Published in final edited form as:

Cult Health Sex. 2018 November ; 20(11): 1171–1184. doi:10.1080/13691058.2017.1421708.

‘Pure’ drug users, commercial sex workers and ‘ordinary girls’: gendered narratives of HIV risk and prevention in post-Soviet Ukraine

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Abstract

International best practices call for a gender-responsive approach to HIV prevention for women, including those who use drugs and those who engage in sex work. This paper draws on multiple qualitative data sources collected over five years in Ukraine to explore the notions of gender, women and family that buttress HIV-related programmes for women. Our analysis reveals that service providers often cast women as hapless victims of unfortunate family circumstances and troubled personal relationships that produce sudden poverty, or social strivers who seek access to wealth and privilege at the expense of their health. Women are portrayed as most vulnerable to HIV when they lack a male ‘protector’. We argue that the programmes constituted around these stereotypes of women and their vulnerabilities reflect new forms of institutional power that deflect attention away from gendered socio-economic processes that contribute to women’s HIV vulnerability, including job insecurity and unemployment, workplace discrimination, unreliable social benefits and power imbalances within their relationships. We explore how to transform HIV prevention efforts to better address the causes of women’s increased vulnerability to HIV in Ukraine and in Eastern Europe more generally.

Keywords

Ukraine; women; gender; HIV; drug use

Introduction

In September 2014, members of a US and Ukraine-based research team and eight representatives from Ukrainian HIV prevention agencies met in Vilnius, Lithuania to finalise a survey to assess the effectiveness of HIV prevention programmes developed by the agencies (Owczarzak, Filippova, and Phillips 2014; Owczarzak et al. 2016). Because one of the agencies planned to work with female clients exclusively and the others planned to

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Disclosure statement

The authors have no conflicts of interest that could affect their objectivity.

include women in their work, we needed survey questions that captured the unique risks women face related to drug and condom use with sex partners. To develop the survey, we conducted a thorough literature review related to HIV risk among women, with a focus on Ukraine and other post-Soviet contexts. We also consulted public health researchers experienced with working on HIV-related issues in Ukraine and Eastern Europe in general and with women in particular. In the survey, our inclusion of references to *mamkas* (мамки) (female pimps) and *tochkas* (на точке) (an outdoor market for prostitutes) and finding sex trade partners at train stations and along highways, hinted at an understanding of local experience. In place of ‘sex work’ and ‘client’, we used what we considered neutral (but admittedly cumbersome) phrases such as ‘exchanged sex of any kind to get money, drugs, a place to stay or any other goods and services’ and ‘a partner who paid you for sex’. We aimed to convey our understanding that ‘sexual contact in exchange’ for goods, money, shelter, drugs and sex work may not be the same thing, and that some women may not want to identify as ‘sex workers’.¹

***Mamkas, tochkas* and the creation of a localised understanding of HIV risk**

Problems with our questions were quickly revealed when we piloted the survey in Vilnius among the agency representatives and later when the survey was administered to clients. For example, we knew that agencies were recruiting women known by staff to engage in sex exchange broadly defined (for example, both women who identified as sex workers and those who engaged in ‘compensated dating’ (Swader and Vorobeva 2015; Swader, Strelkova, and Sutormina 2013)). However, we were getting extremely low response rates to the questions about women’s experience with sex exchange. Respondents were either skipping these questions entirely or choosing ‘Refuse to answer.’

When we queried staff of the agency that worked exclusively with women, the programme director explained:

For this project we have recruited only those female IDUs [injection drug users] (женщин ПИН[потребители инъекционных наркотиков]) who are eligible for our HIV prevention intervention; some of them ... have experience in providing commercial sex (for money, shelter, drugs, gifts) and others don’t. However, we also have clients who do not consider themselves CSWs [commercial sex workers] (работники коммерческого секса), since they consider sex with several partners as friendly and for mutual pleasure. So, if their friends give them drugs, gifts, etc., it is a sign of goodwill or a friendly gesture ... Having a permanent sexual partner or husband at the same time does not change anything. Psychologically, it is very difficult for them to accept that they are sex workers. They even show aggression and contempt toward CSWs. Therefore, any hints or questions alluding to commercial work would provoke denial. ... [When completing the survey,] ... they just ... [select] ... ‘I don’t know’, and ‘I don’t want to answer.’

¹A typical question in our survey around ‘sexual exchange’ read thus: ‘Случалось ли Вам когда-либо в жизни вступать в любые половые контакты в обмен на деньги, наркотики, приют или другие вещи или услуги?’ Trans: ‘Have you ever entered into any sexual contacts in exchange for money, narcotics, shelter or other goods or services?’

That is, women filling out the survey understood that ‘exchange’ implied ‘sex work’, but the term ‘exchange’ also erased the complex sexual, emotional and pragmatic aspects of women’s relationships to their sex partners. Moreover, our agency partners emphasised that commercial sex workers and drug users were two different groups with distinct risk profiles, different types of relationships and even different demeanours.

Gendering HIV risk and prevention

Discussion about how to ask study participants about their involvement in sex work reflects a broader debate within public health about women’s HIV risks. In general, women face different HIV-related risks than men, and these risks are shaped by power dynamics within relationships; and marginalisation, stigma and isolation within their communities – especially for women who use drugs (Blankenship and Koester 2002; Cleland et al. 2007). Research has documented that women who use drugs are more likely to delay approaching health facilities than men who use drugs (WHO 2008), are less likely than men to use needle/syringe exchange services (Magnus et al. 2013) and may try to hide their drug use so as to avoid the negative reactions associated with breaching stereotyped gender roles (e.g. having their children removed from their custody) (Barnard 1993).

As our opening vignette suggests, what constitutes risky sex, is contested. Various phrases – transactional sex, commercial sex work, sex exchange and prostitution – are used in public health research to better capture and understand women’s vulnerabilities to HIV. The term transactional sex for example often refers to the exchange of gifts (material, monetary) for sex framed outside of prostitution or sex work by those who participate in the exchange (Stoebenau et al. 2011). Commercial sex work or prostitution on the other hand is often understood to refer to cash given by a sex partner for a single act of sex. Despite this parsing, terms such as commercial sex work and transactional sex may belie local sex work economies and concomitant differences in HIV and other risks. For example, in Ukraine, sex work takes many forms, including street-based sex workers who find partners on their own or through a pimp, and more formalised sex work that may be run out of hotels or other fixed locations. These two categories of sex workers potentially face different HIV risks. Women engaged in more formalised sex work may benefit from established relationships between the pimp and non-governmental organisations (NGOs) that distribute prevention materials (condoms, lubricants) and educational materials, and conduct HIV and sexually transmitted infection tests. By contrast, women who seek partners on their own by standing on the sides of roads may lack access to such resources (Alliance 2013).

Moreover, the lines between transactional sex, sex exchange and commercial sex work are often blurry and contested, as the above vignette highlighted (Jewkes et al. 2012). For example, while material gain may be one factor that sustains a sexual relationship, other factors such as love, emotional support and social expedience may also play a role in transactional sex (Jewkes et al. 2012; Swader and Vorobeve 2015). Material rewards for sex may not be perceived as problematic or stigmatising, particularly when romantic love may be expressed through gifts, and sex given without material reward may be perceived as demeaning for women, as in South Africa (Jewkes et al. 2012). Research has also demonstrated that not using condoms and sharing needles with drug and sex partners can be

a sign of trust between women and their partners (e.g. Sobo 1995). Women engaged in sex work, transactional sex or trafficking may have little say in the negotiation of their partners' drug and condom use, which consequently increases their risks of being infected with HIV. At the same time, women labelled as sex workers may face discrimination and can prompt risks for police abuse and harassment, as well as coercive sex and physical violence at the hands of clients and other partners, all with significant HIV risk implications (Decker et al. 2012, 2013).

In recognition of women's complex and unique HIV risks, numerous international policy and funding organisations have called for gender-specific HIV-related programming, particularly for women who use drugs. For example, the New Funding Model of the Global Fund to Fight AIDS, Tuberculosis and Malaria encourages applicants to include gender-responsive programming in their funding requests and outlines recommendations for ensuring gender equality (Ukraine Harmonized AIDS Response Progress Report 2014). A gender-responsive approach to HIV prevention acknowledges the ways in which violence, marginalisation and discrimination against women and girls create vulnerability to HIV, and strives to address these root causes through rights-based advocacy and empowerment strategies (Bloom and Covington 2008; Fried and Kelly 2011; Tang et al. 2012). Gender-responsive programmes also aim to address the contextual factors that contribute to HIV risk among women who use drugs (El-Bassel and Schilling 1992; El-Bassel et al. 2011, 2014; Kissin et al. 2014; Strathdee, Beletsky, and Kerr 2015; Strathdee et al. 2011).

Similar to other countries, in Ukraine, donor mandates have spurred increased attention to women, substance use and HIV risk (Burruano 2010; Gaventa 2013; Ukrainian Ministry of Health 2010; Ukraine Harmonized AIDS Response Progress Report 2014). For example, in 2010 the US President's Emergency Plan for AIDS Relief (PEPFAR) – a significant source of funds for HIV-related programmes in Ukraine – partnered with the Alliance for Public Health (formerly the International HIV/AIDS Alliance in Ukraine) to launch several initiatives to help understand and address the needs of women who use drugs. PEPFAR supported several pilot projects in Ukraine aimed at increasing women's access to and use of HIV prevention and other harm-reduction services, including short term child care at project sites, secondary syringe exchange and NGO staff training on gender issues and gender-specific HIV risk practices. The Global Fund to Fight AIDS, Tuberculosis and Malaria – the most significant source for HIV-related funding in Ukraine – also increased its support for programmes for women, particularly for commercial sex workers.

In this paper, we explore the connection between gender and HIV in the Ukrainian context, with a focus on how ideas of gender, women and vulnerability are expressed through and incorporated into the HIV prevention programmes of NGOs. In particular, we look at the ways in which risk for HIV through drug use and sex are seen as intertwined or separate issues for Ukrainian women. We ask what kinds of gendered subjects these 'gender-sensitive' and 'gender responsive' programmes in post-Soviet Ukraine construe women at risk for HIV to be. We also explore what types of prevention programmes are available for women, and how they reinforce or challenge existing gender paradigms and ideas about risk. We argue that these programmes reflect new forms of institutional power that use particular

interpretations of vulnerability, sex work, womanhood and intervention to constitute women and their struggles in profoundly influential ways.

Methods

Our paper draws on data collected during a five-year HIV prevention project that included site visits, in-depth interviews, structured interviews, focus groups and conversations with staff from eight HIV-focused NGOs in the central, southern and eastern regions of Ukraine, areas with the highest HIV rates and epidemics concentrated among people who inject drugs (PWID). Agencies were recruited as part of a larger study investigating the ability of NGOs to develop and implement behaviour change HIV prevention interventions (Owczarzak, Filippova, and Phillips 2014; Owczarzak et al. 2016). We announced the study to HIV prevention organisations throughout Ukraine and invited interested agencies to complete an application. We selected 8 NGOs from the 14 that completed the applications to reflect real-world variability in terms of agency history, size, mission and context. All study agencies worked from a harm reduction perspective with diverse clients, including people who inject drugs, and conducted street-level outreach that included needle distribution/exchange and information dissemination. Agencies also provided a range of other services including HIV and hepatitis C testing, social support, community centres, psychosocial support for opioid substitution therapy patients and advocacy. Agencies varied in size, from a small NGO primarily staffed by volunteers to a large organisation staffed by paid professionals. Study NGOs differed significantly in their leadership, which included medical doctors, former drug users, university professors and lawyers.

In 2013, we conducted 54 in-depth, semi-structured interviews with directors, staff and volunteers from these eight NGOs (see Table 1). Programme directors and staff in the study sample were not evenly distributed across agencies due to differences in agency size and scope. Of the interview participants in agency director-level positions, seven were female and nine were male. Among the 38 interview participants in staff positions, 26 were female and 12 were male. (See Table 2.)

All interviews were conducted in Russian (informants' preferred language) by members of the research team and digitally recorded; interviews lasted between 30 minutes and 3 hours. All interview participants provided informed consent. This research was approved by the Institutional Review Boards at Johns Hopkins School of Public Health and the Sociological Association of Ukraine. Interviews were conducted in private rooms at the person's place of employment. The interviews were semi-structured, organised around an interview guide with a set of topics to be covered during the interview depending on the individual's position in the agency (e.g. agency director, programme director, outreach worker) but allowed flexibility to probe participant responses and explore topics in greater depth (Bernard 2011). Among other topics, participants were asked about their experience working at the organisation and on topics related to HIV and drug use; the target populations with which they work; how they understand drug addiction and what treatment options are available for people who use drugs; policies towards drug users that affect their work; and how drug users are viewed and treated in Ukraine.

During site visits and interviews, we asked interviewees to tell us their ideas about what leads people to use drugs and what puts the populations they work with at risk for HIV. While we did not ask gender-specific questions, our interlocutors often took the conversation in that direction and honed in on gender differentiated risks and experiences. When agency staff indicated that they had programmes specifically for either women or men, we asked them to elaborate on these programmes, including who works in these programmes, why they were started and the underlying philosophy and approach that informs the work. Additional information about the gendered dimensions of these programmes emerged throughout the research project and site visits. Extensive field notes were written after all site visits. Focus groups and other meetings with providers were digitally recorded and notes taken.

Analysis

Interviews were transcribed verbatim into Russian by a native Russian speaker and checked for accuracy against the original audio recording. Russian language transcripts were entered in MAXQDA, a qualitative data management and analysis software program (VERBI GmbH 2011) to be coded and sorted.

Next, the first and second authors (JO and SP) and a Ukrainian research team collaboratively and iteratively developed the coding scheme to ensure reliability and consistency (Carey, Morgan, and Oxtoby 1996; Ryan 1999). All team members first read the same transcript and identified preliminary themes such as HIV experience and training, organisational context, target populations, prevention programmes and services and drug use. We then developed an initial coding scheme and each team member individually coded the same transcript with this initial coding scheme. After discussion, the coding tree was revised to clarify coding definitions, add new codes, remove unnecessary codes and create categories of related codes. In addition to codes for particular target populations, new codes relevant to the current analysis included ‘attitudes toward clients’, ‘barriers to services’, ‘ideas about behaviour change’, ‘ideal prevention programmes’, ‘stigma and discrimination’, ‘social support’ and ‘HIV risks’. Each team member then used this revised coding scheme to code a second transcript. After discussion to resolve any continued discrepancy in application of the codes and to clarify code definitions, the coding scheme was finalised. Then each team member coded a subset of the total interviews and the final set of 54 coded interviews was entered into a common MAXQDA database for further analysis and interpretation.

Second-level and axial coding explored issues of gender more specifically and the relationships between codes. This analysis focused on reasons and ways – as identified by service providers – that women are at risk for HIV (for example, why they engage in sex work), how women and men are conceptualised as the same or different in terms of HIV risks and prevention needs, how women’s roles as mothers fit into programme development and service provision, how different aspects of HIV risk (i.e. sex and drug use-related risks) were addressed among female clients, and women’s specific barriers to services (e.g. stigma).

Results

Conceptualising women and women's risk

Agency staff explained *who* they saw as at risk for HIV and *why* they were at risk. When talking about women, a commonly expressed view pointed to life circumstances such as poverty and unstable family situations (for example, growing up in an orphanage) that led young women to sex work:

I used to work at an orphanage. These children just did not have anybody. When it was time ... to leave ... some of them had relatives who did not want them at all ... They were given a pair of underwear, a set of bedding, then sent to the gates and there life begins. Many girls became CSWs (Очень многие девчонки переходили в РКСницы).² (Tereza, agency 3, social worker)

A similar narrative suggested that women entered into sex work out of practical necessity: fathers and husbands did not provide for them financially, and the women became sex workers to help the family, presumably because they lacked other options such as formal employment:

There are women who – I have some special sympathy towards them – because of life circumstances, because their financial economic situation collapsed radically, because the family fell apart. Like, her husband left and didn't care at all. And in order to feed the family, the woman ... Here's a victim, she went to the highway (вот жертва -то есть она пошла на трассу) [for sex work]. (Valia, agency 3, psychologist)

In these narrative formulations, and without male figures in their lives taking care of them, women became 'victims'. Together, women in these scenarios were cast as 'lost children' without the social ties necessary to ensure economic survival. On the one hand, women in these narratives lack economic opportunity and are buffeted by the negative forces of social isolation and the absence of a social or economic safety net. On the other hand, they are portrayed as having some sense of personal agency but no real choices: the only option for survival is sex work.

A contrasting narrative portrayed socio-economic desires for wealth and privilege as a driving factor in a woman's decision to engage in transactional sex – that is, the exchange of sex for gifts rather than money:

We see ordinary girls from ordinary families (обычные девочки из обычных семей) ... coming to the bars and cafes. Ordinary girls, to put it bluntly, who are also coming to be picked up (приходят на съём), only not for money, but for a ride in a nice jeep or a visit to some night club, or something else. ... Probably that is because TV, mass media and all of this promotes the luxurious life, and many get attracted to this. (Vasya, agency 2, project manager)

In contrast to the women in the preceding narrative about those who engage in sex work out of economic necessity, the agency staff characterised these 'ordinary girls' as using

²In Russian, where RKS [PKC] in Russian stands for работники коммерческого секса (commercial sex workers).

transactional sex to fulfil an economic desire. The self-described RKSs (работники коммерческого секса) with whom the agency worked did not make a distinction between so-called transactional sex and commercial sex. In fact, these self-described RKSs also classified these ‘ordinary girls’ as sex workers and saw them as competition.

While these dominant narratives of women’s HIV risk focused on sexual transmission, service providers also recognised women’s risk for HIV through injection drug use. As HIV epidemiology in Ukraine has changed, so has the prevention programming landscape. As one provider described, their early programmes primarily serviced ‘RKS-PIN’ (РКС-ПИН = работники коммерческого секса-потребители инъекционных наркотиков), that is, ‘women who are standing on the highway who provide sexual services for money but also inject drugs’. Its current programmes, however, served a different population:

Well, now I work with female PWIDs (женщины-ПИН) who are not sex workers. In other words, we call them pure PWIDs (чистые ПИН), who only inject drugs. They don’t stand on the highway, they don’t serve clients or provide sexual services. They just inject drugs. (Maria, agency 3, project manager)

While this provider attempted to disentangle women’s risk for HIV, parsing whether women’s primary risk came from sex or from drug use was often challenging for providers who observed overlap among their clients:

They [the men who inject drugs] expose the women who are close to them to numerous risks. Well, first, sex without a condom happens very often ... Second, it is the use of drugs, sometimes with the same syringe, which a partner or a husband had used. It happens occasionally ... there are moments that drive women out to the street for money. I mean, such informal pimping from partners also happens very often. (Nastya, agency 2, director)

In this scenario, women face risks for HIV through multiple pathways simultaneously: unprotected sex with steady partners; injection drug use; and sex work. Significantly, whether through sexual transmission or drug use, the passage above casts women as victims whose HIV risk is largely shaped by the actions of men.

The distinction between ‘RKS’ and a ‘female PIN’ had implications for how agencies understood a range of problems that their female clients faced. One agency staff member explained this distinction among their female client groups:

Women are also divided. In principle, we wouldn’t divide anybody, but we clearly understand that, for instance, a successful woman, who just has access to drugs, [and] currently does not sell her body for a dose or something else, she is just using [drugs] ... So, it would be very hard for her to interact with, say, girls who provide sexual services for money. They have different problems ... These are two different groups. (Ruslan, agency 8, director)

Whether through drug use or sex work, women were either victims of men or suffered due to a lack of a man in the role of a ‘protector’ in their lives. Men were seen as indirectly creating women’s risk for HIV by not providing for them financially (and forcing them to engage in sex work) or directly exposing them to HIV through needle-sharing, unprotected sex and sex

work. Together, these narratives centred on issues of agency and power. Women were in many ways portrayed as lacking a sense of personal agency – forced by men and circumstances to put themselves in risky situations. In situations when they were cast as having personal agency, they either exercised it poorly – by seeking wealth and pleasure in the clubs – or with only bad choices – to engage in sex work.

Responding to women's HIV risk

Service providers often characterised women's vulnerability to HIV as stemming from life circumstances, lack of personal agency and lack of motivation for self-care. At the most basic level, many agencies tried to meet women clients' material needs through access to washing machines, feminine hygiene products and temporary shelter. Beyond this material support, NGO staff developed strategies to address what they saw as women's social isolation, dependence on men, and lack of a sense of self-care. Many service providers characterised their clients as lacking a motivation to take care of their health and as being generally unaware of HIV risk:

They [female clients] don't want to be healthy ... Well, not in the physical sense but spiritually, they are dead. Here, too many spiritually dead people are wandering around us. I don't know what should happen, maybe getting struck by lightning on the head so they can wake up and see. (Alexei, agency 1, social worker)

One agency had sought to create a programme that would cultivate this sense of self-care by bringing women together to build a community and develop skills that could potentially generate income.

They [female clients] mostly stay home and hang out with friends of their husbands or with a few girlfriends who also use drugs, or with their neighbour from whom they would borrow some salt or bread ... We are trying to teach them how to take some time for themselves ... [to] understand that there are other women who need [them]. They will find things in common to talk about. For some, it will be hairdressing or knitting, and others will find something else. Everybody has something she can do, like cooking. [We are trying to] teach them to love themselves. At least once a week, at least for two hours. (Anna, agency 7, project coordinator)

Notably, the programme focuses on domestic skills and stereotypically feminine interests such as hairstyling, knitting and cooking as a way of creating bonds and building community among female clients. This agency was not alone. Others promoted programmes that focused on teaching women sewing and cosmetology skills or planned to offer massages, manicures and pedicures so that their female clients could feel more 'beautiful and healthy in life' (e.g. agency 6). In many group-based HIV prevention programmes, the women convened in order to exchange information, offer mutual assistance and provide moral support.

Another agency that primarily worked with female clients since its founding in the early 2000s attempted to link women's HIV risk to individual psychological factors and social and structural contexts. Recognising that stigma and discrimination are significant problems for

these women in terms of accessing and receiving HIV, reproductive, health and other services, they trained specialists such as gynaecologists, family therapists, drug treatment specialists, infectious disease physicians and other professionals to work with female drug users. This organisation also ran a group intervention programme for female drug users to train them to be outreach workers. In contrast to the group programme described above that focused on teaching women self-care and stereotypically ‘feminine’ income-generation skills, this programme aimed to help female drug users improve their communication skills so that they could advocate on their own behalf within a care setting:

We train these women to be outreach workers, since they have a better connection to their fellow PWID ... The topics of these group sessions vary. Of course, they all include prevention activities, but we also might include a focus on legislative issues. For instance, [we are] targeting building communication skills. You know, female PWID – they are unique ... We know this group has many complaints, I mean, they don’t like how they are being treated. We teach them how to communicate when they face stigma and discrimination. Like in medical settings, when doctors offend them, [people] talk to them and look askance at them, maybe even abuse them ... So, we are working to teach them to communicate in the right way ... If you approach [the doctor] with good intentions, not demanding this or that from him, the doctor will treat you with a completely different attitude. (Maria, agency 3, project manager)

However, this approach potentially misrecognises the source of women’s problems when trying to access services and receive care: it places the blame on women’s attitudes and inability to communicate ‘in the right way’, rather than – for example – service providers’ attitudes towards the women and discriminatory and stigmatising practices.

Teaching women to advocate on their own behalf and training health care and other service providers was extremely important, given the very real stigma and discrimination that women identified as drug users, sex workers or living with HIV faced. This stigma and discrimination was even more intense for women with children or seeking to get pregnant:

Women have complained [about their experiences of discrimination], *Spidoznye* [спидозные] [offensive name for people with AIDS], how can she want a child? She tries to get pregnant, why on earth would she need it? ... Doctors say ... what kind of wretch she is, they [doctors] are not interested in the fact that she is a woman and wants to become a mother. (Vasya, agency 7, outreach worker)

Gender stereotypes had real-world consequences for women living with and at risk for HIV, and decisions to access services could have grave results. For example, agency staff we interviewed described children being taken away from female clients, women being thrown out of their apartments, doctors denying medical care to female drug users and women living with HIV not given support to have safe pregnancies. Women living with HIV must overcome additional barriers related to expectations of who is a ‘good’ mother and deserving of children. One programme manager described how the agency supported female clients in legal custody troubles, so the women could retain their parental rights. Staff would provide the women references documenting that they were programme clients – and thus actively

engaged in self-improvement – and accompany them to court to provide moral support and resolve legal and logistical issues.

In the gender-oriented HIV prevention programmes we encountered, women were often reduced to their role as current or future mothers. Creating spaces and opportunities in which women could rebuild their identities as ‘fit’ candidates for motherhood was important, given the central role that motherhood plays in Ukrainian women’s identity. As the (male) psychologist and key service manager at one organisation explained:

I understand that the primary role of women in this world – is to be a mother. Well, is it right or not? Your key characteristics, different from us [men], your most important social role is to be a mom. If we take this mom thing away, I am here left trying to understand what else is special in women ... Maybe you will explain to me, honestly, I might be thinking narrowly here, but ... what else can there be in women different from men? [If] not related to the reproductive sphere, [she is] the same person [as men]. [She] eats and drinks the same [as men], injects, walks and goes to the police the same [as men] ... I don’t see any key differences. (Ruslan, agency 8, director)

This provider’s explanation of women’s needs reflects a Ukrainian national discourse that portrays women as ‘mothers of the nation’ (Phillips 2014) whose bodies exist in service to the nation as Ukraine forged a new identity following the collapse of Soviet rule in the early 1990s. As Rubchak (1996) has argued, issues of women’s economic and political rights have historically been subordinated to concerns with national liberation and the role women can play in the domestic sphere – through reproduction and domestic responsibilities – in the rebuilding of the Ukrainian nation.

Discussion: recasting Ukrainian women’s risk for HIV

An ideology of motherhood culturally configures HIV NGOs’ programmes. The moral judgement becomes stronger and more salient towards women than men when they are viewed as unfulfilling responsibilities for caring as current and potential mothers (Murney 2007; Solari 2014; Tolstokorova 2010; Tyldum 2014). This moral evaluation of women who use drugs, particularly women who use drugs and are also mothers, can divide those vulnerable to HIV into those who are ‘deserving’ and those who are ‘undeserving’ of assistance, protection and treatment (Ryabchuk 2014). As Dworkin (2006) suggests, who is perceived to be ‘epidemiologically fathomable’ is rooted in cultural stereotypes and assumptions about male and female sexuality that infuse how we talk about and operationalise ideas about risk. Narratives about how risk is defined shaped the real-world prevention practices of these agencies. Agencies felt compelled to separate out their participants by rigid boundaries of risk categories that also served to reinforce cultural stereotypes about who is and is not a ‘drug user’ (PIN) or a ‘sex worker’ (RKS), as the provider asserted when he claimed that a successful woman (женщина успешна) who uses drugs does not belong in the same group as someone who ‘provides sexual services for money’ (занимается сексуальными услугами за деньги). That is, public health discourses and practices mutually constitute what programmes are possible and who can benefit from them. Public health interventions are themselves structural forces that include

or exclude certain women while at the same time creating the categories of women they aim to help. In the examples above, the HIV prevention programmes siloed women into ‘risk groups’ and individualised their struggles through individualised (not institutional or structural) strategies.

Rather than focus on the complex interplay between behaviour, gender roles and socio-economic status, the majority of the programmes we studied concentrated on women’s reproductive health or communication skills. Offering such services to female clients may address basic needs and attract them to the agency in order to recruit them into other programmes (such as needle and syringe exchange) or link them with other services (such as legal aid or reproductive health services). The concern is that if access to basic material resources, support groups and reproductive services are the *only* services and programmes offered, attention will not be paid to the socio-economic and cultural factors that drive risk, given that power inequality in personal relationships reflects socio-cultural norms. Studies report that contemporary Ukrainian women face many economic challenges that include rising unemployment and underemployment, job insecurity, workplace discrimination, lack of opportunity and unreliable social benefits such as maternity leave and paid child care (Vijayarasa 2012).

When tropes of who is at risk for HIV infection narrow our lens of what contributes to HIV risk, both contributing factors and new places of intervention remain outside the realm of possibility. This precludes the possibility that these interventions can become a forum for reconstruction of social identities, advocacy to challenge gendered norms and inequalities (Jangu, Tam, and Maticka-Tyndale 2016) and empowerment of marginalised groups (Cornish 2009; Euser et al. 2012). Returning to our opening vignette, if public health policy-makers and service providers draw sharp boundaries between different ‘types’ of women, the ways in which multiple factors compound to exacerbate women’s HIV risk will be left unattended. We argue that this dearth reflects a misrecognition of where the roots of HIV vulnerability lie. In order to create better HIV prevention programmes, we must interrogate the gendered and social production of risk.

Acknowledgments

Funding

Funding for this study was supported by the US National Institute on Drug Abuse under [grant number R01DA033644]. The study sponsor has no role in the study design; collection, analysis and interpretation of data; in the writing of the paper; or in the decision to submit it for publication.

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Table 1

Characteristics of study agencies.

Agency	Region	Clients Served	Existence	Full-time/Part-time/Volunteers	Annual Budget (US\$)	Number of Interviews
1	South Central	PWID (63%), youth, CSW, street children, TB patients	10	8/14/2005	180,500	5
2	South-eastern	PWID (60%), CSW, prisoners, PLWHA, youth, homeless	13	17/17/10	150,000	5
3	Southern	PWID (70%), CSW, youth, PLWHA	12	20/45/10	375,800	10
4	Central	PWID (80%), CSW	12	15/22/<100	271,000	5
5	Southern	PWID (65%), CSW, MSM, prisoners, street children	10	50/0/3	500,000	5
6	Eastern	PWID (60%), CSW, PLWHA, TB patients, street children	9	21/12/14	170,000	6
7	Southern	PWID (80%), CSW, prisoners, street children	13	35/80/0	712,822	13
8	Central	PWID (60%), prisoners, PLWHA, youth	12	36/38/4	587,500	5

PLWHA = persons living with HIV/AIDS; MSM = men who have sex with men.

Table 2

Characteristics of interview participants.

	Agency 1	Agency 2	Agency 3	Agency 4	Agency 5	Agency 6	Agency 7	Agency 8
Number of Interviews	5	5	10	5	5	6	13	5
Director								
Male	1	0	0	1	2	2	1	2
Female	0	2	1	1	1	0	1	1
Staff								
Male	2	2	0	0	0	1	5	2
Female	2	1	9	3	2	3	6	0