

Identity Factory: HIV/AIDS and the Figure of Its Sufferer in Early Independent Ukraine

Viktoriya Zhukova, Central European University

Abstract

The article provides an analysis of state discourses on HIV/AIDS and the figure of its sufferer in Ukraine during the early years of the state independence. It examines various analytical categories i.e. race, age, sexuality, drug use, space, etc. involved in the discursive formation of the figure of HIV/AIDS sufferer. In the article, it is not my intention to deny the importance of personal responsibility in prevention of HIV-spread; nor do I intend to say that political-economic and social hardships are the sole factors facilitating the epidemic. I argue, however, that shifting the vector of analysis from power inequalities as perpetuating HIV/AIDS proliferation towards the pathologization of certain categories has served to implicitly justify the state's inefficient action to prevent the HIV-spread. A biomedical approach to the epidemic has produced clusters of categories which reinforced boundaries between the "general population" and "risk groups." This way state discourses temporarily "defended society" from HIV/AIDS, instead of dealing with socio-economic, political and structural inequalities to prevent or slow down the epidemic's spread.

Keywords: HIV/AIDS, discourses, body, space, Ukraine.

Introduction

This article aims to contribute to the critical HIV/ AIDS literature (of which little exists on Eastern Europe) by focusing exclusively on state discourses on HIV/AIDS in Ukraine, from the beginning of the state independence until the first years of the official epidemic in the country. I am interested in exploring the intersection of bodies, spaces, knowledge production, governmentality and the political economy of the epidemic there. I analyze the verbatim record of speeches delivered in 1993-1996 by the first state bodies that were set up to deal with HIV/AIDS in Ukraine: the National Committee to Combat AIDS, Responsible to the President of Ukraine (NCCARPU), and the National Committee on the Problems of Prophylactics of Drug Addiction and AIDS (NCPPDAA). I am interested in the state as an actor involved in the production of discourses on HIV/AIDS that revolve around the coordinate of "general risk", forged in conjunction with particular groups of sufferers as risk factors. I deal with the period prior to, and at the beginning of, the epidemic, when the state was the main stakeholder on HIV/AIDS-related issues (Golichenko 2005). With the NGOization of HIV/AIDS sector in Ukraine since the early 2000s, the state ceased to be the sole actor in dealing with the epidemic.

I employ a Foucauldian approach to the concept of discourse. For Foucault, discourses are fusions of power and knowledge (Foucault 1978:100-2) – they are both a tool and an effect of power, embodying positive aspects of power by producing certain knowledge on

various issues and representing certain groups of people in a particular way, as subjects to/figures of that knowledge. In the context of epidemic disease, biomedical discourses are entities which translate “coordinates of vulnerability to disease” - related to “coordinates of social inequality and powerlessness”¹ - into risk behaviors and call for personal responsibility in the management of disease. Due to the positive aspects of discursive power, diseases serve as a tool of biopolitics,² i.e. for the surveillance, control and normalization of the population(s), as well as the production of certain identities and spaces as more (or less) prone to illness.

To analyze discourses, according to Foucault, is to see what effects of power they support through certain kinds of knowledge production, and to track what political processes facilitate certain discourses at a given point of time (Foucault 2008:100). Similarly, Judith Butler has argued that subjects and identities are constructed in relation to a “politics of dual power”. Both juridical and productive, power here refers to the means by which the legal subject appears as an a priori category represented by law, rather than an effect of juridical power itself (Butler 2006:354):

Juridical power inevitably ‘produces’ what it claims merely to represent . . . the law produces and then conceals the notion of ‘a subject before the law’ in order to invoke that discursive formation as a naturalized foundational premise that subsequently legitimates that law’s own regulatory hegemony (Butler 2006:354).

In a similar vein, Joan Scott emphasizes the need to analyze knowledge production and question normative explanations, not through denying the subjects’ existence, but instead interrogating “the processes of their creation” (Scott 1999:96). It is in the scope of my research interest to analyze such processes while examining discursive representation of HIV/AIDS.

Biomedical Discourse: Bodies and Spaces

From the beginning, the HIV/AIDS epidemic has been approached by dominant discourses throughout the world (deployed by state officials, mass media, medical personnel, etc.) as largely a medical issue. Biomedical interpretations of the epidemic have successfully translated what Susan Craddock calls “coordinates of vulnerability” into behavioral “risk factors” associated with certain groups within the population (i.e. sex workers, intravenous drug users, homosexual men, etc.; Craddock 2000a, 2000b). In biomedical discourses, “risk” is often defined within a paradigmatic framework of socially constructed (moral) rights and (diseased) wrongs, inscribed on particular bodies which inhabit particular, marginalized spaces, threatening disease leakage to the “general population.” As Susan Craddock, while talking about AIDS and tuberculosis, states: “Like smallpox before them, these diseases [AIDS and tuberculosis] are now serving in part as codifiers of normality, a discursive categorization driven largely by medical discourse and embraced by a society wanting to believe itself outside the boundaries of pathological” (Craddock 2000a:253).

Biomedical interpretations of disease are part of the process of its depoliticization. Biomedical discourse shifts analysis of disease, and subsequently responses to it, away from

structural inequalities, environmental and institutional practices involved in the perpetuation of disease to risk behaviors, personal responsibilities and individual bodies. Craddock attributes the emergence of “individualizing” biomedical discourses to the rise of germ theory, which came to facilitate the separation of public health policy from social welfare (Craddock 2000a:13). The process of individualizing disease went hand in hand with the logic of a changing socio-economic order at the end of the 20th century, when cuts in social provision and welfare accompanied the rise of new markets – including pharmaceutical empires – in the US and decentralization in “developing” states, not without the influence of the US and Bretton Woods institutions. In this climate, individualizing risk meant removing it from the realm of public sector responsibility and addressing disease in relation to “risk groups” (Selective Primary Health Care). Such measures appeared to be more economically cost-efficient than following the logic of the WHO-UNICEF Alma-Ata Declaration (1978), with its “Health for All” goal (Fort et. al 2004). Biomedical discourses on disease also served to avert the gaze from the creation of global markets alongside the production of structural and socio-economic inequalities, to focus instead on issues of surveillance, normalization and social control carried out in the name of protecting the “general population” from the leakage of the disease inscribed on “deviant” bodies in marginalized spaces.

Craddock states that in order to contain disease in a definite (marginalized) space, it is necessary to keep marginalized bodies within this space and ensure that they are easily coded according to different analytical criteria: sexuality, ethnicity, nationality, etc. (Craddock 2000a:9). However, in the era of global mobility, this becomes unfeasible. The impossibility of preventing disease leakage out of marginalized zones creates what Craddock refers to as “border anxiety,” a collapsing of both social categories and spatial boundaries” (Craddock 2000a:9). It is largely due to the implicit appeal to the risk of leakage that the biopolitical call “society must be defended” appears over and over again.

Governmentality: The First State Bodies Dealing with HIV/AIDS in Ukraine

The first state body to deal with HIV/AIDS in Ukraine was set up by the Cabinet of Ministers in 1991. The Governmental Committee was in charge of the organization and the implementation of measures to combat AIDS in the Ukrainian Soviet Socialist Republic (Cabinet of Ministers of the Ukrainian SSR 1991). The Committee consisted of about twenty people and was a separate governmental body responsible for dealing with HIV/AIDS on the state level.

The next year, however, the government dissolved the Committee and set up another body, the National Committee to Combat AIDS, responsible to the President of (now independent) Ukraine (President of Ukraine 1992). Among the main tasks of the Committee was to govern, implement and coordinate state AIDS-related measures and policy, facilitate international cooperation and cooperation with the WHO in particular, monitor HIV- spread among the population and assist in the formation of public opinion related to AIDS. The Committee succeeded the Ministry of Health in creating projects and implementing the First National Programs to Combat AIDS (1991-1998), and indeed the relations between the two state agencies were quite tense (NCCARPU 1995:6).

In his speech during the sixth session of the Committee, its Head, V. Ivasyuk, stated that it was due to the establishment of the Committee on the national level, as well as due to the changes made by that committee in the National Program (1992) that Ukraine had gained international recognition in the HIV/AIDS related area and “was recognized as a pilot country, [a] role model for other countries,”³ in its AIDS-related state policy (NCPPDAA 1997:36).

In the first national programs to combat HIV/AIDS as well as during its first sessions, (when there were no officially pronounced HIV/AIDS epidemic in the state yet),⁴ the National Committee addressed socio-economic and political hardships in Ukraine as factors facilitating HIV-spread in the country. Ukrainian analysts also address the period 1990-1994 as one of deep economic decline in Ukraine (Besedin 1996:6).⁵ According to them, economic activity in the state sector has been decreasing constantly. In 1994, the level of production was just 60% of that in 1990 (Geits 2010:17). All industrial branches were in decline, default crisis among national producers rose, and rates of production and selling output continued to decrease (Geits 2010:30). Unemployment rose from 7,000 in 1991 to over one million in 1999 (Bytsyura 2004:14), an effect of the closures of factories and industrial plants that accompanied changes to the economic structure (Bytsyura 2004:17). In 1993, according to Ukrainian analysts the rate of inflation and prices skyrocketed, a phenomenon linked to state budget deficits, the rapid ascension of the US currency and the politics of trade liberalization in Ukraine (Bytsyura 2004:27). The economic situation in Ukraine was among the worst in the post-Soviet world. Between 1990 and 1994, the standard of living of the majority of the population declined by half as a consequence of continuous economic crisis (Besedin 1996:69).

According to Ukrainian analyst Vasiliy Besedin, the shift to a market economy resulted in the rapid worsening of social security and quality of life in Ukraine, gauged by the transformation of 80% of the population into “paupers”, according to international standards:

Qualitative changes in the standard of living of the general population, which accompanied development of market relations in Ukraine during 1990-1994, led to significant qualitative transformations, negative by nature; a decrease of all basic indices of the level of the life of the population is one of the manifestations of economic crisis and inflation (Besedin 1996:75).

Education also suffered (Bytsyura 2004:311-4), as teachers and professors left their positions and educational establishments closed down.⁶ The quality of medical care deteriorated, and the material basis of medical establishments worsened, too. National production of pharmaceutical products was neglected, while state budgets could not afford to import medicines from abroad.

The Committee regarded such conditions as fertile ground for flourishing black market economies: prostitution, drug addiction, and, with them, the spread of the HIV virus. Thus, the statement during the second session of the National Committee in 1993 was typical of general state discourses on HIV/AIDS prior to the epidemic: “...in Eastern Europe, including Ukraine, there are all the factors facilitating [the spread of the] AIDS epidemic:

economic crisis, unemployment, [and the] rise of drug addiction and prostitution.” (NCCARPU 1994:3). Similarly, as participants of the third session of the National Committee in 1994 admitted:

Our country is living through difficult times of active social, economic and political changes. In this situation, problems such as drug pushing, a rise in drug circulation, the spread of prostitution, STDs, etc. have become highly significant ones. The crisis in health care is complicated by financial difficulties and a deficit of resources. These factors lead to serious negative effects on the population, one of which is the further spread of HIV-infection (NCCARPU 1995:9).

In 1995, the then President of Ukraine, L. Kuchma, stated: “AIDS is a multidimensional problem because it combines medical-biological, socio-legislative and economic aspects of our life” (NCCPDAA 1997:3). However, as I shown further in the article, with time, the multidimensionality of HIV/AIDS was addressed less and less on the state level.

The Beginning of the Epidemic

In the mid- to late-1990s, against a background of general impoverishment a new social group of wealthy “oligarchs” was undergoing gradual formation, which only widened the gap between rich and poor and prolonged the crisis in the country further (<http://www.economist.com/node/12078400>; Tyzhden’ 2011:34-5). The restructuring of the Ukrainian economy prioritized particular forms of big business interests (Tyzhden’ 2011:34-5). State budget expenses during the 1990s were often higher than state revenues, reflecting loss of monies due to privatization, taxation, custom dues, excise duties, etc. , with many producers opting to participate in a semi-legal “shadow economy”. During the 1990s, there was also a tendency to pay off the overdue debts of private companies for imported energy resources from the state budget (Geits 2010:68). At the same time, large amounts of money were spent on covering state loans, law-enforcement, national security, and the general maintenance of the state apparatus, etc.

In this period of economic crisis, the transmission and spread of HIV was an issue kept very much in the background. The amount of money required for the social sphere to prevent the epidemic emergence were simply not covered by the budget (Bytsyura 2004:311-4). For instance, in 1995, when the number of HIV-positive people registered in Ukraine increased almost tenfold compared to 1994,⁷ the Ministry of Finance directed only around 10% of the money required by the Committee for the implementation of the National Program to combat HIV/AIDS (NCCPDAA 1997:5).

For a number of years the National Programs to Combat HIV/AIDS in Ukraine could not rely on any external funding either. In 1993, the Committee published a call for donations for the National Program in Ukrainian business newspapers; however, no money was forthcoming. The same year the Committee stated: “we can’t rely on charity donations yet” (NCCARPU 1994:41). The situation was the same for the implementation of the Program the

following year: “except for state money, the Committee has received no financial support from civil and international organizations...” (NCCARPU 1995:40) and the year after that: “except for the state money the Committee has received no financial support from civil and international organizations...” (NCCARPU 1995:59).

Against this background of the epidemic’s emergence “country-wide”, state discourses on HIV/AIDS in Ukraine perceptibly changed. Political and economic hardships, which the Committee referred to as facilitating the spread of HIV in Ukraine, were gradually overshadowed by discourses individualizing the epidemic spread. Apart from medical and social aspects, other factors perpetuating the spread of HIV in Ukraine were addressed less and less on the state level. A year after the epidemic started, the head of the Committee, V. Iavsyuk, admitted that across the world, the AIDS epidemic was addressed as both a socio-political and a bio-medical phenomenon (NCPDAA 1997:35). Nevertheless, he added that in Ukraine the phenomenon was of a mostly social character because officially registered HIV-infected people in the main “led an asocial way of life which made them the root of infection” (NCPDAA, 1997:38). The statement reflects an evolving productive and normalizing process, whereby People Living with HIV/AIDS’ (PLHA) become a discrete and stigmatized set of group identities and individual lifestyles at a time when the economic and political dimensions of AIDS were being increasingly disregarded on the state level.

Measures included by most National Programs to combat AIDS hardly ever addressed economic and political factors as facilitators of the HIV-spread either, instead concentrating on the medicalization of AIDS, donor blood testing, “risk groups” and “safe sex.” During its second session, the National Committee stated that “the disease [AIDS]... can be prevented by taking simple measures: issuing propaganda on normal sexual conduct and basic medical prophylactic treatments” (NCCARPU 1994:16). Hence, the efforts of the state bodies to deal with HIV/AIDS in the country focused more on “governing population” than on addressing more complex processes perpetuating the epidemic emergence and spread (e.g. unemployment, low quality of life, worsening of education and medical care, social and economic insecurities of the great majority of population, etc.).

Categories Constituting the Figure of HIV/AIDS Sufferer in Ukraine (1987-1996)

As it will be shown further in the article, from the first officially registered cases of HIV in Ukraine and throughout the period of epidemic spread across the country, categories constituting the figure of HIV/AIDS sufferer were not stable but constantly changing related to already existing as well as emerging discourses and different socio-political processes taking place in the state.

The first discourses on HIV/AIDS in Ukraine were imported from Western countries, via Soviet Russia,⁸ and linked HIV/AIDS to homosexuality. At the same time, influenced by “Russian-grown” discourses, they also helped construct the figure of the HIV/AIDS sufferer as a foreigner. Thus in Soviet Ukraine, the first references to the figure of the HIV/AIDS sufferer depict him (mostly him) as a foreigner and a homosexual (male). Female extra-familial sexuality was not widely addressed in the written press at that time. Thus, women sex workers and homosexual women were seldom discussed overall, and even more rarely in relation to HIV/AIDS.

The separation of the figure of the HIV/AIDS sufferer from the “general Ukrainian population” was facilitated by a pre-existing concept of Slavic sexual purity, which considered homosexuality as uncharacteristic of Slavs.⁹ Identity construction in Soviet Russia was heavily rooted in an opposition to the “bourgeois West” and “underdeveloped” parts of the East (Healy 2001; Essig 1999). Soviet nation-state formation demanded identity to be cleansed of ‘Western-Eastern abnormalities.’ While the dominant Western paradigm held a “cold-war” picture of the world in which Soviet bloc was depicted as “gray, oppressive, poor, and joyless” (Penezic 1995: 63), Soviet Russia disseminated an image of Western “neurasthenic perversion”, which included the “oriental depravities” of the Caucasus and Central Asia (Healey 2001:253). In this context, the issue of sexuality acquired a tremendous importance for Soviet national identity formation. Communists created this identity on the ideals of compulsory heterosexuality as a distinct sign of Slavic sexual purity. This purity above all served as an evidence of Communist “civilization and modernization” (Healey 2001). Thus, homosexuality for a long time has been perceived as endemic to a race of non-Slavs. (Essig 1999; Healey 2001). Therefore, the already discursively intertwined concepts of homosexual as foreigner in Soviet Russia coherently amalgamated the figure of “HIV- carrier” as well, making this figure foreign/alien to Slavs.

With Ukrainian independence, and in the context of HIV/AIDS in particular, male homosexuality largely ceased to be a publicly debatable topic (Zhukova 2009). Since 1991, Ukrainian nation-state formation has been grounded in opposition to Soviet socialist society. Ukrainian national identity formation has relied heavily on the notion of “neo-familialism,” which marked a return to the “traditional family” (heterosexual, nuclear parents and their children, with a man as breadwinner and a non-working mother) supposedly destroyed by Soviet rule (Zhurzhenko 2001; Zhukova 2008). Therefore, homosexuality and any remnants of Soviet-identity were obstacles to be destroyed in the course of ‘modern’ nation state formation.

Unlike late Soviet and Western discourses, discourses in Ukraine more often targeted injection drug users and heterosexual intercourse rather than homosexuality in connection with HIV/AIDS.¹⁰ Until 1995, official state discourse pointed to heterosexual intercourse as the main root of HIV transmission (NCCARPU 1994; NCCARPU 1995). In 1993, according to the official statistics, out of 141 cases of HIV-transmission, 92 cases (66.2%) occurred through sexual intercourse; 76 of these cases were registered as “heterosexual” (NCCARPU 1994:4). Transmission through injections constituted 15 cases (10.9%), from mother to child 10 cases (7.2%), and in 16.2% of cases the roots of transmission remained unknown. In 1994, heterosexual intercourse was still believed to be the main root of HIV-transmission (NCCARPU 1995:9).

The peculiarity of the situation was that transmission happened mainly within the heterosexual “general population.” In the early-mid nineties, even among intravenous drug users, it was widely held that the infection was spread mainly through sex and not needles. During the third session of the National Committee it was stated that “there are infected drug addicts in Ukraine too but they were infected through sexual intercourse” (NCCARPU 1995:13).

During the second session of the National Committee the concern was raised that: “the low levels of HIV-spread among groups of population at high risk of HIV-transmission

(homosexuals, drug addicts, prostitutes, people with STDs) make us study the situation more deeply” (NCCARPU 1994:4). The same concern was raised during the third session, as the low spread of HIV among “risk groups” continued to be noted, despite the fact that after the collapse of the USSR, “Ukrainian borders were opened” and the number of intravenous drug users (IDUs) in the country rose: “The question appears, is it either really so, meaning that the level of AIDS spread is low, or are we involved in the surveillance of the wrong groups of population with the wrong methods?” (NCCARPU 1995:8,10).

The confusion still remained during the fourth session. The members of the Committee were bewildered by the fact that HIV/AIDS in the country did not involve “risk groups,” which had already been a scapegoat for AIDS in ‘more progressive’ countries for quite a while: “The infection spreads through sexual intercourse (68.5% of all cases)... Unlike in Western countries, in Ukraine, the majority of HIV-infected (more than 2/3) are people who do not belong to the traditional risk groups in the context of AIDS”(NCCARPU 1995:55). Since the epidemiological control of the population reflected no risk groups that might be held responsible for HIV/AIDS within the country, the risk was located outside the borders of the country – the situation Craddock refers to as “border anxiety,” in which space and social categories are collapsed into each other (Craddock 2000:9).

Race/Citizenship vs. Hetero/sexuality

The categories of race and citizenship played out in significant ways at the beginning of the HIV/AIDS epidemic in Ukraine, as state officials worked hard to distinguish carriers of the virus from members of the Ukrainian “general population.”

During the first years, the main root of the infection was foreign citizens who came to Ukraine from African countries to study. Later their numbers went down, but there appeared a new threat of the epidemic spread of AIDS from large numbers of illegal immigrants, among whom we have already registered two people with AIDS...(NCCARPU 1995:55).

Characterizing the state of affairs regarding AIDS across the world, the head of the Committee in 1993, G. Matsuka, stated that the epidemic had stabilized, mainly due to the success of preventive campaigns among homosexuals and IDUs (NCCARPU 1994:13.). However, he stated that two big “reservoirs” for AIDS remained, i.e. heterosexuals and Africa. Matsuka was reproducing a broader global discourse linking AIDS in Africa to AIDS in Ukraine: “It is noteworthy, that in Ukraine there are a big number of students from Africa. Contacts with African countries, in particular commerce, are widening. Therefore, this way of permanently ‘importing’ HIV infection to Ukraine should not be overlooked. By the way, the first cases, according to an epidemiological survey, were also imported” (NCCARPU 1994:13).

The head of the Committee, while constructing AIDS as a disease imported to Ukraine from African “reservoirs” (how else if epidemiological data showed a low level of HIV-transmission among “risk groups”?), concomitantly redefined the Ukrainian

heterosexual population as not being an AIDS reservoir but a population at risk. Hence, sexuality, when combined with nationality/race represented either an “AIDS reservoir” (African) or the “general population at risk” (Ukrainian).

While positioning Ukraine in an oppositional relation to Africa, the head of the Committee at the same time made efforts to portray developments in Ukraine as following a decidedly Western scenario in the context of AIDS, marking the country’s ‘more progressive’ European identity: “According to WHO conclusions, AIDS in our country develops by the same laws (principles) as in the West, but with several years’ lag” (NCCARPU 1994:13). Hence, a geopolitical vector of the newly independent Ukraine directed towards the West was reflected in AIDS discourses on the state level.

Citizenship as a category also played out in the context of AIDS in Ukraine. The split of PLHA in Ukraine into “citizens” and “foreigners” could be traced in the way statistics on AIDS were represented, as follows: “according to the data of the Ukrainian center of AIDS prophylactics and treatment, in 9 months of 1993, 34 people infected with HIV were registered, among them 29 citizens of Ukraine and 5 foreigners” (NCCARPU 1994:3). The same report stated that since 1987 in Ukraine, there had been 141 people infected with HIV and 196 foreigners registered as HIV-infected. According to a report presented during the third session, up to May 1994, in Ukraine among PLHA, there were 205 foreigners and 165 of “our compatriots” (NCCARPU 1995:9).

During the fourth session, the head of the Committee dismissed the national-racial assumption that some races and/or nations are naturally “resistant” to AIDS. At the same time he stated that the reason for the low level of the epidemic in the country might still reflect the peculiarities of Ukrainian AIDS: i.e., HIV in Ukraine might have modified to changing conditions and therefore could not be recognized by diagnostics; or, the ecological situation in Ukraine due to radiation was so bad that the immune system of an average Ukrainian reacted to the virus differently than it might do otherwise in a “classical scenario” (NCCARPU 1995:57). The discourse of “imported” AIDS remained during the session: “We realize that complete transparency – or more precisely absence – of eastern Ukrainian borders and uncertainty of its western borders requires us to have a serious discussion with our neighboring countries in order to guarantee safety of migration in relation to AIDS” (NCCARPU 1995:64).

The fear of the Ukrainian “open borders” was often voiced during the fifth sessions of the Committee:

We have fragile borders as nowhere else in the world. Transit flows of people from all regions of the planet are coming through this country. Inhabitants of the most “HIV-infected” countries actively come to us. And theoretically we can expect that their behavior leads to maximum infection around them (NCCARPU 1995:25-6).

The power of the discourse triggered predictable forms of political reaction. Since the threat of HIV/AIDS to the body of population carried external characteristics, the deportation of foreign carriers seemed to be a logical solution to the case. One of the Russian newspapers addressed then current Ukrainian politics concerning HIV-positive foreigners as a cautionary

tale: "...it is ridiculous to think that control of the foreign immigration will have a sufficient effect here [in Russia] on the spread of the epidemic. Ukraine is a good example in the case. It expatriated all of the infected foreigners from the country and banned the entrance for HIV-positive foreigners into the country, but failed to stop the epidemic anyway" (Ogonek 1996).

When state discourses gradually stopped attributing the virus-spread to foreigners and admitted that HIV reached large numbers of the Ukrainian citizens, the alienation of the virus from the "general population" took place by means of fragmenting "the general" into various "risk groups." From then on, the category of "our citizens" was mainly referred to in official statistics without an explicit intention to blame the category of "foreigners" for the epidemic's spread. For instance, during the fifth session, it was stated that in the period from 1987 to 1995, there were 1,485 cases of infection total - 224 foreigners and 1,261 – Ukrainian citizens (NCCPDAA 1997:7). While summing up the situation with HIV/AIDS in Ukraine during the sixth session, the numbers given referred to "our citizens" predominantly: "In general as of 1st September [1996] in Ukraine...138 of our compatriots reached the final stage of the disease – AIDS; 55 of them died, including 10 children" (NCCPDAA 1997:37). Soon after the epidemic ceased being the issue attributed to foreigners in Ukraine, new categories started to characterize its sufferer in the country, e.g. drug use and its geographical location.

Drugs and Their Regions

Already during the third session, several presenters drew attention to the fact that the number of drug addicts in Ukraine, including IDUs, "was approaching world record levels" (NCCARPU 1995:8, 26). The relation between sex and drugs in the context of HIV/AIDS in Ukraine was maintained during the fourth session in 1995: "In 1994 the first cases of HIV-infected people infected through injection drug use were registered in Ukraine (in Poltava *obl.* (region) and Mykolaiv *obl.*). Obviously, they had numerous partners and this gives us reason to conclude that in our country HIV *potrapyv u seredovyshche narkomaniv* (entered the environment of drug addicts)" (NCCARPU 1995:67).

Thus, illegal drug use and sexual intercourse was linked to HIV-spread among IDUs. During the fourth session, drug related issues were increasingly highlighted. The then current President of Ukraine, L. Kuchma, while opening the session, stated that due to the risk of HIV spread to the environment of drug addicts, Ukrainian political-legislative priorities now included combating *narkobiznes* (drug business) and *narkomafia* (drug mafia) (NCCARPU 1995:51). Another presenter of the session admitted that, by 1995, Ukraine had not only become a transit country for narcotic drugs, but also "a country-user, a country-market and a country-producer" of narcotic drugs (NCCARPU 1995:63).

The end of the year 1995 marked the beginning of the officially recognized epidemic in the country. Since 1991, the main route of HIV-transmission had been believed to be heterosexual intercourse, but during the fifth session of the Committee the epidemic became officially linked to drug addicts. The Committee stated that the epidemic emergence was related to the rapid HIV-spread among injection drug users in certain regions of Ukraine:

The year 1995 witnessed important developments in relation to the spread of the AIDS epidemic in Ukraine, which is connected to the *spalah* (sharp

increase) of HIV/AIDS in Mykolaiv obl. and Odessa obl. [South-Eastern Ukraine] among intravenous drug users... However, we must admit that the registered high levels of infection did not happen today but perhaps have been developing over the last couple of years (NCCARPU 1995:22).

Meanwhile, the speed of the epidemic spread and amount of people infected was dramatically increasing. During the several years prior to 1995, 183 HIV-positive people were registered in Ukraine; in the first 11 months of 1995, 1,100 people were registered, 880 of who were IDUs (NCCPDAA, 1997:7).

With the official beginning of the epidemic, state discourses were quick to produce the main “risk group” based on drug use and locate it in a definite geographical space, preserving the borders between “HIV-reservoirs” and the “general population.” Concomitantly, the discourse naturalized the “IDUs equals HIV” formula by admitting that HIV ‘was already there’ and refusing to dwell further upon the reasons which led to the increase in drug abuse in the newly independent state.

While talking about the explosion of HIV-spread in Ukraine, one of the members of the Committee also linked it to young users of intravenous drugs in the “southern regions”, and he emphasized the general rise of HIV-transmission through sexual intercourse (NCCPDAA 1997:47). During the fifth session of the Committee it was stated that the regions most affected by the epidemic were south-eastern regions, i.e. Donetsk obl., Lugans’k obl., Mykolaiv obl. and Odessa obl. (NCCPDAA 1997:3). By the end of 1995, all regions of Ukraine, apart from Rivnenska, Volynska and Hmelnytska obl. were involved in the epidemic process (NCCPDAA 1997:22-3). The most affected regions were Odesa obl. (520), Mykolaiv obl. (483), Crimea (26), Donetsk obl. (31), Dnipropetrovsk obl. (7), and Kyiv city (40). Southern regions of Ukraine (Odesa obl., Mykolaiv obl., Crimea) were the most affected by the epidemic among IDUs. In 1996, two thirds of all cases of HIV-infection among IDUs occurred in Odesa obl., Mykolaiv obl., Donetsk obl. and Crimea [south-eastern Ukraine] (NCCPDAA, 1997:41-2). Later Dniropetrovsk obl. joined them, and by 1996 there was no HIV- free region in Ukraine. The then current President of Ukraine, L. Kuchma, voiced his concern about the impossibility of controlling HIV/AIDS once it had spread to the environment of drug addicts (NCCPDAA 1997:3).

The resulting situation was a paradoxical one. On the one hand, state discourses on HIV/AIDS referred to an “out of control” epidemic spreading across the country. On the other hand, they linked high numbers of HIV/AIDS to certain well-defined regions and “risk groups,” enclosing the epidemic within certain territorial and bodily boundaries.

Gender, Sexuality, Drugs and Age

With the official beginning of the epidemic the relation between drug use and sexual intercourse did not disappear; on the contrary, it was reinforced in state discourses on HIV/AIDS. During the fifth session, some concerns were voiced that related to sexuality and the gendered dimensions of the epidemic in Ukraine. Until 1993, the percentage of men and women infected with HIV was almost equal. Unlike the US, where the HIV-positive status of women was largely ignored,¹¹ in Ukraine, in official documents and reports, the categories of

HIV-positive women (both pregnant women and mothers) were included - even before the official outbreak of the epidemic. Hence, during the second session of the Committee, it was mentioned that:

According to epidemiological surveys, the number of HIV-positive women in Ukraine constitutes almost half of the general number of HIV-carriers and people with AIDS registered in Ukraine: 61 cases among those aged 16 to 50 years old, respectively. In 10 cases it [infection] occurred as a result of mother to child transmission and during pregnancy, and in two cases due to breastfeeding (NCCARPU 1994:60).

After 1994, however, the share of HIV-positive men began to rise: "...the increase in numbers of HIV-positive men is due to the rise of an active epidemic process among homosexual and bisexual men. It could be that the tendency will continue because among HIV-positive drug addicts registered in 1995 the majority is men" (NCCPDAA 1997:23).

During the sixth session it was announced that among people with AIDS, there were twice as many men as there were women (NCCPDAA 1997:47). While referring to the general spread of HIV-infection in Ukraine, the Committee concluded that the rapid rise of the epidemic among IDUs might trigger its rise among the "general population", as well as among "people without stable [sexual] partners [...]" since from every HIV-infected male drug addict the infection can be transmitted in two ways at once, and from women – in all possible ways" (NCCPDAA 1997:9). Hence, the gender of a female drug addict transformed this figure of the HIV/AIDS sufferer into a more socially dangerous one than her male equivalent.

Since 1995, transmission among IDUs and heterosexual intercourse have been represented as constituting the most widespread modes of HIV-transmission: "Along with the rise of number of HIV-infected people as a result of using intravenous drugs, there is a rise of infection through sexual intercourse (by 13 percent in 1995, compared to 1994). The majority is people with STDs and people who do not have a stable sexual partner" (NCCPDAA 1997:37).

Concomitantly, sexual intercourse as a mode of virus transmission became entwined with representations of promiscuous and/or diseased sexuality: "...it would be a mistake to think that today the problem of HIV transmission through sexual intercourse is not that important any more...the explosion of HIV-infection among certain sections of the heterosexual population – primarily patients of STD clinics, as well as prostitutes and their clients –is going to happen in the near future..." (NCCPDAA 1997:20). Hence, in the context of the epidemic, the heterosexual population was also fragmented into those possessing 'healthy' sexuality and those possessing 'diseased' sexuality.

The relation between sex and drug use also brought age into the equation as another significant factor affecting HIV/AIDS transmission. According to the report delivered during the third session, the majority of HIV-infected people by 1994 were aged 20-40: "people in the most socially productive age" (NCCARPU 1995:10). The fourth session supported the following statement: "the infection affects the most socially active and productive group of the population – those aged 20-40 years old (more than 70% of the infected)" (NCCARPU

1995:55). Since 1995, however, when the epidemic started being linked to drug addicts and the majority of people living with HIV were believed to be unemployed (e.g. “from these 1,000 [HIV-infected] drug addicts only a few work, and the rest of them do not have permanent jobs”) (NCPDAA 1997: 22), the emphasis on the age of HIV-positive people shifted from “socially active and productive” to “sexually active” segments of the population. In other words, active sexuality constituted a threat in itself in the context of the epidemic: “The fact that among the HIV-infected, people aged 20-39 constitute the majority – the most sexually active – means that the next epidemic wave will be the spread of HIV through sexual intercourse” (NCPDAA, 1997: 23).

Initially, the category of age facilitated a representation of HIV-infected people as victims of the disease who were losing their social and productive value for the country as a whole. However, when the category of age was linked to drug use and sexual activity, the ‘victims’ were redefined as the ‘catalyst’ of the forthcoming wave of the epidemic: “Due to the fact that modes of AIDS-transmission¹² and STDs are the same...and also taking into consideration intimate relations between both risk groups in the context of AIDS (drug addicts and people with risky sexual behavior) – we should expect a second, even higher wave of HIV-infection in the near future” (NCPDAA, 1997: 40).

Based on these statements it appeared that people with STDs were necessarily involved in “risky sexual behaviors” with “drug addicts”, and that both these groups represented a significant proportion of the population (with the second wave of the epidemic predicted to be “even higher”). A paradox inevitably paralyzed HIV/AIDS politics in Ukraine at this point, namely: how did this wave of infection reach a “general population” that does not engage in “risky sexual behavior” and does not use drugs? In a context where the entire population is identified to be ‘at risk’, how can we speak of the “general population” as distinct from certain specified risk groups? In other words, does the concept of “risk group” indicate a group which is at risk of becoming HIV-infected? Or does it instead represent a risk for a mysterious “general population”?

Whatever the concept of “risk groups” in the context of HIV/AIDS in Ukraine was supposed to mean, when the groups were finally identified the Committee rushed to declare that the epidemic in Ukraine had begun to reflect a “classical scenario:” i.e. a spread of infection from the “risk groups” to the healthy heterosexual population. This involved a slow spread of infection among the “general/heterosexual population” and a more rapid spread among “people with promiscuous sexual relations, prostitutes and homosexuals,” as well as high spread of infection among IDUs (NCPDAA, 1997: 23).

The “risk groups” that were identified included IDUs, sex workers, homosexuals, prisoners, drivers of international vehicles, etc. (NCPDAA, 1997: 10). During the sixth session one of the members of the Committee drew attention to prisoners as a risk group in the context of HIV/AIDS. Taken at face value, however, the statement might apply to any “risk group”: “There is no good evidence that the epidemic of HIV-infection started in prisons, but taking into consideration the fact that we cannot *protystoyaty ts’omu* (prevent it) only by mandatory medical check up and diagnosing prisoners with AIDS, it is clear that the epidemic will start growing from within” (NCPDAA, 1997: 43).

The above mentioned statement, alongside the fact that between 1987 and 1995 during all the four sessions the main way of HIV-transmission was regarded as heterosexual

intercourse, indicates that the epidemic might be seen as a result of the inability of the state officials to prevent HIV-spread (*protystoyaty ts'omu*), which as a consequence started “growing from within” various communities. With time, general discourses on HIV/AIDS defined some of these communities as “risk groups,” representing HIV-spread as an issue of personal responsibility and avoiding larger political-economic processes perpetuating the epidemic (e.g. general impoverishment of the population, unemployment, and decrease in the quality of life, motivations driving people onto the street for drugs, into sex work, etc.).

While certain groups were labeled “risk groups” in their relations to the epidemic, the spread of HIV in other groups went largely unaddressed. For instance, even though there was a significant increase of HIV-infection registered among young military men in Odesa obl. and Mykolaiv obl., especially those who were to serve their military service in the army in spring 1995, this group was not mentioned as a risk group in the context of HIV/AIDS during the sessions (NCPPDAA, 1997: 7). On the contrary, the increase of HIV-spread among “other groups” (i.e. drug addicts, prisoners, people with STDs and those who did not have a stable partner) went “especially noticed” by the members of the Committee, which often referred to them as “risk groups”, following its function to “defend” (control, normalize and govern) (NCPPDAA, 1997: 38).¹³

Conclusion

The discursive formation of the figure of HIV/AIDS sufferer in Ukraine varies with time depending on the different processes involved in its formation. State bodies dealing with the epidemic played an important role in knowledge production concerning the epidemic. Although relying on existing discourses on HIV/AIDS in the world, the Ukrainian state did not become their passive recipient. Knowledge production in the state went in line with nation state formation, obscuring certain categories and giving more emphasis to the others depending on their relation to already existing state discourses.

With the development of the epidemic, constellations of categories representing its sufferer were undergoing gradual change. The collapsing of bodies and spaces as “HIV-reservoirs” shifted from an external location (African AIDS, illegal migrants) to defined regions and bodies within the Ukrainian population. Prior to the epidemic the line between ‘healthy’ and ‘diseased’ was written largely with race and citizenship. With the emergence of the epidemic within the state among “our compatriots,” state discourses started fragmenting the “general population” from within. It was no longer an external enemy but a particular sub-race within the Ukrainian population that represented risk of HIV-infection. In an effort to make the epidemic tangible and to a certain extent controllable, state discourses located it within the margins of definite groups and spaces. On the one hand, it facilitated the biopolitical function of the state bodies. On the other hand, it temporarily locked the epidemic within its “reservoirs.” This way the biomedical interpretation of HIV/AIDS also justified the lack of the Ukrainian state’s involvement with political-economic and social hardships that perpetuated the epidemic spread. Instead, such discourses were translating coordinates of power inequalities into personal risk behaviors and inscribed them on certain bodies and territories as “diseased” or, in this particular case, as “HIV-infected.”

Acknowledgements: I would like to thank Sarah D. Phillips and Elissa Helms for providing me with this excellent publishing opportunity. I am also very grateful to my supervisor, Anna Loutfi, for her inspiring work, good advice and continuous support of my research project and her generous help with polishing this article.

¹ The idea of the relation between coordinates of vulnerability to disease, coordinates of social inequality and powerlessness and risk behaviors is taken from Craddock (2000a).

² By ‘biopolitics’ I refer to a set of (transnational) governmental politics which concentrate on managing “health, hygiene, birth rate, life expectancy, race...” of population. The notion of biopolitics helps to explain politicization of health and its relations with the realm of the social through the discourses and practices which strive at normalization and control of various social groups (Foucault 2008: 317).

³ All translations of the researched material into English are mine.

⁴ According to the official narrative, the first cases of HIV/AIDS among the citizens of Ukraine were registered in 1987. During the next seven years the HIV- spread was slow but gradually increasing by 15-30 cases per year. By the end of 1994, there were 183 officially registered HIV-positive people. The majority of the first cases of HIV-transmission in the country, according to the state data, happened through heterosexual intercourse. During the period from 1987 to 1994, 43 citizens of Ukraine were diagnosed with AIDS, in 1994 – 17 new cases were registered (NCPDAA 1997: 37, 47).

⁵ A more profound analysis of politico-economic processes, including the role of neo-liberalism, “shock therapy,” “transition” and local elites in the history of independent Ukraine is not provided in the article mainly due to the space constraint.

⁶ In 1993 alone, more than 25,000 teachers and more than 5,000 professors resigned (Bytsyura 2004:311-4).

⁷ By the end of 1995 the number of HIV-infected people in Ukraine constituted already 1,490 cases (NCPDAA 1997:37). Drug users started to represent 70% of the registered HIV-positive people in 1995, marking the epidemic emergence in Ukraine. In September 1996, the total number of registered HIV-positive people in the country constituted 9,720 cases. In 1995 there were 38 new cases registered of people diagnosed with AIDS and for the first nine months of 1996 their number rose to 89 cases; of those diagnosed with HIV, 44% already had AIDS (NCPDAA 1997:47).

⁸ Most of the research findings were presented in the paper Zhukova 2009.

⁹ For more information see Healey 2001, Essig 1999, Penezic 1995, Zhukova 2009.

¹⁰ According to Golichenko, it is only in 2001-2005 that men having sex with men (MSM), appear in general discourses as a more or less prevailing way of HIV transmission, following IDU, heterosexual sex, and sex workers (Golichenko 2005); The research published in the book *Gender and HIV/AIDS: New Approach to Prevention and Politics* (2004) states that according to the bulletin of the Ministry of Health and National Center of Combating AIDS #

23, 2004, in Ukraine there were only 46 registered cases of HIV-transmission through homosexual intercourse, two new cases were registered in 2002 and tree cases registered in 2003 (Midentsev 2004:8).

¹¹ In the Western context at the beginning of the epidemics, the figure of HIV positive women was constructed as often “invisible victims” of HIV/AIDS. Consequently, very little attention, research and resources were directed at HIV-positive women. This silence was pointed out by one of the US HIV/AIDS related activist group, ACT UP, challenging sexism in medical and governmental institutions with slogans like “Women Don't Get AIDS. They Only Die from It!” (Stockdill 2003:7-8).

¹² By that time in the reports of the Committee one could still notice the confusion between HIV and AIDS by the members of the Committee. Calling it “modes of AIDS transmission,” the member of the Committee refers to modes of HIV-transmission. The HIV being a virus can be transmitted, AIDS being a syndrome of immune deficiency cannot.

¹³ Taking into consideration the close relationship between drug addiction, STDs and AIDS in Ukraine, during the sixth session the Committee (1996) declared a need to combine respective programs on their prophylactics into one program. As a result they set up a NCPPDAA, under the purview of the Cabinet of Ministers (NCPPDAA, 1997:40). The same year the National Committee on Prophylactics of Drug Addiction and AIDS was set up as a central body of executive authority on the basis of the Committee on AIDS (President of Ukraine 1996). A year later, however, the Committee lost its “national” status and became responsible to the Ministry of Health ((President of Ukraine 1997). In 1998 the Committee was dismissed and its head, V. Ivasyuk, lost his position, too. Instead of the Committee, the National Coordinative Council on the issues of AIDS prevention was set up in 1999 (Cabinet of Ministers of Ukraine 1999). The majority of the members of the former Committee were not included in the Council.

References

- Besedin V.F. 1996. *Overview of the Economy of Ukraine*. Edited by Besedin V.F. and Kulpinska L.K., Vol. 1; Kyiv: Institute of Economy.
- Butler, Judith. 2006 [1990]. “Excerpts from Gender Trouble” (1990). In *Theorizing Feminisms*. Edited by Elizabeth Hacketts and Sally Haslinger, eds.; New York: Oxford University Press.
- Bytsyura, Yuriy V. 2004. *Economy of Ukraine in Numbers: Methodological Manual*. Kamyanets-Podilskyi: Abetka-NOVA.
- Cabinet of Ministers of the Ukrainian SSR. Decree # 68. June, 4, 1991.
- Cabinet of Ministers of Ukraine Decree of the #1492. August 13, 1999.
- Craddock, Susan. 2000a. *City of Plagues: Disease, Poverty, and Deviance in San Francisco*. Minneapolis: University of Minnesota Press.

- Craddock, Susan. 2000b. "Disease, Social Identity, and Risk: Rethinking the Geography of AIDS." In *Transactions of the Institute of British Geographers, New Series/Vol. 25*, No. 2: 153-168.
- Essig, Laurie. 1999. *Queer in Russia: The Story of Sex, Self, and the Other*. Durham and London: Duke University Press.
- Fort, Meredith. 2004. *Sickness and Wealth: The Corporate Assault on Global Health*, ed. by Meredith Fort, Mary Anne Mercer, and Oscar Gish., Cambridge, Mass.: South End Press.
- Foucault, Michel . 2008. *The Birth of Biopolitics : Lectures at the Collège de France, 1978-79*. Edited by Michel Senellart ; transl. by Graham Burchell, Basingstoke [England] ; New York : Palgrave Macmillan.
- Foucault, Michel. 1978. *The History of Sexuality: Vol. 1, an Introduction* , New York: Pantheon.
- Geits, V. M. 2010. *Ukrainian Economy 1991-2009*. Edited y Geits V. M., Danylenko A.I., et. al.: Kyiv: Derzhkomstat Ukrainy.
- Golichenko, O. 2005. "International Organizations State and Civil Society : the Case of HIV/AIDS Policies in Ukraine (1995-2005)," MA thesis, Budapest: CEU, Budapest College.
- Healey, Dan. 2001. *Homosexual Desire in Revolutionary Russia: The Regulation of Sexual and Gender Dissent* , Chicago and London: The University of Chicago Press.
- HU OSA 205-4-206, container 182, AIDS 1995-1995:Social Issues, Russia, "AIDS Does not Hurt Our Sight?", *Ogonek (Flashlight)* (29.05.1996
- Midentsev, Sergiy. 2004. *Гендер та ВІЛ / СНІД: новий підхід до запобігання і політики* (Gender and HIV/AIDS: New Approach to Prevention and Politics), Ukraine: UNDP.
- National Committee on Combating AIDS, Responsible to the President of Ukraine. 1994. *Collection of Materials of the Second Session of the National Committee on Combating AIDS, Responsible to the President of Ukraine: Verbatim Record of Speeches 8-9 November, 1993*, Kyiv , Kyiv: Zdorovya.
- National Committee on Combating AIDS, Responsible to the President of Ukraine. 1995. *Collection of Materials of the Third and Forth Sessions of the National Committee on Combating AIDS, Responsible to the President of Ukraine: Verbatim Record of Speeches 23-24 May 1994, 24 January 1995* Kyiv , Kyiv: Zdorovya.
- NCPDAA. 1997.

Collection of Materials of the Fifth and Sixth Sessions of the NCPPDAA: Verbatim Record of Speeches 19-20 December 1995(Kyiv), 5 December1996 (Odesa), Kyiv: Zdorovya.

Penezic, Vida. 1995. "Women in Yougoslava." In *Post-communism and the Body Politic*, ed. Ellen Berry, New York: University of New York Press.

President of Ukraine. Decree #141/92-pn. "On the National Committee on Fighting AIDS." September, 16, 1992.

President of Ukraine. Decree N 1184/96 "On the National Committee of Prophylactics of Drug Addiction and AIDS". December, 10, 1996.

President of Ukraine. Decree N 1275/97 "On the Committee on Prophylactics of Drug Addiction and AIDS." November 14, 1997.

Scott, Joan. 1999 (1991). "The Evidence of Experience." In Sharlene Hesse-Biber, et al., *Feminist Approaches to Methodology*; New York: Oxford University Press.

Stockdill, Brett C. 2003. *Activism Against AIDS: At the Intersections of Sexuality, Race, Gender, and Class*. Boulder, CO: Lynne Rienner.

"Twenty Years of Distress without Elite." In *Tyzhden* # 33 (198) Aug-Sept 2011.

"Ukraine: Country Fact Sheet." Sep 24th 2008. In *The Economist*.
<http://www.economist.com/node/12078400>

Zhukova, Viktoriya. 2008. *An Ideal Victim: Gendering the Legal Subject in Domestic Violence Politics and Discourses. Supranational and (Ukrainian) National Levels*. The US/UK: VDM Verlag Dr. Muller.

Zhukova, Viktoriya. 2009. "Ukraine without AIDS or AIDS without Ukraine?": Discourses On HIV/AIDS and the Subject(s) of its Sufferer in Ukraine, 1998-1995". Paper presented for the course "Foucault – A Critical Introduction", CEU, Budapest, Hungary, November 19.

Zhurzhenko, Tetiana. 2001. "Strong Women, Weak State: Family Politics, and Nation Building in Post-Soviet Ukraine." In *Social Reproduction and Gender Politics in Ukraine*, Kharkiv: Folio.