainian farming village, to thank Osadchuck-Buchko for her heroism. Righteous Gentiles who saved Jews during the **Holocaust** are eligible for the same services as Jewish victims of **Nazism**, and the **JDC** currently provides services to 1,013 such saviors. In this poverty-stricken area, where Western toilets are a luxury and pensioners are often forced to choose between food and medicine, the decision to provide the Righteous Gentiles with much-needed help stands as a small measure of justice 60 years after most Ukrainians welcomed Nazi persecution of the Jews with open arms.

In the case of Ivcha, 77-year-old Samojluck - himself a **Hesed** client - informed the **JDC** of several villagers' role in saving his life. Samojluck, whose father was drafted into the Red Army at the start of the war, was orphaned in 1941 when the Nazis rounded up his mother - an act witnessed by Osadchuck-Buchko.

"It was terrible for her to see such a weak woman surrounded by Germans," says Galina.

Osadchuck-Buchko and several neighbors, including Olga Klishova, now 79, took turns hiding Samojluck and providing him with women's clothing so he could move around the village.

This summer, Samojluck asked the **JDC** to help his former saviors, whose village still features the outhouses, wells, and coal heating stoves of a century ago. In mid-September, social workers drove to the village in a "Hesedmobile" with food packages, jars of honey for Rosh Hashana, and a pledge that the Jewish community would help Osadchuck-Buchko and Klishova live their last years in dignity.

Klishova's two-room shack, decorated with crucifixes, is located near the Nazis' former headquarters; a retired factory worker who never married, she seems at a loss to explain the heroism of her war years. "Everyone did what they could," she says.

Holding a certificate of thanks signed by the Jewish Council of Ukrainians and the Foundation of Jewish Victims of Ukraine, Klishova smiles shyly as a translator reads the words of thanks aloud: "The Jewish

people will never forget your noble deed, and will tell your name from one generation to another. You are the pride of the Ukrainian people."

When asked what she knows about the JDC's work, Klishova shakes her head; she had never heard of the organization until that day. She says she could use heating fuel to help her get through the winter, and eyeglasses to help her see. Nodding toward the fruits, vegetables, and honey the Hesed workers dropped off, she expresses her gratitude that the group found her.

"What can I say except thank you."

GRAPHIC: 5 photos: Nestled in a dense pine forest, Kiev hosts a Jewish community of 220,000. Hesed helps Rosa Zaitseva, 88, and her full-time caregiver, Luba. The pride of the Ukrainian people. Polina Osadchuck-Buchko holding a certificate of thanks.

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Ethnic NewsWatch
Jewish Telegraphic Agency

May 11, 1999

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LENGTH: 1193 words

HEADLINE: Jewish centers offer safety net for elderly in former Soviet Union

BYLINE: Krichevsky, Lev

BODY:

Jewish centers offer safety net for elderly in former Soviet Union

By Lev Krichevsky

YEKATERINBURG, Russia, May 10 (JTA) -- Evgeniya Fridman pours into a glass jar some of the free soup she's just received at a soup kitchen here.

"These lunches give us life," says Fridman, as she adds more food to the jar.

The leftovers will serve as her dinner, she explains. "I will have it at home."

The 78-year-old former schoolteacher is one of 63 elderly and needy Jews who receive free hot lunches daily at two locations in this city in the Ural Mountains, 900 miles east of Moscow.

Another woman says the free lunches she eats here are the only hot meals she has had for several months.

Some 30 percent to 35 percent of an estimated 1.5 million Jews in the former Soviet Union are elderly, and of this number, anywhere between one-half to two-thirds require at least some social services.

For example, in St. Petersburg, which has Russia's second-largest Jewish population, some 30,000 of the estimated 100,000 Jews are listed in the database of the local Jewish charity center.

Many elderly Jews at the soup kitchen, located in a restaurant, say they never thought they would have to survive on charity.

When these people retired, during the days of the Soviet Union -- having worked for decades as engineers, teachers or doctors -- their pensions seemed more than adequate.

However oppressive the Communist regime was, it allowed people to survive on retirement or disability payments and provided the needy population with a safety net of free social services.

But post-Communist Russia's economic hardships and the collapse of the state-run welfare system have thrown the most vulnerable populations below the poverty line and left many without hope.

Most elderly in Russia and elsewhere in the former Soviet Union receive pensions of less than 20 a month, far below what is necessary to make ends meet. In some places in Russia, such as Yekaterinburg, even such meager payments are made several months behind schedule.

The situation turned even worse last August, when Russia devalued the ruble. As a result, prices skyrocketed, but pensions remained the same.

As Ada Katz, director of the Hesed Menorah welfare center in Yekaterinburg, simply puts it: "After the onset of the crisis, the standard of living of our elderly declined sharply."

According to official statistics, the prices of 25 basic foodstuffs rose between 30 percent and 115 percent after the onset of the economic crisis last summer. The price of utilities jumped 60 percent and the price of medicines also climbed steeply.

The skyrocketing prices have left many elderly with the option of choosing between medicine and a diet that consists mainly of bread, hot cereal and the cheapest vegetables -- potatoes and cabbage.

Leonid Kolton, the director of St. Petersburg's Hesed Avraham, Russia's oldest and largest Jewish welfare center, says food programs are again becoming a major focus of charitable activities -- similar to the early 1990s, when, following the disintegration of the Soviet Union, Jewish welfare services in Russia were first re-established.

Jewish welfare workers now say their clients' most urgent need is medicine.

In the Soviet Union, the pharmaceutical trade was a state monopoly and included state-subsidized or free medicines for veterans and the disabled population.

Today, this system is almost nonexistent. Medicines are sold at free-market prices that usually correspond to world market prices. Medicines

that are distributed free or at reduced prices are almost unavailable as most supplies go to commercial pharmacies.

According to a recent survey of the Jewish elderly, 65 percent say they don't have enough money to buy even the most necessary medicines -- and among the most poignant cases are those people who have chronic diseases such as diabetes.

Homebound Eva Vinokur of St. Petersburg says she spends most of her \$11 pension on medicine, including insulin.

"Medicines are the most critical problem for our clients," says Ada Katz of Hesed Menorah center in Yekaterinburg.

Jewish welfare workers say community centers now have to look for additional funds to implement medication programs, which could be the most expensive part of the aid they provide.

Understandably, the material deprivation has placed the elderly under great strain.

"People are living under continuous psychological stress," says Benjamin Haller, director of the American Jewish **Joint Distribution Committee's** William Rosenwald Institute for Communal and Welfare Workers in St. Petersburg, which trains Jewish social workers and conducts sociological research of the Jewish elderly in the former Soviet Union.

"Everything is available in stores but people cannot afford it, and they are not quite used to seeing this situation."

The demographic profile of the Jewish population in the former Soviet Union makes the need for such centers especially acute.

According to a recent sociological survey, the Jewish elderly population is distinguished from the overall elderly population in the former Soviet Union by larger proportion of singles and small families

As a result of the **Holocaust**, mass aliyah to Israel and Jewish emigration to other countries, more Jewish pensioners live alone than do those among the general population.

About 5 percent of needy Jewish pensioners are bedridden and require a full range of services, from home care to meals-on-wheels.

Government institutions provide the services of social workers for only half of those who need them. In many cases, social workers' visits are irregular even for those elderly who live alone and are homebound.

The situation on the periphery of Russia is worse than in the big central cities, where people generally receive more services.

"In the provinces, people more often die of malnutrition, or simply because they had been forgotten," says Haller.

To cope with the worsening crisis, an increasing number of poor and elderly Jews are turning to the welfare centers that the JDC operates throughout the former Soviet Union.

Created in the past five years in partnership with local communities, the centers, known as **Heseds**, run both community-based and home-based services -- food, medical assistance, home repairs and home care -- for clients with different degrees of impairments.

Last year, 23 new **Heseds** were established throughout the former Soviet Union, bringing their number to 88 spread across 10 time zones.

For many Jewish poor and elderly, the **Heseds** are a godsend.

Lyubov Aleksandrovskaya, 78, a Jewish woman living in St. Petersburg, says it would be nearly impossible to survive on her 12-a-month pension. She says free lunches, hairdressers' and laundry services she receives from the Jewish community allow her not only to avoid hunger, but "to remain a human being."

"These services are like a life buoy to me," she says.

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HEADLINE: IN UKRAINE, MANY SURVIVORS OF THE HOLOCAUST STILL AWAIT RECOMPENSE;
EASTERN EUROPE: JEWS WHO RETURNED TO THE FORMER SOVIET UNION FACED MORE SUFFERING. BUT EFFORTS ARE AT LAST UNDERWAY TO ALLEVIATE SOME OF THEIR BURDENS.

BYLINE: MARY MYCIO, SPECIAL TO THE TIMES

DATELINE: KIEV, Ukraine

BODY:

When American forces liberated Mikhailo Soikys in Germany in 1945, he could have emigrated to the United States. But Soikys, who survived Auschwitz by pretending to be a Georgian Turk and then escaped from a train bound for Buchenwald, decided to return to what was then the Soviet Union.

"I thought things had changed," the 75-year-old Ukrainian Jew explained while visiting a center for Holocaust survivors in Kiev. "But it was worse. Had I known, I would have chosen differently."

Unlike their Western counterparts, Jewish survivors of Adolf Hitler's concentration camps who returned to Eastern Europe continued to suffer at the hands of the state. Even now, more than 50 years after the end of World War II, questions linger over how to compensate those who suffered at the hands of the Nazis.

"In the Soviet Union, Holocaust victims were persecuted for surviving," said Anya Verhovska, who coordinates the videotaping of East European survivors' testimony for Hollywood producer Steven Spielberg's Visual History Foundation. The foundation is collecting Holocaust survivors' testimony around the world.

If survivors were alive, the Stalinist thinking went, they must have collaborated with the enemy. At the very least, they were considered dangerously contaminated by exposure to the "bourgeois" West.

"Some people were sent to the gulag immediately. One survivor even asked why we were so interested in Auschwitz when the gulag was worse," Verhovska said.

Clara Vinocur, who in 1942 ran away from a firing squad preparing to execute Jews sick with typhoid, now heads the Kiev branch of the Ukrainian Assn. of Jewish Concentration Camp and Ghetto Victims.

"It wasn't just Jews but other Ukrainians too. Any civilians who lived in Nazi-occupied territory were considered 'enemies of the people,' " she explained.

Given the official Soviet bias against Jews in education and the job market, the added stigma of having spent the war in occupied territory meant that Holocaust survivors suffered a double discrimination.

"If you talked about having been in the ghetto, you were blocked from getting jobs," recalled Liubov Patsula, 74, who in 1942 watched the Germans shoot her mother and neighbors in a village ghetto outside the Ukrainian city of Odessa.

The silence was so impenetrable that until Vinocur attended the Soviet Union's first congress of Nazi concentration camp and ghetto survivors in Moscow in 1991, she didn't know a single person like herself in Kiev. A front-page announcement in the Jewish supplement to the Ukrainian parliament's newspaper eventually led her to more than 150 Holocaust survivors in the Ukrainian capital. Altogether, Vinocur says, there are about 4,000 survivors throughout this country of 52 million, where the Jewish community, numbering 500,000, is the third-largest in Europe.

Vinocur's group includes some middle-aged members, who were infants during the war. But Holocaust survivors are mostly old and therefore most vulnerable to post-Soviet economic upheavals. Most are barely surviving on tiny pensions that don't cover the cost of staple foods, much less utilities, medicine and clothing.

With the end of the Cold War, these elderly Ukrainians became eligible for compensation from Germany. But the 1 billion marks--about \$ 660 million--earmarked for Belarus, Russia and Ukraine is for all those who "especially suffered" from the Nazis, not just for Holocaust survivors.

While ghetto and concentration camp victims are entitled to the largest awards--of about \$ 600--the vast majority of people eligible for compensation are Ukraine's mainly Slavic Ostarbeiter, people who were shipped to Germany to perform forced labor. Saul Kagan, executive director of the New York-based Conference on Jewish Material Claims, established in 1951 to obtain German compensation for Holocaust survivors, thinks that reflects a lack of understanding of Hitler's Final Solution. Forced laborers suffered, but they were not faced with extermination as a group, he told journalists at last month's opening of Hased Avot, a Kiev welfare center for elderly Jews.

Such arguments are not very persuasive in the former Soviet Union. Even after half a century, the war that killed every sixth inhabitant of Ukraine--more than 5 million people--and wiped out a third of Belarus' population still looms large in public consciousness. "Everyone in Ukraine suffered. But there isn't enough money for everyone," said Anatoly Omelchenko, deputy director of the Ukrainian government agency charged with distributing the compensation.

One problem is that Ukraine has more claimants than originally estimated. "It was thought that Ukraine and Russia each had 600,000, and Belarus 300,000," Omelchenko explained. "But in reality, neither Russia nor Belarus has that many, while we've already received 624,000 applications."

At least 300 of those applications came from Jews who eluded capture by hiding, in forests or with non-Jewish families. The latter, ironically, are eligible for aid from an American fund for "righteous Gentiles."

But since the Jews they sheltered were not in ghettos or concentration camps--and were hiding precisely to avoid that fate--they don't fall into the recognized categories for reparations.

Vinocur, with the help of the claims conference, hopes to persuade the German and Ukrainian governments to change the rules.

In the long term, however, the one-time payments can be of only marginal help, covering the costs of some needed clothing, utility debts and perhaps gifts for grandchildren. They can't fill all of the gaps in Ukraine's tattered post-Soviet safety net.

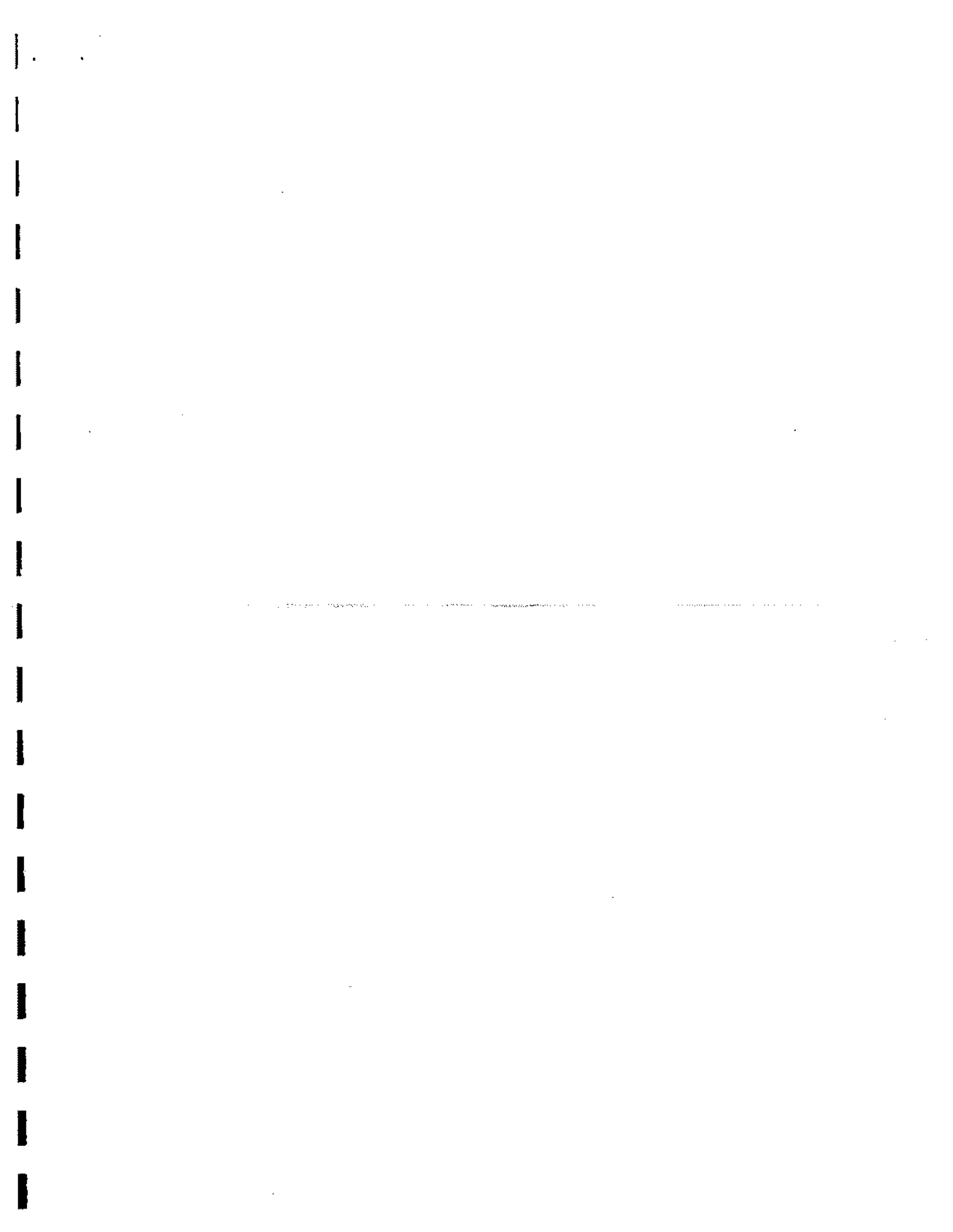
That's what the **Hesed Avot**--which means the "loving care of ancestors"--welfare center intends to do. At the freshly renovated ex-kindergarten in an outlying district of Kiev, elderly Jews--including **Holocaust** survivors--can get free medical consultations, attend Hanukkah celebrations or lectures on Jewish culture, and rent wheelchairs, walkers and crutches for a nominal fee. "This is a God-given place," said Lev Pikersky, 74, while waiting in the neat little hair salon for volunteer barber Aaron Furier to trim his flowing gray locks.

The claims conference raised the \$ 1 million to refurbish the center by selling unclaimed Jewish properties in what was East Germany. It is administered by the **American Jewish Joint Distribution Committee**, an overseas aid organization.

"This is paid for by the people who did not survive," said Kagan of the claims conference, gesturing at the center's small auditorium. "It's the mystical heritage of those who perished to benefit those who lived."

GRAPHIC: PHOTO: In 1945, Auschwitz survivor Mikhailo Soikys chose to return to what was then the Soviet Union rather than emigrate to the U.S. Had he known what awaited him, he says, "I would have chosen differently." **PHOTOGRAPHER:** MARY MYCIO / For The Times

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THE HESED WELFARE MODEL

A Community Response to Crisis

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After the fall of communism there was a socio-economic-political breakdown affecting all areas of life. The JDC worked to provide immediate relief in a way that would foster the rebuilding of a Jewish communal infrastructure. The Hesed centers fulfill those aims and are based on the principles of voluntarism, Yiddishkeit, and a community orientation.

KATASTROIKA

The term "katastroika," a hybrid of "pere-stroika" (meaning rebuilding or restructuring) and "catastrophe" originally coined by Zinoviev, (Ellman, 1994), captures the dimension of the social crisis in the former Soviet Union (FSU) following the collapse of communism. The socio-economic-political breakdown encompassed all spheres of life: health and welfare services disintegrated (Field & Twigg, 2000; Leitch, 1997), pensions and salaries were reduced to sums not sufficient to cover food (Ronge, 2000), medications became unavailable or prohibitively expensive, and savings were wiped out by hyperinflation (Rush & Welsh, 1996). Virtually the entire population was left without a meaningful safety net (Field & Twigg, 2000). The blow was particularly painful to the needy and the aged (Papirus, 1995). This led to a drastic reduction in life expectancy (Breev, 1998), widespread poverty, pockets of hunger, increased crime, and a rise in unemployment (Field, 2000). Many viewed the situation that succeeded the collapse of communism as a post-disaster chaotic situation (Field & Twigg, 2000).

Prior to the collapse of communism, the Soviet state provided a relatively stable social safety net. Through an intricate system of entitlements and eligibilities, it took care of virtually all the physical needs of the population more or less effectively from birth to death.

The collapse of the totalitarian state and the disintegration of its ideological, institutional, and economic foundations, as well as the basic family structure, created a crisis situation in each of these areas, with far-reaching consequences for the population as a whole and the elderly in particular.

The Institutional Crisis

During the communist era, welfare services constituted a contradiction in terms. A welfare case could not exist in a state that by definition cares for everyone. After the breakdown of communism, the existing health and welfare services, including hospitals, polyclinics, and personal services of the *Sobes* (Soviet welfare ministry), deteriorated rapidly due to a lack of resources and mismanagement. The medical care system was on the verge of disintegration.

The Economic Crisis

The transformation from communism to a free market economy was followed by rapid inflation and the rising cost of services formerly provided free of charge by the state. While inflation obliterated personal savings, government salaries and pensions became not only insufficient for the purchase of food and other basic services but were also often paid only after a delay of many months. Social retirement funds, which were controlled by the state, were inadequate to meet spiraling needs.

The Family

During the communist regime, the family was legally required to support its members and played a major role in social welfare (Hegelson, 1989). The aging of the population and the disintegration of the extended family have increased the vulnerability of the elderly. Following *perestroika*, with its accelerated emigration and freedom of movement, the elderly, particularly the Jewish elderly, were left behind while their children migrated to the west or moved from the periphery to big cities.

INTERVENTION BY THE AMERICAN JEWISH JOINT DISTRIBUTION COMMITTEE (JDC)

The JDC is an American non-governmental organization (McPeak, 1999) and functions as the overseas arm of the American Jewish community. Since its establishment in 1914, JDC's mission has been to assist distressed Jewish communities throughout the world, and has a long history of post-crisis interventions.

In the Soviet Union, the JDC operated from the 1920s to 1935, when Stalin banned its activities on grounds of its association with the imperialist United States and Zionism. In 1989, the JDC was one of the first foreign organizations to re-establish its presence in the former Soviet Union after the collapse of the communist regime. The main goals of the JDC in the FSU were (1) to

assist in the development of Jewish communal infrastructure, (2) to reconnect the Jewish population to the Jewish people, and (3) to provide immediate material assistance to the most needy Jewish population, particularly the elderly.

In October 1991, in response to the crisis situation and the diverse needs of elderly and disabled members of the Jewish community, the JDC initiated a relief and welfare operation with a massive food distribution program among the elderly of the FSU. The dilemma faced was how to integrate the initial emergency response, which included such material assistance as delivery of food packages, with the long-term goal of capacity development.

It was possible to identify unstructured manifestations of solidarity among the volunteers in the Jewish community. However, it soon became evident that this solidarity derived not only from their desire to assist fellow Jews but also from an unconscious desire to recreate a Jewish community and a Jewish identity. Therefore, immediate efforts were made to create congenial structures for volunteers to develop a sense of community.

The following intervention strategy was formulated:

1. Food package distribution was to be used not only to relieve hunger but also to assess the overall needs of the population, to establish a database, and to map the geographic distribution of the Jewish population.
2. Local groups were entrusted with food distribution, despite their lack of experience. Where no local groups existed, efforts were made to organize them (capacity building). Direct intervention by JDC was to be avoided.
3. The initial food distribution program was directed toward the identification and mobilization of volunteers in order to facilitate the welfare operation.
4. The intervention in general and food distribution activities in particular also aimed to reconnect volunteers and clients to Jewish tradition.

THE HESED MODEL

Using the experience gained from the food distribution activities and based on local conditions, the Hesed model was developed as an attempt to foster local community infrastructure in the area of welfare. It is based on the following assumptions:

- Welfare and welfare structures must serve as vehicles for community building.
- All other community structures should be viewed and if possible mobilized as levers for the promotion of welfare.
- Welfare and welfare structures must serve as vehicles for the promotion of voluntarism.
- Welfare activities should be based on Jewish values and traditions (*Yiddishkeit*). Jewish content must be incorporated into all activities.
- The provision of welfare services must be conducted according to high professional standards.

The Hesed center was thus developed as a multifunctional outreach service organization, based on three principles—*voluntarism*, *Yiddishkeit*, and *community orientation*.

The services provided by Hesed relate to all aspects of the human condition. They include health and medical services, feeding, winter relief, home care, social clubs, emergency assistance to individuals in crisis, activities for volunteers, educational activities, and intergenerational programs encompassing elderly, young mothers, and children. Services are provided on the premises, as well as on an outreach basis.

Voluntarism

The Soviet regime crushed virtually all forms of voluntarism. The absence of civil society and grassroots organizations was characteristic of the state-controlled society. During seventy years of communism, voluntarism was reduced to *subbotniks*—"voluntary" forced public works.

Following *perestroika*, it became apparent that within the Jewish community, as

often occurs in a crisis situation, the manifestations of voluntarism increased dramatically. The Hesed model was based on capturing these new energies.

The principle of voluntarism manifests on one hand a fundamental dimension of Jewish tradition, and on the other the mobilization of untapped human resources for the provision of services during and following a crisis situation. Voluntarism has become the catalyst for the creation of informal social networks and safety nets. It provides a framework for the impoverished and socially isolated Jewish volunteers to congregate, affiliate, and engage in self-help activities. It also offers both material and spiritual compensation.

The Hesed model's emphasis on voluntarism breaks down the distinction between clients and volunteers. Clients are encouraged to volunteer while receiving assistance. Hesed provides volunteers with a wide array of tasks and rewards. It grants them a sense of belonging and provides opportunities for involvement in activities that the volunteer feels are significant for the community and the clients. It is a vital source of meaning in a crisis situation. The material rewards, such as food packages and clothing, supplement a volunteer's salary or pension. Volunteering for Hesed is also perceived as a sort of insurance in a crisis situation: just as I serve the community and the clients now, the community will give me the same care when I am in need.

Jewish Traditions and Values (*Yiddishkeit*)

The Hebrew word "*Hesed*," which denotes lovingkindness, compassion, and mutual aid, is deeply rooted in Jewish tradition and has profound Jewish connotations. Welfare institutions and values have always been the cornerstone of Jewish tradition. Following the elimination of these traditions under the communist and Nazi regimes, Hesed has revived them as a lever for Jewish renewal.

In the context of the Hesed model, the concept of welfare was broadened to include

a comprehensive response to the physical, communal, and spiritual needs of the client population. Thus Hesed, with its Jewish orientation, linked the material and spiritual-social dimensions of the crisis.

Hesed's Jewish character is reflected in its internal structure, as well as in the nature and content of its services, its staff training, the composition of its board, and, of course, its client population. The *mezuzza* at the entrance tells all visitors that this is a Jewish home. The "Jewish corner of Hesed" holds exhibits of major Jewish artifacts that remind staff and clients of Jewish traditions and practices long forgotten. Frequent exhibitions of Jewish artists manifest Jewish revival, and Hesed's library of Jewish and Israeli themes responds to the thirst for Jewish learning.

Jewish content is an integral part of Hesed services. Food packages are provided around Jewish holidays and include relevant literature and Jewish articles: matzah at Passover, menorahs at Chanukah, and a Jewish calendar at Rosh Hashana. The packages are often distributed by Jewish schoolchildren and other volunteers.

Communal dining facilities serve kosher or kosher-style meals and include activities with Jewish content, such as group singing, lectures, and Shabbat services. Whenever possible Hesed sponsors dining facilities that are located in other Jewish institutions such as schools and synagogues, thus enriching the service with Jewish content, strengthening the host organizations with additional resources, and promoting interorganizational cooperation.

Community Orientation

Under the Soviet regime, which bred mistrust and discouraged cooperation, groups and organizations operated under the premise of a zero-sum game: one's gain was the other's loss and vice versa. The Hesed system, by contrast, fosters trust and cooperation among co-workers and volunteers, as well as between clients and workers. In addition, the principle of trust is expressed in

collaborative ties with other communal organizations and in the notion that every communal organization is a lever for promoting welfare. In this context, a school with dining facilities might lend its premises to a Hesed-sponsored food distribution program on Sundays, a summer camp might host elderly volunteers and grandparents of the campers, and a school library might serve the elderly with the assistance of young volunteers. This normative orientation generates a win-win situation.

Hesed is an instrument for community building that promotes cohesion among workers, clients, and volunteers. It serves as a focus of Jewish communal life where welfare activities promote collaboration with and interaction among local Jewish organizations. The trust that develops is based on common values and Jewish traditions—primarily those of *zedakah* (charity), justice, mutual help, and strengthening Jewish identity. The Hesed Board of Directors, which comprises representatives from other major local Jewish organizations, aims to serve as a local governing body and to promote reciprocal relationships between Hesed and its Jewish organizational environment.

Hesed attempts to combat the divisiveness that characterized Soviet organizational culture and that continues to prevail among post-Soviet Jewish organizations. Since welfare is by far the most dominant issue facing the emerging Jewish community in the crisis situation, it serves as a unifying concept, and Hesed has thus become a unifying force in the community.

It is common knowledge that after a crisis, the victim's level of dependency on outside services and resources increases sharply. Assistance from the outside can be given in two opposing modes. The first is direct intervention whereby the assisting organization maintains control and the recipients remain passive, without an opportunity to participate. The second can be referred to as institutional or capacity building, whereby the recipients are mobilized to increasingly take control over the new developments. Par-

adoxically, the first approach reinforces dependency and thereby lengthens and strengthens the crisis. The second approach, although it may be slower, is by far more effective in the long run, as it allows for indigenous development.

The Hesed model follows the second approach. With its community orientation, Hesed was intended to become a vehicle for community development. The emphasis on volunteers increased local involvement and facilitated the mobilization of local resources. Similarly, the *Yiddishkeit* orientation addressed the missing dimension that the local population was seeking in either an articulated or unarticulated fashion. It facilitated the community's identification with the imported model and allowed them to internalize it and view it as theirs, thus participating in its development.

As a comprehensive community-based response to material and social-spiritual crisis, Hesed took root rapidly. In 2001, eight years after the first Hesed was opened in St. Petersburg, there were 164 Hesed welfare centers serving 272,525 clients in 2,640 locations throughout the FSU and utilizing 14,100 volunteers (see Table 1). The Hesed network reaches from Murmansk in the Arctic Circle to Yalta in the Crimean Peninsula; from Tashkent, Tbilisi and Almaty to Khabarovsk in the Far East and Orenberg in the Ural Mountain region. The network of Training Institutes that was developed concurrent to the establishment of the Hesed centers was a major force behind this growth.

The most significant recognition of the Hesed model as an effective institutional response to a crisis situation that benefits the most vulnerable population, particularly Holocaust survivors, was the decision of the U.S. District Court in its ruling regarding the plan of allocation and distribution of the Swiss restitution funds (U.S. District Court):

It is recommended that \$90 million be set aside for up to ten years to help fund the humanitarian assistance programs described below and in greater detail at Section III(B).

Table 1. Services provided by Hesed Centers during 2001

<i>Food Packages</i> —More than 1,599,215 food packages were delivered to 266,135 clients.
<i>Communal Dining Rooms</i> —4,779,695 meals served to 28,040 clients.
<i>Meals-on-Wheels</i> —4,040,220, cooked meals were delivered to the homes of over 17,725 needy elderly.
<i>Medicine Distribution</i> —109,720 needy elderly received medicines at no cost or subsidized prices.
<i>Home Care</i> —28,390 elderly clients received 6,303,230 hours of homecare service, provided during 2,439,005 home-care visits.
<i>Loan of Rehabilitative Equipment</i> —40,705 pieces of assistive and rehabilitative equipment, including canes, walkers, and wheelchairs, were distributed to 20,100 needy elderly.
<i>Winter Relief</i> —79,740 needy people in 1,797 localities received winter relief, including heating and cooking fuel, blankets, and home repairs necessary to withstand harsh winter conditions.

Up to 75% (67.5 million) of the 'looted assets' allocation for Jewish Holocaust survivors should be designated for the augmentation of the JDC-Claims Conference "*Hesed*" program, which provides food packages, medical care, winter relief and other direct assistance to impoverished and ill elderly Nazi victims in the former Soviet Union.

THE ROLE OF THE SOCIAL ENTREPRENEUR

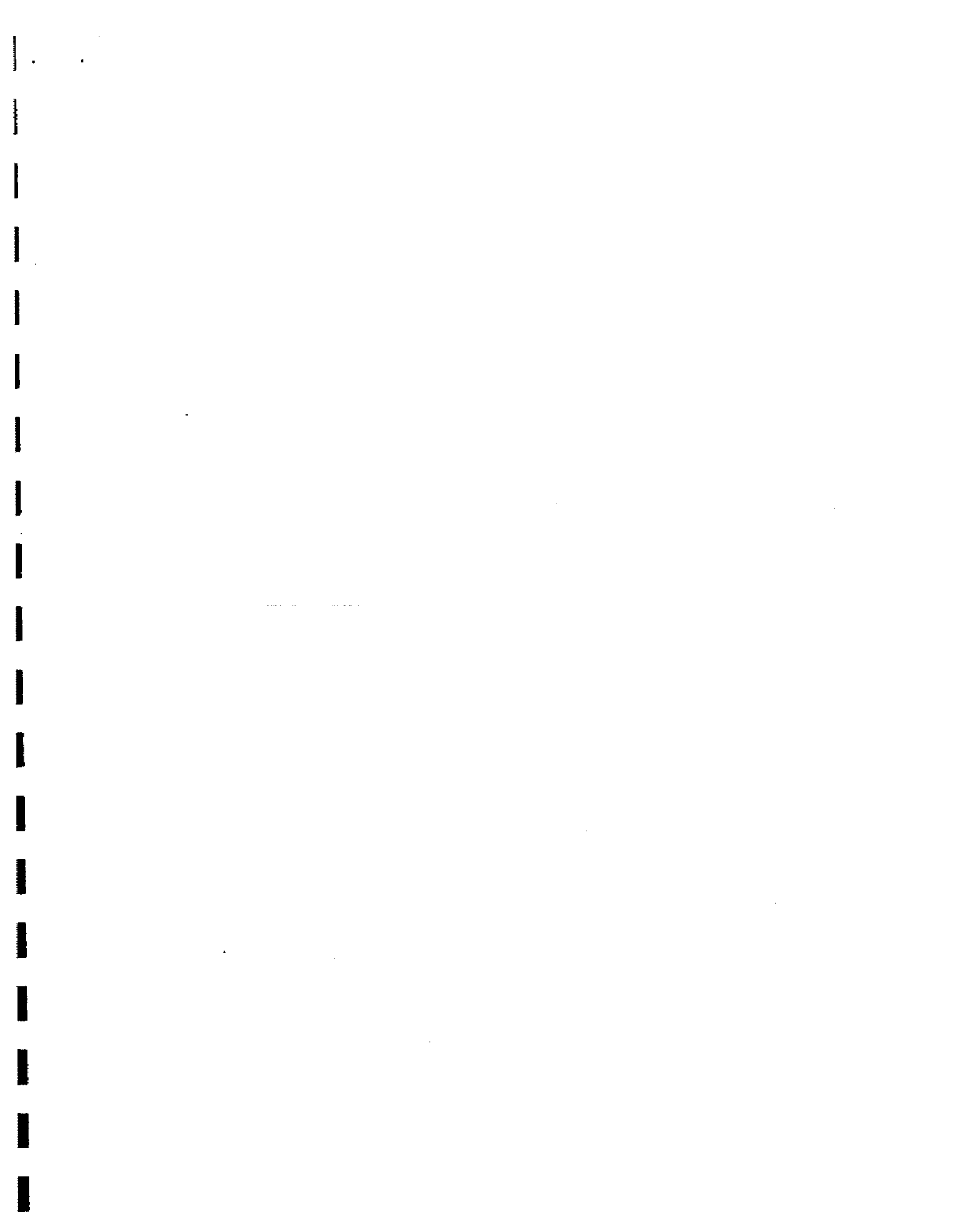
The development of the Hesed model in the FSU was initiated by outside social entrepreneurs (Schachtman, 2001). In light of the crisis and the absence of a local welfare model, the role of the outside entrepreneur as a change agent was critical (Paneyakh & Uryupina, 1989). His or her intervention began by diagnosing the situation, identifying potential key players and mobilizing them, and designing a tailor-made model for confronting the needs of the community. In this respect, the social entrepreneur acted as a

change agent, imparting new ideas and technologies and adjusting them to a new situation.

The intervention following a crisis is a complex process, requiring critical decisions to be made along the way. The most critical decisions are those related to using the crisis as an opportunity and the new directions and/or developments that are created in its aftermath.

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RECRUITMENT AND RETENTION:

IMPERATIVES FOR THE FIELD OF
JEWISH COMMUNAL SERVICE

Larry S. Moses and Dana R. Sheanin

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THE HESED MODEL

Jewish Community Welfare Centers in the Former Soviet Union

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First developed in 1993 by American Jewish Joint Distribution Committee, there are now 145 Hesed Centers throughout the Former Soviet Union that provide a wide range of social services. Founded on the pillars of community, voluntarism and yiddishkeit, the Hesed network is the largest and most effective of all welfare services in the FSU, whether governmental or private.

The word "Hesed" was officially added by the Russian Academy of Languages to the Russian language in March 2000. It is defined as the "provision of social services with special compassion." This addition testifies to the profound impact of the network of Hesed Centers not only on the Jewish community but also on the general social services and communal landscape in the Former Soviet Union (FSU).

First developed in 1993 in St. Petersburg by professionals of the American Jewish Joint Distribution Committee (JDC) in response to the multifaceted unmet needs of elderly and disabled Jews, the Hesed model has grown and multiplied into a movement. From Murmansk on the Barents Sea to Vladivostok on the Sea of Japan, throughout the European countries in the West to the former republics of Central Asia, there are no Jewish communities of any size that are without a Hesed center. Such centers exist in the cities with which we are all familiar—Kiev, St. Petersburg, and Minsk—as well as those that very few have heard of: Taganrog, Tcherkesk, and Yesintuki. The Hesed network constitutes the largest and most effective of all community welfare services in Russia and its former republics.

Hesed centers are ethnically based non-profit welfare services and, like many services of this kind, have their roots in religious traditions. Charity, tzedekah, has always been a central aspect of Jewish communal life. Assisted by donations from their more affluent members, Jewish communities for centuries maintained an elaborate network of voluntary services, such as free loan societies, burial societies, home visiting for the sick, and orphanages. A similar network provided social services to the Jewish settlers prior to the establishment of the State of Israel and the development of state welfare services (Spiro et al., 1997).

Social services in Eastern Europe also originated in voluntary organizations, but following the 1917 revolution a social net was created by the state in the Soviet Union. It functioned as a highly compartmentalized system of social control, as non-government organizations were either nationalized or closed down. In some cases they managed to continue clandestinely. Only after Perestoka did they begin to re-emerge (Solovyov, 1998).

Hesed centers were established as a part of this awakening. Like other non-profit organizations, Hesed centers complement and sup-

port services given by the state. But while in other countries such organizations develop in the course of a gradual process by which established welfare concepts and strategies are transferred to the nonprofit sector with partial state funding, Hesed centers were established in a social, economic, and professional vacuum. The first Hesed centers stepped in when the state collapsed and was practically incapable of providing for its needy citizens. No state funding was available, social work as a profession did not yet exist in the FSU, nor did advanced welfare provision models. These circumstances render the Hesed model especially interesting.

The aim of this article is to describe the Hesed model in the hope that other welfare communal services can benefit from its experience. Taking Hesed Avraham in St. Petersburg as an example, we point out the socio-political circumstances in which the model came into being, delineate the principles on which it is based and its development, and review its status at the present.

This study is part of a larger research effort undertaken by a team of JDC professionals and faculty and students of the Social Work Department of Ben-Gurion University (BGU). The senior author launched the Hesed model when in charge of the JDC welfare program in the FSU, and the other JDC professionals were involved in different aspects of its development. The BGU partners acted in this project as researchers and participant observers.

THE NEW SOCIAL DISORDER IN THE FSU

The "Russian Revolution" of December 1991 brought about the fall of the Soviet Union and the emergence of a new social disorder. The rigid political, economic, and social order that had prevailed until that time collapsed in silence without giving birth, as Marxist theory might have predicted, to a new social order (Yergin & Gustafson, 1993). Instead, the former Soviet Union entered a state of chaos, which left the population without any meaningful social safety net (Yakovlev, 1996).

Prior to the collapse of communism the state had provided a relatively stable social service system that took care of virtually all the physical needs of the population, more or less effectively, from birth to death. The collapse of the totalitarian state and the disintegration of the ideological, institutional, and economic foundations left a serious vacuum in each of these areas, with far-reaching consequences for the population as a whole and the elderly in particular.

The fall of communism brought about the end of an all-embracing ideology and created a spiritual void. For many Jewish elderly, who in their youth willingly or unwillingly, had converted to communism and rejected or abandoned their Jewish religion and traditions, the void was particularly acute. Many of them also became isolated, physically and socially, when their children immigrated to the West or moved from the periphery to big cities. Health and welfare services—delivered from hospitals, polyclinics, and social security departments—deteriorated rapidly, and the state was no longer able to provide social protection and medical care (Barr & Field, 1996; Borodkin, 1997; Chernichovsky & Potapchik, 1999). Rapid inflation and the rising cost of services formerly provided free of charge followed the transformation from communism to free market economy. Inflation obliterated all personal savings, and government salaries and pensions were insufficient and paid late as a rule. The elderly were hardest hit by the economic crisis (Avgar et al., 1997; Papius, 1995).

In light of all these problems there was an urgent need for a social safety net and grassroots structure to meet the economic and social needs of the deprived, impoverished, and socially isolated Jewish elderly. The American Jewish community, through its overseas arm, the JDC, met this challenge.

JDC IN THE FORMER SOVIET UNION

JDC has a long history of involvement in the territories of the FSU both before and after the Communist revolution. It was evicted during Stalin's rule and then officially invited

to re-enter the Soviet Union 50 years later, in 1988. Its first contributions were nonsectarian: a contribution of 750,000 syringes for insulin and a gift of \$10,000 to the Soviet Children Fund in 1988. A year later, in 1989 when a disastrous earthquake shook Armenia, the JDC donated \$530,000 to the Soviet government to create a rehabilitation center for children in Leninokan, Armenia. In addition, it flew 61 amputee victims to Israel for rehabilitation treatment. These contributions were made well before systematic planning and implementation of welfare projects within the Jewish community began (Elishevitch, in press).

JDC's welfare strategy within the Jewish community was derived from its overall mission and was based on the following principles. Welfare assistance was perceived as a lever for community building and Jewish revival. Its aim was to establish and strengthen local institutions, mobilize volunteers, and develop training frameworks and activities. Although in principle, the JDC assistance was aimed not at short-term relief but rather at long-term community recovery, the immediate needs were too pressing to be ignored, and by the end of 1990 JDC decided to implement food relief programs.

In anticipation of the winter of 1991-1992, thousands of food packages were shipped from Israel to St. Petersburg, Moscow, Kiev, and Odessa. A great incentive for the further development of Jewish welfare services in the FSU came when the JDC received a grant from the U.S. Department of Agriculture (USDA) to deliver 550,000 non-sectarian food packages in Moscow and St. Petersburg. JDC was the most successful of all non-governmental organizations involved in food distribution in the FSU. Compared with other organizations it had no logistical problems and a much lower rate of food loss.

JDC undertook this project after the USDA agreed to allocate 10 percent of their shipment for distribution within the Jewish community. Not only did Moscow and St. Petersburg Jews receive 55,000 extra food packages but also a hidden agenda was achieved. The food distribution became an excellent way to organize

and strengthen the local Jewish welfare organizations. Twenty-five thousand names of needy Jewish elderly in Moscow were recorded from the USDA project and the database was started. Food became a vehicle to gain access to homes of elderly Jews and assess their needs. It became evident that elderly people lacked not only food but also many home services and were suffering from terrible loneliness. JDC therefore decided that community-based social welfare services for the elderly should be developed. These services would be able to reach people in their homes and become a vehicle for re-engaging them and their families in Jewish communal life.

HESED AVRAHAM AND SARAH: THE MODEL AND THE BEGINNING

"Welcome to Hesed Avraham, the largest non-government welfare service in Europe" was the greeting that one of the Hesed executives extended to our group of students in Spring 2001. Indeed, with over 42,000 clients (almost all the Jewish elderly in St. Petersburg), 900 volunteers, and 300 employees on its books, Hesed Avraham may rightfully claim this title. But the beginning was much more modest.

The development of the Hesed model entailed the introduction of new concepts and values into the social reality of the FSU. Deeply rooted in the Jewish tradition of *tzedekah* and social justice, the model promoted social responsibility and mutual support. Contrary to previous Soviet patterns it addressed not only material and instrumental concerns but also psychosocial needs of the clients. The model was also novel in that it was client-oriented and emphasized the Western social work values of clients' participation and empowerment. Because of the revolutionary nature of these concepts, it was decided that an exemplar service, a Hesed center, should be built by the JDC in St. Petersburg. It was hoped that once the success of the model was demonstrated in St. Petersburg, it could be replicated in other communities.

Community, voluntarism and yiddishkeit are the three pillars of the Hesed model. Its *raison d'être* is to provide care within and for the community, and since its inception it has incorporated a communal outlook into its welfare programs. It is aimed at strengthening the local Jewish community in that it belonged to it, not to any of its specific sectors and not to the JDC.

Volunteers are recruited from the community and from among the potential clients themselves. Under communism, voluntary organizations were disbanded, as they did not fit with the ideology that the government provided for every citizen's needs. Those who grew up under the Soviet regime had no notion of the positive change they could affect, for the less fortunate and for themselves, by joining forces with others and donating their time and efforts. Voluntarism and community orientation are now recognized by FSU specialists as a basic tenet of welfare provision (Borodkin, 1997), but most charitable organizations in the FSU continue the paternalistic approach of distributing material aid to passive recipients of help. Only a few base their strategy on the assumption that "people can help themselves" (Pshenitsyna, 2000).

Yiddishkeit is the third pillar upon which the Hesed model is built. To achieve JDC's overall goal of returning Jews to the Jewish people, Hesed services and activities accentuate Jewish heritage, culture, and traditions; for example, food packages contain items related to major holidays, and the cultural activities of the Hesed are centered on these holidays. This emphasis on ethnicity, religion, and the return to traditional roots is another revolutionary notion of the Hesed. However, the Jewish community is by no means the only one to be revived in the post-Soviet society, and many other ethnic and religious groups are now thriving in the FSU (Markowitz, 2000).

The uniqueness of the Hesed model—the community solidarity, the blurred boundaries between volunteers and clients and its Jewish spirit—is perhaps best illustrated by the following account of a recent volunteer in Hesed

Avraham.

Olga brought her mother to the Hesed for help. When her father died, the two women were ill provided for and depressed. Olga was fired from her job, their economic situation deteriorated even further, and she would "sit home doing nothing and crying all day long." Her mother was eligible for food assistance and started visiting the day center, which she enjoyed very much. But Olga was still home crying until her mother asked the day center coordinator whether Olga could volunteer at the Hesed. Now Olga volunteers at the Hesed once a week. She says, "We both love it here and mother says that the Hesed was sent to us by God. People are nice and friendly." When asked about what keeps her going, Olga answers: "The results. A woman broke her leg. I helped her get all the medical documents she needed and she received a walking cane. It felt so good to participate in helping someone. The elderly people here are very lonely, they suffered a lot, some have lost their children—their situation couldn't be worse. But, when they come to the Hesed they forget their troubles a little and feel well." Olga is now looking for a job, and would like to work for a Jewish organization. "I am glad to be helping Jews; they are my people. Once I thought that all Jews are kinder than others. Now I realize that maybe not all, but I still think there is a special concentration of kindness among the Jews."

The first Hesed was established in St. Petersburg in 1993 in a hastily restored building with five employees and twenty volunteers. Food programs were a primary vehicle for development of the Hesed, but since many of the first volunteers were physicians they offered to call on the ill and disabled patients in their homes. Medical consultation and home care came to be a part of Hesed Avraham, and subsequently of all other Hesed centers. An Israeli organization, Yad Sarah, donated desperately needed rehabilitation equipment for the elderly, which was rented out to the disabled. One of the founders recalls: "When we rented out the first wheelchair, the daughter of

the woman who needed it objected furiously. She said that her mother was bedridden for eight years and now she would be able to move and would be in her way. We managed to convince her and when the mother sat in the wheelchair, there were tears on both sides."

Later, a number of retired engineers offered their services, giving birth to the home repair service and a rehabilitation equipment production center that now serves all Hesed centers. Over time the services expanded to include a variety of educational, religious, and cultural activities. Everything was done to create a warm and informal Jewish atmosphere in the Hesed, in contrast to the grimness and stiffness of the state social services.

The first director of the Hesed was an Israeli, but by the end of the first year a local director was appointed from among the original five employees. He received ongoing mentoring from JDC professionals and has grown with the Hesed to become one of the prominent leaders of the Jewish community in St. Petersburg and the FSU. To initiate a process of community partnership and eventual transfer of responsibility for the Hesed to the local community, a board of directors was created that drew its members from various sectors of the community. One of the JDC professionals recalls: "The first chairman of Hesed Avraham board was the late Prof. Lev Gulo, a renowned specialist in geriatrics. He was not only a representative of the Jewish community but also contributed to the Hesed his extensive professional experience. His death was a great loss. But, now we have a Gulo on the Hesed board again, his son, also a physician, who is continuing the family tradition."

SERVICES PROVIDED BY HESED AVRAHAM

The centrality of voluntarism is striking on one's very first encounter with the Hesed. Volunteers are the first Hesed representatives that new applicants encounter since they staff the reception desk and are involved in the intake procedure. Volunteers even sit in on the eligibility committee that decides the ser-

vices for which the new applicant is eligible. And those on the feedback committee keep in touch with the new applicants to make sure that they receive the services and are satisfied.

Ongoing economic hardships have diminished little since the establishment of the Hesed and make food provision a central part of its activity. In St. Petersburg the Hesed runs 14 communal dining rooms where hot meals are served to the elderly every day; 178,000 meals were served in these dining rooms during 2000. Food packages that are distributed several times a year and winter relief, which includes heating and cooking fuel, blankets, and arm clothing and footwear, are still indispensable. In 2000 over 128,000 food packages were distributed.

As in the beginning, food distribution goes hand in hand with strengthening the community. For example, food packages are distributed around Jewish holidays and include food and other articles related to the holiday; for example, apples and honey on Rosh Hashanah and matzoh on Pesach. Picking up their packages, clients arrive at the Hesed and receive information about it. Their children are encouraged to collect the packages for them, which is an opportunity to draw younger people and children into Hesed activities. Volunteers and pupils of the Jewish school bring packages to the home of elderly who are bedridden.

A major Hesed service is home care, which is offered regularly to disabled elderly by 300 employees. Volunteers also visit these clients to keep them company. Other services include (1) a repair workshop where volunteers repair small electric appliances and do house repairs, (2) medical consultations, and (3) subsidized medicine, eyeglasses, and hearing appliances. Meals are delivered daily to confined clients in the "Meals-on-Wheels" project. A "Club-on-Wheels" is a social program for those confined to wheelchairs. Once a month they are driven to the Hesed day center for activities or tour the city and its numerous museums.

A project that perhaps exemplifies best the Hesed model and impact is the "Warm Homes" program. To bring the Hesed atmosphere to

those who cannot come to the center, mini-Hesed centers were created in volunteers' apartments. At the present 47 warm homes operate in St. Petersburg daily; 20 of them serve hot meals and thereby make food assistance accessible to elderly who are not strong enough to make a daily trip to a community dining room. The food is a vehicle for creating a support network and community spirit: members keep in touch with each other, visit each other, and care for their ill peers. Shabbat and Jewish holidays are celebrated in the warm houses, as are birthdays and other personal anniversaries. Many members bring their grandchildren and children to these celebrations. Thus, warm homes not only make essential services accessible to needy clients but they also enrich and strengthen Jewish community life.

ON THE THRESHOLD OF THE 21ST CENTURY

Hesed Avraham is still the largest of all Hesed centers and the originator of many of the services offered in them. The rapid and successful dissemination of the Hesed model is truly amazing. Within the first year of its existence the one model Hesed center grew in 1994 into a network of 8 centers, 16 in 1994, and 34 in 1996. From 52 centers in 1997, the network kept expanding to include 88 centers in 1998, 121 in 1999, and 145 in 2000 (Avgar & Avraham, 2001; Barasch, 1999). On the threshold of the new century Hesed centers provided assistance to 235,000 Jewish elderly spread through 2,100 cities, towns, and *shtetlach* of the FSU. In 2000, 1,481,000 food packages were distributed, and 101,500 needy elderly received winter relief support. Almost 22,400 clients enjoyed 4,290,000 hot meals in communal dining rooms, and 13,500 needy elderly had 3,306,500 cooked meals delivered to their homes. More than 10,400 elderly participated in 820 warm homes, and over 20,600 clients benefitted from more than 2,023,000 homecare visits. Close to 31,000 pieces of rehabilitation equipment were rented out and 25,000 medical consultations given.

CONCLUSION

The key to the success of the Hesed model lies in its ability to deliver desperately needed assistance to a population in deep economic crisis. The JDC's work in developing the Hesed network has been carried out on behalf of and in partnership with the Jewish federations throughout North America and particularly the Conference on Jewish Material Claims Against Germany. Hesed welfare programs have also benefitted from substantial ongoing support provided by the Weinberg Foundation, World Jewish Relief (UK), the Abraham and Sonia Rochlin Foundation, and scores of additional contributors concerned with the well-being of Jews in need in the FSU. Local philanthropy is also starting to develop in the Jewish community in the FSU; Hesed Avraham now raises 10 to 15 percent of its budget from local donors.

Yet, its success goes beyond meeting basic human needs. The collapse of the Soviet Union created a spiritual void and led to a search for meaning. The Hesed model not only satisfies material wants but also responds to the often unarticulated needs of the Jewish population to develop a community and return to their traditions. These needs are reflected in the clients' openness for assistance and communal life, and they are embodied in the extraordinary dedication and motivation of the local employees and volunteers. This dedication is supported by the professional expertise, tutoring, and training introduced by the JDC through a network of Training Institutes for Communal and Welfare Workers.

A Hesed center in any given city in the FSU is like an oasis surrounded by sands threatening to reclaim the desert. Hesed's Jewishness, community orientation, and volunteers guard against destructive forces. The human potential of Hesed employees, volunteers, and clients has been unlocked through the introduction of new concepts and values. It is essential to continue, in a systematic and organized fashion, to nurture the spirit and the Jewish *neschama* (soul) of Hesed staff, volun-

teers, and lay leaders. It is also important to maintain the initial enthusiasm and sense of purpose. Ongoing professional development, training, and supervision are essential for both employees and lay leaders. The challenge of the future is to strengthen the defenders of Hesed—the volunteers, staff, and Yiddishkeit, the forces against the sand—so as to ensure that the oasis will continue to provide the renewing source of life, dignity, and spirit to hundreds of thousands of clients, volunteers, and workers.

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