# A Woman Among Addicts: The Production and Management of Identities in a Ukrainian Harm Reduction Program

***Jennifer Carroll,*** **University of Washington**

## Introduction

When HIV first appeared in Ukraine in the mid-1990s, it spread like wildfire through users of injected narcotics. By 2008, Ukraine was estimated to be home to 29% of all reported cases of HIV in Eastern Europe and Central Asia, making it the nation with the highest infection rate per capita in the region (UNAIDS 2008:24). Nationwide, the prevalence of HIV among injection drug users in Ukraine rose from 11% in 2001 to 17% in 2006 (UNAIDS 2008:24). Local prevalence has been reported to range from 11% to a staggering 89% in some urban areas (UNAIDS 2007:26). In response to this, many non-governmental organizations have formed to implement prevention efforts among drug users specifically. The mid-1990s saw a "…boom of civic organizations called *fondy* (funds) that administered international charity…" (Petryna 2002:18). Lighthouse[1], a non-profit HIV-prevention program in southern Ukraine, is one of these "charitable funds." Most receive the vast majority of their funding from benefactors in North American or Western European countries as well as international groups such as UNAIDS, UNGASS, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Lighthouse is no exception. As a consequence, it runs a program model that is very similar to prevention efforts commonly employed in North America and Western Europe.

In this article, I share a few insights about drug use as a social marker and women's access to prevention programs, which were gained through several weeks of observations and interviews at Lighthouse. My original aim in undertaking this research was to explore the unanticipated social consequences of running an American-style harm reduction program in a post-Soviet environment. I came away from Lighthouse with two realizations: first, the growing network of HIV/AIDS related non-profits and NGOs hinges upon the establishment of a generalized (and often medicalized) categorical construct that defines who injection drug users are and what limits exist to the social and biomedical knowledge about them; second, this constructed social identity that is applied to intravenous drug users has the ability to unwittingly write certain people—namely women—out of the equation.

I argue that the daily interactions of both current and former injection drug users at Lighthouse are mediated by this social and biomedical identity in a way that shapes not only their behaviors and relationships, but also affects their access to different social roles and physical spaces. Furthermore, I argue that this social construct that defines who and what an injection drug user is has primarily incorporated masculine tropes of identity. Simply put, drug users are generally assumed to be male. This puts female addicts, who already suffer greater social and logistical obstacles in accessing preventative and therapeutic health care (Pinkham and Shapoval 2010), in an even more difficult position.

**Harm Reduction in the Post-Soviet State**

Under Soviet rule, all citizens were entitled to full health care—at least from a legal point of view. Mark Field (1961) has described the Soviet system as "Third Party" medicine (as opposed to "Fee-For-Service" medicine, which is the primary structure of healthcare in the United States). "Third Party" medicine is characterized by the state's role as the financial intermediary between the healthcare system and the patient (Field 1961:253). In the Soviet Union, the healthcare system was informed by this authoritative government involvement as well as by under-the-table commercialization of medical services. That is to say, medical services were meant to be offered broadly as a fundamental citizens' right, but the quality and extent of medical care was greatly determined by the amount a patient was willing or able to pay to providers in the form of gifts and bribes (Field 1961; Schecter 1992). Responsibility for citizens' health technically lay in the hands of the state, yet was something that citizens often negotiated for themselves in their interactions with healthcare professionals. The medical system in Ukraine is still centralized, but, due in large part to the region's increasingly neoliberal economic environment, the amount of personal responsibility that each citizen must bear for his or her own healthcare has grown in the years following independence.

This gradual transition of healthcare responsibility from the hands of the state into the hands of the individual is characteristic of what Ulrich Beck (1992) calls "risk society." Beck defines risk society as a stage in the development of the modern nation-state in which risks and dangers "escape the institutions for monitoring and protection in industrial society" (1994:5). Individuals gain charge of their own protections, gambles, and opportunities, and become entirely responsible for the determination of their own uncertainties (Beck 1994:14). Beck also insightfully links this new phase of modern society and the post-socialist sphere. He highlights the recent withdrawal of the Soviet state from efforts of civil protection and care and openly questions whether Western constructs such as capitalism and democracy are capable of successfully filling this void (Beck 1994:5). Beck's question is similar to the one that I continue to ask in my research, namely: now that Western systems and methods of public health have been brought into Ukraine by leviathan donors like UNAIDS and the Global Fund, are these approaches accomplishing what they were meant to do? Is harm reduction actually a good fit for Ukraine, and, if not, how are Ukrainians adapting?

Tensions between the need to resolve contemporary social ills and the recent absence of state responsibility continue to frame the social and political landscape of Ukrainian harm reduction and HIV-prevention NGOs. Injection drug use, and the associated health impacts, are condemned and criminalized by the Ukrainian state, yet little to no government services exist to ameliorate the harms suffered by injection drug users or the behaviors (and underlying socio-cultural environments) that cause them (Human Rights Watch 2006). In part, this tension is mirrored in the foundational assumptions of the harm reduction philosophy—namely, that social and legal condemnation of illicit drug use has failed to curb either the use of these drugs or the resulting health consequences (Human Rights Watch 2006). At Lighthouse, this tension also

manifests in the further shift of responsibility for injection drug users' preventative and therapeutic healthcare from the individual to public health organizations. Lighthouse pairs its authority as a party responsible for managing the health and health-risks of its clients with a Western notion of risk-management that gives sovereignty over private behaviors to the individual. This often results in the organization bearing responsibility for the healthcare of injection drug users who cannot or will not take on that responsibility for themselves. Below, I argue that this daunting task is, in part, mitigated by the production, maintenance, and public diffusion of a stable, manageable identity for injection drug users.

**Risk and Identity**

Risk paradigms often frame struggles of agency and identity for individuals that are subject to biomedical authority. For instance, Campbell and Shaw (2008) note that many North American drug users have learned the "right answers" to prying questions about their injection behavior, thanks as much to decades of ethnographic work as to any public health effort. "During ethnographic research on HIV risk among people who inject drugs, participants would repeat these mantras—'I always use bleach' and 'I never share needles'—even while failing to use bleach or using their partner's needle before an ethnographer's eyes" (Campbell and Shaw 2008: 696). Drug users would try to position themselves as moral agents, regardless of the contradictions between their words and actions. At stake was not only the "ethical harmony" (Campbell and Shaw 2008: 696) of the immediate conversation between the informant and the researcher, but also the ability of informants to reclaim moral citizenship within a society that seeks to marginalize and exclude them.

In their analysis of risk paradigms among patients undergoing cancer screening, Scott et al.(2005) note that the use of risk categories is a part of a broader paradigm shift that considers *potential* illness to be under the jurisdiction of biomedical authority. They argue that living in a constant state of disease potential —being at a high risk for cancer, heart disease, or HIV—often places people in an uncomfortable, liminal position where they are neither sick nor fully "well" (Scott et. al. 2005:1872). This may lead "at risk" persons to wrestle with their risk or disease status in order to better comprehend their identity within the medical system. Outreach workers at Lighthouse and other similar organizations, who are former users of injection drugs, find themselves in a similar quandary. They are no longer the socially and medically troublesome addicts they once were, but neither are they fully re-assimilated into the realm of typical, well-functioning citizens. Something of their past always stays with them. It could be argued that the mainstream population is so accustomed to the extreme "otherness" of well-known risk groups (homosexuals, intravenous drug users, etc; Glick Schiller et. al. 1994), that the social space in between the two extremes of behavioral norms and 'risky' behavioral deviance is too liminal to provide adequate social meaning. One either is a drug user or is not, and recovered addicts exist in a murky place in between. This is, perhaps, what gives a homogenous definition of injection drug users, as a specific, "othered" category, so much discursive room to survive in the public

imagination.

Scholars working in Eastern Europe have also made important contributions to the discussion of identity within risk paradigms and non-traditional uses of "risk." Specifically, questions have been raised about whether (and how) risk can be used as a social and economic resource. Adriana Petryna (2002) has suggested that the official designation of "sufferer"—a person physically affected by the Chernobyl catastrophe—has come to be actively sought after for its social and financial benefits. She spoke of residents deliberately exposing themselves to radiation, since exposure levels are a standardized indicator of risk, in order to achieve the "sufferer" status. In the field of mental health, Jack Friedman (2009) has identified an ad-hoc diagnosis, the "social case," within Romanian psychiatric institutions. This diagnosis simultaneously empowers doctors to use psychiatric treatment and care as a proxy for non-medical social services and encourages patients to invest in the perpetuation of their stigmatized mental health diagnoses for the sake of their social and financial welfare. Jill Owczarzak (2009) has described the social implications of shifting HIV-prevention messages in Poland from targeted, "risk group" centered initiatives to broad public campaigns that spoke of generalized risk behaviors and universal risks. In this instance, the othering of "at risk" identities and the partitioning of society into those who are and those who are not "at risk" proved to be such a powerful construct that prevention messaging targeting the general public spurned a backlash of moral, Catholic, and nationalistic rhetoric, since all actions that might lead to HIV infection are seen as unmoral, un-Catholic, un-Polish behavior. Thus, these categories that emerge from risk paradigms hold enormous potential for all actors across the continuum: doctors, researchers, "at risk" persons, and members of the general public.

**Methods**

Fieldwork for this study was completed in 2007. At that time, Lighthouse was one of only a few organizations in its region that sought out injection drug using clientele for harm reduction services. I spent the majority of my days there shadowing Lighthouse staff and outreach workers in their daily professional and personal routines. I observed staff and clients throughout Lighthouse's programming and agency space, including the central resource center, social work offices, private consultation areas, the community center, stationary and mobile needle exchange sites, the substitution therapy clinic, the local tuberculosis ward, and various parks, alleys and public spaces frequented by outreach workers who seek clients on foot during the day. I also conducted semi-structured interviews with members of the agency's professional staff. My casual interactions with staff and clients were in English, Ukrainian, and Russian. Interviews were conducted in English and Ukrainian—often a mixture of both—according to the interviewee's preference.[2]

**The "Injection Drug User" as a Social Category**

One of the most common springtime sights in the Old Town district of this southern town is dogs—all kinds of dogs that roam in packs as large as ten or twelve. In this regard, the morning that I spent waiting in the park with Ihor was typical.

"There are so many dogs here," I wondered out loud, as a pack trotted past me into the city park. "And they are all so healthy-looking."

Ihor looked at me and let a drag of his cigarette go with a long, slow exhale. "Yes, these are street dogs. You do not have them in America?"

"We do. We have plenty, but the city collects them. Sometimes they try to find homes for them, but mostly they're killed."

He furrowed his eyebrows in a distinctively condescending way. "Here," he said, "we care for our animals."

Ihor is a young doctor who works two days per week at Lighthouse. In the mornings, he accompanies Katya, an outreach worker, on the agency's bright, neon-colored bus, which serves as a mobile needle exchange. Ihor sought out work at Lighthouse for several reasons, not the least of which is the need to earn what he believes is an adequate paycheck. (He once asked me, "Doctors in America, they make big money, yes? Here, we make little money.") He also claims to have a strong, personal drive to work with impoverished patients who lack access to quality medical care and, as an anesthesiologist, feels that his training has prepared him for helping narcotics users particularly well.

For the most part, only Katya interacts with clients when the bus is in operation. Ihor is there to provide medical consultation to clients, should they ask for it, and is very patient and helpful when approached. Otherwise, he spends the majority of his time lingering out the backdoor and smoking. When I join him in conversation, he tells me about the different clients that we see. "This woman is AIDS positive," he says, pointing to a woman approaching the bus with her boyfriend. "This *narcoman* (addict), he has lice in his head. He comes for medicine. And he—" Ihor says, nodding to a fellow sitting in the front and pointing to his own throat, "—he is very drunk today."

Katya spends much less time narrating her work to me. She generally stays busy dealing with clients. While a few new faces are seen from time to time, the vast majority of the people who come for services and supplies are well known. The trust that has been built between them and Katya is strong. Many of the clients, particularly the startlingly few women who come on board from time to time, greet her with great affection.

On that spring day, while sharing a cigarette and watching the street dogs wait patiently for scraps outside a butcher shop, Ihor and I were waiting beside the bus in anticipation of Katya's arrival. She recently emerged, lit cigarette in hand, from the city's buprenorphine dispensary and has stopped to buy a cup of instant coffee from a kiosk on the street corner. After gathering early in the morning at Lighthouse's community center to refill their supplies of syringes, cookers, and condoms, Ihor and Katya always drive to this place as the first order of

business. Here, on the north side of town, opposite one of the busiest commercial centers in the city's bustling Old Town district, resides the city's only substitution therapy clinic, where Katya goes every day to take her prescribed dose of buprenorphine. All of the outreach workers at Lighthouse are former injection drug users, most of whom are also patients in this substitution therapy program. All of the outreach workers at Lighthouse—except for Katya—are men.

When asked about the reason for exclusively hiring former injection drug users as outreach workers, the staff at Lighthouse often answers by referring to studies that have shown that addicts are best reached by those who were once addicts themselves. The decision is characterized as a matter of practicality rather than some agency-specific belief or strategy. When asked to explain why they think this pattern exists, staff remarks often turn to the outward characteristics of their former clients. Drug users and outreach workers are familiar with the same places, know the same dealers and buyers, and share common experiences and personal histories. They even look the same.[3] Ihor explained to me:

> If I want to go out as an outreach worker, I am not good, because I do not use drugs. Katya and another outreach worker can. They—they speak with *narcomans*. And we [indicating himself and me] cannot do this work, because I am not *narcoman*. If I come to a *narcoman* and say, "Come with me. I'll give you needles, condoms," they will not go. They will think I work for the police [said as he tugs on the collar of his designer jacket], not our organization. And Katya, outreach workers, they can gain the trust of *narcomans*. They know Katya, these *narcomans*, and they know that they are not lied to.

It is significant that, in spite of what are clearly complex, multi-faceted causes for this division between injection drug users (current or former) and everybody else, including socioeconomic status, social networks, and a learned body of knowledge, the division was *consistently* articulated in terms of the presence or absence of a personal history with drug use. One of my interactions at the mobile needle exchange was particularly illustrative of this:

"What was your name, again?" Vera asks me. This quiet, middle-aged client gives a kind, embarrassed smile and adds, "Forgive me. I forgot."

"My name is Jennifer," I reply.

Vera pushes her large plastic sunglasses back up onto her nose, her fake nails brushing against the UV sticker that is still affixed to the left lens. "How old are you?"

"I'm twenty-five."

"Ah, still young. I am thirty-seven," she laughs. "Do you shoot drugs?"

"No," I say casually, "I don't inject."

Vera pauses a moment. "Where are you from?"

"Chicago."

"Where?"

"Chicago," says Ihor. "In the USA, by Lake Michigan."

"Wow!" She exclaims with a laugh. "You are so far away!"

This interaction with Vera served as more than just a casual introduction. The conversation was her deliberate attempt to determine my position within locally (and in this case, immediately) relevant social structures. Vera's question, "do you shoot drugs?" reveals the degree to which this label, indicative of a distinct social identity, has been "successfully applied" to those people it is meant to describe (Becker 1973 [1963]:11). Vera also revealed her own acceptance of this label by reproducing and using it in a meaningful context. All those present at the needle exchange belonged either in or out of this "intravenous drug user" category, and Vera sought the specific information needed to define me in this way. In order to be a meaningful, recognizable social actor in this environment, one needs to be labeled as "an addict" or as "everybody else."

**Addiction, Gender, and Conflict between Identities**

The effects of this social labeling have become normalized and are visible on a day-to-day basis in Lighthouse's main offices. Specifically, those who have been categorized as a typical "intravenous drug user" are easily distinguishable through subtle patterns of spatial segregation. There is a distinct divide between the work, roles, and responsibilities assigned to street outreach workers and those whom I refer to as "professional" or "office" staff, most of whom, if not medical practitioners like Ihor, are trained in social service or public health, and who often carry certifications for counseling or social work. The professional staff is uniquely privileged to go into any area of the center, whereas outreach workers move within a limited geography consisting entirely of spaces designed for clients to occupy. For example, the stationary needle exchange, which distributes all the injection materials for the program, is situated right at the front entrance. Three women, Anna, Oksana, and Ivanna, stay behind the counter monitoring paperwork and distributing supplies to outreach staff and walk-in clients. The professional staff comes and goes freely from this area, but the outreach staff congregates at the counter. Past the front entryway is a large room where men usually hang out in the afternoon. Male outreach staff and male clients chortle with each other and circle around a seemingly never-ending backgammon tournament. Professional staff may pass through, or stop in to chat with someone, but they conduct almost no business, social or otherwise, in this space. Finally, in the far back, the professional staff has a shared office behind a door that is frequently closed. Just like the needle exchange out front, the professional staff comes and goes, but outreach workers never enter. They may knock, and, when answered, speak from the doorway, but never actually cross into the office.

Within this landscape, Katya also negotiates her own identity. As an outreach worker and a former injection drug user—though still technically an addict due to her heavily regulated regime of buprenorphine—she limits herself to the main community rooms where other outreach staff and clients like to spend their afternoons. More often than not, though, she remains isolated from the crowd. Sitting alone a few feet from the backgammon game, she busies herself with paperwork and pays little attention to this men's activity to which she, as a woman, has little

access. Katya also gets involved in conversations with Anna, Oksana, and Ivanna by the syringe exchange. They have frequent, chuckle-filled exchanges that look unmistakably like girl-talk, despite the fact that they are discussing things like condom distribution and abscess care. None of the other outreach staff spend as much time with them as Katya does, who is privileged by the fact that she, too, is a woman. Despite Katya's inclusion in the women's discourse, she is not able to fill the same role.

In addition to practically running the front end of Lighthouse's services, Anna, Oksana, and Ivanna make sure everyone is fed, that cakes and cookies are properly distributed, and that everyone has tea or coffee dressed with powdered milk and sugar. They empty all the ashtrays and sweep the front steps. They are as much involved in general housekeeping as they are in the agency's regular services. Katya, on the other hand, does not get to act as mother or housekeeper. She does not make tea. She is someone for whom tea is provided. She is part of the house for which the more traditionally feminine women care. In this way, the embodiment of Katya's gender, which might have been expressed through these expressions of typical, matronly femininity, is stymied.

Tatiana Zhurzhenko has observed that "the…process of national identity formation has involved the construction of images of Ukrainian women and the Ukrainian family through the reinterpretation of historical, ethnographic, and sociological data" (2004:28). This association of the Ukrainian nation with the normative Ukrainian family engages a discourse that perceives the nurturing role of the mother as intricately connected with the health of the nation. "Childbearing and the raising of children are the highest goal and ideal in a women's life… Responsibility for children is responsibility for the contemporary and future society" (Zhurzhenko 2001:6). This move towards the domestic feminine ideal is perceived within nationalist discourses to be a "…[return] to the 'natural' gender roles" (Zhurzhenko 2001: 4), which had previously been altered by Soviet policies that sought to "[apply] principles of democracy… to intrafamily relations, which [Ukrainians] consider to be unequal by their very nature" (Zhurzhenko 2004:26).

Furthermore, Irina Zherebkina (2001) has referred to the actualization of a symbolic body—a female body that has been violated by outside aggressors—in the production of national identity. The normative manifestation of this national womanhood is Berehynia—the mythological goddess and protector of the home and the hearth. In addition to representing heroic claims of national independence, she stands for women, for home, and for family. She justifies the traditional roles of mother and caretaker as, in Zhurzhenko's words, "'natural' and 'vitally important' for society" (Zhurzhenko 2004:4).

Ironically, it is this heightened domestication of Ukrainian women that is often mobilized in order to delegitimize Western feminism. Feminist philosophies are often criticized for the "historical 'humiliation and elimination of Ukrainian manhood'" (Zhurzhenko 2001: 9), as well as the allegedly obvious fact that "Ukrainian women do not need feminism because they are already empowered enough—due to their historical tradition" (Zhurzhenko, 2004: 31). The role of Berehynia does not exist without critics. Natalia Kutova (2005) accuses Berehynia imagery of

forestalling any feminist discourse in the country by publicly relegating the responsibilities of the private sphere to women. Oksana Kis argues that Berehynia "is used to manipulate Ukrainian women," (2005: 118) and Marian Rubchak goes even further to claim that women's false consciousness, which fails to recognize their identity as a central construct in a male-dominant system of power, helps this discourse to spread deeply into the social fabric of Ukrainian society (2001: 158). Women are portrayed by these Ukrainian feminist scholars as victims of the oppressive male society around them on multiple fronts. They are privileged to be the caretakers of the nation, but also surreptitiously shooed away from the public sphere in the process.

Seemingly at odds with this particular, oppressed image of the Ukrainian woman is former Prime Minister Yulia Tymoshenko. She is one of, if not *the*, most politically prominent women in Ukraine. Despite her divisive public image, her nurturing rhetoric and her traditional hairstyle of a married Ukrainian woman make her a favorite example of strong, maternal identity. Rather than being a revolutionary figure for women's political participation in Ukraine, however, Tymoshenko has become the object of a strange sort of tokenism. She has succeeded not in opening pathways for women in Ukrainian politics, but in actualizing *herself* as a figure of womanhood and as mother of the nation. First as prime minister, and now as the charismatic leader of her political party, the Yulia Tymoshenko Bloc (BYuT), she exists almost as a singularity, having claimed the sole, political opportunity to embody the symbolic womanhood of the nation. There is only one Berehynia, and, in effect, there can only be one Yulia Tymoshenko.

I am led to wonder whether Katya is subject to a similar sort of tokenism at Lighthouse. Does she—and I strongly suspect that she does—occupy a singular position of symbolic womanhood that can only be actualized within her achieved role as an injection drug user? Her status as an addict prevents her from achieving traditional femininity to be sure. However, she appears to have been assigned a more feminine or maternal role within that clearly delineated, marginalized, and masculinized addict population. Not only is she presumed to be naturally the best at coaxing or 'mothering' uneasy clients into the program, but the mobile exchange that she operates functions as a surrogate domicile that allows Lighthouse policy and procedures to literally relegate her to an ad hoc private and domestic realm. Among the women of the agency, she will always be a drug user, but among the outreach staff, she is the token woman. Is not her position, then, the epitome of what Zherebkina (2001) calls the "dual standard" of elevation and marginalization as achieved through an embodiment of the Berehynia? On the surface, her role makes female addicts appear visible, while simultaneously obscuring the fact that there is no real place within the organization for female addicts to exist.

## Conclusion

Alexandra Hrycak has claimed that new and hybrid feminisms and identities in Ukraine can be best understood as "resulting from the encounter between the unexamined assumptions of foreign aid projects and the cultural presuppositions, existing networks, and organizational

strategies of local actors" (2006:70-71). Hrycak is quite right in highlighting the productive forces that arise when these two landscapes overlap. This is precisely what we see happening at the intersection of local and international discourses in the realm of HIV-prevention and injection drug user services. I would go farther, though, to argue that the ways in which female identity is locally mediated through other, more potent forms of subjectivity—such as that of an injection drug user—cannot be ignored.

Whether and what room is being made for and by drug-addicted women in non-profits like Lighthouse remains unclear. As more and more foreign money pours into non-profit organizations and networks in Ukraine, women seem to be primarily targeted through empowerment campaigns designed to promote Western feminism (Phillips 2008). Within other targeted development and aid campaigns, such as the harm reduction efforts of Lighthouse, distinctions might not be made at all between the social positions or vulnerabilities of men and women. Androcentric conceptions of drug use and addiction may inadvertently exacerbate for women the social distinctions and inequalities that such programs were designed, in part, to alleviate. They may be seen as addicts first, women second, or as addicts only and not as women at all. Worse, these agencies may end up with tokens of womanhood, with their own local Katya or Yulia, which can give women the illusion of visibility, while actively denying them a socially acceptable space to participate.

---

**Notes**

*Acknowledgements*: Earlier versions of this paper were presented at the 6th Annual Graduate Student Conference hosted by the Graduate Organization for the Study of Europe and Central Asia at University of Pittsburgh (February, 2009) and at the 108th annual meeting of the American Anthropological Association in Philadelphia (November, 2009). I am extremely grateful to Laada Bilaniuk, Helena Goscilo, Sarah D. Phillips, and many of my colleagues at the University of Washington for their thoughtful comments on this paper in its earlier stages.

[1] To protect the privacy of my informants, I have used pseudonyms throughout this article.

[2] All translations into English are my own.

[3] While just beginning my research at Lighthouse and meeting everyone in the organization, even I had difficulty distinguishing between outreach staff and clients due, in part, to similarities of physical appearance, including clothing choices, visible tattoos, and my general impression of their physical health.

**References**

Beck, Ulrich.

1992. Risk *Society: Towards a New Modernity.* London: Sage Publications.

1994. *The Reinvention of Politics: Towards a Theory of Reflexive Modernization. In Reflexive Modernization: Politics, Transition and Aesthetics in the Modern Social Order.* Ulrich Beck, Anthony Giddens, and Scott Lash, eds. Pp 1-55. Cambridge: Polity Press.

Becker, Howard S. 1973 [1963*] Outsiders: Studies in the Sociology of Deviance*. London: The Free Press.

Campbell, Nancy D. and Susan J Shaw 2008. *Incitements to Discourse: Illicit Drugs, Harm Reduction, and the Production of Ethnographic Subjects*. Cultural Anthropology 23(4): 688-717.

Field, Mark G. 1961. *The Doctor-Patient Relationship in the Perspective of 'Fee-for-Service' and 'Third-Party' Medicine.* Journal of Health and Human Behavior 2(4): 252-262.

Friedman, Jack 2009. "The 'Social Case': Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania." Medical Anthropology Quarterly 23(4): 375-396.

Glick Schiller, Nina, Stephen Crystal, and Denver Lewellen. 1994. "Risky Business: The Cultural Construction of AIDS Risk Groups." Social Science and Medicine 38(10): 1337-1346.

Hrycak, Alexandra. 2006. "Foundation Feminism and the Articulation of Hybrid Feminisms in Post-Socialist Ukraine," East European Politics and Societies 20(69).

Human Rights Watch. 2006. "Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS." Human Rights Watch. **18**(2D). Electronic document. (URL: http://hrw.org/reports/2006/ukraine0306/ukraine0306web.pdf). Accessed 03/2007.

Kis, Oksana. 2005. "Choosing Without Choice: Dominant Models of Femininity in Contemporary Ukraine." In Ildiko Morell et. al. eds. Gender Transitions in Russia and Eastern Europe. Eslöv : Förlahs ab Gondolin.

Kutova, Natalia. 2005. "Gender Identity and the Ukrainian Nation-State Formation: Clinging to the Past" Presented at Gender and Power in the New Europe, the 5th European Feminist Research Conference: August 20-24, 2003 Lund University, Sweden. Electronic Document, accessed 08/2010 URL: http://www.iiav.nl/epublications/2003/Gender%5Fand%5Fpower/5thfeminist/paper_343.pdf

Owczarzak, Jill. 2009. "Defining HIV Risk and Determining Responsibility in Postsocialist Poland." Medical Anthropology Quarterly 23(4): 417-435.

Petryna, Adriana. 2002. *Life Exposed: Biological Citizens After Chernobyl*. Princeton: Princeton University Press.

Phillips, Sarah D. 2008. *Women's Social Activism in the New Ukraine: Development and the Politics of Differentiation.* Bloomington: Indiana University Press.

Pinkham, Sophie and Anna Shapoval. 2010. *Making Harm Reduction Work for Women: The Ukrainian Experience*. The Open Society Institute. Electronic Document, accessed 07/2010. URL: http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/harm-reduction-women-ukraine_20100429/harm-reduction-women-ukraine_20100429.pdf

Rubchak, Marian. 2001. "Evolution of a Feminist Consciousness in Ukraine and Russia." The European Journal of Women's Studies. 8(2): 149-160.

Schecter, Kate. 1992. "Soviet Socialized Medicine and the Right to Health Care in a Changing Soviet Union." Human Rights Quarterly 14(2): 206-215.

Scott, S, Prior, L, Wood, F, and Gray, J. 2005. "Repositioning the Patient: The Implications of Being 'At-Risk'" Social Science and Medicine 60: 1869-1879.

UNAIDS.

2007. "Eastern Europe and Central Asia" from 2007 AIDS Epidemic Update. Electronic Document, accessed 03/09. URL: http://data.unaids.org/pub/Report/2008/jc1529_epibriefs_eeurope_casia_en.pdf

2008. "Status of the Global AIDS Epidemic" from 2008 Report on the Global AIDS Epidemic. Electronic Document, accessed 03/2009. URL:http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp29_62_en.pdf

Zherebkina, Irina. 2001. "Who is Afraid of Feminism in Ukraine? How Feminism is Possible as a Post-Soviet Political Project" in Gender in Transition in Eastern and Central Europe, Proceedings. Gabrielle Jaehnert and Jana Gohrisch, eds. Berlin: Trafo Verlag. Pgs. 142-147.

Zhurzhenko, Tatiana.

2001. "Ukrainian Feminism(s): Between Nationalist Myth and Anti-Nationalist Critique." IWM Working Paper No. 4/2001: Vienna. Electronic Document, accessed 10/2010. URL: www.multiculturedonne.com/files/ukr.feminism.pdf

2004. "Strong Women, Weak State: Family Politics and Nation Building in Post-Soviet Ukraine" in Post-Soviet Women Encountering Transition, Kathleen Kuehnast and Carol Nechemias, eds. Washington DC: Woodrow Wilson Center Press. Pgs 23-43.