Choosing Methadone: Managing Addiction and the Body Politic in Ukraine

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Abstract

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This dissertation explores the lived experience of opiate substitution therapy (OST) patients in Ukraine. To complete this research, I conducted fourteen months of ethnographic research in OST programs across Ukraine between 2012 and 2014. I conducted extensive clinical observations and collected more than fifty interviews with patients and clinicians. The first chapter, the introduction, describes the historical and contemporary landscape of harm reduction and drug treatment services in Ukraine. The second chapter positions this research as a 'neurochemical ethnography,' which taps into critical medical anthropology, phenomenology, and science studies to explore human-chemical relationships. The third chapter reveals that, in Ukraine, scientific utterances are also political utterances. This complicates the interpretation of evidence and destabilizes the epistemological foundation of 'evidence-based' practice. The fourth chapter shows that patients and clinicians in OST programs espouse conflicting explanatory models of addiction. This causes antagonism over the utility of OST drugs and the definition of treatment success. The fifth chapter analyses the semiotics of OST drugs and

patients' active resistance to the clinical distinction between 'street drugs' and 'medicine.' The sixth chapter demonstrates that treatment-seeking decisions are motivated by patients' desire to embody normative social roles. They hope to achieve this goal by simplifying the logistics of their chemical self-management. In the seventh chapter, the conclusion, I outline practical recommendations for improving OST programs in Ukraine and elsewhere. In sum, this dissertation argues that clinical cultures and treatment-seeking behaviors are shaped by a 'somatic ethic,' which not only governs discourses on drug use and addiction but also places social integration and acceptable personhood at odds with the practicalities of treatment.

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CHAPTER 1: INTRODUCTION

1.1 INDEPENDENCE DAY

The Fourth of July, America's Independence Day, is celebrated in Kyiv, Ukraine, with pomp and circumstance. Each year, the Embassy of the United States throws a huge, daylong party for the who's who of the nation's capital. In 2013, the theme of the event was "The State of California." Guests were invited to nosh on hamburgers and hotdogs—the likes of which are served at San Francisco Giant's games—and sip on Sonoma and Napa Valley wines. A miniature replica of the Golden Gate Bridge was available for inspection and, for the more ostentatious locals, staged photo opportunities. The décor, donated by the San Francisco Giant's franchise, allowed Kyiv's elite to luxuriate amidst model cable cars, redwood trees, and a likeness of the Santa Barbara Mission.

On that day, July 4, 2013, I spent my afternoon across town from the Embassy bash in a very different sort of place. There was no high society to be found. Other than myself, there were no American expatriates—no foreigners of any kind—for miles around. The people where I was were poor, unemployed, with few social connections. There was no food, no drink, no music to dance to. The only entertainment was two backgammon boards, which remained in constant use in the shady courtyard where I sat. The mood there was not fueled by the ebullient celebration of independence, but by a begrudging resignation to dependence. I was at Kyiv's Regional Narcological Dispensary No. 3[1], home to a state-run opiate substitution therapy (OST) program, where opiate addicts came to receive synthetic substitutes for the illegal narcotics they once took.

[1] The names of all OST clinics and the persons connected to them have been changed to pseudonyms.

The OST clinic is not a terrible place, but neither is it a happy one. Being there is both relieving and bothersome, familiar yet uncomfortable. One patient at this clinic, a woman of about 45 years, told me that she had used street drugs for nearly 15 years before coming to this clinic for methadone, a prescription drug used in OST to replace those street drugs, about four months ago. When I asked her how she liked the program, she pondered my question and asked me if I knew of the Russian novelist Mikhail Bulgakov. I did. She brought up his novel *The Master and Margarita* and began quoting passages from the book at astonishing length—as only those who were once Soviet schoolchildren, once subjected to ceaseless memorization and recitation exercises, can do. She gave a detailed analysis of Bulgakov's philosophy on the relationship between good and evil and his argument that these oppositional elements must intersect in our lives for either one to have any meaning. There is no good without bad, no bad without good. One must tolerate both or live with neither. "For me," she mused, "it's like that." A few moments later, she excused herself to dash off into the tall grasses near the clinic with her husband to inject the narcotics he had brought with him. The clinic was fill of such contradictions.

With the blessing of the head doctor, I had arrived at the dispensary that day with a phone, a notebook, and a bag of pistachios, intending to simply hang around the courtyard. I spent a good deal of my time this way, learning how the clinic operated and engaging in casual conversation with the people it served. Though patients didn't have much to accomplish there other than check in with the nurse, take their pills, and be on their way, few of them had jobs or other obligations to return to. Most also had long commutes back home ahead of them. Consequently, many people lingered, congregating along benches, smoking, chatting, playing

with their children, and pooling money to buy sodas or packages of sunflower seeds from the gas station up the street.

Not long after I arrived that day, a young man in a panama hat and a scruffy beard took an interest in me. As I settled into a space on the benches near the backgammon games, he tilted his head to look over the smoke streaming from the cigarette in his mouth. “Who are you?” he asked suspiciously. I introduced myself as an American researcher. I explained that I had spent a long time working in programs for drug users, like needle exchanges, in the US, and that I was now interested in how these programs work in Ukraine. His demeanor changed. He sat up, his eyes wide. “Fascinating,” he mumbled. He pursed his lips around his cigarette, shuffled over from his bench to the spot right next to me. He introduced himself as Maksim and began asking me questions.

“Do doctors in the US give out methadone in tablet form?”

“Can a person get methadone by prescription and pick it up at the pharmacy?”

“Are there supervised injection sites?”

“How much money do your doctors make?”

“Does America have incentive programs that pay addicts to take methadone?”

“Are drug addicts allowed to get drivers licenses?”

“Is it easy to buy drugs in America? From what I see on TV, it seems easy to get drugs there, especially if you are in places where there are a lot of drugs, like Brooklyn.”

“Can cops just throw you in jail and forget about you?”

“How do doctors treat addicted people? Are they nice to you or do they toss you out?”

“And pregnant women who use? What happens to them?”

The questions I received, whether from Maksim or from someone else, were always the same.

Some of them reflected patients' norms and social values. Others revealed their imaginings of personal rights. Taken as a whole, they chart out a massive terrain of uncertainties that OST patients must learn to navigate in order to participate in (or avoid) the program. I came to this clinic as a medical anthropologist intending to explore the ways in which therapeutic trajectories in Ukrainian OST programs are inextricably bound up matters of identity, sociality, and personhood. It is precisely these uncertainties, therefore, that interest me the most.

As Maksim began telling me about himself, I learned that he had been taking methadone for nearly eight years. That made him one of the most experienced patients in the program.

"Does you still like it, after all this time?" I asked.

"Well," he said, "I long ago realized that I'm an addict. That's just how it is [Russian: Я наркоман. Вот это вот]. If I didn't come here, where would I be? Back in prison or something. I've already been there three times." He held three fingers up in front of his face.

In conversations like this one, regardless of how I framed my questions about their experiences in OST, most patients structured their responses in terms of pros and cons—*plyusy* and *minusy,* as they are called in both Ukrainian and Russian. Maksim said that, overall, OST is wonderful for addicts. He said it changed his whole life. There is, he remarked, only one *minus* to the program: even though you are on methadone, you are still an addict.

The biomedical logic of OST frames addiction as a disease affecting the physical or psychological state of a person (Bourgois 2000; Bourgois and Schonberg 2009; Campbell 2007; Campbell and Shaw 2008; Hunt and Barker 1999). Though the disease model of addiction can certainly be an efficacious approach for some who seek to change their relationship with drugs, this perspective nevertheless tends to obscure larger social and structural factors that shape drug use on the individual and the community levels (Bourgois 2003; Spradley 1968). It also renders

invisible the fact that many medical interventions for addiction are disciplinary technologies. Medicine doesn't only act upon the body; it acts upon the body politic, "the regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference" (Scheper-Hughes and Lock 1987, 7–8).

For many years, social researchers have argued that a holistic understanding of OST's therapeutic efficacy can never be fully understood without a full consideration of the patient perspective (Hunt and Barker 1999; Bourgois 2000; Bourgois and Schonberg 2009; Garcia 2010; Meyers 2013). Despite these claims, and despite vast body of literature on the design, operation, and management of such programs, research on the perspectives of individuals who receive this intervention is troublingly sparse (Tsogia, Copello, and Orford 2001). In Ukraine, where the drug use and HIV epidemics remain uncontained by public health efforts, the need for qualitative research that reaches beyond behavioral and programmatic indicators to explore drug users' experiences of addiction and addictions treatment is very real and increasingly urgent.

This dissertation presents new, ethnographically grounded information on the perspectives of patients in OST programs. It aims to illuminate how drug use and treatment-seeking behaviors are perceived, negotiated, and strategized by the individuals who adopt them. Specifically, this dissertation offers answers to two questions: (1) how and why do users of illicit drugs in Ukraine decide to seek treatment in the form of methadone- or buprenorphine-based OST, and (2) what do patients believe they can accomplish (therapeutically or otherwise) by staying in the program?

Ukraine, where research for this dissertation took place, is a nexus of transformative processes. It is home to an internationally savvy middle class as well as poor and working class

populations that remain largely disenfranchised by the country's troubled infrastructure. There are Russian-speaking adults who maintain a strong, emotional ambivalence towards the Soviet past, as well as an enthusiastically nationalist, Ukrainian-speaking youth whose daily lives are deeply intertwined with Soviet symbolisms and modes of thought, despite never having lived in the Soviet Union. Ukraine receives large sums of international money to bolster its budget and support public health responses to the intravenous drug use and HIV/AIDS epidemics. It is a country currently mired in military conflict, political revolution, and intense economic upheaval. For these reasons, Ukraine is a profoundly fruitful place for exploring the far-reaching effects of international health and development efforts on the local landscapes in which they are enacted. By considering how global forces intersect with local structures in small, out of the way places like Kyiv's Regional Narcological Dispensary No. 3, this research contributes to a culturally informed critical engagement with global health efforts and the ideologies they represent.

Above all, this dissertation argues that clinical cultures in Ukrainian OST programs are shaped by a "somatic ethic"—an ideology that "accords a moral virtue to the search for profit through the management of life" (Rose 2007, 8)—which places patients' attempts to forge an acceptable personhood at odds with the practicalities of their treatment. In other words, these clinics are rife with disagreement about what addiction is, what OST does, and what 'recovery' from drug abuse actually looks like. When the multitude of answers offered in response to these questions are scrutinized, the scientific quickly blurs with the social, and it becomes hard to decipher what should and should not be counted as 'the truth.'

1.2 A Thin White Line

Addiction is a fundamentally slippery concept. It has, over time, managed to defy or undo every attempt to squarely define it, and the definitions that have gained prominence over

the years have varied greatly. Research has shown that drug use is fueled by structural factors and social contexts (Bourgois 2003; Brave Heart 2003; Garcia 2010; Schüll 2014) and is often imbued with rich symbolisms and various forms of social capital (Becker 1963; Spradley 1968; Pilkington 2007). Experts have theorized various psychological components of addiction such as wanting (Lende 2005) and choice (Heyman 2009) and have explored how drug use is connected to neurology, biology, and human genetics (Cloninger 1987; Kendler et al. 2000). In spite of these many scientific efforts, however, even the most broadly accepted case definitions of addiction are not terribly scientific. Instead, then employ culturally bound, moral values in order to define and diagnose an addicted state (Glasser 2011).

For example, the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) lists the following diagnostic criteria for Substance Use Disorder:

1) Taking the substance in larger amounts or for longer than you meant to
2) Wanting to cut down or stop using the substance but not managing to
3) Spending *a lot of time* getting, using, or recovering from use of the substance
4) Cravings or urges to use the substance
5) Not managing to *do what you should* at work, home, or school, because of substance use
6) Giving up *on important social, occupational, or recreational activities* because of substance use
7) Using substances again and again, even when it *puts you in danger*
8) Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
9) Needing more of the substance to get the effect you want (tolerance)
10) Development of withdrawal symptoms, which can be relieved by taking more of the substance [emphasis added] (American Psychiatric Association 2013)

While two of these criteria (tolerance and withdrawal) describe measurable physiological consequences of substance use, many require a socially informed value judgment to properly identify. What, for example, constitutes "a lot of time," "important social, occupational, and

recreational activities," or "[that which] you should [do] at work, home, or school"? These criteria do not measure categorical differences in human behavior. Rather, they are a tool for determining whether or not the drug users have egregiously violated social norms to the extent that medical intervention is warranted.

The case definition for dependence syndrome in the World Health Organization's Tenth Revision of the International Classification of Diseases (ICD-10) is similar in its inclusion of culturally contingent criteria:

1) A strong desire or sense of compulsion to take the substance
2) Difficulties in controlling substance-taking behavior in terns of onset, termination, or levels of use.
3) A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms.
4) Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses
5) Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance, or to recover from its effects.
6) Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; *efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm* [emphasis added]. (World Health Organization 2015).

Here, not only are social considerations an essential element in the differential diagnosis of addiction, but the knowledge and intentions of the individual are also informative. To meet the case definition of addiction, not only must drug use behaviors be socially or physically destructive but the user must also be *cognizant* of that destruction. Therefore, the addict must either be *willfully* engaging self-destructive behaviors or must *lack the willpower* to stop their behaviors in the face of the damage they cause.

Medical anthropologists Merrill Singer and Hans Baer have observed that the classification of alcohol addiction as a medical problem has become "accepted as an established 'fact,'" due to concerted efforts to draw alcoholism into the realm of biomedical authority and render it "a respectable disease" (1995, 303) defined as "a malfunction of the individual, be it at the chemical, genetic, biological or psychological level" (1995, 304). The criterion for substance dependence listed in the DSM-V and the ICD-10 make the same move, actively translating the dominant 20th century view that addiction is fundamentally a disease of or deficiency of the will (Valverde 1998) into medical vernacular. As a result, those individuals who manifest symptoms of a 'diseased will' are constructed as medically ill persons who deserve to be placed under the supervision of medical authority to rectify their socially problematic behavior. In making this claim, I do not mean to say that struggles with substance use are not real or that medical professionals have nothing to offer to persons experiencing those struggles. Rather, I mean to emphasize the fact that the construction of addiction as a medical disorder actively shapes the narrative categories available to drug users for interpreting their own experiences, for understanding what is happening in their minds and bodies.

The medicalization of addiction has had a profound impact on the development of OST as an intervention in the last half-century. In the 1950s and 1960s, researchers in the US discovered that methadone (a synthetic opiate first produced as an analgesic in Germany prior to World War II) could be used effectively to treat withdrawal in heroin addicts. This led to some clinicians prescribing decreasing doses of methadone to addicts for a period of seven to ten days (Herman, Stancliff, and Langrod 2000, 347-348). The use of methadone for long-term OST was first conceived in the 1960s, at a time when heroin-related mortality was the leading cause of death for adults between 15 and 35 years of age in New York City (Joseph and Appel 1993, 14).

Most federal authorities on drug use in the US, including the National Institute of Mental Health (NIMH) and the Drug Enforcement Agency (DEA), were categorically anti-methadone (and therefore anti-OST) throughout the 1960s and 1970s, due largely to the perceived practical and ethical quandaries of prescribing a highly addictive substance to addicts because of its addictive qualities (Joseph and Appel 1993, 17). As a result, federal regulations governing OST were extremely restrictive until the 1980s, when the emergence of AIDS quickly shifted public health priorities. This change is well illustrated by a 1993 report on the clinical utility of OST published by the Substance Abuse and Mental Health Services Administration (SAMHSA), which reads, "Today, with the concerns for the spread of the AIDS virus, treatment modalities that result in the reduction of high-risk behaviors, such as needle use, needle sharing, and the exchange of sex for drugs, are even more desirable" (Joseph and Appel 1993, 17).

Today, OST is included in the comprehensive package of services recommended by the World Health Organization (WHO) for combating HIV/AIDS. Methadone and buprenorphine, another synthetic opiate used in OST, are both on the WHO list of essential medicines (World Health Organization 2010). In response to the global HIV epidemic, numerous international organizations such as UNAIDS, UNODC, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) have been formed for the purpose of promoting and supporting OST within the framework of a broad package of HIV control strategies in countries with limited resources. The most significant of these international donors supporting OST worldwide is the Global Fund, an international group founded in 2002 for the specific purpose of reducing the burden of these three diseases worldwide ("About the Global Fund to Fight AIDS, Tuberculosis and Malaria" 2015). The Global Fund receives 95% of the funds it distributes (which totaled more than $12billion in pledges during its 2013 replenishment conference) from

ten donor countries: the United States, France, the United Kingdom, Germany, Japan, the European Union, Canada, Italy, Sweden, and the Netherlands ("Government Donors" 2015). Ukraine is currently receiving a grant from The Global Fund of nearly $550million for combating HIV as well as a second grant of more than $130million for combatting tuberculosis/HIV co-infection (The Global Fund to Fight AIDS, Tuberculosis, and Malaria 2015). With these monies, the Global Fund supports OST programs in Ukraine almost exclusively.

This dissertation considers the culture of local OST clinics in Ukraine in relation to these global actors. As such, it is firmly grounded in the theoretical traditions of critical medical anthropology, an academic subfield that links the anthropological study of health related phenomena with a classical Marxist analysis in order to bring the role of social structure and, in particular, social oppression in population health more sharply into view (Singer et al. 1992, 77). The analysis presented here follows the work of many critical medical anthropologists who have chosen OST programs as a site in which to investigate the interplay between culture, medicine, and lived experiences of health and illness (Bourgois 2003; Lupton 2003; Campbell and Shaw 2008; Harris and Rhodes 2012; Meyers 2013). These works have shown that OST programs, like so many other "wide-net" public health interventions, are designed to capture individuals displaying certain types of troublesome behavior or embodying specific forms of social deviance. In turn, exiting the problematic realm of addiction by submitting oneself to treatment is a move deeply entangled with discourses of citizenship and identity. It constitutes a form of work upon the self that Tomas Matza has called "a means of sorting value and of ascribing and managing social difference and futures, but also of healing and care" (2012, 804). In other words, therapeutic trajectories in Ukrainian OST programs are bound up in value-laden

social paradigms that determine what makes someone a socially appropriate subject (Carroll 2011a; Carroll 2011b). In drug treatment, much more than addicts' physical or mental health is on the line.

1.3 Narcology in the Time of HIV

In regions that were once part of the Soviet Union, addiction and addictive behaviors have historically been managed by medical professionals specializing in narcology. Narcology is a subfield of medical practice, such as dermatology or pediatrics, which has no equivalent in the US system. Narcologists diagnose and treat a wide variety of addictive behaviors from alcoholism to opiate use to compulsive gambling. Across Ukraine, one can find numerous advertisements for narcology clinics printed in newspapers or running during daytime television programs. In Kyiv, subway cars are typically papered with fliers advertising apartments for rent, cheap children's clothes, auto mechanics, and addiction treatment services.

Eugene Raikhel (2010) has argued that these forms Soviet medicine emerged from an epistemological split from 'Western biomedicine' that occurred in the 1950s. At that time, the behavioral theories of Russian psychologist Ivan Petrovych Pavlov gained prominence in the Soviet medical sphere. Pavlov's theories offered "a way of conceptualizing the 'dialectical' relationship between human biology and the environment" (Raikhel 2010, 142). Pavlov provided a means for connecting lived experience (such as trauma, habit, desire, and other forms of behavioral conditioning) to bodily health and disease. In practice, however, taking this approach "may have often meant a reduction of psychology to physiology, of mind to brain—or more precisely—of personhood to reflex action" (Raikhel 2010, 143). The prominence of these theories in Soviet medicine resulted in an explosion of placebo-based therapies for substance abuse behaviors (Raikhel 2010), many of which are still available today. For example, it is not

uncommon for practitioners in Ukraine offer a treatment called "coding," an aversion-therapy that relies on the power of suggestion to convince addicts that their brain physiology has been altered in such a way as to make the ingestion of drugs painful or fatal (Murney 2009). Such a therapy would appear to be a conflation of medical and behavioral interventions, not to mention ethically problematic, to a trained physician in the United States. This approach aligns well, however, with the Soviet perspective that physiological and psychological mechanisms in the body are not mutually exclusive.

During the 1990s, as the Soviet Union collapsed and individual governments suffered the political and economic shock of sudden independence, public health systems began to withdraw from their roles as active caretakers of the population. According to Raikhel, this shift had the effect of

> [rendering] alcoholism, previously treated as a social disease, increasingly individualized and medicalized by default. Thus, even while biomedical explanations of heavy alcohol consumption remain unpopular among many lay people in Russia, medical (and quasi-medical) treatments have gained significance as the primary means by which alcoholism is governed. (Raikhel 2010, 133).

In contrast to alcoholism, narcotics addiction had typically been dealt with under the Soviet regime as a criminal matter, not as a social one (Raikhel, 2010; Ball, 1998; Human Rights Watch, 2006). This distinction has helped produce what is, today, a disconnected set of institutionalized responses to various forms of addiction—some still closely tied to the state medical system and the legacy of narcological approaches, others having developed in the civil sphere with a closer affiliation to Western biomedical approaches.

In the past decade, Ukraine's national response to its intravenous drug use and HIV epidemics has shifted to accommodate international trends. New policies have allowed for the establishment of OST programs and the import drugs for this purpose. Buprenorphine was first

legalized in Ukraine in 2004 (Semigina et al. 2007, 42). Methadone, once banned outright, was reclassified as a legal prescription drug by the Ukrainian Ministry of Health (MoH) in 2008 (UNAIDS 2008). Today, drug use remains a major cause of new HIV infection, and the historical dominance of this route of transmission has left in its wake a significant population of intravenous drug users who are HIV-positive. Unfortunately, the number of persons actively receiving OST remains small, with only 3-4% of all injection drug users currently enrolled in these programs (Zaller et al. 2015).

It was no accident that the establishment of the regulatory environment for OST in Ukraine coincided with the Global Fund's first round of applications for HIV-prevention and treatment efforts in 2002. The MoH received and acted as the primary recipient of a Round 1 grant from the Global Fund and began receiving disbursements approximating US$90million in early 2003 (International HIV/Aids Alliance in Ukraine n.d.). The MoH soon frustrated members of the Global Fund executive board by failing to disburse any of that money towards the programs outlined in Ukraine's Round 1 application. Not a few HIV-prevention activists in Kyiv insinuated to me that the government never moved any of the funds because they couldn't find a way to embezzle it as it went out the door. In March 2004, the Global Fund stripped the MoH of its status as primary recipient and transferred this authority to the International HIV/AIDS Alliance in Ukraine (the Alliance), a Kyiv-based non-profit that had only been in operation as an independent entity since 2003 (The Global Fund to Fight AIDS, Tuberculosis, and Malaria 2010). By the summer of 2010, the Alliance had received a total budget of $99,057,868 from the Global Fund, which made it one of the largest financial entities in HIV-prevention in Ukraine (The Global Fund to Fight AIDS, Tuberculosis, and Malaria 2010). In December 2010, more than US$300million was pledged to a coordinating council composed of

multiple Ukrainian organizations through the Global Fund's Round 10—one of the largest grants the Global Fund has ever offered (PEPFAR 2013). This not only gave the Alliance unprecedented financial ability to undertake massive public health initiatives, but it also firmly seated the responsibility for HIV-prevention in Ukraine in the civil sector, away from government involvement and control. This trend is slowly reversing, and the Global Fund has made it clear that they expect the MoH to take financial control of Ukraine's OST programs when the current grant comes to a close, but little optimism can be found among Ukraine's civil sphere that the MoH will step up to this role.

Recent scholarship on Eastern Europe has illustrated that the goals of foreign donors like the Global Fund are often hindered by their misunderstanding of the local context as well as the implementation of programs ill-suited for local communities (Hrycak 2006; Phillips 2008; Rivkin-Fish 2005). Sociologist Alexandra Hrycak has highlighted, in particular, the unexpected, negative outcomes that frequently result in Ukraine from "the encounter between the unexamined assumptions of foreign aid projects and the cultural presuppositions, existing networks, and organizational strategies of local actors" (2006, 70–71). Since the biomedical approach to addiction is founded upon numerous culturally contingent criteria, the concept of addiction (and by extension, the concept of addictions treatment) can be imagined quite differently within different cultural contexts. In the former Soviet Union, the medical imagination of drug use diverged significantly from the view taken in the US and Western Europe (the view from which the concept of OST emerged in the first place), creating a situation ripe for producing such 'mismatches' between the perceptions and strategies of international donors and those of local actors in former Soviet territories. In other words, clinicians and patients in Ukrainian OST programs navigate therapeutic encounters with unique,

local perspectives on drug use and addiction. This means that clinicians must situate themselves and their expertise within powerful international bodies of medical knowledge and authority. It also means that patients must make sense of their own experiences in the presence of not one but two prevailing discourses that seek to define and contain them.

1.4 The Structure of This Dissertation

Anthropological scholarship on post-Soviet Europe has long delighted in describing societies 'in transition,' focusing on the simultaneous reordering of culture and society deemed unique to this part of the world (Verdery 1996; Humphrey 2002; Elizabeth C. Dunn 2004; Lindquist 2006; Patico 2008; Adams 2010). This notion of 'transition' is often taken to be a primarily *economic* process, indicating the shift from a centralized, state-run industry to a de-regulated, market-based economy. It is defined secondarily as a *political* process, as in the transition from Soviet power structures to something allegedly more liberal or democratic. Katherine Verdery has questioned this attention to political and economic formations, arguing that "postsocialist change is much bigger. It is a problem of reorganizing on a cosmic scale, and it involves the redefinition of virtually everything, including morality, social relations, and basic meanings. It means a reordering of people's entire meaningful worlds" (1999, 35).

While the new forms that have, in Verdery's words, "emerged from [the ruins]" (1999, 10) of the Soviet collapse are diverse, the stresses that people across the former Soviet sphere are responding to have much in common. For example, Elizabeth Dunn has described common "epistemological and ontological questions" about what counts as fact, what rights exist, how knowledge is produced (2004, 32). Jarrett Zigon has argued that the social and cultural changes following Soviet collapse bred analytically murky and deeply unsettling questions of moral uncertainty, which haunted the ethos of the post-Soviet citizen (2009, 264). New forms of

nationalism have emerged (Verdery 1996; Zhurzhenko 2004). New forms of social distinction have gained traction (Bilaniuk 2005). Gendered categories, which were once strictly defined by the Soviet state, have bounced back to allegedly 'traditional' and pre-Soviet forms in many places (Rubchak 1996; Phillips 2008), while becoming re-invented in others (Gal and Kligman 2000). In light of these trends, it not surprising that drug users' interactions with health care in contemporary Ukraine have been tied up with citizenship claims and demands of the state based upon those citizens' rights.

This dissertation explores OST as a site of self-making in the context of these contemporary struggles for economic stability, historical stability, and the stability of one's role as a social actor. I argue that clinical cultures and treatment-seeking behaviors are shaped by a "somatic ethic" (Rose 2007), which not only governs discourses on drug use and addiction but also places efforts to engender social integration and acceptable personhood at odds with the practicalities of treatment. I demonstrate these conclusions by exploring addiction and addictions treatment first from the clinicians' point of view, which dominates the patients' experience of the clinic, and then from the patient's perspective as it emerges from this clinical context.

The following chapter of this dissertation, "A Neurochemical Ethnography," frames this research project as a *neurochemical ethnography*: a grounded, qualitative study that uses insights from critical medical anthropology, phenomenology, and science studies to explore human-chemical relationships. In particular, this dissertation builds upon Nikolas Rose's concept of "ethopolitics," a system of ethics, which "concerns itself with the self-techniques by which humans should judge and act upon themselves to make themselves better than they are" (Rose 2007, 27). Within this framework, I conceptualize OST as a technology of the self.

Anthropological research has shown that habitual drug use can be shaped by the need to stave off withdrawal symptoms, to "feel normal," rather than the urge to 'get high' (Agar 1973; Bourgois 2003; Dai 1937; Lindesmith 1968). For OST patients, the chemical management of the body is central to the project of self-making, as it is a mechanism not only for controlling their state of consciousness but also for stabilizing their outward presentation of identity. OST allows addicts to construct a socially appropriate subjectivity at the molecular level, to forge a new 'neurochemical self.'

Chapter 3, "A Political Science: The Practice of Evidence Based Medicine in Ukraine," explores how the discourse of evidence-based medicine (EBM) has been adopted into the practices and ideologies of clinicians and other public health professionals working in Ukraine's HIV-prevention sphere. Through ethnographic evidence collected via interviews and participant observation among various public health professionals in Ukraine, this chapter outlines two major conclusions. First, many public health professionals in Ukraine frame the validity and reliability of statistical data, the 'evidence' of EBM, not just practically or quantitatively, but also discursively and symbolically, creating or denying evidentiary crises in the production of statistical data according to their own values and purposes. Second, the production of evidence has become an act of tangible social and political value, as much as it is of 'scientific' value. By producing evidence, public health professionals are not only developing the tools to improve their public health efforts. They are also presenting themselves as morally appropriate and deserving. It is through these discursive moves that the clinical culture in Ukraine's OST programs has developed, providing clinicians with license to evaluate the efficacy of OST through means other than treatment outcomes.

Chapter 4, “Drugs and Desire, The Medical Efficacy of Wanting,” examines the psychological discourses that shape physician and patient understandings of addiction in OST programs. Inside the OST clinic, biomedical paradigms of addiction, promoted and paid for by international donors and elite global health entities, are being met by Ukrainian notions of personhood and psychology. Ukrainian physicians who work with OST patients frequently reference *desire* (Russian: желание; Ukrainian: бажання) as the most significant factor determining the success or failure of treatment. The moralized imperative to possess this *desire* to get better is, in many ways, a reflection of how addiction and the addicted psyche is constructed and understood by professionals in the Ukrainian context. By exploring discourses of *desire* in narratives of addiction and treatment, this chapter examines how notions of psychology, will, and self-control intersect, shaping the subjectivity of the patient population.

Chapter 5, “This Is Not American Heroin,” explores the phenomenology of OST and the role it plays in patients’ strategies of chemical self-management. As an opioid-based chemotherapy for opiate dependence, OST blurs the lines between drug and medicine. It is onto that blurred space that this chapter turns its gaze. Much biomedical discourse on OST draws a very clear line between heroin and OST drugs like methadone and buprenorphine, each of which are synthetic opiates. For many Ukrainian opiate users, this categorical distinction between one opiate as drug and another as medication simply doesn’t hold. Instead, these individuals interact with a variety of opioid substances, each of which can be distinguished according to its quality, effect, and ease of procurement. This chapter asks what kind of sense the idea of methadone-as-medicine can make, what kind of technological or therapeutic intervention OST can be, when deployed in this social terrain where multiple narcotic substances are already seen as acceptable substitutes for each other.

Chapter 6, “To Live Like Normal People,” takes as its focus the concept of a ‘normal life’ as it is conceived both by patients and in the popular imagination that marginalizes them. In interviews, many OST patients portrayed their motivations for starting and maintaining treatment in similar terms: they want to live like normal people (Russian: жить как нормальные люди). They often grounded their descriptions of ‘normal people’ in ordinary details. Normal people are able to access quality health care. Normal people are able to find work and raise their children. Normal people support their parents. They take care of themselves and their families as well. In their statements, the word ‘normal’ was not simply used to index the embodiment of normative social roles, such as being a good mother or being a good son. Rather, ‘normalcy’ was evoked as a measure of social integration. This chapter considers the experience of addiction as a permanent state of exception in terms of normative social roles and of integrated sociality. As such, it responds to a body of research that seeks to explain contemporary sociality in the Post-Soviet sphere through the emerging ideal of the neoliberal subject (Zigon 2010; Yurchak 2008). This chapter highlights OST patients’ disinterest in embodying these ideals. Rather than seeking to become ‘responsibilized,’ they seek to move logistical barriers aside to become, once again, the good human beings they always knew they were.

This research comes at a time when the need for effective public health strategies in Ukraine is higher than ever, at a time when the global funding crisis and Ukraine’s protracted military conflict with Russia has rendered the future of Ukraine’s existing OST programs fragile and uncertain. With astonishingly high rates of HIV-infection among IV drug users—as high as 22.9% in 2009 (Ministry of Health of Ukraine 2010)—and a growing body of evidence that the HIV and tuberculosis epidemics in Ukraine are merging (van der Werf et al. 2005; van der Werf

et al. 2006; Zignol et al. 2008; Drobniewski et al. 2005), the need to optimize efforts to treat and halt the spread of these diseases is significant. Powerful social factors are at work behind these statistics: the rapid transformation of local economies, contentious public discourses on citizenship and the state, and local cultures that remain in the flux that Verdery has called "the reordering of people's entire meaningful worlds" (1999, 36).

This dissertation humanizes the public health problem of drug use and drug use-related infectious diseases in Ukraine by focusing on processes of decision-making and meaning-making through which OST patients perceive and make sense of their drug use and drug seeking behaviors. These processes are illuminated through patients' lived experiences, which are shaped by the biological realities of addiction, the practicalities of drug use, and the historically-embedded discourses of health, society, and personhood that remain salient and compelling in contemporary Ukrainian society. Above all, this dissertation reveals how drug use and treatment-seeking behaviors are connected to the political, economic, and social realities of contemporary Ukraine and acknowledges the personal strategies that its denizens use to re-assert discipline and control over their own bodies and the body politic.

CHAPTER 2: A NEUROCHEMICAL ETHNOGRAPHY

2.1 INTRODUCTION

In 2004, I was in the United States working at a secure mental health facility for youth and children living with disruptive psychological symptoms. Though their mental health problems were chronic, each resident could tell you the specific thing they were "in for." One boy had run away from his foster home too many times. A teenage girl was there who had skipped school and spent the day racking up more than $4,000 in expenses from the Home Shopping Network on her mothers' credit card. There was a young boy who had taken a table knife, the only tool within reach at the time, and stabbed his younger sister at the dinner table.

All the residents were admitted to this facility because they, in one way or another, displayed chronic behaviors that made their presence in their home or community problematic. Yet, it is also true that they were also there because of a particular incident—the straw that broke the camel's back, so to speak; the "crime" for which they were now "doing time" in a secure facility. This place was not juvenile detention. Residents were not there to receive any kind of punishment for their behaviors, but their interpretations were nonetheless astute. They were being, in a way, their own sociologists, drawing into the light with their daily claims, complaints, and negotiations the fact that they were locked up not necessarily for a generalized pattern behaviors, but for the rest of society's intense frustrations with a few specific acts.

These behaviors were treated with a variety of substances meant to help the youth "normalize" their experiences and emotions: lithium, diazepam, risperidone, dextroamphetamine. I recall being amazed by how much of the therapeutic process was organized by cycles of trial and error. The prescribing therapists relied on the patients' mood,

affect, and self-report to determine which drugs were helping them to be "better." I recall vividly one summer afternoon when a female patient, about 15 years old, known for her intense outbursts, sat down on a couch in the common area and snuggled securely into the pillows. She wasn't stoned. She was relaxed—relaxed in a "normal-looking" way. The evening before, her therapist had switched her from her previous medication to dextroamphetamine (the third in a series of drugs that had been tried). When the therapist came into the unit to check on her that afternoon, the girl looked up at her with wide, earnest eyes and said, "I want to stay on this forever." The therapist was happy to oblige.

Treatment staff at this facility believed in the ability of these pharmaceutical treatments to resolve the problems faced by their patients. However, even the most highly trained mental health professionals there provided service across a chasm – one that stood between them and their patients, one that could never be fully crossed no matter their skill or expertise. Treatment staff had no access to the *lived experience* of psychosis, no access to the *lived experience* of the pathological brains and bodies in which the residents lived, and no way to integrate an awareness of these lived sensations into their provision of care. The available indicators of treatment efficacy were, at best, second hand: changes in demeanor; greater interest in social activities; fewer outbursts and behavioral incidents. But, as to how the patients felt, as to how the sensation of being medicated made the residents feel more or less in control of themselves, as to how they integrated these chemical substances into the daily routine of managing their bodies (shower – tooth brushing – breakfast – brain pills), this was all knowledge that treatment counselors (those who were not themselves on a pharmaceutical mood regulator of some kind) were categorically unable to acquire.

Nowhere was patients' integration of this knowledge, the matter-of-factness of these therapies as tools of chemical self-management, more evident than in the facility's youngest residents. They were not yet old enough to understand the absurdity of their social position or the stigma surrounding their illness. For many of them, intense mental health interventions had been a regular part of their lives for as long as they could remember. Pharmaceutical treatment was as familiar as bubble gum, hand washing, and footie pajamas. This was powerfully illustrated early one morning as the youngest residents were preparing to walk to the cafeteria for breakfast. The children were expected to form a line and walk quietly to the cafeteria together with one staff member leading the line at the front and another following the line from behind. This was a particularly rambunctious morning, and a staff member encouraged her wards to settle down by holding the unit door closed and stating in a commanding tone "I still hear voices!" In the silence that followed, a small voice emerged. Suzie, a resident only six years old, looked up at her unit leader and, with an empathic sincerity, said, "Try Risperdal."

This dissertation addresses these same pharmaceutical quandaries in a different setting. The focus of this text falls not on residential mental health facilities in the US but on state-run outpatient institutions for the medical treatment of opiate addiction in Ukraine. This project explores the multiple forms that "expertise" on drug addiction can take – professional, clinical, and personal – and the moments of coordination and conflict that can arise between these different systems of knowledge when they interact. In this way, this dissertation constitutes a *neurochemical ethnography*, a fundamentally anthropological attempt to expand our collective knowledge and understanding of what it feels like to want or consume opiates, to experience physical distress in their absence, and to build an ordinary life around the managed, deliberate ingestion of such substances (just as many others' lives are organized around the regulation or

consumption of other substances like alcohol, nicotine, caffeine, or serotonin). This dissertation is about the strategies we produce for the chemical management of our bodies. Specifically, it is about the chemical management of bodies belonging to people we call "addicts."

2.2 The Anthropology of Addiction

The term 'anthropology of addiction' is a misnomer. In many ways, *addiction* is not what anthropologists are really interested in. At least, it is not precisely what I am interested in. What often captivates ethnographers who seek to study drug use and so-called addictive behaviors, what captivates me as well, is the tenacity of society's drive to marginalize these behaviors and relegate countless individuals to the social fringe, making them, in Howard Becker's words, true '*outsiders'* (1963).

The problem with this particular imagination of drugs use, however, is that drug use isn't limited to society's nefarious margins. Substance use is common to every sphere of society—from the most impoverished communities to the highest echelons of the wealthy upper class. What drug use ethnography tends to gravitate towards, then, is not addiction in general, but addiction that is *visible*, that is practiced *too openly,* that violates institutionally-backed norms of social organization *too much*, that is managed in *fundamentally socially unacceptable ways*. To put it another way, we tend to concern ourselves with drug use behaviors that society deems unmanageable and the related people, practices, and paradigms that society, in response, tries to manage.

For this reason, the 'anthropology of addiction' has historically sought to investigate drug use as a violation of social protocol, framing it as an act of deviance or a symptom of social pathology. Drug users were viewed as somehow 'different,' and it was that difference that researchers sought to investigate and uncover. Though this dissertation rejects this idea of

difference, instead classifying the use of illicit drugs with a vast realm of other human behaviors dedicated to the chemical management of our bodies (drinking coffee; taking vitamin supplements; mountain biking for the adrenaline rush), it remains, nevertheless, a product of the field of drug use ethnography as it has evolved over the past century.

The earliest ethnographic studies of drug use were produced in the Department of Sociology at the University of Chicago in between the 1930s and the 1960s. Bingham Dai's 1937 book *Opium Addiction in Chicago* is considered to be one of the very first 'modern' ethnographies on addiction in an urban setting. Dai premised his entire study on the idea that "no individual is born a morphine addict, just as no race is born an opium smoking people. Opium addiction as a cultural pattern can be explained in terms of culture" (1937, 32). Dai believed that the mechanism by which drug use spread among the population of Chicago was ordinary cultural diffusion (c.f. Wirth 1928; Zorbaugh 1929). He claimed the entire history of opium use among humans was a culturally informed and culturally driven pattern of behavior (1937, 16). Following Durkheim's insights on *anomie* and social integration (Durkheim 1979), Dai suggested that "drug addiction is at bottom a symptom of a maladjusted personality; and since the source of an addict's maladjustment either as a child or as an adult is social, drug addiction may also be said to be a product of general social disorganization" (1937, 175). In sum, Dai theorized that all drug use behavior resulted from the disintegration of individual drug users from the social fabric.

The second major contribution to this sociological canon on addiction was Alfred Lindesmith's 1947 book *Opiate Addiction* (republished with a new preface in 1968 as *Addiction and Opiates*). Lindesmith also considered addiction to be a phenomenon of the individual, suggesting that the origins of drug addiction are cognitive in nature. "Persons become addicts,"

he argued, "when they recognize or perceive the significance of withdrawal distress that they are experiencing, and that if they do not recognize withdrawal distress they do not become addicts regardless of other considerations" (1968, 8). This 'recognition' is not simply the perceived biological effects of opiate withdrawal, but the user's *learned interpretations* of this bodily experience as resulting from (and resolvable through) opiate use (1968, 73).

In many ways, these two works are characteristic of the qualitative sociology that was prominent at the time; however there is a specter of structural analysis lurking underneath each of these works. Dai refers to a so-called "underworld" or an "underworld environment" as the most significant factors driving addicts' journey into addiction (1937, 42). Dai also insisted, "drug addicts are made liars (or, alternatively, criminals, deviants, etc.) by a society that condemns them" (1937, 97). Lindesmith (1968) too speaks somewhat uncritically of an "underworld" where the drug users he studied reside, though he makes no attempt to equate the structural forces that push people into these marginalized positions with the structural forces that set the stage for problematic drug use in the first place. So, while both of these works describe drug use in terms of larger social structures, the nature of those structures escape critical analysis.

The next tangible phase in the evolution of drug use ethnography is defined by the cognitive turn in anthropology and the adoption of linguistic approaches for the study of culture. Anthropologists have since criticized this approach for providing a view of emic knowledge structures that do little to illuminate the connections between these local cultural forms and the social structures in which they reside (Keller 1992; Singer 1970). However, drug use ethnographies from their period remain canonical contributions, nonetheless. Two works are particularly exemplary of this period: James Spradley's *You Owe Yourself a Drunk* (1968) and

Michael Agar's *Ripping and Running* (1973). For his study, James Spradley sought out persons that he called "urban nomads" (migrants suffering from chronic alcoholism and criminalization) in Seattle. Through arduous linguistic exercises like card sorting and name associations, he developed extensive taxonomies within the urban nomad vernacular to describe types of persons, types of sleeping places, even types of 'time' one keeps while in jail.

Mike Agar adopted a similar methodology, seeking to develop taxonomies of cultural categories and cognitive frames that shape the worldview of drug users. Agar also wanted to dispense with the notion that *deviance* was the key focus of sociological interest in drug use. "Most studies of addiction assume the social-psychological failure status of the addict as the problem to be explained," he argued. "What if such a priori judgments were temporarily suspended and addicts were studied ethnographically as a legitimate community with an alternative?" (1973, 1). Agar observed that "the implicit social environment against which behavior is measured as "adaptive" or "maladaptive" is that of the psychiatrist—white, upper-middle-class" (1973, 125). He thus interpreted the so-called 'maladaptation' of the addicts he studied as an artifact of a class culture that was not their own.

The next major surge in the ethnography of addiction coincided with the emergence of HIV. More specifically it coincided with "the revelation that 'certain risk groups,' including heroin users, had developed an immune disorder variously called GRID or AIDS (among other names) eventually led to the conclusion that any effort to understand and arrest the spread of this malady would need more drug ethnographers than were currently available." (Page and Singer 2010, 71–72). The heightened profile of drug use ethnography also resulted from the growing academic profile of critical medical anthropology (CMA), which emerged as a fully articulated subfield of anthropology in the early 1980s (Baer and Singer 1982). As the CMA

approach was largely concerned with structural factors that shape health and illness, CMA research on drug addiction focused largely on the question of "who ultimately controls bourgeois medicine and what the implications are of such control" (Singer et al. 1992, 79).

One of the most prominent ethnographers of addiction and drug use in the field of CMA is Philippe Bourgois. In his first book, *In Search of Respect* (2003), Bourgois takes great pains to locate his informants' impetus to deal drugs in their exclusion from the primary economic market and, by extension, from legal means of earning a living. In his later works, Bourgois drew upon the structural theories of Marx and post-structural theories of Foucault to propose the concept of *lumpenabuse*, a term that "highlights the way structurally-imposed everyday suffering generates violent and destructive subjectivities" (Bourgois and Schonberg 2009, 19). For Bourgois, the lumpen consists of "a subjectivity that emerges among population groups upon whom the effects of biopower have become destructive" (Bourgois and Schonberg 2009, 19).

In recent years, a number of extremely innovative approaches to drug use ethnography have emerged in answer to (or in rejection of) the fundamentally structural approach that defined CMA research on this topic. Maria Yellow Horse Brave Heart (2003) has proposed Historical Trauma theory, which illuminates historical and intra-familial patterns that perpetuate high rates of alcoholism among Lakota families in North America. In a similar theoretical move, Angela Garcia (2010) has taken up the concept of *melancholia*, an idea originally developed by Freud, to explain frequent and occasionally violent recidivism among drug treatment patients in rural New Mexico. She contextualizes these behaviors within lengthy histories of material loss, personal dislocation, and social disenfranchisement. Todd Meyers' (2013) ethnography of adolescents in drug treatment in Baltimore explores the social and interpersonal effects that

pharmaceutical intervention is expected to render. He scrutinizes the spaces "where the *clinical* and the *social* become difficult to distinguish" (Meyers 2013, 7). Equally compelling is E. Summerson Carr's (2010) description of the semiotic work undertaken by staff at American drug treatment centers for the purpose of imparting specific ideologies of relatedness and self-presentation to the patients.

Each of these unique ethnographic efforts seeks to reveal something new about the production of addiction and addicted bodies. Their purpose, writ large, is not to dispense with earlier theoretical modes completely. Rather, each seeks a path for escaping the reification of hegemonic concepts of "addiction" and the characterization of drug use as a visible, maladaptive, socially deviant behavior. They are, in a way, experiments in representation. They attempt to articulate substance use behaviors in terms of universally human qualities and shared modes of life, to reject the cultural logic that appeals to the socially marginalized state of drug use to justify the continued marginalization of these behaviors and the people who engage them.

This dissertation joins this new literature by considering non-recreational substance use (i.e. drug use undertaken for the purpose of feeling 'normal') as one element within a broad class of human behaviors through which people chemically manage their bodies. It is through this lens that I interpret the statements of the many Ukrainian OST patients I spoke with for this project. "It's great," a woman told me as we sat in the courtyard of the Kyiv Narcological Dispensary. "You come here, you take your pills, and no one even suspects that you're an addict." Was it truly the drugs she sought to be rid of by coming to the OST program, or did she want to be free from the social characterization that followed them? This dissertation suggests that it is possible for both answers to be true.

2.3 Medical Ontology in a Molecular World

In its capacity as a response to CMA, this dissertation is also a response to—if nevertheless influenced by—the work of Michel Foucault. Foucault has written extensively on the topics of discipline, governmentality, and the production of medical knowledge (Foucault 1994; Foucault 1980; Foucault 1977; Foucault 1982). Medical anthropologists have long found these approaches fruitful for exploring the social construction of health and illness in contemporary settings. The influence of Foucault's work is apparent in the earliest textbooks and treatises on critical medical anthropology in the American academy (Scheper-Hughes and Lock 1987; Singer and Baer 1995; Sargent and Johnson 1996) as well as in many well-known and in-depth critiques of the current public health regime authored by medical anthropologists (Lupton 1995; Rhodes 1996; Navarro 1976; Balshem 1993).

Foucault's most significant contribution to CMA's theoretical canon is arguably the analysis of biomedicine (the science-based system of medicine that is taught in most professional medical schools) as a *cultural* system. Contemporary medical anthropologist Lorna Rhodes elaborates this conclusion as follows:

> In Western society biomedicine is generally believed to operate in a realm of "facts"; many people experience their most intimate contact with science through the biomedical description of the facts of bodily function and disease. This realm of bodily fact is often perceived to be quite separate from other cultural and social domains. (1996, 166–167)

Rhodes also states that we are able to escape this false image by "exploring the ways in which [biomedicine] is socially, culturally, and historically constructed and showing how its perspectives influence the lives of its patients" (1996, 164). "For Foucault," Rhodes observes, "medicine is one of a number of related disciplines that have shaped the body as a vulnerable site for the articulation of social relationships" (1996, 168). In other words, CMA remains very

much defined by "links to the social analysis of Marx and Engels" (Singer et al. 1992, 77). However, it is also centrally defined by what Deborah Lupton calls as "a dialectical approach [to the body], which recognizes the location of bodies in nature, but also the ways in which discourses act to shape bodies, and experiences of bodies, in certain ways of which individuals have only a certain degree of control" (1995, 5).

The mechanism by which biomedical culture establishes the individual body as an object of inquiry is addressed by Foucault in *The Birth of the Clinic* (1994), which details the history of institutionalized medicine in France starting from the late 1700s. In particular, Foucault marks the formation of the Société Royale de Médecine in 1776 as a pivotal moment in the establishment of the contemporary biomedical system. In response to a number of zoological epidemics that deeply impacted the local economy, this professional group was formed for the purpose of undertaking the organized study of medical epidemics. Specifically, they were charged with three roles—the investigation and quantification of epidemics; the elaboration and comparison of epidemics; and the supervision and prescription of ongoing epidemics and their responses—all of which, Foucault argues, set the stage for a positivist approach to medicine that relied on a highly coordinated form of objectivity (1994, 27). What emerged out of this innovative approach was a form of medicine (biomedicine) rooted not simply in the expertise of individual doctors, but in a "*collective consciousness* of pathological phenomena" (1994, 28).

This collective consciousness constituted a new epistemology, or, in Foucault's words, a new method of "carving up the field" of the human body (1994, 29). Specifically, the clinician's gaze assumes "a structure of identical objectivity" in which the totality of the object (the disease) is made visible through known signifiers (1994, 96). A central feature of this medical objectivity is the concept of the "model man [which] is organized along the axis of the normal

and the pathological" (1994, 35), an idealized, healthy, "normal" body against which all pathologies are quantified. Foucault portrayed this "model man" as a culturally constructed ontological tool, a creation of the medical scientific project, not as an *a priori* measure of the quality of health or the "goodness" of one's physiological states. In this way, he built his theories off of the works or George Canguilhem, who was active in the French academy a decade prior to Foucault's first publications (and who remained active through the 1980s).

Canguilhem expended significant energies unpacking the seemingly "common sense" ideas of *the normal* and *the pathological*, revealing them to be not only cultural constructs, but also ideas resulting directly from the individualized, scientifically objective mode of inquiry about the human body that biomedicine had become (Canguilhem 1991). The irony of this epistemological shift was that since the "normal body" or "model man" was not objectively or materially real in any *a priori* sense, pure knowledge about the "normal body" remained accordingly elusive to those who sought to study it. "Every conception of pathology must be based on prior knowledge of the corresponding normal state, but conversely, the scientific study of pathological cases becomes an indispensable phase in the overall search for the laws of the normal state" (Canguilhem 1991, 51).

Another consequence of the new biomedical epistemology, according to Foucault, is that this framework allows for the cultural construction of pathologies, for the shared, coherent conception of human abnormalities that are not grounded in objective assessments of the body but are instead held together by gossamer threads that link moral judgments about human behavior to the medical establishment's ability to police those behaviors. The definition of homosexuality as a mental illness is a classic example of such a moralistic maneuver. Foucault explained this phenomenon in practical terms:

> The clinical gaze effects a nominalist reduction on the essence of disease…Pleurisy has no more being than the word itself: it expresses an abstraction of the mind; but, like the word, it is a well-defined structure, in which all or almost all the accidents are combined. If one or more are lacking, it is no longer pleurisy, or at least not real pleurisy. (1994, 118–119)

In other words, what is pleurisy but a set of symptoms we call "pleurisy"? What is "homosexual sociopathic personality disturbance" (American Psychiatric Association 1952) but a set of socially charged symptoms that were once called "homosexual sociopathic personality disturbance"? One could further ask: what is addiction but a set of socially and morally derived behavioral indicators we call "addiction"?

Many, though not all, addictive behaviors have become medicalized through similar processes. In the 20th century, for example, many researchers adopted the theory that a certain psychopathy predisposed people to drug use. This pathology was understood to be an identifiable and diagnosable (and therefore treatable) mental illness, not a matter of individual will (Campbell 2007, 16). Nikolas Rose has argued that this disease model of addiction has become further and further embedded in biomedical culture as technological developments have increased clinicians' ability to "probe" the depths of the body. "Visualization of the long hypothesized opiate receptors and the technical capacity to image the brain in situ created a new optics that made plausible the neuroscientific claim that addiction results when neurobiology goes awry" (Rose 2007, 201). These technologies add material substance to the idea that drug abusers have addicted brains, thus rendering it comprehensible within a biomedical ontology and framing addiction as a fundamentally biological pathology.

2.4 Biomedical Subjectivities

The medical definition of "addiction" as a certain kind of pathology, one that can be visualized through technological means, translated many social judgments about problematic

drug use into medical discourse. Biomedical research certainly did not trigger the moralization of drug use or the marginalization of socially problematic drug users, but the pathologizing of drug use certainly did allow these moral discourses to become cloaked in the appearance of the concrete. By affording scientific legitimacy to the concept of addiction, the socially constructed image of "an addict" became equally reified, a black-boxed social concept (Callon and Latour 1981), and removed it from the realm of everyday critical discourse. It became, therefore, not only possible but also justifiable to use medicine to police someone's behavior if that person could be successfully declared addicted.

For several decades, medical anthropologists have taken up the idea that biomedical practice is a seat of pervasive disciplinary powers that produce this kind of social identity by policing such "abnormalities" in contemporary society. Through this disciplinary power, healthcare apparatuses seek to accomplish a number broader social goals: (1) "governing via 'risk', 'knowledge' and prevention" (i.e. by proscribing appropriate behaviors for individuals who are deemed to be 'at risk'); (2) creating "'responsibilized' entities of individuals and communities of interest" who independently choose to abide by those behavioral prescriptions; and (3) "eliminating risk, danger, and disorder" by reinforcing and normalizing these disciplinary technologies (Fischer and Poland 1998, 188). For example, sociologist Deborah Lupton observes that medical and epidemiological statistics have become the primary mechanism of knowledge-production in the era of public health (Lupton 1995, 25, 42–43), and can be seen as disciplinary technologies intended to bring unruly populations under control via efforts to promote child health (1995, 26), vaccination (1995, 32), hygiene (1995, 34), and so on.

Pharmaceutical interventions for addiction, such as OST, are often interpreted as disciplinary mechanisms in this regard. As Philippe Bourgois has observed, "the literatures on

[OST] in the field of substance abuse treatment and research offer a classic case study of Foucault's understanding of the disciplinary impact of the power/knowledge nexus" (2000, 182). Bourgois conceives of Foucault's concept of biopower as the "historically entrenched institutionalized forms of social control discipline bodies" (2000, 167) and argues that methadone maintenance, when used as a replacement for illicit substances, is "a particularly concrete example of biopower at work" (2000, 167).

What is of particular interest to this dissertation is how subjectivities are created within the moral landscape shaped by the biomedical power/knowledge nexus, and how those subjectivities are determined by their positions within these greater relationships of power. In Deborah Lupton's words, "each era privileges certain kinds of subjectivity. The modern subject is characterized by an interest in the deportment of oneself and others in the social realm, a belief that one's appearance and behavior are reflective of one's disposition, and a new self-consciousness about one's individualism" (1995, 7). This 'modern subject' that Lupton describes will not be found in places where the individual is not accepted as the primary site upon which risk and discipline are enacted, such as biomedicine itself.

Insofar as the addict is defined as a person with a particular pathology, so the addict subjectivity is also defined. Another way to put this is to say that the addict is thusly *interpellated* as a subject (Althusser 2001), which biomedical ideology makes coherent within its social and epistemological order, and that the individual being labeled has, to one degree or another, been compelled to acknowledge his or her subject designation within that order. In the North American context, as historian Nancy Campbell and anthropologist Susan Saw observe, "addicts have long been represented as unreliable subjects, incapable of self-government, and by extension undeserving of public trust" (2008, 697). Campbell and Shaw also argue that

public health discourses and disease prevention interventions in the US have allowed drug users a platform from which to re-assert themselves as disciplined and moral (and therefore deserving) subjects: "In response to such constructions, users define themselves as ethical beings concerned about the effects of their drug use on themselves and others, and who act responsibly to reduce negative consequences: 'We always use bleach!'" (2008, 698). A small number of drug users included in Campbell and Shaw's report even repeated such declarations as "I always use bleach" and "I never share needles" to ethnographers even while injecting with shared and un-sanitized needles in front of the researchers (2008, 696). Their attempts to position themselves as ethical subjects through claims of self-regulation reveal the depth of biopower's influence on the actions of individual people.

By affording patient perspectives on OST an equal platform with clinical narratives of addiction, and at times even prioritizing that perspective over more authoritarian discourses that seek to pathologize them, this dissertation aims to explore this creative, symbolic realm in which 'addicts' as a known category of person, are produced. When Maksim looked me in the eyes and said, as many did, "Look, I'm an addict. That's just how it is. [Russian: Смотри. Я наркоман. Вот это вот.]" I felt compelled to ask myself: whose language is he speaking? Is he representing his own version of reality, or is he trying to speak in words that he thinks I, the American researcher with a nice haircut and designer jeans will understand?

Over time, I came to see that significant effort was put into patients' self-representation. A deliberate calculus was apparent, one which revealed not only their profound expertise on the social and moral terrains out of which their "addicted" subjectivities had been forged, but also numerous marked attempts to negotiate their public image, to reorient the manner in which they

were interpellated by society. They sought to create and take on the role of new *neurochemical selves*.

2.5 Making the Neurochemical Self

A significant body of research indicates that habitual drug use is often shaped by the need to stave off withdrawal symptoms, not by uncontrollable impulses or an overpowering desire to get "high." Thus, the apparent compulsion that drives addictive behavior can sometimes be understood not as an urge to feel euphoria or to escape reality, but as an urge to feel "normal" (Agar 1973; Bourgois 2003; Bourgois and Schonberg 2009; Dai 1937; Heyman 2009; Lindesmith 1968). In this situation, where the stability of an individual's sense of self rests upon his or her ability to manage a waxing and waning sense of normalcy, the phenomenological organization and chemical management of bodily sensations with OST drugs like methadone and buprenorphine are central to the process of self-making, to what Foucault calls "the way a human being turns him- or herself into a subject" (1982, 208).

Nikolas Rose has argued that such subjectivities are constructed not only via the codification and standardization of pathologies in authoritative texts like the DSM-V and the ICD-10 but also through new neuroimaging technologies. Such technologies allow clinicians to engage in what Judith Butler has called "recourse to the material" (2007) in order to 'show' patients that they are really ill by referencing perceived abnormalities on brain scan images. Rose defined this technologically-aided approach to neuropathology as "a whole style of molecular argumentation designed to emphasize the specificity of the neurochemical basis and the mode of action of the drug" (2007, 203). However, the certainty of fact conveyed by a physician's ability to point to a blip on a brain scan, Rose argues, remains something of an illusion. He notes,

> …[though] there has been no shortage of neurobiological theories of causation for psychiatric disorders, psychiatry had thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacological treatment. (2007, 207)

This is the very dilemma faced by caregivers and patients in the mental health facility for youth, which I discussed at the beginning of this chapter. It is the same dilemma faced by OST patients in Ukraine, who must navigate not only their own bodily sensations but also broader clinical and social expectations that their participation in treatment will result in concrete changes to their behavior or disposition. Those changes are expected to match the concrete molecular mechanisms of the drugs they take in their specificity of action.

> [Such] drugs promise to help the individual him or herself, in alliance with the doctor and the molecule, to discover the intervention that will address precisely a specific molecular anomaly at the root of something that personally troubles the individual concerned and disrupts his or her life, in order to restore the self to its life, and itself, again. (Rose 2007, 203)

Rose calls this process the *"becoming [of] neurochemical selves*" (2007, 211).

From this perspective, OST can be interpreted as a technology of the self. OST drugs are chemical compounds designed to interrupt *both* the negative sensations of opiate withdrawal and the allegedly euphoric sensations of an opiate high (many such drugs include opiate receptor blockers in their formulation or include opiates that induce fewer euphoric effects). Their therapeutic mechanism can be glossed as the "pharmaco-therapeutics of desire" (Rose 2003, 410). Thus, participation in this therapeutic regimen can serve as a mechanism to regulate the phenomenological experience of opiate dependence and act as a "prosthesis of the will" (Raikhel 2013) for those who struggle to chemically manage their bodies in other environments where neither the quality nor the availability of opiate drugs are regulated.

Theories of embodiment are indispensible when considering the molecular constructions of the neurochemical self, if for no other reason than the allegedly euphoric effects of heroin and other narcotics are central to the moral politics of OST and are the key elements of addiction experience that are 'policed' by drug treatment. Embodiment is generally defined as the "perceived sensation of bodily states, mental states, signs, and images that exists prior to objectification, prior to cognition about those sensations" (Csordas 2002, 61). It is that which Maurice Merleau-Ponty calls 'the preobjective' (Merleau-Ponty 2013). Social theorist Thomas Csordas has combined Merleau-Ponty's approach with Bourdieu's concept of *habitus,* which he glosses as "the psychologically internalized content of the behavioral environment" (2002, 63) to assert that body, mind, and cultural context are all interrelated. He argues, "The habitus [both bodily habit and cognitive habit] regulates improvisation by defining the limits of reality, and semiosis [language, symbolism, and culture] regulates improvisation by defining the limits of specificity in revelatory imagery" (Csordas 1994, 106). In other words, just as the way we feel affects how we see the world around us, so do our culture, language, and ideology shape the physical and emotional sensations of everyday life.

Jarrett Zigon warns that many anthropologists misunderstand the study of embodiment (or, to use Zigon's preferred term, phenomenological anthropology) as simply a matter of physical sensations and lived experience. Zigon responds by describing a phenomenology concerned with processes of interrelationships, one that takes into account the interactions between cultural domains, social institutions, various discourses, and individual persons. (2009, 287). Zigon contends that the meaningful realities humans perceive, understand, talk about, and think about, "can never be considered as total and unified...but rather can only be found in the social world in the various aspects…elaborated above," and only "after the fact of articulation

in speech or thought" (2009, 287). It is, therefore, through specific articulations of OST patients' lived realities that the addict-subjectivities or "neurochemical selves" they are forging can be brought into view.

This dissertation trains its attention to these articulations, arguing not only that OST is a technology of the self, but also that it is also a practical tool for facilitating social integration and making ordinary citizenship claims. In Ukraine, as in the US, drug users are perceived to be a kind of "anti-citizen," a set of individuals "who seem to lack all the self governing capacities that are at the heart of civilized moral agency in an advanced liberal society" (Rose 2007, 242). Ukrainian OST patients counter this image with claims of biological fatalism ("I'm a drug user. That's just how it is."); declarations of commitment to their social roles ("I'm here so that I can be a mother to my daughter"); and strategic moves to skirt a set of stigmas that they can't manage to overcome ("No one even suspects that you're an addict."). In the chapters that follow, the tactics used to stake these claims are explored. The strategies through which drug users attempt to re-create their social, "neurochemical" selves and the clinical environments in which they leverage those attempts are thoroughly considered. What this dissertation ultimately reveals is a population of medicated individuals who make calculated, social moves from within a therapeutic environment that seems to help them and hinder them in equal measure.

2.6 Methods

The data presented in this dissertation reflects a total of 17 months of research conducted in Ukraine between 2010 and 2014. The first phase of formal research took place over the course of three months in the summer of 2010. During this time, I gained an understanding of the social and moral implications of OST in the eyes of the clinicians and public health professionals who operate and manage OST programs. I conducted semi-structured interviews

with doctors, program directors, and harm reduction activists in the cities of L'viv, Cherkassy, and Kyiv. During this time, I also attended local harm reduction conferences, trainings hosted by the Alliance designed to teach North American intervention methods to local social workers, and nationwide stakeholder meetings in preparation for the 10th round of grants from the Global Fund.

I returned to Ukraine in the fall of 2012 for a period of two months with financial support from the International Research and Exchanges Board. During this time, I made visits to OST clinics in Kyiv, Odesa, Kherson, Simferopol, and Sevastopol[2]. Some of these clinics were located within tuberculosis hospitals or AIDS centers. Others were housed in free standing narcological dispensaries. Still more were located in small rented basements and office spaces. Some of these clinics I was able to visit once; others I visited numerous times. More than twelve clinicians and nearly thirty OST patients sat for lengthy interviews and introduced me to their world both inside and outside the clinic walls.

The final phase of this dissertation project was carried out between March 2013 and March 2014 with financial support from the Wenner-Gren Foundation. During these 12 months, I conducted research in three different locations: Mykolaiv, Kyiv, and L'viv. Mykolaiv, which I visited in the spring of 2013, proved a difficult place to conduct fieldwork. Social workers and

[2] Unfortunately, the clinics I visited in Simferopol and Sevastopol were forced to close after the Crimean Peninsula, where these two cities are located, was forcibly annexed by the Russian Federation under fabricated pretenses through a sham electoral process in early 2014. Methadone is banned outright in the Russian Federation, and the occupying authorities that now control Crimea have brought the provision of OST services to a halt. In March 2014, nearly 800 residents of Crimea were receiving OST; the programs that were serving them closed indefinitely on May 1 of that year. I am able to share the stories that people in this clinic shared with me here, on paper, but it is difficult, if not impossible to know where they are now, how they are doing, and which of them are still alive. Some, I have been able to confirm, are not.

local harm reduction advocates were welcoming and eager to share their opinions on the troubles facing drug users and the general state of public health in their region. Clinic physicians, on the other hand, were less receptive to my inquiries. I spent no small amount of time being politely tolerated in waiting rooms or simply refused by the directors of various OST programs, many of them integrated into local hospital facilities. This experienced served as a visceral reminder that OST programs, though funded by the Global Fund, are technically operated by Ukraine's state-run healthcare apparatus and that corruption, bribery, cronyism, and bureaucratic obstruction are daily realities. Perhaps these physicians felt that my inquiries could reflect poorly upon their work (something that could bring real consequences upon them). Perhaps some were too busy managing the burdensome paperwork requirements and clinical protocols that were set in place by the national parliament. Most, it seemed, were simply not paid enough to expend their energies on a generous welcome to a foreign researcher.

During the summer of 2013, I spent a great deal of time at a single methadone clinic in Kyiv's left bank bedroom communities. This clinic is housed in a small, concrete building nestled in a ravine along the side of a busy highway. Staffed by two physicians, a social worker, and a steady rotation of nurses, it serves about one hundred twenty clients at any given time. I spent many lazy mornings in the courtyard of this clinic eating fresh cherries and chatting with clients who spent their afternoons in the patches of shade spotting the courtyard. Through these informal interactions, I learned a great deal about the clients' daily routine. In the case of more than a few, I learned the finer details of their lack of routine. Many were unable to find work. Inconvenient clinic hours (OST was usually distributed between 10am and 4pm) were often cited as a barrier, though the social worker assured me that none of his clients had applied for a job in months. I bore witness to social relationships, both intimate and hostile; to barter for

cigarettes and cellphone minutes; to the injection of street drugs in park behind the clinic; to child care and childrearing in the context of addiction; to the daily concerns that plagued their minds and bodies. In addition to the general observations I took over several months, I also conducted lengthy interviews with the medical staff and clients at this clinic.

In the fall of 2013, I spent several weeks shadowing clinicians and outreach workers from different service providers in the city of L'viv and the surrounding rural areas. I spent several weeks travelling around to various small towns in the L'vivska region with the staff of a local NGO that provided mobile needle exchange services and rapid testing. These services were offered out of a small, converted bus, which took a nurse and two social workers to scheduled stops on a monthly or bi-weekly basis, depending on the distance of the trip. Between twenty and fifty individuals received services from this mobile exchange point on any given day. When not accompanying this organization on their service runs, I spent time at an OST clinic that operated near the L'viv city center. The head physician at this clinic was fiercely dedicated to his work and was eager to speak to me about the needs of his patients and the many ways, physical and spiritual, in which he sought to help them. This clinic served about fifty patients in total. A number of individuals received services regularly from both entities.

The recruitment of OST patients for interviews often began with a phone call. I, or sometimes a local contact, would speak briefly to a clinic's head physician about my research and request a meeting. At that meeting, the physician and I would introduce ourselves formally. We would often drink some tea, talk a little about politics, and discuss the mutual interests of our work. After explaining my purposes more fully, I would request the physician's assistance in recruiting patients. I hoped that he or she could tell clients about my research and offer them a chance to contact me if interested. I would arrive at each new hospital or clinic with a stack of

business cards in hand. I intended to leave them in the physician's office so that any patients receiving OST could choose to contact me on their own, away from the influence and oversight of the clinic.

I learned quickly that OST clinics are very social places. Patients tend to build new and supportive social networks with other patients, and their connection to the resident physician and social worker whom they see daily represent some of their most intimate and stable relationships. My intended recruitment methods worked well at a number of the clinics I visited throughout the course of my fieldwork. At others, however, the degree of interpersonal distance I was trying to maintain in order to reduce the risk of coercion was immediately and thoroughly disrupted by patients who bounded freely into the physician's office to see who I was and chat with me about my business there. In some locations, every patient who approached me in the clinic looked at me sideways, with disbelief and confusion, when I suggested they contact me to schedule a meeting at a later date. We were both in the office now, weren't we? If I have questions, I was told, I should just ask. Aren't I a researcher? Don't I have a pen to take notes with? What do I want to know about?

When not conducting interviews, much of my time was spent simply hanging out. I would share cigarettes with clients and receive instruction on backgammon strategies. I would chat with doctors and nurses, nibbling cookies and discussing European health care policies. One of the hallmarks of ethnographic research is the length of time that the researcher spends in the field partaking in seemingly mundane activities such as these. For this reason, ethnographers are able to gain an unusual amount of credibility. We develop long-term relationships with key informants and increase our level of integration into our population of interest.

As a fundamentally anthropological project, this dissertation is a concerted attempt to harness each of these relational aspects of long-term ethnographic research to gain a hybrid insider/outsider view of the strategies that OST patients use to embody desired social roles. This written thesis, the result of these ethnographic efforts, does not seek to map out the private, interior experiences of individuals involved in OST; rather, it aims to illuminate the "webs of significance [they themselves] have spun" (Geertz 1973, 5), to reveal a world where drug users try to make and remake themselves, a world where discourse is everything.

CHAPTER 3: A POLITICAL SCIENCE: EVIDENCE-BASED MEDICINE IN UKRAINE

3.1 INTRODUCTION

I first observed Ukraine's model of OST delivery in April 2007. I was spending several weeks in the city of Odesa shadowing Yuriy, an outreach worker from a local harm reduction organization. He spent his days travelling set routes throughout the city, distributing clean needles to clients, and collecting their dirties in a plastic juice bottle. Like his clients, Yuriy was an opiate addict. He managed this condition with a daily dose of buprenorphine, a popular OST drug, which he received once per day from a nurse in a small, unassuming office in the city center.

I accompanied Yuriy to this clinic often. Each time I stopped in, I was surprised by how many people could fit into the cramped interior. In stark contrast to the wide-open parks and breezy corridors of the nearby polyclinic and tuberculosis ward, this office confronted patients with tiny rooms, low ceilings, and narrow doors. The truth is that this was never meant to be a clinic. It was an ordinary basement unit, like those often leased by small businesses and clubs. It was a temporary space for a temporary program. Yuriy was visiting one of the very first OST distribution points his country had ever seen, opened as part of a pilot program meant to test how well OST would work in Ukraine. This pilot phase was an key step in the establishment of a clear evidence-based approach for scaling up OST services across the country in subsequent years (van Teijlingen and Hundley 2001).

Evidence-based medicine (EBM) has become a central ideological concept in the field of public health in the last two decades. It has been hailed as a "long overdue and dramatic evolution" in modern healthcare, one in which clinical expertise and patient values are informed

by scientifically rigorous external evidence (The Cochraine Collaboration 2012). Perhaps the most frequently cited definition of EMB states that it is "the conscientious, explicit, and conscious use of current best evidence in making decisions about the care of individual patients" (Sackett et al. 1996, 71). EBM is motivated by the goal of letting external, scientifically rigorous, medical evidence take precedence in making both policy and clinical decisions. It has been adopted as the "gold standard" process for medical decision-making by the WHO (World Health Organization 2012) and adopted as a major component of the work of The Global Fund (The Global Fund to Fight AIDS, Tuberculosis, and Malaria 2012), who has been the sole funder of Ukraine's OST programs from the time Yuriy began receiving pills in Odesa.

This chapter considers what evidence-based practice can mean in the Ukrainian context, where epidemiological and HIV-prevention research remains limited in a number of strategically significant ways, and where public health professionals remain beholden to international donors (such as USAID and The Global Fund) to adopt EBM as a fundamental standard of practice. These pressures motivate local organizations to not only engage in EBM, but also to *appear* as though they are. I argue that Ukraine's public health professionals are shaping EBM as a *discourse*, motivated in large part by the logistical and practical realities in Ukraine that hinder EBM as a *practice*, thus re-shaping the biomedical cultures and clinical environments in which OST services are offered. These cultural phenomena directly impact the therapeutic encounters in which OST patients are engaged. Therefore, a clear understanding of the former is essential for generating a discursively sound and ethnographically grounded comprehension of the latter.

In the Ukrainian context, the practice of EBM is, first and foremost, defined by the need to interpret and manage external evidence. In other words, the validity of evidence is something

that must be "discursively managed" (Carr 2010, 68). A significant body of research indicates that the ease with which objective knowledge can be manipulated for moral, personal, or political ends (and the frequency which with it *is* manipulated) was well known to the Eastern European citizens during both the Soviet and post-Soviet periods (Field 1953; Verdery 1999; Petryna 2002; Ninetto 2005; Rivkin-Fish 2005; Patico 2008; Phillips 2008). Historian Tricia Starks has observed that the political nature of medical statistics had been discussed by Soviet physicians as far back as the 1920s during the era of the USSR's New Economic Policy. "Statistics," she notes, "should be regarded in the same way as any political utterance—with circumspection" (2008, 66–67). My informants similarly revealed themselves to be poignantly aware of how flexible and manipulable statistics are. Every epidemiological record, survey, or artifact was viewed, at the very least, as requiring some sort of qualification or interpretation in order to read. In other words, in Ukraine, the meaning and gravity of statistical evidence can be shaped by persons familiar with tactics of data manipulation and knowledgeable in the language of EBM.

Furthermore, the imperative to measure outcomes, keep records, and produce evidence with which to support evidence-based practices has, for Ukrainian clinicians and public health professionals, become an end in and of itself. Recorded evidence is often seen as a *pro forma* necessity, a by-product of a properly functioning entity that follows the standard operating procedures of EBM. By maintaining these practices, public health professionals position themselves as authoritative experts in their field, claiming significant political currency both within Ukraine and in the eyes of the international entities who control the financial weight of Ukraine's public health interventions. In this way, the Ukrainian professionals whom I came to know throughout my research were able to claim agency by strategically situating themselves as

"socially and morally appropriate persons" (Zigon 2008, 90) within the larger structure of public health entities and international organizations guided by the ideology of EBM—just as OST patients like Yuriy were able to forge their own socially and morally appropriate identities through their participation in OST (see Chapter 6). These actions can be understood as a discursive strategy that Carr (2010, 153) has called "anticipatory interpellation," the act of adopting an established social role and imploring powerful others to address you as such. In this way, the Ukrainian public health professionals I interviewed treated EBM in locally meaningful ways as a strategy for integrating themselves into those global systems.

3.2 Evidence Based Medicine in Cultural Context

The term "evidence based medicine" entered into medical discourse in 1992 (Tonelli 2001, 1435). Enthusiasm for this approach to medical decision-making has propelled EBM to a place of prominence. It is both an epistemological project focused on developing systems of medical knowledge, as well as a mode of clinical practice that grounds treatment decisions in knowledge produced by large, clinical studies (Tonelli 1998, 1235). Put more simply,

> The general approach of EBM is to formulate a clear, clinical question in relation to an individual patient, search the literature for relevant evidence related to that question, critically evaluate that evidence, and then implement the findings. A clear pathway from the patient to the evidence and back to the patient is described. (Tonelli 1998, 1236)

This pathway is structured by widely accepted hierarchies of evidence, which privilege forms of knowledge generated by large, randomized studies over experiential, intuitive, or otherwise un-systematic forms of knowledge gained by medical practitioners through the course of their work.

Ukrainian NGOs and public health organizations have been obliged to engage with the language and the ideology of EBM, insofar as they have been reliant upon The Global Fund to

support HIV-prevention efforts. In its own words, The Global Fund "supports *evidence-based* interventions that aim to ensure access to HIV prevention, treatment, care and support for most-at-risk populations" (The Global Fund to Fight AIDS, Tuberculosis, and Malaria 2010; emphasis added). Ukrainian NGOs must present applications to The Global Fund that embrace evidence-based responses to the HIV and drug use epidemics, which are "tailor[ed] and justif[ied]…within the context of the epidemiological situation and the needs of the people at risk" (The Global Fund to Fight AIDS, Tuberculosis, and Malaria 2010), in order to gain the monetary support they need. In other words, Ukrainian NGOs desperately need to coordinate their efforts in order to show that their programming is effective, reliable, and adaptable to the constantly fluctuating political and epidemiological realities of Ukraine. They must create coherency between clinical realities, epidemiological data, cultural values, and political ideologies (i.e. multiple elements other than simply 'evidence').

Physician Mark Tonelli, one of the most outspoken critics of EBM in US medical practice, has argued that the clinical logic of EBM is rooted in the cultural values of modern science and based upon a hierarchy of evidence (Oxford Center for Evidence-Based Medicine 2014) that is "neither "evidence-based" nor scientific in any sense of the word" (Tonelli 2001, 1437). He implies that this hierarchy is maintained by philosophical and cultural values rather than some scientific evaluation of the quality of different forms of evidence, whatever that might be. Cambrosio et. al. (2006) suggest that the coordination of this kind of collectively produced scientific knowledge has become an integral element of current biomedical practice in general. They describe the production of medical knowledge not only as a collective effort to produce information and coordinate it across multiple sites (clinics, hospitals, labs, etc.), but

also as a recursive process that incorporates the ideologies of standardization into decision-making and justifies that ideology with the standardized knowledge it produces.

> What counts, in other words, is not whether or not the results produced by a particular laboratory are true, in some absolute sense, but whether or not they are compatible (within conventionally determined statistical limits) with results produced by other laboratories (Cambrosio et al. 2006, 192).

Ethnographic research has shown that clinical decision-making consists of the effortful coordination of multiple (and highly variable) types of evidence, systems of knowledge, and lived realities (Berg and Mol 1998; Mol 2002; Gardner et al. 2011). The scale of EBM's most preferred source of medical evidence and knowledge (i.e. meta-analyses of large clinical trials; Oxford Center for Evidence-Based Medicine 2014) is matched by the scale of coordination that must be managed by clinicians, scientists, public health organizations, and policy makers as they frame their work as coherent and effective within the ideological realm of EBM.

The philosophies that framed the Soviet medical system were fundamentally incompatible with this evidence-based approach in a number of ways. During the Soviet Union, the role of medicine was framed by Marxist and Leninist philosophies, which attributed disease to social causes. Early communist leaders believed that social inequalities led to illness among the workers, and that the Bolshevik revolution, by bringing an end to capitalist exploitation, would also bring an end to the disease and illness that it fostered (Field 1967). Public health and medical care were seen as the responsibility of the state and offered at no cost (no official cost) to the entire population (Field 1967). As the economy, not just the healthcare system, was centralized, the role of the physician was not simply to treat the ill, but also to keep labor losses at a minimum. It thus became the *de facto* job of clinicians to curb malingering and to validate illness (and the reprieve from work that it granted) among his or her patients (Field 1953). The state guarded against malingering by setting quotas for the illness certificates that physicians

were able to distribute. The accepted norms for illness in any given population were determined by the central administration, and physicians risked fines or other sanctions if they violated these norms (Field 1953). Thus, it is not that the expectations for population health and the resultant medical practices in the Soviet medical system were supported by a different kind of evidentiary base than is employed by EBM; rather, these outcomes and expenditures were pre-determined by central administration according to goals set for labor and production.

Recent socio-cultural research on the adoption and implementation of EBM in the Post-Soviet sphere has revealed local engagements with EMB as a *political discourse* rather than a scientific or medical paradigm. Anna Geltzer argues that the language of EBM has been adopted by some Russian doctors as "a discourse of power, both in the sense of being the dominant discourse of a group that is vested with tremendous symbolic power (the western medical profession) and in the sense that it is a discourse that confers power on those who use it effectively (the Russian advocates of EBM)" (2009, 527). She argues that EBM is also "a medium through which the Russian medical profession is attempting to redefine itself and its relationship to the rest of the world" (2009, 527). These discursive moves are particularly significant when considered in light of Soviet standards of medical practice and the mechanisms by which they were set. The act of utilizing or promoting EBM as a legitimate paradigm constitutes a radical departure from the logic that has historically governed Russian (and Ukrainian) governed medical practices and standards.

Western medical and public health elites, including The Global Fund, often use the language and logic of EBM as an allegedly unbiased means of critiquing medical practices abroad (Geltzer 2009, 530). Owing to the reputation of Soviet science as a sphere "in which politics and ideology only interfere with, rather than produce or construct, scientific knowledge"

(Ninetto 2005, 448), western experts often use EBM as a baseline for comparing the efficacy of public health practices in the post-Soviet sphere. It is also used as an appeal to a higher authority of knowledge that discredits local forms of knowledge about public health and health care practices. What Geltzer observes among Russian physicians, then, can be interpreted as a strategic engagement with the discourse of EBM designed to position physicians and their practices as legitimate, effective, and deserving in the eyes of foreign experts and international agencies that fund health services abroad.

Furthermore, Amy Ninetto, who has conducted ethnographic work among scientific communities in Russia, observes:

> …even as Western science recognizes its transformation into what Latour (1998) has called 'the culture of research' — an enterprise whose authority can no longer rest on a denial of its multiple contextualizations — Russian science is faulted for having yet to become properly Mertonian: inadequately disinterested, skeptical, open, and universalistic. (2005, 488).

In other words, all scientific discourse is embedded in the social structures and political schemas that surround it, but in Russia (and, I would argue, in Ukraine) the fact that science can be swayed by politics is no secret. It is part of the most basic cultural logic that statistical utterances are also political utterances (Starks 2008, 66).

Ukrainian public health professionals face a significant specter of unreliable data due to inconsistent collection techniques, poor research design, and data falsification. In 2012, the director of a Kyiv-based institute specializing in public health research emphasized the extent of this problem to me, saying, "We analyzed recently a report from [a local group of researchers]. The sample claimed to represent only IV drug users, but when we talked to people in the field, we realized that they had mostly recruited alcoholics…[Confirming the reliability of data] is important, because sometimes we analyze fantasy. We conduct advanced analyses, use

sophisticated techniques, but it's just air. Not reality, just numbers." In Ukraine, the discursive force of both of these uncertainties plays a role in public health professionals' daily lives.

3.3 Statistics and Politics

Lena is a program manager for The Alliance, a large NGO that coordinates public health interventions and manages large sums of money from Global Fund grants. I met her in 2010 on the recommendation of an American colleague who had worked on several projects with her. Lena invited me to her office in Kyiv, where she explained to me the nature of her work and the tools her team uses to assess the social and epidemiological situation among high-risk individuals (i.e. drug users and sex workers) throughout the country. Lena discussed with me at length a program she had recently worked on, which promoted naloxone distribution for overdose prevention. I remembered this conversation with a mix of hope and disappointment when I visited her office again in 2014, four years later. At that time, a naloxone kit gifted to the Alliance from a harm reduction collective in the Catalan region of Spain hung on the public bulletin board, serving as a constant reminder to the Alliance staff of what they were working towards and what they had not yet achieved.

At our first meeting, Lena told me that she and the other projects leaders had many problems getting the naloxone program off the ground. She said, "People are very scared of drugs." She complained that many Ukrainians believe only a special doctor like a narcologist should be prescribing something like naloxone, when in reality any doctor is perfectly capable of prescribing or administering it.

Overdose is a serious problem in Ukraine. Lena expressed frustration with the lack of available information on the human health consequences and mortality resulting from overdose, as there were no national statistics on this cause of death. Overdose cases, she said, "get hidden."

They are categorized as instances of heart failure or poisoning. In Ukrainian death records, there is no distinction made or recorded between how or with what a person was 'poisoned.' Lena's naloxone program could have been aided by supporting evidence about the number of overdoses that actually occur, but current policies which categorize these deaths as indistinguishable from other accidental poisonings renders drug overdoses invisible to scientific and epidemiological technologies, essentially erasing this cause of death from the public record.

I asked Lena how significant she believed the risk of overdose to be in typical Ukrainian drug users.

"In all practicality," she replied, "we just don't know."

Lena's frustration is justified. Record-keeping practices, even when carried out according to Ukraine's current standards, frequently undermine public health goals. However, Lena's statements also reveal a deeper, more symbolic form of interaction with statistical evidence of overdose. Lena spoke of the importance of the naloxone program before acknowledging that the morbidity and mortality statistics that could justify this program simply do not exist. While Lena rightly points out the need for more external evidence, she also indicates the need to gain this evidence in order to support (and thus qualify as "evidence-based") a program that has already been deemed valuable and worthy by other measures.

Large organizations like the Alliance aren't the only entities whose staff recognizes multiple means for evaluating their programs. Sveta is a program officer at a large NGO in Kyiv that coordinates HIV-prevention grants across a network of smaller organizations throughout Ukraine. Her job is to help monitor the programs at nine different NGOs in various parts of the country. I was meeting with her to learn more about gender-sensitive approaches to providing drug-user services in Ukraine.

I asked if there were different needs or problems or approaches between male and female clients. Sveta said there aren't many female clients. She suggested that fewer female clients exist because fewer injection drug users, in general, are female. She pointed out that drugs cost money, and a man can get a job more easily than a woman, especially if neither has any education. She clarified, though, that young drug users who start using stimulants in the club scene are probably more evenly split between men and women. For the most part, she remarked, female injection drug users are a rarity.

Later in our discussion, Sveta openly offered the fact that there is research available indicating that male and female injection drug users exist in equal numbers. She quickly rejected these empirical findings, though, doing so in large part because these statistics don't agree with her own experiences.

"That just isn't the real picture," she said. "Female users are much more stigmatized, and if they even get drugs at all, it's from their husbands."

Numerous surveys of Ukraine's drug using population conducted both before and after this interview was taken (Booth et al. 2009; International HIV/Aids Alliance in Ukraine 2010; International HIV/Aids Alliance in Ukraine 2011; International HIV/Aids Alliance in Ukraine 2012b), proved Sveta's intuition to be correct, recruiting nearly three-times as many male drug users as female drug users through respondent-driven sampling techniques, in which new research subjects are found through recommendations made by previous research subjects. The reports that Sveta critiqued for generating false conclusion were produced by smaller agencies with smaller sample sizes. From a scientific point of view, she was right to be critical of them. However, Sveta did not critique the methods or procedures of the research she dismissed. Rather, her rejection was based upon her understanding of the social mechanisms of female

drug use. The merit of a particular statistical measure, in this conversational moment, rested not upon the methodological rigor of that measurement, but rather on the degree to which the statistic coordinated with her own understanding of the social mechanisms of drug use.

In both of these examples, data is questioned not only for where it comes from, but for what it may indicate. Through appeals to their own professional knowledge and expertise, both Sveta and Lena actively managed the way certain data are interpreted. They were also working to manage the way *I* interpreted these data, coaching me to see that their expertise always took precedent even in the face of nonexistent or contradictory evidence. They keep the meaning of data in question and use the uncertainty they have constructed as a pivot for asserting their own professional conclusions

Even more cynicism about the meaning of statistical data can be found among the clinicians running Ukraine's OST programs. Though they do not answer to The Global Fund directly, these clinicians are still responsible for maintaining all of the documents and records required by the MoH, of which there exists an extraordinary amount. Multiple signatures are required on multiple forms for every patient every day. One form is for logging the exact dosage that each patient receives daily. Another logs the specific time and date the patient was at the clinic. ("This is in case the police have any questions," one doctor told me.) A third form requires the nurse's signature and the patient's signature to record the fact that each daily dose has been distributed. These records were kept on paper, rendering them utterly useless for tracking trends in patients' progress through the program.

In several instances, OST clinicians were especially critical of certain statistics and indicators they felt could be cherry-picked and selectively emphasized for the purpose of supporting a desired conclusion. One such occasion took place on a sunny September day in

2012 at a narcological dispensary in Simferopol, Crimea. Two physicians, Ivan and Pavel, managed this OST clinic. I met both of them in Ivan's office and spent my afternoon being overwhelmed by offers of tea, cookies, and *zefir*, a marshmallow-like confection for which I harbor a serious weakness.

"The problem here is that we have people who settle into methadone treatment." Ivan told me as he pulled the bag of leaves out of his third cup of tea. He pensively dangled it over his cup for a moment before lobbing it into a nearby trashcan. "They don't want to quit taking drugs. They say 'this program is alright,' and they just stay there."

"You know," I replied, "one of the indicators that is often discussed in the US is the percentage of methadone patients who finish the program, who successfully decrease their dosage and step off methadone completely."

"Are those statistics used to measure the success of the program?" Ivan asked.

"Sometimes."

"Well, there are lots of statistics that you can use to make this program look like a failure." Ivan paused to smile and wave hello to a energetic, upbeat methadone patient who had popped his head into the office to say 'good morning' and snatch a cookie from his stash of pastries. He seemed deeply pleased with the irony of this moment. "And not just social outcomes either," he continued, "It could be the percentage of patients with HIV, the percentage of patients with tuberculosis, the percentage who have started treatment for other diseases since they entered this program…"

"You know, we have this one well-known statistic," interrupted Pavel. "Lots of people here like green cucumbers, especially in the summer when they are really fresh. Everybody eats them. We could say that nearly eighty percent of the people in Ukraine eat green cucumbers on

any given day in the summer, including the people who die. So that's where we get this statistic, that 80 percent of people who die in the summer die from eating cucumbers!"

Ivan and Pavel smiled at each other and erupted into laughter.

3.4 Evidence of a Job Well Done

Despite the slipperiness that they perceive in statistical data, Ukrainian public health professionals have become adept at speaking the language of their international benefactors—i.e. the language of EBM. Adopting EBM as a gold standard allows HIV-prevention organizations to make claims of legitimacy, rationality, and authority both in the local political sphere and on the national stage by successfully producing 'evidence' through their own accounting and data collection activities. Recently, when I suggested the importance of maintaining this legitimacy to the coordinator of a Kyiv NGO, he paused for a moment and then laughed. "Yes, this is true," he said. "We Ukrainians are very good at writing reports, at making our work *visible*, you know?"

During our interview in her office in Kyiv, Lena described this task of "making work visible" as one of the central responsibilities of her organization. "We go to our partner organizations and talk to them about what they need," she explained. "Once we collect this information, we reformulate those needs into a formal working plan to submit for a grant proposal. There are only two organizations in Ukraine that do this sort of work. We are one of them."

Lena's employer also conducts behavioral surveys among various target populations every two years in an attempt to track changes in high-risk behaviors. She said it is sometimes hard to analyze their data collectively, because the survey tool changes (sometimes significantly) from year to year. Regardless, they still do the report every two years, and this,

she said, was what really mattered. Lena's complaint about the variability of her organization's survey instruments is well founded. Without a consistent tool, the utility of the data, of the external evidence they collect, will suffer, and their ability to enact higher standards of EBM will be compromised. The existence of these difficulties, however, did not prevent her from reporting—with pride—that the surveys reach nearly 1500 respondents year after year.

I asked Lena to clarify which organizations conduct this kind of large-scale behavioral research. She replied that, once in a while, everyone is doing this kind of research. Programs have to evaluate what they do, to some degree. However, she was clear to make a distinction between the scale of what the Alliance is doing and what other organizations do. "We are trying to gain some sort of information to build up our programs, some kind of evidence from the field," she said.

This perspective was echoed by Andriy, another program manager at the Alliance. As we chatted in his office in Kyiv in 2010, he emphasized the empirical sophistication of his agency's work and the rational soundness of his own business practices. He said:

> Most of our work in here is actually getting the best expertise we can get from around the world in our area of interest. I mean, responding to HIV in the most at-risk populations. And we're trying to get as much as we can. We have The Global Fund support, which helps a lot in terms of funds, and also we have a monitoring team here, which does a lot of, well, they have like regular studies and surveys and so on. Like sentinel surveillance and quite scientific stuff, using respondent driven sampling and going deep into the population… It was a quite simple task when we were just starting. Now it's more complex. We have like sophisticated software, which every organization uses, so they can track clients' numbers, cards—how much was distributed and so on.

The practical necessity of this sort of record keeping is obvious, and Andriy is correct in his assertion that taking such accounts, when done properly, can help improve the work of his organization. However, he also emphasized the need to produce various accounting records and

reports as a way to "make their work visible" to donors like The Global Fund. Andriy framed these activities as authoritative and methodologically rigorous by commenting that his organization's monitoring activities include, "sentinel surveillance and *quite scientific stuff*, using respondent driven sampling and going deep into the population" [emphasis mine]. While his organization is most certainly doing its best to operate in-line with EBM as a standard of public health practice, Andriy is careful to see that the political and symbolic benefits of those practices are conferred on his employer as well as the practical ones.

I witnessed one of the most astonishing examples of the performance value of statistical data in 2010 as I was being given a tour of the Kyiv offices of a US-based global health organization. My tour was being led by Yulia, a Ukrainian woman who worked as a project manager in these regional offices. At the time of our interview, she had just concluded her participation in a pilot program designed to promote HIV testing and awareness through pharmacies. The intervention involved providing pharmacists with basic training on how to identify and counsel high-risk individuals who come into their pharmacy. Does this person look like a drug user? Do the symptoms being described sound like an STD? If so, the pharmacist was meant to give a referral card to the customer that provided further information on how and where to be tested. They also printed HIV-awareness and testing information on plastic bags that were used to pack pharmacy purchases at the counter, thus spreading information about HIV-testing into the household of every customer.

Yulia was very enthusiastic about the outcomes. "The results of our intervention were 20%!" she proudly exclaimed. In the seconds immediately following this statement, I held my breath, waiting for Yulia to let me in on the rest of the story. "20% of what, exactly?" I asked. Yulia barely hesitated before proceeding with her account (and effectively ignoring my

question). “Who knows if this is a good or bad result,” she continued, “but it was so wonderful to have real numbers to report and to receive the feedback from our colleagues.”

According to Yulia’s account, evidence serves two different purposes. On one hand, she reveals herself to be a dedicated and conscientious public health professional doing what she can in order to manage the logistical realities of running an effective HIV-prevention program. At the same time, Yulia anchors the importance of evidence, a potential index of the efficacy of her program, to its political and symbolic ramifications *entirely.* The legitimacy she believes her project has earned was so significant that she failed to even clarify *how* that evidence reflects upon the program’s efficacy or success or what was even measured in the first place. Even if her omission was a simple oversight in her narrative, her emphasis on the importance of the number, regardless of its value, reveals that statistical evidence is more than just a necessary work product of a legitimate public health enterprise. They are also the foundation of her NGO’s claims that it is a deserving entity worthy of support. Quite a lot, then, is riding on her ability to project evidentiary rigor in an ontologically uncertain territory.

3.5 Conclusion

Ukrainian public health professionals are able to establish certain identities and claim certain forms of agency by engaging with EBM as a discourse. In my conversations with them, many were actively engaged in the “discursive management” (Carr 2010, 68) of evidence in order to produce what Cambrosio et. al. referred to as “[not truth] in some absolute sense, but whether or not [the results] are compatible (within conventionally determined statistical limits) with results produced by [others]” (2006, 192). The public health professionals interviewed here are producing coordination, in this sense**.** Some accuse data of being incompatible with standards for creating sound scientific evidence or with their own personal experience. Others

highlight the value of producing data for the sake of presenting the practices of their organization as legitimate or for the sake of gaining approval and resources from powerful actors. These individuals are asserting their own political and moral evaluations of data. They are positioning themselves as capable, aware and morally upright actors. They present themselves as fluent in local forms of the manipulation and fallibility of evidence and as capable of rescuing efforts at evidence-based public health practices that might fall victim to those fallibilities. In so doing, they construct identities as authoritative actors within the sphere of public health, able to produce evidence about their own practices and frame that evidence as reliable and sound.

The work of Bruno Latour is frequently used to problematize interactions between so-called 'universal' scientific knowledge (in this context, the standardized ontological field of EBM) and local knowledge (public health professionals' ability to interpret and manage the meaning of evidence and evidence-based practice). According to Latour, scientific knowledge is created through abstractions, by measurements that place distance between a concrete reality and scientific discourses about that reality (1999). This knowledge, then, claims the ability to operate at a certain distance from the world, to travel far without sacrificing its relevance and applicability (Latour 1987).

EBM, as a system of standardized practices, constitutes a method of knowledge-production similar to that described by Latour (1999). Indeed, the central tenets of EBM hold that the most valuable sources of evidence are those that are the most generalizable and maintain the greatest level of abstraction: randomized trials and meta-analyses of randomized trials (Tonelli 2001, 192). However, Ukrainian public health workers are departing from this ontology and adapting EBM as a discourse for their own political purposes. Doing so allows

them to successfully engage in the practice of "anticipatory interpellation" (Carr 2010, 153). They are able to take on a particular social role (that of the deserving expert) and to "speak effectively from these designated locales, in politically efficacious ways" (Carr 2010, 154).

In a grand rounds presentation on the epistemological challenges of EBM, science historian Brian Dolan observed, "Saying that one uses evidence to make decisions gives the impression that the decision is itself calculated. But this hides much that is implicit in the act of deliberation" (2007, 2). Dolan claims that the interpretation of evidence is much more entangled with culturally informed moral heuristics than the philosophies of EBM would have us believe. In fact, he asserts that the very process of translating between statistical evidence and a so-called evidence-based decision is a moral one. Data and decisions, he claims, are constructed in constellation with one another—each one capable of bending to fit the other (2007). His conclusions open up questions about culturally defined values and moralities that shape how EBM will work 'on the ground' in different cultural settings. What elements of morality will be filtered in or out of evidence-based decision making as EBM, the 'gold standard' of public health practice, gets re-interpreted by local social structures and systems of meaning? How will the pre-conceived moral heuristics and 'black-boxed' cultural logics unique to new cultural contexts alter this relationship and the policy it produces?

The political and financial context of HIV-prevention in Ukraine brings this symbolic, value-laden character of EBM into clearer focus. Public health professionals use EBM to expand and improve the national response to Ukraine's HIV epidemic in significant ways, but they are also using EBM as a discursive tool for framing their identity and claiming new forms of agency within the larger international structures. I am not arguing that these social discourses

hinder the establishment of evidence-based practices in Ukraine. Rather, EBM as a social discourse is mutually constituted with EBM as a set of scientific or biomedical practices.

The following chapter of this dissertation moves one step closer to the lived experience of OST patients by exploring moments of epistemological disagreement the OST clinic, wherein drug users, doctors, and international donors have each constructed a unique problem that methadone intervenes upon in a unique way in order to produce unique outcomes, of which none are the same. Though everyone is able to engage with methadone as a physical, pharmaceutical technology, and everyone can appeal to a disease model of addiction in their narratives, none of these three groups are actually using these words to refer to identical objects. This phenomenon is made possible by the availability of EBM as a discourse in Ukraine's OST clinics.

I contend that evidence-based practice actually fuels blindness to the pluralisms that attribute multiple meanings to biomedical activities, especially when the outcomes sought by those multiple perspectives don't overtly contradict each other. In the context of internationally funded global health efforts, the principles of EBM do not necessarily attend to what mechanism your epistemology attributes to the success of a public health intervention. Ultimately, all that matters is whether something "works" or "doesn't work" to achieve the goals of the person writing the check. In the case of OST in Ukraine, what happens is that first the evidence-based intervention is implemented, and *then* the social fabric takes hold of that intervention and its component parts (i.e. the disease model of addiction and the therapeutic model of methadone) and renders these technologies meaningful in its local context.

CHAPTER 4: DRUGS AND DESIRE: THE MEDICAL EFFICACY OF WANTING

4.1 INTRODUCTION

Timur complains of terrible dreams. He sleeps badly. His body is often weak, and he suffers frequent fevers. He has tried various strategies for easing his symptoms: first methadone from the clinic, then *shirka* from the street, and now tramadol from a pharmacy that, for one reason or another, continues to sell to him. None of these solutions has remained effective for very long. After a while, he says, things always get bad again.

Timur is enrolled in one of the L'vivska region's few OST programs. On paper, he is a free man. He is no longer in jail. Serious troubles with the police are a thing of the past. He no longer wakes up worrying about where his next dose will come from or whether his body will hold out long enough to find one. "My mornings have become peaceful," he says. This is a positive change. His evenings, though, are not so pleasant. This is when the headaches come, and then the fevers, the weakness, and, finally, the dreams. "My dose [of methadone] right now—it's not enough," he complains. "It doesn't hold me up anymore."

When he first began receiving OST at the AIDS center in his hometown, Timur was given 40mg of methadone per day. Soon after, he started feeling badly, and his doctor (a kind, middle-aged man whose patients call him by his formal name, Alexey Sergeevich) agreed to increase his dose. "We are here to help them," Alexey once told me. "There is no reason for them to suffer when they are in our care." As they worked to manage his symptoms, Timur's dose crept up, bit by bit, until he reached 150 mg, the upper limit of what his clinic is allowed to prescribe.

"Obviously the point is not to raise your dose, but to lower it," Timur observed. "At these levels, I'm worried about my liver." Unfortunately, his persistent withdrawal symptoms don't present to him a very convincing case for lowering his dose either. Now that he's reached the maximum methadone allowance, he has been trying out additional cocktails of opioid analgesics—like *shirka* and tramadol—in the hopes of finding a regimen that will work. His mornings are spent commuting to the AIDS center for his methadone, and his afternoons are spent seeking out other things to help him get through the night. Timur claims that he would like to quit, but the drugs have too much control over his body.

Timur is a problematic patient. He frustrates his doctor and nurses; however, the root of their frustration does not seem to be his overt self-administration of street drugs in addition to the methadone. It seemed clear that the staff of his OST clinic were well aware of, and reluctantly tolerated, Timur's extra-curricular activities. They did not chastise him. Instead, they pitied him and wondered how to resolve the real issue that lay underneath: his lack of desire to be treated.

In this chapter, I address narratives of desire that are produced in the therapeutic environment of the OST clinic and reproduced by OST clinicians and patients in their conversations with me. As Nikolas Rose has observed, "The role of biomedical authority here is not to encourage the passive and compliant patienthood of a previous form of medical citizenship. Citizenship is to be active." In these clinics, an 'active' medical citizen is one who *actively desires* to regain his or her health. Thus, I consider the ways in which appeals to the presence or absence of different forms of 'desire' fit into local understandings of the social and psychological mechanisms of addiction. I map out a model of addiction that is popular among the medical professionals operating Ukraine's OST programs and the individual prognoses and

treatment trajectories contingent upon that model. In my analysis, I pay close attention to the local values, histories, and structures that give shape to the physical and social body that these therapeutic encounters attempt to render.

Above all, I argue that professional claims regarding the presence or absence of a patient's desire to be treated have far-reaching social and moral effects. These claims bolster the validity of OST as a modality of treatment and determine the personal availability of individual drug users to the mechanisms of that treatment. They leave little room, however, for alternative assessments—least of all the self-assessments of patients who perceive their addiction as a practical difficulty, not a psychological one. As a result, many addicted persons ultimately reject any interpretation of their addiction and treatment trajectory that contradict their own lived experiences. In so doing, they also reject the medical authority that seeks to shape their clinical behaviors and their social engagement. They develop their own treatment strategies, implementing them as best as they can within the confines of their OST program. Small wonder, then, that "success" on OST appears so difficult to achieve.

4.2 Soviet legacies in contemporary drug treatment

In the Soviet medical system—out of which the contemporary Ukrainian medical system emerged—individual 'will' was seen as a lynch-pin characteristic of addiction and of patients' therapeutic trajectories. It is well established in anthropological literature that patterns of addiction are driven by social and structural factors, that the characteristics and meanings of drug use behaviors are largely determined by cultural context (Becker 1963; Bourgois and Schonberg 2009; Bourgois 2003; Brave Heart 2003; Pilkington 2007; Spradley 1968). This fact is highly pertinent in light of Mariana Valverde's observation that "scholarly literature on alcoholism and addiction…tends to repeat [an] ahistorical and ethnocentric perspective"

(Valverde 1998, 18). It is deceptively easy, she argues, to overlook how social and moral values have shaped contemporary beliefs about addiction. In response, anthropologists often view organized interventions for controlling or policing addiction's undesirable elements as socially adapted technologies of governance cloaked in the appearance of the scientifically concrete (Bourgois 2000; Campbell 2007). The medical management of drug addiction in the Soviet era was no exception.

Throughout the early Soviet period, two etiologies of drug abuse and addiction fought for prominence: one focused on the social exterior and the other on the psychological interior if the addict. Both of these approaches sought to articulate the relationship between environment and addictive behavior and, in so doing, prescribe an appropriate response. The first of these, what can be called the 'social etiology' of addiction, aligned with the foundational principles of Soviet medicine as established at the First All Russian Congress of Medical-Sanitary Sections in June 1918. It was decided at this congress that emphasis was to be placed on the prevention of disease via appropriate sanitary and social measures. At this time, leaders in the Soviet medical field were especially concerned with "the influence of the economic and social conditions of life on the health of the population and on the means to improve that health" (Solomon 1989, 255). This social orientation dovetailed with the larger view that the Bolshevik Revolution "eliminated the basic antagonistic contradictions between the socioeconomic structure and the health of the people, and thus did away with the basic source of illness for the workers" (Field 1967, 39). In other words, substance abuse and addiction were not caused by individual failings; they arose as a result of harsh or oppressive social and economic environments.

Interestingly, this logic led to the brief implementation of an OST program in Leningrad in the 1930s. A physician named Kantorovich initiated the program on an experimental basis, taking in those allegedly "incurable" patients who, he believed, still displayed the 'potential' to become productive members of society once more (Latypov 2011, 11). Kantorovich's claim that nearly seventy percent of the patients enrolled in his maintenance program achieved 'good' or 'satisfactory' results, as measured by the patient's maintenance of family relationships and the stability of employment, flew in the face of the alternative view, which stipulated that chronic opiate addicts did, in fact, suffer from a "moral disability," that they were "lacking will" and therefore useless to both country and society (Latypov 2011, 11). The alleged implication of Kantorovich's findings was that most so-called 'incurable' addicts do possess the will to re-integrate into society, provided the obstacles that prevent them from doing so are successfully managed. Recovery, he argued, is possible with the right tools and the personal will to achieve it.

This approach ultimately lost the ideological battle when Soviet medical establishment adopted psychologist Ivan Pavlov's concept of the conditional reflex as its theoretical foundation. Pavlov defined the conditional reflex as an automatic response to physical or psychological stimuli that becomes physiologically hardwired in the brain via the neurological analysis and synthesis of that stimuli (Chilingaryan 1999). Though this focus on individual physiology departed from the socially oriented Marxist approach to public health, it succeeded in articulating a concrete link between the environment and specific pathologies where the explanatory powers of Marxist theories failed. For example, in 1925, Soviet psychologist Mark Sereisky used Pavlov's ideas to argue that most addicts possess pre-disposing factors—a "pre-narcotic personality"—and simply needed a trigger, such as a first dose of morphine, to awaken

the addict reflex [Russian: наркоманий рефлекс], the psychological 'hook' that drives addicts' compulsive behavior (Latypov 2011, 7). These Pavlovian ideas encouraged Soviet clinicians to suspect that if certain stimuli can trigger addictive behaviors, then different, therapeutically controlled stimuli might be able to repress or control them. A particularly striking example of such a therapeutic approach is 'coding' [Russian: кодирование], which consists of an attempt to physically re-wire the addict's brain by exposing them to substance-use-discouraging physical and psychological stimuli of various kinds, ranging from antagonistic pharmaceuticals to performance, misinformation, and even deliberate deception in the health care setting (Murney 2009; Raikhel 2010).

Though Pavlov's ideas focus entirely on the effect of exogenous factors on human biology and behavior, Eugene Raikhel's work on the contemporary use of coding and placebo therapy for alcohol addiction in Russia reveals that the patient's motivation for sobriety is considered to be central to the efficacy of the treatment (Raikhel 2010). Raikhel has remarked that the fear- or aversion-based techniques designed to steer the patient's behavior away from alcohol consumption constitute a "prosthesis of the will, [which allows] for a change in behavior without a change in the self" (Raikhel 2013, 190). Many of the most successful coding patients return regularly to renew their exposure to the drugs or processes that avert their desire to consume, using treatment protocols as "pragmatic aids for the care of the self that bolster the motivations for sobriety" (Raikhel 2013, 210). In this framework, the efficacy of coding is not produced by external stimuli re-shaping behavior on its own; rather, the desire of the patient to seek out that stimuli and, in doing so, re-shape their own reflexes becomes the primary mechanism of recovery.

It is unsurprising, given this history, that clinicians operating Ukraine's OST programs today have also forged interpretations of OST as a treatment that embrace patient volition as a central and necessary element for success. Many clinicians perceive addiction as a context-dependent battle between the conscious desires of the addict and the drug seeking behaviors that they find necessary. OST is interpreted, in turn, as a tool with the capacity to intervene in this conflict. Each patient's personal battle is one that, with the right support and scaffolding, can be won if they possess a conscious desire to win it. It is a battle, however, that *can't* be won *without* this conscious desire, and the success or failure of OST as an intervention is a direct measure of the patient's individual will.

4.3 What the Patient Wants

There are two common ways to discuss 'wanting' in the Russian language, the language of choice for all but a few of the patients and clinicians I interviewed. The first is to use the verb хотеть (*khotet'*), which means, "to want." One can use this verb to indicate very straightforward desires such as "I want to become a teacher" [Russian: Я хочу стать учителем] or "I want milk in my coffee" [Russian: Я хочу кофе с молоком]. The other way is to use not a verb but a noun: *zhelanie* [Russian: желание]. In English, the word *zhelanie* means 'desire.' It also means 'wanting' or 'longing,' or 'will.' It lends itself to the same kind of poetic license in Russian as it does in English. You can ascribe to someone *zhelanie umerit'* [Russian: желание умереть], a death wish. It is possible to *goret' zhelaniem* [Russian: гореть желанием], to burn with desire. The Russian language even shares the idiom *bylo by zhelanie, a umenie naidyotsya* [Russian: было бы желание, а умение найдётся], where there is a will, there is a way.

The distinction between these two modes of representation is important. While it is possible to want [Russian: хотеть] or not want [Russian: не хотеть] something without great

moral consequence, desire [Russian: желание] is a much more innate human characteristic without which there would be little drive to act at all. To accuse addicts of having or not having the desire to be treated is, in essence, to assert that they are either driven, morally active persons or passive, indifferent, emotionally unengaged persons who are beyond help. The actions of Alexey Sergeevich's *shirka*-using patient Timur—his ardent refusal to decrease his dose and his unwillingness to comply with the OST program's prohibitions against the use of street drugs—fall squarely into the discursive realm of *zhelanie* [Russian: желание]. Timur has been told how to treat his addiction. He has been given the tools that he needs to do so. Yet his problematic drug use persists. The problem, his doctors say, is not that he is physically incapable of quitting. Instead, Timur's behavior is iconic of a problem that clinicians claim plagues so many of their clients. Timur suffers from a lack of desire—a lack of *zhelanie* [Russian: желание].

Nearly every clinician I have met in Ukraine has complained to me about the lack of conscious desire to change among some or all of their addicted patients. This frustration was especially common among those who do not specialize in addiction treatment. The head doctor of an HIV clinic near Kyiv once threw up his hands in exasperation when I asked about the number of HIV-related deaths among injection drug users. "These deaths," he said, "are related to the anti-social element. They strove directly to the grave. They had no desire to live [Russian: У них желания жить не было]!" A tuberculosis specialist in a different hospital voiced a similar complaint. As I sat in her office, she scowled and looked behind me to a group of men milling outside the entryway of her department. "Doctors tell them to come here [to this office to receive anti-tuberculosis pills]," she said, "but they just hang out, they talk in the hallway, and then they leave. They are alcoholics, drug users. They have no desire. [Russian: Желания

нету.] Maybe the wife already died, the daughter is already sick. It's all the same to them. They need narcotics to deal with their psychological problems. That's addiction."

Clinicians who work directly with OST patients perceive the same pattern among their patients; however, they are much more delicate about interpreting each individual case. A social worker from Mykolaiv, who has been advocating for the expansion of OST in his region since it first became legal in 2006, elaborated on this distinction as follows:

> It is important to understand that there are three kinds of addicts. First, there are those who used street drugs, but managed to fully substitute those street drugs with methadone. They slowly lowered their dose, and eventually quit. But remember, even after they quit, they are still addicts. There is no such thing as a former addict [Russian: Бывших наркоманов не бывает]. Second, there are those who don't even think about quitting [Russian: Бросать не думают]. They like to keep their methadone regimen at the maximum dose—maybe 150mg—rather than working to slowly decrease it. They may *want* to quit, but they are too afraid—afraid that they will return to narcotics on the street and completely relapse. The last group is those who never think about quitting methadone and never plan on quitting street drugs either. They continue to use whatever they want the whole time they are on methadone—things like *shirka*.

This taxonomy was repeated to me with different words but similar content by many other clinicians. Within this framework, clinicians engage with individual will as a quasi-diagnostic category. If you have it, you will get better. If you don't, you won't. The ability of the drugs distributed by OST programs to affect change is also determined by a patient's position in this schema. Treatment efficacy is understood to be modulated by the desires of each individual patient to be aided by that treatment. OST, then, is not exactly a "prosthesis of the will" (Raikhel 2013). Rather, it is perceived to function, in some ways, as an *extension* of the will.

According to the model of addiction embraced by international health organizations (World Health Organization, 2004) OST does not produce its therapeutic effect by engaging individual desire. Rather, it works by shutting desires off. The dominant international view holds that OST "works" by "'block[ing]' the euphoric effects of heroin, thereby discouraging

illicit use and thereby relieving the user of the need or desire to seek heroin" (Mattick et al. 2009). OST is often considered a form of 'harm reduction,' an approach that "frame[s] substance use practices in terms of a series of choices around consumption along a range of possible actions, from the most harmful (e.g., sharing needles) to the least harmful (abstinence)" (Lovell 2013, 145). By blocking euphoria and simplifying the logistics of staving off withdrawal symptoms, OST, according to this framework, engages with drug users as fundamentally rational actors, aiming to alter their behavior by re-shaping the factors that affect their decision-making processes. In the international ideal, OST serves as a disciplinary technology for limiting and controlling desires and, by extension, controlling behaviors linked to those desires. In other words, each patient's internal desires are relevant only insofar as the desire to use drugs is successfully modulated by the intervention, rather than the intervention being modulated by desire.

Certain practical understandings of desire—the patient's social volition to seek treatment and regain an acceptable level of sociability—are fundamental to professional understandings of addiction in Ukraine, and have been for nearly a century. This mode of thought is an inextricable element of the Ukrainian context into which international standards for OST must be—and have become—situated. The standardized protocols of EBM may shape the daily activities of the clinic, informing processes like patient tracking, diagnostic procedures, and direct observation of treatment, but the clinical structure that these standards prescribe form only the background against which doctors and patients carry out their own discourse about what OST can accomplish and how patients should make themselves available to this treatment in order to achieve success. In particular, Ukrainian doctors make especially strong claims to expertise on the clinical management of addiction based upon their alleged familiarity with

desire and indifference in their patients. They have spent enough time with such patients, many claim, to identify desire when it is present and note its absence when it is not. For me to gain a better understanding of just how important desire really is, I was often told, I would also have to learn to read these signs—to see as they did past the words and behaviors of their patients into the motivations that drove them. This would help me see what addiction truly is and what OST can do about it.

4.4 Interpretation of Wanting

My first practical lesson in 'reading' a patient's desire came from a man named Borys, who has served as a consultant for OST programs across Ukraine. Borys invited me to accompany him on a number of planned visits to OST programs. He introduced me to clinicians and NGO leaders in a number of cities and provided me with an informed perspective on how these different medical and social service entities interact with each other. During the fall of 2012, I spent several weeks visiting eight OST sites, located in five different cities in Ukraine's southern regions and in what was then the Autonomous Republic of Crimea, in Borys' company. Our first journey together took us to an OST clinic in a tuberculosis hospital in the southern port city of Odesa, whose enclosed grounds overlooked the rugged shores of the Black Sea.

Before entering the hospital, at the request of the head physician we purchased simple masks to protect vulnerable patients in the hospitals from any infections we may have brought with us. We crossed the street in front of the hospital, entered a little basement pharmacy, and stood in line for our turn with the pharmacist at the window. As we waited, a woman at the front of the line completed her purchase and walked passed us towards the door. Her fist was clenched tightly around her newly acquired goods. Borys whispered "It makes me so sad to see

that." When I responded with a confused look, he explained what he had seen in her hand. "She is buying needles and eye drops. It was tropicamide. This is common here. Drug users will drink it, or sometimes inject it. I don't know what it is supposed to do, but lots of people use it."

In fact, tropicamide is an anticholinergic eye drop that is frequently used to dilate the pupil during eye exams. Anecdotal evidence collected during the course of my research indicates that tropicamide may act as a mild hallucinogen or that it may amplify the effects of opiates, even when opiate-receptor blockers, such as those used to decrease the euphoric effects of OST drugs, are ingested.

Once Borys and I purchased our masks, we hurried back across the street to the hospital. We were accepted graciously onto the hospital grounds. Borys greeted the staff with affection, and I was properly introduced. Tea and cookies were distributed generously, and Borys conducted the necessary business of his official site visit, which included a brief survey with the doctors and an inventory check.

The first patient we met in this clinic was a young woman. She had been lingering in the hallway drinking free coffee with a nurse while Borys and I chatted with the head physician. Intrigued by our presence, she let herself into the doctor's office to see who we were and what we were up to. As she strode confidently through the door, I immediately recognized her as the woman we had seen just moments ago purchasing needles and tropicamide at the pharmacy. She happily agreed to an interview.

She told us that her name was Lyuda. At that time, she had only been part of the program for a year and a half—not very long compared to some of the other patients there. In our interview, she confessed feelings of frustration with the program.

> L: Do I like [OST]? No. At the beginning, when I first came here, I thought it would solve all my problems, like, I didn't have to hunt for money, didn't have

> to find drugs on the street. I just came here, took my pills, and went about my business. But after a while…well, I can't go anywhere. Not even on weekends, just to visit anyone. It doesn't even matter where. I can't. Because every morning, even on New Years Day, January 1, everyone else is asleep, and I, like a fool—forgive me—I get up and I come here. So, at the beginning it's nice, but it's this vicious circle. And I can't quit. I can't go without this [the methadone]…psychologically it's very hard.
>
> JC: And how did you come to the decision to start this program in the first place?
>
> L: I had a baby. I can't tell you if I am a good mom or a bad mom, but I try. And I do this in order to spend time with her—nearly all my time, not counting the two hours I spend coming here every day. I joined the program so that I could be with her.

Interestingly, Lyuda displayed characteristics associated with two different "types" of drug users—according to the clinical taxonomy described by the social worker in Mykolaiv. On the one hand, she articulated her decision-making in such a way that highlighted how she has prioritized her motherly duties. She needs to spend time with her daughter, so she has taken steps to reduce the portion of her day that she spends acquiring narcotics by switching over to a quick and reliable source: OST. Her decision to begin treatment constituted a management strategy for keeping her multiple priorities in order. She was sacrificing the attention she gives to one (her addiction) so that she could afford greater attention to the other (her daughter). The disparaging assessment of the tuberculosis nurse, who insisted, "they have no will…. It's all the same to them [because] that's addiction" does not easily apply in this case. By prioritizing her duties to her child over some of the immediate necessities of her opiate dependence, Lyuda is testifying to her possession of the very desire that clinicians say addicts need in order to recover.

On the other hand, through her extra-curricular drug use, Lyuda is also strategically controlling the effects of methadone on her body. By adding tropicamide (and perhaps other substances) to her regimen, she is taking steps to alter, adjust, or amplify how she feels on

methadone. Her attachment to the physiological effects of her controlled opiate regimen is obvious in the actions she takes to modulate and maintain them. This is part of the risk of getting caught: not only could she be punished by the program staff, she would also have to overcome the stigma that accompanies an unwillingness to bear the physical effects of decreasing her methadone. She would have to face the consequences of being labeled 'indifferent.'

As our conversation continued, Lyuda voiced skepticism about OST as a mechanism for treating addiction and subsequently ending one's drug use. She clearly articulated her position that the *desire* to quit was not sufficient for overcoming her dependency, regardless of how serious or deeply held that desire might be.

JC: How would you describe, in your own words, the goals of this program?

L: To lower… I mean, the program gives people…we try to live like normal, healthy people. But the truth is that we don't always succeed. Because the brain of an addict is always searching for a high [Russian: все время хочется кайф], and here there's no high. Here it's just, like, I take my pills and I feel fine. Nothing hurts, I sleep regularly, I eat regularly, and everything's fine. And the whole time your dose is decreasing down to that minimum and then you're already going with out and we live like normal people. But the reality is that this takes a really long time. A year. Two. It depends on the person. I've already been here for a year and a half and I'm not ready to give it up.

JC: What is it, then, that you would like to gain for yourself?

L: For myself? Honestly? I'd like to wake up in the morning and know that I'm healthy. But that morning won't be coming anytime soon. Because every morning I wake up with just one thought on my mind: I need to get dressed and head out for this place…but I'm really tired of it.

JC: If you felt able to, would you want to quit taking methadone entirely?

L: I want to, but I'm not psychologically ready for it. I just know that if I go off the methadone, maybe a week will go by, not more, and I'll start looking for street

drugs again. Cause, here [pointing to her chest], it's not just physical, here [pointing again to her chest] it's more important than you could even think.

JC: What do you mean by "ready" to quit? What does "ready" mean?

L: Ready to quit and live like normal people. I can't say that I'm ready because I'm still craving the next high all the time…in my head. I struggle with it. I have this daughter who is growing up so fast, and I am very well aware that I need to stop, but it hasn't happened for me.

Lyuda was the first person I heard speak about feeling 'stuck' in an OST program, unable to change or to quit, but she was far from the last. Gaining an understanding of local paradigms of addiction was one of the primary goals of my research, so I always inquired about the treatment plans that addicts had designed for themselves. I asked about what quitting methadone would signify for them, about what it meant to be "ready." I asked how they would be able to recognize if and when they ever were. My questions were met with a constant refrain of "I want to quit, but I'm just not ready." The significance of this simple phrase was renewed by each new patient who uttered it.

What struck me about this particular moment at the tuberculosis hospital, and what Borys made efforts to drive home to me as we left the clinic that day, was the conflict that Lyuda, the loving mother who topped off her methadone with tropicamide, presented to her medical providers. Both Borys and Lyuda's physician attempted to coach my interpretation of this encounter, telling me that Lyuda will not be successful in her efforts to maintain control over her competing familial and chemical obligations. I was especially encouraged to see that Lyuda was deceiving herself. "You know she's lying to herself, right?" Borys told me. She may talk about her daughter and claim a desire to live peacefully with her family, but, in the estimation of the medical professionals around her, this just isn't realistic. She would never be

able to quit using drugs until she *really wanted to*; her tropicamide use is evidence that she doesn't. She's not letting herself be treated; she's just as addicted as her first day in the clinic 18 months prior.

4.5 Metaphysics of Addiction

Many months into our acquaintance, Borys and I found ourselves sitting across his kitchen table, eating linden flower honey from the jar with a spoon and once again discussing the so-called successes and failures in OST that he had witnessed throughout his career. Borys quietly pondered my questions about what makes OST "successful" for some drug users and not for others. I had asked him these questions dozens of times, and, by then, they had become almost rhetorical—part of our regular exercise of thinking through what he believed addicts were really getting up to in these programs. "Of course you have to have the desire to change your behavior," he said, switching from Russian to English, which he often did to emphasize a point. He continued:

> Drug users, they must have this desire to quit, because the behavior is bad. But the sin—the consequence—of this behavior is that it destroys your constitution—the thing inside of you that should be the strongest. So, when you are addicted, you understand. You know what is happening to you. But you can do nothing about it.

What Borys was working so hard to articulate was a psychological profile of addiction that is based upon a dualistic understanding of human consciousness. He explained that addiction is characterized by the inability to act upon one's inner desires. You want to quit, but you have lost the self-control needed to do so. He explained that each one of us possesses a mind, a body, and a metaphysical connection between the two. When we are sober, all three elements are strong and intact. When we use drugs or alcohol, one or more of them becomes compromised.

He also explained that clinical professionals are able to intervene in this quandary by generating and then hooking the desire of a patient. It is that very desire, in fact, upon which many treatment professionals hope their efforts will have effect. Borys elaborated:

> If someone is seeking rehabilitation with a psychologist, their success will depend on their motivation. They must want to change. The psychologist cannot do all of the work. But the addict cannot get better without the help of the psychologist. Sometimes the patient is motivated inside and just needs to find help. Other times, the psychologist must be skilled at generating their interest, building their desire, lighting a fire in you to change your ways.

When people are involved in substance abuse, he argued, their mind, their will, loses its ability to act upon them the way they want it to. As they become more and more addicted, drug users are able to see themselves losing control. They may even retain their desire to be in control, to live their lives, to maintain their relationships, but they are unable to. This is why both professional treatment *and* the desire to be treated are necessary for overcoming addiction.

This idea is not held by Borys alone. Svetlana, a social service program director from Cherkassy, articulated this same logic to me several years before I met Borys. She described this weakened connection between mind and body as an illness in one's soul. She explained, "We know that a doctor can only help with 10%. The other 90% is for you to work on. This is true for any disease, everywhere. A drug-addict is an ill person: ill psychologically, physically, and in the soul. Their soul is ill. But they can't just sit and wait. They have to go to NA groups, therapy, look for the way out." If they have no desire, she insisted, their situation will never improve; however, if they maintain an internal desire to change their lives, or if a skilled psychologists or social worker is able to generate such desire within them, then treatment—including OST—can be the last piece of the puzzle. It is a necessary step towards realizing those desires, and a step that addicts must actively seek. They have to want to find that help.

After hearing these professionals map out the psychological and emotional terrain of addiction in this way, I began seeing echoes of these ideas in my interviews with addicted patients. For example, Mariya, a woman from the OST clinic on Kyiv's west bank, explained her initiation into drug use by describing a similar gap between her desires for herself and her personal control over her drug use:

> When I started, we had no drug addicts in our village. I had no idea that I would end up like this, living the life that I'm living now. You know, there are some people who like drinking. They like the feeling. I don't. I never enjoyed the feeling of being drunk. I did other things. But the purpose of all of it is just to relax a bit, right? But, unfortunately, it wasn't that kind of relaxation. It alters your perception of reality, making everything fluffy around the edges. And you have these moments where you realize that you're tired of all of it, tired of using, but you go out looking or more just the same. You hunt, you buy, you cook, you shoot it up. You're even doing it when you have no veins left, even after you've been sitting for two or three hours looking for a place where the needle will hit….

This frustration, this sense of wanting to stop but simply having no control over one's use, is also apparent in Timur's recollection of his path in and out of different hospitals and treatment programs. "The point is not to raise your dose," he said. "But to lower it…I want to quit, but [the narcotics] are holding on too tightly to my body." Timur claims that he has a desire, but the nature of addiction makes it impossible for him to regain the control he needs to make that desire a reality. The major difference, however, is that these patients insist that they desire to quit in spite of their failure to progress on OST. For them, OST can intervene on their daily logistical troubles, but not on the root psychological or biological elements of their dependency. As clinicians mark them as failures, blaming their difficulties on a deep-seated indifference, patients frame their entire lived experience with addiction as saturated in frustrated and unsatisfied desires. They insist that, in the face of all of this, they are doing the best that they can.

4.6 Conclusion

International protocols for the implementation OST (discussed in Chapter 3) may be considered a hegemonic discourse. In her analysis of standardized tuberculosis treatment in the Republic of Georgia, Erin Koch has noted, "the translation of the cultural, historical, and institutional processes within which standardized [international] medical protocols and standards are made and circulated globally are rendered invisible" (2013, 58). Koch's ultimate position, and mine as well, is that these standards constitute an ideal that can be attempted in all places but achieved in none. As these international approaches move across national, cultural, and geographic boundaries, they will become situated within local discourses that fit or contradict these ideals to varying degrees. International paradigms will necessarily be re-interpreted and incorporated into the local context wherever it goes. Ukraine is no exception.

OST clinicians in Ukraine are adopting a clear and prescriptive interpretation of the medical terrain where addiction, psychology, and personhood intersect. Patients like Timur and Lyuda, however, are levying their own claims as well. They are both are quick to take ownership of their self-management strategies and to defend the validity of their efforts. It is clear, though, that these strategies, whether they be seen as attempts to simplify logistics or deliberate moves towards socially acceptable citizenship, are not equally valued by their medical providers. Throughout his time in as an OST patient, Timur has displayed complex and creative treatment seeking behaviors. He goes by his clinic at 10am, like clockwork, every day. He is a regular visitor of his city's other harm reduction programs. He is open and honest with all of the social workers that interact with him. He takes medical consultations when they are offered. Yet he is not seen by OST professionals as having any desire to improve his situation. Similarly, Lyuda's claims of motherly duty are rendered invalid because she is a mother who

uses drugs. Her tropicamide use is taken as a sign of her indifference to her health and wellbeing, rather than an attempt to exert more control over her physical and mental state.

If we consider the premise that addicts become defined and targeted by public interventions like OST because something about them is socially problematic, it is logical to expect that the addict's recovery will be defined by their re-entry into the social fabric as a less-problematic agent. E. Summerson Carr has observed the same logic in American treatment programs where addicts are considered troublesome because they are epistemologically problematic (2010). They are seen by their treatment staff as unable to recognize their own personal states and are, therefore, unable to produce honest, unfiltered speech that reflects those inner states. Since the problem that is that they cannot be trusted, addicts' treatment trajectory, if successful, will be defined by the emergence of appropriately regulated speech (Carr 2010). In Ukraine, this logic also has traction, but in a different form. Addicts are seen as problematic and dangerous because addiction, as many clinicians claim, can only arise in someone who is indifferent. Indifference disconnects people from their primary social roles and relationships. That lack of integration is what makes them troublesome, and it is what treatment efforts aim to resolve.

The theory that addiction traps the will by forcing the addict to lose control of himself reaches far throughout the biomedical sphere and even into the popular imagination of drug addiction in Ukraine. Timur and Lyuda's persistence, though, reveal cracks around the edges of this theory. They show that the dominant psychological approaches to addiction treatment in these crucial programs are capturing only a part of the lived experiences that they hope to influence. Ultimately, the clinical paradigm of addiction that has taken hold among the professionals operating Ukraine's OST programs must be understood as a discourse that exists

in concert with the diverse strategies that drug users adopt to manage their bodies, their identities, and their lives. A failure to recognize this will hinder the ability of OST programs to produce positive outcomes among the patient population, and will leave many addicted persons, especially those who do not share this clinical view of themselves, effectively on their own to develop strategies for making sense of their experiences and making peace with their bodies, physical and social.

CHAPTER 5: THIS IS NOT AMERICAN HEROIN

5.1 INTRODUCTION

In the fall of 2012, I once again visited the OST clinic overlooking the Black Sea cost in Odesa, the same clinic where I met Lyuda, several times. On one of my subsequent visits, I found myself again sitting in the primary physician's office. This time, an OST patient named Sasha sat across from me. My research into patient perspectives on methadone in Ukraine was still beginning. I was learning the pleasantries and asking all of the broad, general questions that one does when one is just starting out. Sasha sat with me for a long time that day. He was interested in showing off his expertise. He also found me strange and amusing.

During our time together, Sasha, a gruff fellow in his 40s, taught me a number of things. First, I was doing a good job, relatively speaking, of keeping up with Ukrainian etiquette. I had done my due diligence and brought a bundle of crispy butter cookies with me to the office of the head clinician, who had so warmly opened the doors of this program to me time and time again. This was good, he noted, but if I want to make friends with people who are patients in the program, don't bring cookies, he said. Bring cigarettes. Second, Sasha explained to me how he sees himself and his drug-using expertise in comparison to what "you Americans" often do. He delighted in telling me that the social value of narcotics—and, by extension, OST—is different for him than for his American counterparts. "This is not American heroin," he said, referring to the sorts of opiates that are common in his social circles. He looked at me with a proud but gentle smirk. "These are Ukrainian opiates."

In much of the medical discourse surrounding OST in the US, a line is drawn very clearly between heroin—a synthetic opiate and respiratory depressant with analgesic and

euphoric effects, deemed by most national governments to have no medical value—and methadone—a synthetic opiate with euphoric effects that is widely approved for medical use as a respiratory depressant and analgesic. For Sasha and many others like him, this cultural distinction between one opiate as a drug and the other as a medicine doesn't hold. Both substances are seen as variants of the same thing, each able to get the same job done—staving off your withdrawal and getting you a little "high"—but to different degrees and with different secondary consequences. There are, in fact, numerous substances that fit this bill. There is heroin, pharmaceutical grade Demerol and morphine, homemade poppy straw extracts, and pharmaceutical derivatives of various cough and cold medicines. Ukrainian narcotics users interact with a spectrum of substances, all of which will get the job done at the end of the day, but which are distinguishable form one another according to quality, desirability, and ease of procurement.

I, like many others (Bourgois 2000; Campbell and Shaw 2008), take the distinction between "street drugs" and OST drugs to be a disciplinary technology in the Foucauldian sense—one that aims not only to treat addiction, constructed here as a disease, but also to manage the addicted body, to render the addict's behavior less deviant, less problematic. Foucault famously suggested that social power should be examined where it is "at its extremities" in "those points where it becomes capillary" (1976, 96), operating from out of "infinitesimal mechanisms" (1976, 99). Though this approach has been fruitful for many drug use ethnographers, my intentions in this chapter are to engage with an approach that is somewhat the opposite. Rather than looking at social power in its most subtle and insidious forms, I consider power in its most overtly odd and contradictory forms. I am interested in how the discursive forces of OST, as a disciplinary technology, become apparent through an

obstinate allegiance to this medical technology in the face of technological breakdown. To borrow a term from Erin Koch (2013), I am interested *slippages* that occur between the plans and intensions of medical interventions and the social terrain in which they try to take root.

According to the international organizations that promote and fund OST around the world, this treatment constitutes an essential medical service that should be in every national HIV and drug abuse prevention strategy. In a joint position paper, the WHO, UNODC, and UNAIDS, described OST as

> …one of the most effective types of pharmacological therapy of opioid dependence. There is consistent evidence form numerous controlled trials, large longitudinal studies, and programme evaluations, that substitution maintenance treatment for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviors with a high risk of HIV transmission. (World Health Organization 2004, 13)

In the global health framework, the perceived mechanism of addiction—and the mechanism by which OST achieves its therapeutic ends—revolves around physical pleasure and the external regulation of that pleasure for behavior modification purposes. For example, a recent Cochrane Review article summarized the available clinical evidence on methadone as a treatment for opioid dependence. It states, "Methadone can "block" the euphoric effects of heroin, thereby discouraging illicit use and thereby relieving the user of the need or desire to seek heroin" (Mattick et al. 2009, 5). The key mechanism here is the impeding of positive physiological consequences of opiate use.

This strictly biomedical understanding of opiate dependence does not gain much traction among OST patients in Ukraine. As this dissertation has already shown, there are frequently multiple operant definitions of 'addiction' present in just one clinic (see Chapter 4), and most of them contradict this international approach in one way or another. To illustrate this again, let's

return to Sasha's comment about Ukrainian opiates. Here is his comment about Ukrainian opiates in full:

> Yes it's better to live your life without methadone, but what's there to do about it? Of course, it's a switch to something better than those narcotics that flow around the streets here, which are more, like…they're dirty. From a medical perspective they are dirty drugs, so you come here hung up on this muddy swamp water. This isn't American heroin. These are Ukrainian opiates. We have *khimiya*. We make this narcotic ourselves. I can make it with poppy. I take two other components, an anhydride and a solvent, and I'll make you narcotics with it. In America you don't do this, but we old, experienced addicts, we do. Young folks don't know how to do it, but I'm already a long-time addict. I've been doing this since 1987.

In this passage, Sasha highlights a few things that are central to his evaluation of OST. In particular, he notes that methadone (at least the prescription form of methadone that he is receiving at the clinic) is a better, cleaner, safer option than the street drug, *khimiya*, which is produced in large batches and frequently sold in pre-packed syringes on the streets. This point is important, because this logic is anchored to a very specific conceptualization of addiction and OST, which is distinct from dominant medical and psychological understandings. It is one that perceives a variety of narcotic substances, from street drugs to codeine tablets to OST drugs, as different variations of the same thing. For Sasha, the question is not whether to consume opiates or to abstain. The question is "which opiate is the right one for me?"

Given this contradiction between international standards for addictions treatment and the way Ukrainian drug users strategize their own treatment trajectories, this chapter asks the following question: what kind of sense does OST make, what kind of technological or therapeutic intervention can OST be, when brought into a social field where multiple narcotic substances are already perceived to be acceptable substitutes for each other? When methadone and buprenorphine fail to achieve the status of a medicine or a biologically therapeutic substance, these drugs become integrated into local knowledge as yet another element on this

spectrum of elements from which opiate users can choose for chemically managing their minds and bodies. They are distinguished from other opiate sources as choices that are in more steady supply, that are free. But they can also cause bad headaches at night, and they lock you into the geography immediately surrounding your clinic.

However, as Sasha stated from his own experience, "[OST] is a switch to something better than those narcotics that flow around the streets." For him, and for many others, OST is attractive because it frees addicts from what many refer to as "*okhota*" [Russian: охота]—the daily "hunt" for money and drugs. The problem that methadone solves for them is not physical addiction, per se, but the logistical problems that accompany addiction. It frees them from the literal run-around required to manage their withdrawal symptoms and allows them to resolve the negative social consequences that arise as a secondary affect of their drug use. In this chapter, I follows Sasha's cue that the therapeutic capacity of OST drugs may not be pharmacological at all. I take a close look at how OST patients describe their own experiences with the various chemicals (both pharmaceutical and black market drugs). I consider the ways in which patients articulate their satisfactions and their complaints about OST and craft their own vision of the ideal treatment trajectory.

Above all, this chapter argues that patients join OST programs not in order to end their relationship with opiates, but to rid themselves of the destructive social milieus that are exacerbated by their relationship with opiates. They long to exit a situation in which they are caught in a spiral, running around trying gather money, drugs, and other resources in an attempt to manage their bodies and their lives—a situation that would exhaust anyone. This is the reason why drug users choose to begin OST, why they choose to stay in the program, and why some of them eventually choose to leave.

5.2 Patterns of Illicit Drug Use in Ukraine

By all accounts, the forms of injection drug use currently practiced by substance users in Ukraine proliferated wildly in the period immediately following Soviet. Many have argued that this spike in drug use was fuelled by wide-spread poverty, which, in turn, fueled massive growth of the black market, increased migration across former Soviet territories, and a general decline in Ukrainians' quality of life (Booth et al. 2006; T. Rhodes et al. 1999). Trade with Afghanistan also increased during this time, creating new routes for the movement of heroin across Russia (T. Rhodes et al. 1999). In Ukraine, however, heroin was and remains largely non-existent, available only to those elite few wealthy enough to afford it (Grund, Latypov, and Harris 2013; Booth 2013). Street users have little, if any, interaction with imported heroin. Most of those whom I met preferred to avoid it, considering its effects too harsh.

The most commonly injected opiate in Ukraine for the past several decades (according to conventional wisdom among public health experts and users themselves) has been a derivative or poppy straw called *shirka* or *khimiya*—the drug Sasha referred to as "Ukrainian opiates." By the end of the 1990s, it was estimated that between seventy and ninety-five percent of injection drug users injected *shirka* regularly (T. Rhodes et al. 1999). This substance can be made at home with easily obtainable chemicals and solvents. "I produce it myself," Sasha bragged. "I make it from poppies. I add two different components, an anhydride and a solvent, and I can make opiates for you that way. Me, myself. I make opiates for you myself." He laughed. "In America, I know, you don't do this."

Opium poppies have long been cultivated in Ukraine, Belarus, and parts of Russia. The seeds of this plant are a staple ingredient in Ukrainian cooking, used mostly in desserts and usually sold by the kilogram. The injection of poppy straw derivative is a relatively novel use of

this traditional resource that first appeared in the early 1990s (T. Rhodes et al. 1999). Today, most opiate injectors continue to prefer *shirka* to other narcotic substances. OST patients told me that this drug is pleasant but not overwhelming. As one woman described it, "[*Shirka*] makes everything soft around the edges."

A certain number of drug users acquire *shirka* by harvesting their own poppy. This was evidenced by a slow afternoon spent at an NGO in Mykolaiv where I was supposed to be conducting interviews during the summer of 2013. "Sorry, there's no one here," the director told me apologetically. "Everyone is out at the dacha [their country house] harvesting poppy!" Others simply buy *shirka* on the street form those blessed with the resources to be so industrious. In 2013, when I was conducting my research, the price of a bag of this organic poppy straw derivative sold on the street ranged from 60UAH (about $7.50 at the time of data collection) in Mykolaiv to upwards of 100UAH (about $12.50 at the time of data collection) in Sevastopol and L'viv. "They sell it on the street, in these little bags," explained Vova, a young father who, with his wife Masha, received OST at Ivan and Pavel's clinic in Simferopol. "You boil it, parboil it and so on. But that's opium. You [Americans] probably have more heroin….That stuff is opium from a laboratory. Our stuff mostly comes from plants. It grows here, we dry it, grind it, and cook it."

Though this plant is cultivated in small amounts, which can result in seasonal shortages, the production and availability of *shirka* remained relatively stable for several decades. This has changed in the last few years, as police have effectively taken over Ukraine's illegal drug trade. This shift in control of the drug market resulted in a decrease in supply, an increase in cost, and the emergence of numerous physical and juridical risks to opiate users. According to Mariya, a

patient at the Kyiv dispensary, the change to her experienced risk environment caused by police interest in the drug trade was dramatic:

> Those who bought drugs for themselves and didn't take it home, they were thrown in jail. Those who sold drugs, they made a pay off and just kept selling. And the police, well, the get what they get, huh? We have this walkway in the neighborhood, and they would grab guys there, addicts [Russian: наркоманы] would be running, selling right by the apartments. And doing that now takes an incredible audacity. Go somewhere else. Head to a park or something and conduct your business there. It's terrible. And children would see all this, people shooting up by the apartment building. The people will come, folks will pay them off, and then they go. And every one of them is selling drugs.

This situation is not unique to unique to Kyiv. I heard similar stories from drug users in L'viv, Cherkassy, Odesa, Ivano-Frankivsk, and Crimea. The excerpt, below, of a conversation I had with an OST patient from L'viv is typical:

> JC: Do the police control the sale of drugs here?
>
> P: Yea, we also have this problem. They control the sale of drugs on the street. They decide who gets thrown in jail, who doesn't get thrown in jail, who has to pay, who doesn't have to pay.
>
> JC: What do they sell?
>
> P: They sell heroin.
>
> JC: Heroin? Real heroin or *shirka*?
>
> P: Both real heroin and *shirka*.
>
> JC: I didn't even know you had heroin here. Is it expensive?
>
> P: It's expensive. US$320 per gram.
>
> JC: Oi. And how much for *shirka*?
>
> P: *Shirka* goes for like 100UAH. 80-100UAH.

Unfortunately, OST adds yet another complication to this situation. Namely, OST removes potential customers and subjects of extortion from the black market, thus removing corrupt police officers' opportunities for profit. For this reason, the relationship between OST programs (and the medical staff that operates them) and law enforcement officials is usually antagonistic.

This pressure from police has also increased the use of medical grade narcotics from pharmacies (Booth 2013). Though many social workers across Ukraine made this observation, I found the description of OST patients to be the most compelling. In July of 2013, while spending the afternoon at the narcological dispensary in Kyiv, my questions about this element of the drug market spurred a lively conversation among the patients. When I asked if people typically make their drugs or buy them, one man, a stocky fellow in his late 30s who consistently wore button-down shirts and freshly shined shoes to the clinic, responded that this is changing. People used to make it from poppy, he said, and those who made it would be the ones who sold it, but now, the drug market exists for the most part inside the pharmacies. The really good stuff, like morphine and Demerol, which most referred to as "clean narcotics" [Russian: чистые наркотики], was unavailable at ordinary pharmacies. One had to go to a hospital pharmacy to get it. But, he noted, if you didn't have that kind of money, you could just buy some codeine-based cough syrups or whatever else you liked and mix them up.

He briefly mentioned the option of purchasing liquid drops from pharmacies as well (similar to the drops purchased by Lyuda, as discussed in Chapter 4). I asked him what such drops were for. Was it to amplify the euphoria of other drugs, as I had overheard? Of course, of course, another woman replied. She broke into the conversation and began speaking knowledgably about this product. She told of a man she knew who had died from injecting liquid drops. "Well, of course he did," came the general reply from the crowd.

"That was tropicamide, yes?" asked the man with the shiny shoes.

"No," she corrected him. "It was a different kind. Besalol."

"Besalol only comes in tablets," he said. "They don't make drops."

"They come in drops too!" she firmly insisted.

The man laughed. "And how do you know?"

"A friend told me!" She said in retort, visibly offended.

Until the mid-2000s, it was possible to buy potent, medical grade opiates like morphine and Demerol at any corner pharmacy without a prescription. Today, the sale is technically restricted to hospital pharmacies and sold by prescription only. This doesn't stop people from making an effort to buy them, though. The mother of one of my friends in Kyiv is a retired pharmacist who used to work in a hospital in Rivne. She delighted in telling me stories about what people would do in an attempt to procure narcotics from her window. Some would claim that they had lost their paper prescription along the way from their doctor's office to the pharmacy. Others would cry out in feigned agony and beg her to help them by supplying painkillers. Some would openly admonish her for forcing them to take their terribly ill parent or relative out of the house and all the way to a doctor's office for a prescription rather than simply giving them what they needed on the spot. She shook her head as she told these stories, and spoke with great pride about the honest, respectable, legally upstanding pharmacy that she helped operate.

Despite the prevalence of such strict and law-abiding pharmacists in Ukraine, there were still plenty of others who were willing to sell drugs of all kinds to anyone who could pay. Though there existed strict government regulations prohibiting such sales, these pharmacies were rarely monitored or policed, due in no small part to the money that law enforcement

officers stood to make from extorting the drug users who purchased these medications. As a result, most 'black' pharmacies remained unmolested by law enforcement and ran a steady business—so steady, in fact, that the outreach workers I shadowed in L'viv were able to mark these businesses on a map.

The shift in Ukraine's drug market from the streets to corner pharmacies also led to an increase in the off-label use of non-opiate pharmaceutical substances. Tropicamide (eye drops commonly used to dilate the pupil for an eye exam) was, by far, the non-opiate drug most commonly mentioned by OST patients. Its use seemed particularly common in Crimea, where multiple patients and social workers insisted that "everyone did it." I could find no one who would admit to using tropicamide themselves (though clearly some of the people I interviewed did). Many, however, revealed some degree of first- or second-hand knowledge of its use. Most reported that the drops are used to amplify the 'high' of other drugs, including methadone. Both OST patients and social workers supported this claim in interviews. One social worker in Mykolaiv, herself a former injection drug user, said that she had even learned how to identify someone who had been using tropicamide. "They don't act right," she said. "They are too fast and agitated or too slow and messed up."

Amphetamine use has also increased in recent years. The use of methamphetamine, consumed in a form known as *vint* [Russian: винт; English: screw], has become increasingly popular (Grund, Latypov, and Harris 2013). This drug has been present in Ukraine since at least the late 1990s when it was commonly produced from wild-growing *ephedra sinica* (T. Rhodes et al. 1999). In 2013, however, a number of my informants reported that *vint* is typically made from teofedrine (a medical preparation that comes in tablet form and contains theophylline, theobromine, caffeine, ephedrine hydrochloride, and phenobarbital) and phosphorous—a recipe

similar to the Sudafed-based production method used in the United States. Another stimulant called *jeff* [Russian: джефф] is made from pharmaceutical precursors of methcathinone (Grund, Latypov, and Harris 2013). Outreach workers in L'viv explained to me that this drug, also made from tablets, magnesium, and possibly other ingredients (outreach staff disagreed on this point) offers a quick but strong ten to fifteen minute high. Its use was associated with severe nerve damage, visible physical impairments, and difficulties with motor control.

Despite the growing use of amphetamine and other novel consciousness-altering substances such as eye drops, pharmaceutical products that contain opiates remain the most popular acquisition from commercial pharmacies. These include cough syrups, cold medicines, and pain pills that contain codeine, just to name a few. Sometimes, drug users will simply ingest these medications orally in larger doses than prescribed. This does not afford them any physical 'high,' but it does effectively manage withdrawal symptoms. It helps some people feel 'normal.' Those seeking a high may process these products at home to remove the inert ingredients, isolate the codeine, and synthesize it into desomorphine. The resulting, injectable, liquid desomorphine solution is known as *krokodil* [Russian: крокодил; English: crocodile] or, simply, as *krok*.

Krokodil has received a significant amount of media attention in recent years, due largely to its association with rapid and extensive tissue damage ("'Zombie Apocalypse' In Russia: Krokodil Drug Turns People Into 'Zombies'" 2012; Shuster 2013; Laessig 2011; Walker 2011). At the time of writing, only one thorough, academic exploration of this drug has been published: a comprehensive review of literature and knowledge from regional experts, which appeared in the *International Journal of Drug Policy* in 2013 (Grund, Latypov, and Harris 2013). According to this report, the process of synthesizing *krok* is not easy in the best of

circumstances, and the authors suggest that serious nerve and tissue damage can occur if the solutions injected are too acidic or contain other harmful, residual substances. These injuries have given *krok* its nefarious reputation in popular media. However, based upon the apparent prevalence of this practice, it is clear that not all desomorphine users experience these negative physical effects. It is also clear that the use of *krok* is growing across both Ukraine and Russia (Grund, Latypov, and Harris 2013; Booth 2013).

Despite these potential risks, the most attractive feature of *krok* for many drug users in Russia appears to be its cost effectiveness.

> Codeine, generally combined with other pharmaceutical agents such as paracetamol, costs approximately 120 Rubles (€3) for a pack of 10 in Russia and is generally sourced from pharmacies. This produces a yield reportedly equivalent to 500 Rubles of heroin (John-Peter Kools, personal communication, 2012; Walker, 2011) making it an attractive heroin alternative to low income drug users (Grund, Latypov, and Harris 2013, 226).

In Ukraine, it is not heroin that drug users are substitution with desomorphine, but *shirka*, which costs between 30 and 50 times *less* than white powder heroin on the street. Therefore, unless one intends to shoplift these precursor products (something of a challenge in a country where most goods for sale are kept behind the counter), *krok* may end up being more expensive to produce and consume in Ukraine than *shirka*. In other words, Ukrainian drug users appear to be switching more and more often from the cheap, organic, locally grown poppy straw derivative that they prefer to a more expensive, more complicated, and potentially more dangerous alternative. This suggests that *krok* is, for many, a drug of last resort, sought after when police officials have closed off their access to preferable alternatives.

The slow shift from home-grown poppy derivatives to these pharmaceuticals has changed how drug users in Ukraine think about the substances they use. In 2007, when I

conducted my earliest research project on drug user services in the city of Odesa, I heard no one speak of substances like Demerol, Besalol, teofedrine, or even codeine pills. By 2013, I was meeting individuals whose first foray into illicit drug use consisted of popping codeine tablets with friends. Despite these changes, it seems clear that the earliest adopters of *krok*, as well as many who continue to use it today, perceive this drug not as a new variety of drug in its own right, but as an alternative that can be used in place of *shirka* when supplies to make the poppy straw derivative are low or unavailable. It is an alternative that comes with additional costs and risks, but which mitigates the even greater risks that most faced while buying *shirka* and poppy straw on the streets, where the police are driving up prices, threatening extortion, and abusing their authority to arrest and jail people as they please.

These changes in drug use behaviors constitute active risk management strategies on the part of drug users. In a perfect world, 'softer,' home-grown drugs like *shirka* are preferable to most over other available opiate substances, including heroin; however clear risks to their physical, legal, and financial wellbeing have pushed drug users towards alternative substances. Therefore, despite the dangers it brings, *krok* can be interpreted as a strategy of harm reduction through substitution, just as OST is meant to be.

If drug users, then, are so motivated by concern for their wellbeing that they are willing to substitute their drug of preference with something else, the question of why so many continue to use *krok* and other pharmaceutical products instead of beginning OST, which they would receive *for free*, urgently needs answering. In the next section, I discuss how OST drugs fit into this spectrum of mutually interchangeable narcotics. I explore the consequences, positive and negative, of taking OST drugs, from both a phenomenological perspective and from the perspective of the macro risk-environment. Through first hand accounts of patients' experiences

on OST, I will show that OST drugs are evaluated like every other opiate substance available: each user weighs their pros and their cons according to his or her needs and priorities. For some, this calculus comes out in favor of taking OST in place of street drugs—the same conclusion reached by the medical logic that frames drug abuse as a pathology and OST as a therapeutic intervention. Many others, though, employ different logics, developing a variety of strategies for self management, which may or may note include OST.

5.3 Methadone, Buprenorphine, and Other Clinical Distinctions

Just as illicit narcotics are consumed in a variety of forms with different physical and logistical effects, OST can also be performed with a variety of medical drugs that have similar pharmacological actions. The drug most commonly used in OST is methadone, a synthetic opioid agonist. Methadone is sold commercially under several brand names. In Ukraine, two varieties are available: Methaddict®, a methadone hydrochloride tablet produced by the German company Sandoz Pharmaceuticals GmbH, and Metadol®, a methadone hydrochloride tablet produced by Paladin Labs in Canada. A partial opioid agonist called buprenorphine is also commonly used for OST. In Ukraine, this drug is available under the brand name Addnok®, a buprenorphine hydrochloride tablet produced by Basic Pharma manufacturing B. V. in the Netherlands. Each OST clinic is typically stocked with only methadone or only buprenorphine, according to the preferences of the regional health authorities. As a result, few OST patients have personal experience with more than one of these drugs. This allows OST patients and their social networks to develop a collectively deep but individually narrow understanding of OST drugs' and their effects.

The nearly unanimous opinion shared by the OST patients I interviewed was that methadone and buprenorphine offered markedly different physical effects. Buprenorphine is

seen, by patients and clinicians alike, as significantly 'easier' to take than methadone. Many patients expressed either gratitude that they received Addnok® or longing to switch to Addnok® from the form of methadone they were being prescribed. The reason for this preference was also nearly unanimous: withdrawal from buprenorphine is much milder than withdrawal from methadone. This understanding was based on the experiences of the limited number of patients who had taken both drugs. Clinicians also scaffolded this belief. The young narcologist working in the OST clinic on Kyiv's left bank described the distinction like so:

> Buprenorphine is simply, in my view, much softer. Well, in principle, here, we have patients who are typically younger. And so, methadone, that's for places where the patients have more, various somatic illnesses, are of a more appropriate age, much older than here. Well, in any case, buprenorphine is much softer, because, well, pregnant women who are giving birth take buprenorphine, as the withdrawal syndrome in the children is significantly easier and softer than on methadone. You can't even compare the two.

I have also been told by OST patients that buprenorphine causes less 'fuzziness' in their heads than methadone. It doesn't make one want to fall asleep as badly and has less of an impact on perceived reality.

Interestingly, however, a social worker from the same Kyiv clinic as the narcologist quoted above told me that buprenorphine's reputation as a better drug than methadone is simply a myth that drug users have created. He told me that OST patients often consume street drugs of various kinds in addition to their methadone. When patients experience illnesses or harsher withdrawal symptoms, he argued, they think the methadone is to blame rather than all of the other things they are taking. He insisted that he had seen people on methadone for several years who remained perfectly healthy. This was evidence enough for him that OST patients' descriptions of methadone's harsher symptoms were largely invented.

Though I met many individuals who had satisfactory experiences with methadone, I also came across a few who remained wary of this drug. Several OST patients receiving methadone from a clinic in Sevastopol insisted that the methadone was a "bad narcotic" [Russian: нехороший наркотик]. For several months, I suspected that this view was caused by widespread patient dissatisfaction at this particular clinic. For reasons that were never fully clear to me, clinician-patient relations seemed particularly strained at that hospital. My suspicions about patients' bias against their doctors were put to rest, however, when I began meeting drug users elsewhere in Ukraine who made identical arguments.

One of the most memorable of these occasions took place in a small village about a two hour's drive from the city of L'viv. I was accompanying a group of outreach workers who were travelling in a service van to villages like this in the L'vivska region. Several days earlier, I had asked Nastya, the social worker who staffed in this mobile service point, whether any of her clients had refused OST. I was interested in meeting such people, as my time spent in OST clinics could only bring me into contact with individuals who had *already* decided to start treatment. Nastya seemed to have difficulty taking me seriously when I asked this question; nearly everyone she interacted with in her capacity as an outreach worker refused to take methadone.

On the day in question, a local woman from the village where we had parked came to the van to be screened for infectious diseases. A nurse on the outreach team came supplied with rapid tests that screened for HIV, hepatitis B, hepatitis C, and syphilis. After sitting with the nurse in the private room at the rear if the van, the woman emerged into the main cabin, had a seat, and began chatting with Nastya. She confessed that she had recently been diagnosed with

“women’s cancer” [Ukrainian: жіночий рак]. The nurse called the woman back for her test results just as Nastya began asking her about treatment.

“And you don’t want to start methadone?” she asked, as the woman got up from her seat.

“No!” the woman said, firmly, shaking her head. She walked back into the nurse’s private screening room and shut the door behind her saying, “I don’t want to and never will!”

Nastya turned to me with a stern, knowing look. “Did you hear that Jennifer?”

Nastya told me that this woman came from an area where a large number of people had died while they were taking methadone. The clinic in that area switched from Metadol® to Methaddict®. Around that time, many people died. Nastya insisted that these deaths were HIV-related, caused by patient’s failure to take ARVs. “We Ukrainians,” she lamented, “We have this indifference to our own health.” There was also talk, she told me, of methadone from a factory in Kharkiv—Methaddict® specifically—that was killing people who took it. These were rumors that no one could substantiate, but their impact on the preferences and choices of local drug users was apparent.

A significant number of OST patients entered into treatment with experience using black market methadone [Russian: уличный метадон], a locally made version of the same chemical compound provided for OST. The ‘street drug’ variety of methadone is allegedly stronger and provides a more significant ‘high’ than the pharmaceutical one. Some social workers suggested that people were afraid of methadone because they didn’t fully understand the difference between pharmaceutical grade methadone and “street” methadone. The persistence of drug user’s claims that clinical drugs are different but equally harmful, however, serves to contradict this theory. “There’s Metadol® and then there’s [street] methadone,” Vova, the young father from Simferopol explained. “Methadone, you inject that and get fucked up [Russian: ты в

жопу]. But Metadol® is weaker. You don't inject it, you drink it, and it doesn't have the same effect. For the body it's harder [Russian: тяжелее]. The Metadol® is harder on the body when you take it."

The shared body of knowledge that OST patients possess also recognizes a difference between the two brands of methadone—Metadol® and Methaddict®. Clinic staff insisted that this difference existed only in their patients' minds. The lead narcologist at the OST clinic in Odesa actually chose the word "myth" [Russian: миф] to describe this claim. "They all think that [they are different], but it's just psychological," she said. In principle, Metadol® and Methaddict® are identical drugs with identical amounts of the active ingredient, methadone hydrochloride. Their composition varies only among the inert ingredients of the pills, such as the levels of sucrose in each tablet.

Despite clinicians' charges that these two pharmaceutical products are indistinguishable, my own experience providing services to users of injection drugs has taught me to hesitate before rejecting clients' insistence that two ostensibly identical things are not identical after all. For example, I have heard many complaints in my current home town of Seattle, Washington, that there are significant differences between two distinct brands of otherwise identical syringes distributed by needle exchange programs in the city. Regular drug users with whom I have social contact have explained to me that there are microscopic differences in the diameter of the hollow interior of these two brands of needle. This tiny difference led the clumpy, black tar heroin available on the streets in Seattle to pass through the needle of one brand easily while frequently clogging the needle of the other. The off-label uses of these materials (i.e. using them to inject unregulated, low quality, black market heroin) amplified differences between these

allegedly "identical" products, which would probably have been imperceptible in regulated, clinical settings.

For this reason, I am inclined to give some credence to the general understanding among OST patients in Ukraine that, for whatever reason, Metadol® a stronger product than Methaddict®. For some, this means that Metadol® is the more ideal drug to take. For example, Timur from the clinic in L'viv, went to great lengths to explain to me why Metadol® is better. "It comes on faster [Russian: скорее приход]," he said. "It [the Methaddict® he was taking at the time of our interview] isn't holding me up so well now. I don't sleep well on Methaddict®. I have bad dreams. And we drug users, we want that good high." Another man in Sevastopol complained that the Methaddict® he was taking didn't provide him with 24 hours of symptom control. He would experience withdrawal in the middle of the night, which would last until he came to the clinic for his dose the next morning. These experiences were likely exacerbated by the fact that most clinics crush up these tablets and make patients drink them in a cup of water, thus reducing the risk that patients will hide pills in their cheeks and divert pharmaceuticals from the program. According to many clinicians, this process effectively derails the time-release effects of the tablets, causing the pharmacological activity of the methadone to come on faster and wane faster as a result. "It's like being on *shirka*," the patient from Sevastopol complained. "I can't even tell the difference between that and what I'm taking now."

Others took the opposite approach and complained that the higher potency of Metadol® was the cause of their problems. Mariya, from the Kyiv clinic, reported that she was able to tell when her doctor switched her to a 'stronger' form of methadone without telling her.

> I realized that they had switched me over, without asking, to a variant [of methadone] that was two times stronger. That is, I had my dose halved and the just moved me over to something twice as strong. I went in and talked to them and said that I don't need this, that it's better for me to reduce my dose [with

> what I was taking before], so they moved me back and I was suddenly taking something two times as weak, and I started having physical problems. I couldn't even believe that there was such a difference like this. To take one and then the other version, two from two different manufacturers. I was all nervous like a hedgehog.

Despite its status as a 'myth' among many clinicians, the difference between these two products seemed well evidenced among the population whose lives revolve around the consumption of these drugs. To patients, these two brands, Metadol® and Methaddict®, present themselves as better or worse options for each individual depending on the physical and psychological sensations that each patient relied on methadone to provide.

5.4 Choosing Methadone

This complicated terrain of opiates that are more or less available to drug users in Ukraine makes one thing abundantly clear: few OST patients, if any, are entering into this treatment program because they understand OST drugs to be medicines that intervene on their bodies in fundamentally different ways than the poppy straw and codeine derivatives they can acquire on the street. Few perceive themselves as fundamentally changing their relationship with opiate substances; they are simply switching their consumption patterns from one opiate (or many opiates) to another.

This finding may generate suspicion that OST patients are only joining the program because it allows them to acquire the drugs they seek for free. In fact, a number of nurses and social workers employed in OST clinics have made this very claim. The nurse who served clients their daily methadone in the L'viv city clinic run by Alexey Sergeevich, for example, told me that there are two kinds of patients in her program: there are those who want to quit

methadone one day, and those who have no desire to quit at all (a taxonomy supported by many clinicians; see Chapter 4). This last group, she insisted, simply wanted to get their drugs for free.

This theory that OST adherence is tantamount to long-term drug seeking on the part of patients is contradicted, however, by the stories that patients tells of the time, money, and effort that they dedicate to integrating OST drugs into their lives. For example, there are a number of patients who continue to use street drugs in addition to their methadone for the specific purpose of getting "high." Taking OST drugs makes "getting high" a more difficult task to negotiate. Several OST patients described this feature of methadone to me by using the term *doznyak* [Russian: дозняк]. *Doznyak* is a word that has no direct correlate in English. It comes from the root word *doza* [Russian: доза] or 'dose' (i.e. a daily 'dose' of methadone). It refers to the ideal amount of drugs that an individual needs to consume in order to achieve their desired "high." OST drugs raise a person's *doznyak*, increasing the amount of drugs that one must find and consume in order to get high. Vova, from the Simferopol clinic, described the effect in this way:

> V: Well, frankly speaking, they [some patients] still go out and about somewhere. It's just that here there's a big contingent, well, maybe not big, but a contingent. Anyway. Something like 30% of them [OST patients] still go out somewhere on the streets and add on [to their methadone].
>
> Borys: Why do you think they do this, if it's common knowledge that the [OST] drugs block their [μ-opioid] receptors…
>
> V: They don't block them. They, to put it simply, raise the *doznyak*. So, if I, let's assume that I would need, hypothetically, that I would need one *chek* [slang for a standard unit of opiates wrapped up in a sheet of paper that is folded in a precise manner] from the streets. And if I am taking pills here [at the OST clinic] in any amount, and then if I want to use that garbage on the streets, cause what they give here, it doesn't make you high, I would need two *cheky*, for example, and here, for my own *doznyak*, since I take 50mg [of methadone], roughly speaking, or so I hear, I'd have to find two *cheky* somewhere to feel it.

If all these patients sought was a cheaper, easier way to get "high," staying on OST would be fundamentally illogical. The fact that so many "high"-seekers enter and remain in OST reveals that its perceived functionality is not limited to the fact that it is free.

Another group of OST patients are in the same position as Timur, the young man who I met first on the mobile van, where he came to receive social support and clean syringes for drug use, only to meet him again in the L'viv clinic where he receives OST. His goal in mixing other drugs with his methadone is not to get "high" but to control his withdrawal symptoms, to keep his headaches at bay, and to help him sleep at night. This kind of non-compliant opioid use in addition to prescription methadone or buprenorphine is a common occurrence in OST programs, certainly not a feature unique to the Ukrainian context (Casati, Piontek, and Pfeiffer-Gerschel 2014). The way this pattern is articulated by Ukrainian OST patients and clinicians, however, is most often linked to patients' need to achieve a sense of physical stability through active chemical management of the brain and body, just as Timur was attempting to do. A social worker in Mykolaiv, who was, herself, a former methadone patient, explained, "People take tropicamide. They take Demerol, They even drink with their methadone. They try to maintain the feeling they are used to [Russian: как они привыкли], to feel more normal." Again, the fact that OST drugs are given out for free provides an insufficient explanation for patients' attraction to the program. If the only incentive was a financial one, we should expect to see patients abandoning the program since it makes their desired phenomenological outcomes (either feeling 'normal' or feeling 'high') more complicated and expensive to obtain. Instead, the opposite tends to happen. Patients typically buckle down and, much to the chagrin of their clinicians, choose to stay in OST programs for years and years.

This phenomenon cannot be explained by a common motivation or causal factor in OST patients. When asked about their personal treatment plans, patients stated goals for themselves in OST that varied dramatically from person to person. A few patients have managed to lower their dose of OST drugs and eventually quit the program. Most clinicians I spoke to were able to report that between two and four patients had 'left' their program in the previous year (though some of them, it seemed, always came back). Others said that they want to quit methadone eventually but don't feel ready. Many expressed a significant amount of anxiety over quitting OST. Some feared the difficult withdrawal from methadone, which is largely understood to be stronger than withdrawal from *shirka*. A man on OST in Sevastopol voiced this concern:

> People are going from these easy drugs like *shirka* and heroin to methadone. It's harder to quit, you know? I know people who have quit methadone, but it cost them a lot of energy, a lot of health. You have to understand that people here are not healthy, and when they withdraw, their diseases can appear, can flare up really badly, so quitting can be dangerous.

Others fear that they would return to street drugs and, as a result end up sick, in jail, or dead. For them, returning to methadone seems a more reasonable coping mechanism than returning to street drugs, which makes quitting methadone in the first place seem rather illogical. "In any case, sooner or later, we all come back," Vova explained. "There is some kind of thing that is stuck [in us] that becomes hard to cope with [Russian: где то там сидит какой-то клин с которым справится не так легко]." Some even argued that they would never quit, that doing so was the wrong choice for them. "I long ago realized that I am an addict," Maksim, the young man from the Kyiv dispensary, once told me. "I don't want to quit. My body can't carry on without it."

Despite the diversity of treatment goals that patients have set for themselves, a clear pattern does emerge in patients' descriptions of why, despite the nature of their long term plans,

they are satisfied with the benefits that OST offers. The primary benefit patients say they gain from OST is the logistical solution to the daily quandary of sourcing drugs. In the words of a middle aged man who received methadone from a clinic in L'viv, "The benefits of the program are this: I'm not running around. I'm not in jail. I don't have problems with the police. I'm feeling calm in the mornings. My mornings have become so peaceful." Others specifically praised the efficiency of the program. Many OST patients delighted in telling me how quickly they were in and out of the clinic each day. "It's great," a young woman in Odesa told me, echoing the answers of many other patients I had talked to. "I come here, say hello, drink my pills, head out the door, and I'm home and ready to start my day by 9:30am."

A second highly-praised benefit conferred by OST was the feeling of normalcy and peacefulness either in the bodily sense (i.e. avoiding withdrawal, feeling able to physically function in a normal way) or in the sense of one's life falling into order. "I've been here for four years and I've never had problems with the law!" exclaimed a young man who received OST in L'viv. "I don't use illegal drugs, the dose that I get here is enough for me. The tablets hold me up. I feel totally normal." Others connected their feelings of physical stability with the overall stability of their daily life more emphatically. Mariya, from the Kyiv clinic, praised the availability of OST by attributing her increased sense of stability to the program. "Now I feel more or less stable and I live peacefully," she said. "I only deal with problems I had previously, health problems that I've always had, but in terms of my drug use, nothing ever arises to bother me." In sum, the vast majority of patients who chose to begin OST and stay in the program consider the profound simplification of their daily lives and self-management strategies to be the main motivation behind that decision.

Those who expressed dissatisfaction with OST, those who were unhappy with their treatment experiences, those who complained bitterly or even deterred their friends from coming, argued that OST had *added* to the complications they face. Often, unhappy patients were receiving services at the same clinics, suffering, in one way or another, from insufficient social support or inadequate treatment options from which to choose at their treatment site. One OST clinic outside of Sevastopol represented this pattern unusually well. I recall this clinic and the people throughout it embodying an uncomfortable malaise. "This place, it's the end of the road for them—their last stop on the way to death" the director of this program told me. Unlike most other clinicians I'd met, he claimed to be a former addict himself. Despite his alleged insight into the recovery process, the staff at his clinic served a population of largely dissatisfied patients. The following excerpt from my interview with a patient named Oksana, a woman in her late 20s, captures this phenomenon very well:

JC: So how long have you been coming here to this [methadone] program?

O: Two and a half years.

JC: And where did you first hear about the program?

O: From a girlfriend.

JC: She was a patient here?

O: Yea.

JC: And what did she tell you about being treated here?

O: That she had so much free time, you know. She's got work and her kids, and she can take care of those things properly. She said she liked the program.

JC: And do you like the program?

> O: See, for me, it's like this. I came here for the first time, and they were like, 'Oh, we'll help you.' But people are just coming here and they keep coming. The problem here is that there is no detox facility. There is no way to quit the program. I decided that I wanted to quit—to quit the methadone. I talked to the narcologist about this, asking them to lower my dose so that I could quit, and they said, 'Why? Why is this something you want to do on your own?' And they wouldn't decrease my dose. So, in reality, there is no possibility of quitting. And, you know, earlier, I was on Metadol®. I took 25-30mg of that. Here, they started me on Methaddict®. I'm taking 80mg of that. I don't feel good on Methaddict®. They have to give you a dose that's twice as high.
>
> JC: So, if you could go back to before you started the program, if you had the choice to make all over again, whether to start this program, would you make the same decision?
>
> O: No. No …

Oksana describes feeling stuck in the OST program. Just like Lyuda, the young mother at the clinic in Odesa, her characterization of her treatment experience mirrored the frustration patients said they felt when they were caught in a cycle of "running around" or needing to "hunt" for money and drugs on a daily basis.

In sum, the question of whether OST is an effective intervention is answered differently by patients than it is for clinicians and the international organizations that sponsor these programs. While the practicalities of OST successfully simplify the lives of the majority of patients on treatment, others felt that OST simply traded one set of troubles for another, trapping them in an intractable pattern of clinical dependence, preventing them from moving on with their lives. Patients are not concerned, necessarily, with using OST as a mechanism for controlling their opiate consumption. Instead, their concerns revolve largely around how much or how little the opiates they choose to consume affect their bodily experiences and, as a result, impact their *social* wellbeing. The opiates that patients consume, therefore, do not seem to be the primary source of their problems, as they perceive them. The problem, rather, is understood

to be the social and legal risk environments (characterized by black market instability, financial insecurity, police abuse, etc.), which are heightened or abated differently according to the varieties of opiate substances available to each user.

5.5 Conclusion

This chapter has illustrated that the value which OST patients placed on their treatment ultimately had little to do with their long-term treatment goals. Rather, the positive value that OST drugs offered them was the logistical simplification of their self-care needs and other elements of their daily life. In this view, methadone and buprenorphine are effective not because they act on μ-opioid receptors, per se, but because they are able to act upon social, physical, and psychological disorganization.

Interestingly, this finding can help explain *and* refute the claims made by doctors that their patients are not progressing through treatment because they lack the *desire* to do so (see Chapter 4). In fact, patients revealed themselves to be competent negotiators of an array of social and pharmacological risks. They also revealed themselves to be actively involved in the assessment and refinement of their self-management strategies. These efforts hardly merit OST patients, even apparently unmotivated patients, the label of 'wanton addicts,' dependent persons with no second-order volitions underlying their primary impulses to use. Both the molecular biomedical model and the Pavlovian model of addiction fall short in explaining these behaviors.

At the same time, however, it is also clear that patients and clinicians are evaluating 'treatment success' in very different ways. Whereas clinicians generally wanted to see their patients lower their dose of OST drugs and attempt (or even consider) ceasing the drugs altogether, patients largely sought out physical and social stability, regardless of whether or not they ever intended to quit methadone at some point in the future. Therefore, a patient, who has

settled down his bodily symptoms, who has calmed down his life, may be thrilled with what OST has allowed him to achieve and consider their treatment a great success, while his doctor laments his lack of desire to get better and considers him a failure in the program. Alternatively, clinicians could be encouraging patients to reduce their dose and quit, scaffolding these small indicators of treatment progress, as the doctor defines it, only to physically or psychologically destabilize the client, generating in her a greater impulse to use other drugs on top of the methadone in order to maintain her sense of physical calm. As such, a patient who is 'progressing well' through the program, from the clinician's point of view, may feel that OST adds to the complications of her life by interrupting her day, chaining her to the clinic, and offering no way out of that quotidian cycle.

In each of these situations, the patient and the clinician will agree about how the patient is doing on a surface level; there will be no conflict over how long he or she has been a patient, how much methadone or buprenorphine he or she takes, and how that level has varied over time. Where patients and doctors are predisposed to disagree is in the *interpretation* of these clinical realities. Is the patient achieving therapeutic success? Is the OST benefiting her? More often than not, patients and clinicians are predisposed to differ in their answers to these questions.

In Chapter 2 of this dissertation, I argued that the phenomenological organization and chemical management of bodily sensations with OST drugs like methadone and buprenorphine are activities central to the process of self-making. This self-making can occur thanks to the availability of OST and its expansion of the spectrum of chemical compounds from which opiate users may choose, allowing them "to discover the intervention that will address precisely a specific molecular anomaly at the root of something that personally troubles the individual

concerned and disrupts his or her life," thus allowing them more ways to restore the self, to become "neurochemical selves" (Rose 2007, 211). Rose's theory holds true here and is useful for theorizing what OST patients seek to accomplish, what they are "up to" (Geertz 1973) when they engage with alternative therapeutic discourses about the efficacy of their treatment.

However, the patient perspectives explored here also reveal a parallel truth not addressed by Rose's formulation of the role of pharmaceuticals in the construction of the self. Not only are patients able to seek out medical interventions with which to address their particular molecular anomalies, but we also see them seeking out a medical *context* from which to obtain the pharmaceutical that they desire, which is useful for rectifying anomalies in their *social* realities, including their social marginalization. In this way, OST offers two, parallel therapeutic interventions: one molecular, upon which clinicians rely for OST's effect, and one that is social, structural, logistical, through which patients attempt to exert greater control over their lives without, necessarily, dis-integrating narcotics from their self-management strategies.

CHAPTER 6: TO LIVE LIKE NORMAL PEOPLE

6.1 INTRODUCTION

By and large, the OST patients involved in this project were well-educated, active, intensely social individuals. However, they were rarely asked for their perspective on the treatment programs in which they were enrolled. Their perspectives were validated by people in positions of authority even less frequently. For this reason, my invitation for patients to opine about their experiences in a semi-official setting with me and my voice recorder was usually accepted with enthusiasm. I have hours of recorded interviews in which I barely got a word in edgewise.

My interview with Alyona, a confident and strong-willed OST patient in her forties, was typical in that I lost control of it immediately. We met midday at the Kyiv narcological dispensary where she received her daily buprenorphine. We said our hellos and began walking together down a little path that led us towards a nearby park with a lake. Though we barely knew each other, Alyona began weaving a narrative for me with a dramatic intensity that took me off guard. “Jenny,” she said matter-of-factly, “I know you are here to learn these stories, to understand the stories of people who are here and using drugs, to know about the things that brought us here, and I, I am practically the social worker here. I used to be the social worker. This is my job; I perceive it as my job, do you understand? My mother was from Pervomaisk—do you know where this is?” I came to my senses and remembered to switch on my audio recorder only after Alyona’s had finished summarized her teenage years and moved on into her twenties. Her story barreled on at this pace for more than half an hour.

Though Alyona has never been legally married, she refers to the man she lived with in her youth as her 'first husband.' He was an injection drug user, as was his mother, whom Alyona called her 'mother-in-law.' Though she loved him very much, and though she spoke of their relationship as though they were happy together, Alyona emphasized that she refused to marry this man unless he quit using drugs. "I knew that this was addiction," Alyona recounted. "I always fought to stay out of it, to avoid smoking, to live healthy." One day, her 'husband' developed sepsis. He spent ten days in an intensive care unit before the infection finally killed him. Alyona was inconsolable. "God, I almost went blind I cried so hard. I developed conjunctivitis. I had so much stress in my body while I was in mourning. I developed psoriasis and was treated for nerves."

I few months later, Alyona began working for a company that sent her to sea to work as a hairstylist on a passenger ship. This was an opportunity for her to start her life over, but this new beginning quickly came to yet another disastrous end. During a planned shore leave, Alyona was involved in a head-on collision near the central Ukrainian city of Uman. The crash almost killed her. She lost her spleen in the aftermath and still bears a surgical scar, which runs the whole length of her belly. Her job evaporated while she recovered in the hospital, leaving her with new physical limitations, no income, and few options.

After the accident, Alyona's former 'mother in law,' the mother of the man she had called her first husband, took her in. She moved into this woman's apartment on the outskirts of Moscow, and, together, they began working the currency market between Kyiv and Moscow. Through this trade, Alyona and her 'mother-in-law' fell in with a crowd of people operating outside the formal economy. She recalled that foreign students at Lomonosova Moscow State University had started bringing heroin into Russia at that time. Alyona never injected it, but she

snorted it and smoked it. They would also make their own opiate solutions from poppy straw: *shirka* and *makayin* (a portmanteau of the word Russian word for poppy, '*mak'* [Russian: мак], and the word 'cocaine'). Alyona went to discos and was a frequent partier, but she said she "always knew when to quit."

Physical trauma remained a part of Alyona's life in Moscow. She experienced her first ectopic pregnancy and lost a fallopian tube just a year after the accident in Uman. This event was followed by numerous unplanned pregnancies and abortions – as many as twenty in the subsequent decade. "I wanted children, but not with these men," she said. "They are all thieves, do you understand? They all steal, they steal things like cars, grand theft, and they do it a lot. Even during *perestroika*, there was so much social disorder that our police couldn't control anything."

Alyona maintained a long-term relationship with a man from Magadan, a city in eastern Russia, during these years, for whom she held a deep mistrust. They earned money together, which he would subsequently hide from her. Out of desperation, she finally left him. Soon after, a terrible auto accident left his grandfather dead. Since this man's *propiska*, his state-issued identification document, had his residence listed in Magadan, he was unable to make a claim on his grandfather's apartment and suddenly, at 28 years old, had no place to live[3]. As a result, he moved in with Alyona and her former 'mother in law' and soon began injecting heroin in their home. Bit by bit, Alyona recalled, she began using with him. She gradually increased her

[3] It is not uncommon for adults, especially unemployed adults, to live at home with their parents. Many individuals living with addiction face a variety of difficulties in keeping their official paperwork up-to-date, meaning that very few of them are properly registered in the apartment where they live. When parents, who have official ownership of the apartment, pass away, children to not inherit the property. Rather, they lose any claim on the apartment (as they are not registered there) and frequently experience homelessness as a result.

consumption until she was injecting every day. Eventually, they began cooking drugs in the house and started hosting an assortment of regulars who used their home to as a place to acquire and inject drugs. Traffic into the apartment grew so heavy that they began using video surveillance at the front door of their building to monitor activity and keep the police away.

Alyona's life had become so complicated that she once again decided to make a clean break. She and her live-in boyfriend both quit injecting cold turkey. She drove out four different people who had begun squatting her their apartment and were still injecting there out onto the street. She got a job, began earning money, and lived an honest life, one for which she "would not have to be ashamed before God." Alyona stayed clean for more than two years, but this happy turn came to an end when, 12 years after her first, Alyona was diagnosed with a second ectopic pregnancy.

This event sent Alyona's life into a yet another destructive spiral. She was distraught by the physical trauma of the pregnancy as well as the permanent loss of her ability to bear children. Her sister died of throat cancer around this time, as well, and Alyona's life became defined by seemingly perpetual grief. She began injecting a form of methamphetamine called *vint*. "Do you know what it is?" she asked me. "It's a white drug, it's worse than cocaine. It made me crazy; I was going crazy. Taking all that *vint*, I caught HIV." Her 'mother-in-law' threatened to kick her out of the house if she didn't quit using, and Alyona began contemplating suicide.

As she approached her breaking point, Alyona says her 'mother in law' began encouraging her to get treatment.

> Look, Alyona, she said to me. Live. Live your life. God loves you. You have so many good things in your life. You can survive. You can help people. You're a good person….And so I was persuaded to come here, to the OST program. And to start taking ART. Before I came here, so many of my friends and boyfriends

ended up in jail, and I thought to myself, Alyona, you're going the wrong way.
So I moved back to my mother's place in this neighborhood and started this OST.
And now I've been coming for four years.

Alyona is ambivalent about her current situation. She is happy to have decreased the drama in her daily life. She is dating a new man whom she describes as "kind, good, and hardworking." He is also a patient at the clinic, and Alyona is incredibly proud of him. At the same time, Alyona struggles to find stable work, she is unable to find social networks that are not bound by the geography of the clinic, and she longs to create a family.

Alyona's story is one of intense and persistent dispossession. On the one hand, her life is illustrative of what geographer David Harvey has called "accumulation by dispossession" (Harvey 2004), the process whereby privatization and other neoliberal reforms are used to strip the public of its wealth for the benefit of the dominant capitalist class. Despite her many attempts to build a life for herself, Alyona's situation has repeatedly been destabilized by the loss of her bodily health, place of residence, or source of income—or by the loss of someone else's. Each of these chaotic incidents is attributable in some way to failed social support systems, bureaucratic barriers to recovery, and a general lack of security afforded to workers in a largely unregulated job market.

On the other hand, Alyona's story is also characteristic of particular forms of dispossession unique to Soviet society. Caroline Humphrey has argued that the dispossessed in this context "are people who have been deprived or property, work, entitlements, but we can also understand them as people who are themselves no longer possessed. That is, they are no longer inside the quasi-feudal corporations, the collective 'domains' which confer social status on their members…" (2002, 21). Humphrey argues that unpossessed/dispossessed persons in post-Soviet Russia (and, I argue, in contemporary Ukraine) include "the unemployed; economic

migrants; demobilized soldiers, abandoned pensioners, invalids, and single parent families; vagrants and the homeless; and people living in various illegal ways, such as contract laborers without residence permits in large cities (*limitchiki*)" (2002, 21).

OST patients like Alyona—which is to say, *most* OST patients—fit Humphrey's description of dispossession in myriad ways. The vast majority is unemployed. Those who do work hold low paying, dead-end jobs: they are trash collectors, day laborers, and parking lot attendants. Most live with a relative of some kind, often a parent, but lack updated registration paperwork (their *propiska*), leaving them with no legal claim over their place of residence. The death of the family member to whom the home is registered can quickly result in their homelessness, as the state will absorb the property and re-sell it on the public market in the absence of anyone with such a legal claim. Furthermore, a significant proportion of OST patients in Ukraine are co-infected with and actively receiving treatment for HIV and tuberculosis, both of which are highly stigmatized and are associated with vagrancy and the dispossessed underclasses. Most have spent time in prison. Over the course of my research, nearly every OST patient I met disclosed at least one incident of incarceration or involuntary hospitalization in their past. Once, when I cracked a joke with the staff of the Kyiv clinic about the intensity of the non-stop backgammon games that clients played in the courtyard, a social worker responded, "You know, they've all been in prison at some point [Russian: они все когда-то были в тюрьму]. There is nothing to do there but play this game. It's what they're used to [Russian: они привыкли]."

Anthropological theory provides a number of ways to talk about this type of phenomenon, in which large populations, built from diffuse social networks, experiences illness, criminalization, incarceration, poverty, chemical dependence, and social marginalization in

concert. Philippe Bourgois (2003) witnessed the intermingling of these factors among young men in East Harlem, taking note of how poverty, exclusion from the formal job market, and participation in the illegal drug market mutually reinforced each other. James Spradley (1968) observed a similar, cyclical pattern of marginalization among homeless men in Seattle in the 1960s, revealing how the judicial system, which sought to control public drunkenness by forcing vagrants out of town, created the necessity of public drunkenness in the subsequent town, as this was how homeless men built social networks, gained trust, and procured resources. Didier Fassin (2013) researched a parallel situation in contemporary France, in which racism, persistent poverty, the criminalization of youth, and renegade police forces created the context for the very social upheaval and violence that law enforcement was meant to keep in check. Though they are all unique in some ways, each of these intimate ethnographies ultimately draws the same conclusion: these patterns are structurally and culturally perpetuated. They are not coincidences; they are manufactured cycles of social marginalization.

In her ethnography on heroin addiction in rural New Mexico, Angela Garcia refers to addicts caught in similar patterns of recursive dispossession as the "patient-prisoner" (Garcia 2010, 8). Upon witnessing for herself the tenacity of chronic addicts' attraction to heroin, the protracted periods of relapse punctuated by meager socio-medical interventions, and the incredible rate of overdose and suicide among the region's population, Garcia was led to ask "[whether] medical and juridical responses to addiction lock addicts into certain forms of subjectivity where the outcomes of relapse are not only expected but also *produced*" (2010, 18; emphasis mine). In her assessment, addicts (and addiction) are "constituted not only through hardship and loss, but also through the logic, routines, and practices of medical and juridical regimes" (2010, 8).

Addicts in Ukraine exist in a similar "blind spot" (Keshavjee 2014) in state policies and infrastructures. The social, economic, medical, and legal forces that intercede in their lives also predict *and produce* the kind of person that addicts are believed to be: criminals, hooligans, dispossessed, outsiders. OST programs provide much needed relief for chronic drug users, helping to stabilizes their lives, ending the need to "hunt" for drugs every day, connecting them with medical care. This treatment, however, is unable to get at the root causes of the recursive loop of marginalization within which addicts' vulnerability to poverty, illness, addiction, and incarceration, mutually enforce one another.

Against this narrative backdrop, a particular irony emerges from Alyona's story. Extraordinary trauma and upheaval (the death of her partner, the head-on collision that claimed her spleen, her multiple ectopic pregnancies, her physically and financially abusive relationships) appear to be the norm, while "normal" elements of life (earning an "honest" living, finding a husband, raising a family) seem extraordinary and beyond reach. They are, to her, practically unattainable, yet she continually references her desire to build a "normal life" as one of her primary motivations for staying in treatment. It is, as her story reveals, the primary motivation behind most of her major life decisions.

Making claims to or stating one's desire for a "normal life" is common among Ukraine's addicts. It is, in fact, a common discourse among denizens of the post-Soviet sphere in general (Yurchak 2008; Fehérváry 2002; Fournier 2012; Rausing 2014; Zigon 2010). According to Jarrett Zigon, one's ability to lead a "normal life" is primarily defined by one's relationship with authoritative discourses and practices. "If we are to assume the authoritative discourse [in the Post-Soviet sphere] today is of a neoliberal consumer-capitalist type," he argues, "…then a normal person is one who has a kind of relationship with that discourse that sees it as providing

the kind of life a normal person should live" (2010, 150). Thus, in Zigon's view, "normal life" is defined in two ways. On the one hand, it is structural. One must be positioned correctly in relation to the state and to the rest of society. One must be the kind of person who is benefitted by the dominant socio-political and ideological system. On the other hand, it is also symbolic. To lead a life that can be called "normal," one must resemble a "normal person." One must look the part vis-a-vis physical appearance, bodily comportment, lifestyle, politics, patterns of consumption, and countless other axes of comparison.

In this chapter, I argue that OST patients often seek to accomplish the former (a structurally normal life) by making manifest the latter (a symbolically normal life) through the purposeful embodiment of the trappings of normal work life, normal family relations, and more. This chapter offers an explanation as to how OST patients attempt to achieve a "normal life" for themselves and why they are almost exclusively unsuccessful in these efforts. I begin by elaborating the ways in which OST patients talk about and envision the "normal life" that they seek. Then, I examine the cultural and historical foundations, which OST patients reference in their claims to normalcy, because, as Caroline Humphrey has observed, "it is essential for us to grasp the cultural concepts held of the [post-Soviet] polity if we are to understand what it means to be rejected from it" (2002, 27). Finally, I compare the fate of OST patients in Ukrainian society to the fate of Liza Shaposhnik, a young volunteer turned public celebrity who participated in the EuroMaidan Revolution, a massive anti-government protest that shook Ukraine (especially in the capital city of Kyiv) from November 2013 until February 2014. Liza was able to achieve what OST patients were not: a right and profitable place in society, achieved by embodying the characteristics of someone who deserved to be in that position in

the first place. Exploring why Liza Shaposhnik could do this reveals much about why drug users can't.

Specifically, through a discussion of the various modes of social inclusion and exclusion engaged by the Ukrainian polity both during the EuroMaidan revolution and after, it becomes clear that addicts are not relegated to outsider status in Ukrainian society, because their behavior is socially destructive. Rather, they are excluded from the body politic because popular explanatory models of addiction perceive addicts as beings with little agency, barely subjects if at all. The challenge faced by addicts as they seek to build a "normal life," then, is not that they appear to embody the "wrong" sort of human nature. The challenge is that many people refuse to see them as human at all.

6.2 Rehabilitating Normal Life

In Ukraine, diagnosed addicts are listed in an official state registry maintained by the MoH. Registration officially prohibits addicts from purchasing a gun or acquiring a driver's license. It also hinders their access to gainful employment and other basic social opportunities. Though there is no protocol for allowing the public to review the data, the contents of this registry are, in a practical sense, publicly available, as all citizens are required to procure documents from narcological clinics and police stations certifying that they are *not* on this registry prior to conducting a variety of forms of public business. Registration is a prerequisite for receiving OST, which must, in turn, be preceded by an official, medical diagnosis of addiction. The diagnostic process typically involves a few days' hospitalization under observation (and, one hopes, palliative care) for opiate withdrawal symptoms. It is neither an easy nor a pleasant process. OST patients generally saw this situation as difficult and unfair, but

many insisted that they were staying in treatment because they had resolved to take deliberate steps towards improving their lives and achieving normalcy.

For many, that normalcy meant the fulfillment of social roles and obligation that had at one point defined them. One woman receiving OST from a clinic in Odesa described her situation in this way:

> I would like to have a husband…I want to prepare my daughter to take care of herself. This is the most important thing: getting your kids on their own two feet. Obviously I want to find a job. Eventually I'd like to have a job. With this [methadone] program, you can find a job, because you just come in the morning to take your pills and then for the rest of the day you are free. You feel fine, just like a normal person. You don't even think all day about needing your next hit, about the money you'd need to score, running around like that. You can…I'd like to find a job.

Lyuda, the young mother receiving OST at the same clinic, offered the following perspective:

> We try to live like normal, healthy people…Here it's just, like, I take my pills and I feel fine. Nothing hurts, I sleep regularly, I eat regularly, and everything's fine. And the whole time your dose is decreasing down to that minimum and then you're already going with out and we live like normal people…I can't say that I'm ready because I'm still craving the next high all the time…in my head. I struggle with it. I have this daughter who is growing up so fast, and I am very well aware that I need to stop, but it hasn't happened for me.

At first glance, these two statements appear to reflect very different lived experiences of OST. The first woman is motivated. She has set concrete goals and sees a clear trajectory for herself through the treatment program. Lyuda, on the other hand, feels stuck. Her words belie a powerful frustration with the program and the way in which it conflicts with her own physical and emotional impulses. However, these two statements have one key characteristic in common: both women frame their successes and failures in terms of their ability to engage with their socially proscribed roles as wives and mothers. They, like so many others, use the fulfillment of

those roles as a yard stick against which to measure not only their progress through treatment but also their legitimacy as members of the Ukrainian polity.

In interviews, OST patients staked their claims to being "normal people" along various axes of social intelligibility (e.g. professional identity, family identity). Work and the ability to earn an honest living were among the most common elements of the normalcy towards which OST patients mentioned in interviews. When I asked how they had felt since starting treatment, many would exclaim that they felt great, normal, so normal they could find work. One man receiving OST in Odesa cried "Excellent! [I feel] excellent all day…And, normally, you can even work, and physically work." Some would express dissatisfaction with the program, wishing that some aspects were different, that the hours were more flexible, that methadone was easier to obtain by prescription. Still, most had determined that being in the program was better than nothing due largely to their new-found ability to hold a steady job. "How do I feel in the program?" a young man on OST in Sevastopol told me. "Alright." He shrugged. "I'm working."

In the fall of 2012, I spoke at great length with Vova and Masha in Simferopol, both OST patients who had come to their clinic that day with their eight-month-old baby in tow, about how street drugs prevented addicts from working and holding a job. "When you're on that garbage on the street," the young father told me, "it's not possible to work normally. Because, well, I was working and at the same time I was constantly missing work because I had to manage my [withdrawal symptoms]." As he recounted his story, his wife paced in slow, lazy circles around him, rocking their restless baby to sleep. As she listened, she grew up set at his use of street slang. "Speak like a normal person!" she scolded, frustrated by the reminders of the life they had left behind. For her, "normalcy" meant not only becoming a professional worker but acting and speaking like one as well.

Some OST patients took a different approach to their relationship with "normal" employment. Rather than framing OST as a tool that gave them the ability to work "like normal people," they described clinical rules and regulations of OST as the primary obstacle between them and the steady employment they would otherwise achieve. A woman who received methadone from a clinic in L'viv described her predicament as follows:

> The way work is here in Ukraine, no one will let you come in at half past ten [note: most OST clinics open at 10:00am]. There's no employer who offers such work…And if I'm not working, how do I manage? What's left for me? To steal? What else? What else remains for me to do? Unless I have a disability, but our disability support doesn't compare to yours. It only gives 800UAH [about $100 at the time of the interview, less than $40 at the time of writing] for you to figure out how to live each month. I've got prescriptions that cost more than 800 UAH. How do I pay for my house, or support my parents, by clothes—what do I eat? Do you understand? And so, how is it, being on therapy? Handing it out [via prescription] would have been better. I would imagine that I could find a job then…I imagine that I would be able to drink liquid methadone at 9am, at home, and then go out and head to work. I would be able to get a job. Because not every employer considers people with HIV to be "normal." And as for people in OST, well, it's a problem.

This woman's testimony differs in that she shared a significant displeasure with the effect the OST program has had on her life. However the meaning she attributed to regular employment is the same as that communicated by others in treatment: "normal" people have jobs, so having a job makes you a "normal" person.

The fulfillment of familial roles was also a major theme in OST patients' descriptions of the "normal life" they sought to attain. "That's why we come here," another woman from the OST clinic in Odesa explained. "[People want] to get away from the life of disease. In order not to go to jail, so as not to wake up in wrangling with the law, to live a normal life with their families, with their children, which they finally want to have at that age, middle-aged when they've finally realized." Many mentioned to their children and acknowledge the time that being

on OST provided them to be parents, to actively and appropriately raise their children. Masha and Vova cite their infant daughter as the lynch pin holding their new life together. "We have this great joy now," Vova said, gesturing towards his baby. "There is no going back. We have a reason to build a life."

Many OST patients drew direct connections between the enactment of these social roles (as members of the work force, as capable parents, as reliable spouses) and their successful integration into broader society. They hoped these roles would put them on the right side of the ideologies that had stigmatized them and relegated them to the social margins. When I asked what he wanted out of the program, another young man from the Simferopol clinic replied,

> I'd like to rejoin normal society, to not feel like an outcast, to feel like a normal person. To work. Right now, I'm not working, and I feel like, for example, my father is really ill right now. I'd want to help him, but I have no way to help him. I want to help him buy some medications, but he needs an MRI, and that costs 950 UAH [$120 at the time of research; $47 at the time of writing]. Very few people can afford it.

Vova echoed a similar sentiment. "We [he and his wife] just wanted to come back to life, to normal life, where there is work and a car and everything is fine."

This use of OST as a technology of the self is rooted in a particular "ethopolitics," a mode of discursive self-discipline that Nikolas Rose argues "concerns itself with the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are" (2007, 27). Jarrett Zigon has described this process of reconstructing and re-adopting "normal" social roles through drug treatment as the remaking one's moral personhood (2010, 4). "To live a normal or sane life," he argues, "is to cultivate a certain sensibility for living within a particular range of possibilities that *counts* as a normal or sane life" (2010, 13). The particular form that these claims to "normal" personhood take in Ukraine's OST

clinics are shaped by the patients' tenacious insistence that they are, in spite of anything that might be in their way, *deserving* of "normal" personhood, and that they desire to be welcomed and acknowledged as such.

Ethnographers have traced many mechanisms, in addition to those discussed here, by which addictions treatment programs like OST can become technologies of the self. Treatment may be designed to excavate a true inner-self out from under the addict's pathological denial (Carr 2010), provide a crutch for the addict's personal agency, weakened by the perpetual impulse to use (Raikhel 2013), or even forge an entirely new subjectivity, remaking the addict into a new kind of person with a new set of social dispositions (Zigon 2010). In contrast, Ukrainian OST patients do not describe the personhood they wish to embody as obscured by psychological pathology or in the process of formation; rather, patients describe their social integration as first enabled by OST in a dramatic fashion (as it provides the addict with free time and routine) and then thwarted by the practical limitations of the program.

Yet, despite this ever-present hindrance, there were many OST patients for whom the hope of social redemption remained. "Socialization—do you know what it is?" Mariya asked me one day.

> It is your infusion into society. If you work, you will somehow *cling* to normal people. You're not cooking up this garbage with a bunch of other addicts. Your interests, when you take this pill in this office [OST], they will diverge dramatically. For the state—this is profitable for the state. Not because the Global Fund pays for the pills, but because they want their citizens to be on the right path. They help us because we have to move towards Europe. You can't have a European country without these programs.

In her mind, and in the mind of many other public health professionals and activists in Ukraine, OST offers social redemption not only to patients, but to the whole state of Ukraine—the state that once left its drug using citizens behind. The unfortunate truth, however, is that these efforts

were rarely successful. Once pushed outside the bounds of mainstream society, most drug users I came to know persistently stayed there.

6.3 The Khoziaistvo

What are the implications, then, if dispossession means being thrust "outside" of mainstream society? As anthropologist Caroline Humphrey has argued of Russian society, "it is essential for us to grasp the cultural concepts held of the Russian polity if we are to understand what it means to be ejected from one" (2002, 27). Similarly, the meaning and mechanisms of social exclusion in contemporary Ukraine cannot be fully understood without a clear grasp of how Ukrainian modes of social integration are culturally constructed and collectively perceived. The stories that OST patients craft about what they want and how they understand treatment to enable or inhibit their ability to realize those goals are intimately linked with a particular, locally meaningful conception of the social subject. Specifically, the mode of social integration that is sought by OST patients is grounded in a form of collective personhood forged by late Soviet and early post-Soviet economic realities, a subjectivity that Elizabeth Dunn has called the "dividual" person—someone who "acts on the world by acting on others" (Dunn 2004).

The 'dividual' person is made manifest in myriad ways, one of which is the heavy reliance upon secondary economies and systems of informal exchange that grew out of the Soviet Union's economies of deficit. This includes all sorts of informal cooperation from food sharing to gift swapping to factory managers cutting deals with each other for the re-distribution of raw materials (Dunn 2004; Ledeneva 2006; Patico 2008). These economic patterns led even the most intimate interpersonal relationships to be caught up in webs of material exchange and mutual dependencies. One term frequently used to describe these relationships is *blat* [Russian: блат], which refers to both the acquisition of commodities through social networks as well as

the networks themselves (Patico 2008, 175). Another modality of mutual support practiced by these close-knit networks is called *krugovaia poruka* [Russian: круговая порука]. Alena Ledeneva suggests that this term, which could be translated into English as "solidarity," "surety," "collective responsibility," "circular control," or even "cover-up," describes a "pattern in behavior or relationship according to which a person is part of a bigger social unit 'tied up' by joint responsibility and mutual obligations" (2006, 91).

The 'dividual' personhood evolved as the default conceptualization of the ordinary social actor from what Katherine Verdery has called "socialist paternalism," a political ethic which "posited a moral tie linking subjects with the state through their rights to a share in the redistributed social product" (1996, 63). These systems of informal linkages defined individuals not only in relation to the state, but also in relation to each other. Caroline Humphrey notes that this form of socio-political order was perceived and articulated in the Soviet period through the personification of power. "Crucially," she observes, "this idea is also represented in the term for state (*gosudarstvo*) deriving from *gosudar* (the sovereign)" (2002, 28). Put differently, the state, both in the geographic and in the socio-political sense, was conceptually rendered as the domain (*khoziaistvo* [Russian: хозяйство]) of the personified sovereign that brought all its citizens into relation with one another. The personality cult of leadership that defined so much of Soviet politics has not survived into contemporary politics—or, at least, the form that has survived has changed so much in its dynamics that it can't be considered a manifestation of the same phenomenon; however, concepts of cultural heritage (the imperative to "be Ukrainian" in the cultural sense) or even nationalism (the unifying factor of "being Ukrainian" in a political sense) provide convenient stand ins for mobilizing the discourse of the *khoziaistvo* today.

This concept of *khoziaistvo* dominated the biopolitics of the Soviet period. It defined not only the society that was to be governed but also the system of infrastructural and administrative controls that did the governing. Stephen Collier has identified two constitutive movements for this concept of *khoziaistvo* as it exists today. The first was "the displacement of the *khoziaistvo*—the nexus of need fulfillment—from the family to the city" during Soviet planning (2011, 83). This meant establishing the system of mutual dependencies (out of which emerged contemporary social artifacts such as *blat* and *krugovaia poruka*) both at the administrative level and in the minds of subject-citizens. The second constitutive move was "the articulation of the city *khoziaistvo* by prescriptive, substantive norms that encoded human needs into 'complexes' of elements that could be plugged into plans" (2011, 83). In other words, the economic and administrative planning under the Soviet regime considered the region as a whole, rather than considering it to be distinct regional enterprises which needed to be managed individually, thus crafting the discourse of the *narodnoe khoziaistvo* (the people's domain) or the single national economy, which Collier has aptly referred to as "a mono-society" (2011, 74).

The substantive norms that Collier argues were used to encode human needs for Soviet administrative powers resonate with the claims made by OST patients about who "normal" people are and what "normal" people do. These norms are equally apparent in clinicians' assertions about the degree to which their patients want (or don't want) to "get better" while they are in treatment. Each of these contemporary discourses seen in the OST clinic effectively makes moral claims about the ability (or perhaps, in the case of clinicians' speech, even the predisposition) of drug users to forge appropriate forms of mutual interdependence constitutive of *khoziaistvo*. They are assertions about drug users' "infusion into society," as Mariya so aptly

described, through which they will be able not only to be 'normal people' but to "*cling* to normal people" as well.

The key point here is that OST patients do not simply aim to achieve a functional mode of social integration for themselves; they are aiming to achieve the *only* form of social integration permitted within the quasi-hegemonic discourse of *khoziaistvo*. Furthermore, admission into the *khoziaistvo* is not a stepwise process. It is absolute. This social reality affected even my own experiences in Ukraine, as well as those of the other foreign researchers who made up my primary academic community while I was conducting my research[4]. While attempting to navigate their own entrée into Ukrainian professional and social circles, many of us would reassure ourselves by repeating the mantra—shared from researcher to researcher—that "until you're in, you're out." We found comfort in the phrase's implicit message that social acceptance tended to happen all at once, that the feeling of spinning one's wheels was not necessarily a sign of failure, but rather a symptom of the first phase of ethnographic research in the former Soviet world. I contend that this awareness, considered sage wisdom in my academic circles, is fully integrated into the social aptitudes of Ukrainian citizens who were born and raised in a society that is given discursive shape by the concept of *khoziaistvo*. This is why OST patients' claims to normalcy, or to their desire to be "normal," continue despite the appearance that they are stuck in their marginalized positions. When there is only one step to be made (from the outside to the inside), progress doesn't look like progress. It looks like stagnation.

[4] This included not only American social scientists, but also sociologists and social anthropologists from Sweden, Germany, and Denmark.

6.4 The Heroine of Maidan

Unfortunately, addicts, even those in treatment, are rarely able to make this transition from "out" to "in." The reason for this consistent failure can be illuminated by considering the case of a woman who *did* successfully end her own dispossession and move from outside of the Ukrainian *khoziaistvo* to within: a young girl named Liza Shaposhnik. Born with cerebral palsy, Liza was living on disability in Donetsk until a few months before the EuroMaidan revolution sprang to life in Kyiv in November 2013. Liza's role at these protests thrust her into the public spotlight and made her a minor celebrity. She was first noticed by other volunteers in EuroMaidan's kitchens and quickly became immensely popular for her efforts in the anti-government movement and for her embodiment of traditional Ukrainian gender roles. The mechanisms that maintained Liza's marginalization are quite similar to those that marginalize addicts. In this way, the beginnings of their stories are quite similar. However, in the moments where they diverge, a potent ethopolitics (Rose 2007) can be discerned—a moral reckoning and social policing of individuals' inner psychological states.

On December 12, 2013, Liza, already a volunteer at Kyiv's EuroMaidan protests, was interviewed by the Ukrainian-language media outlet Radio Svoboda. "I came to Maidan to stand up for my rights," she said. "The European Union is, for us, a chance to live well, to have a normal life [Russian: жить нормально]." This phrase, "to have a normal life," was the very same as that uttered by OST patients in my interviews. The imagery of "a normal life" was invoked by many EuroMaidan activists as they elaborated the broad goals they held for themselves and their country. This conscious push away from Soviet social paradigms towards a national community that embraces European values and the "normal life" these values are

believed to engender (Fehérváry 2002) was a central tenet of the "declaration of dignity" that the EuroMaidan protesters claimed to be enacting.

Mychailo Wynnyckyj, a professor of sociology at the National University of Kyiv-Mohyla Academy who was active in the protests, has written more than perhaps anyone else about what it meant to call the Maidan movement a 'declaration of dignity.' As he reflected on this idea at the end of March 2014, he put forward a description that bears a striking resemblance to Elizabeth Dunn's concept of the "dividual" (2004):

> Dignity is a concept that has its roots in the Western European Enlightenment, and is viewed as an extension of the concept of individual rights – fundamental to the paradigm of western liberal democracy. However, the concept of dignity as expressed on Maidan is distinctly different from Anglo-American individualism: dignity is a concept that can only be actualized in a relational sense. In order to have dignity, an individual must be recognized as having it by another. Thus, dignity requires more than an individualistic conception of the subject – dignity is only possible within a collectivity of persons…" (Wynnyckyj 2014)

Predictably, the most potent icons of dignity to emerge from the EuroMaidan movement were individuals who were both successful within and made intelligible by the collective labor force—the *khoziaistvo*—that maintained the revolution.

Liza Shaposhnik was a person upon whom the movement enacted its own story. Throughout the course of the protests, the media paid a great deal of attention to her, weaving together a meaningful narrative that cast her as an independent, hard working, and, above all, deserving human being out of scraps of things she said and various details about her life. She became the personification of the *khoziaistvo* during EuroMaidan. Liza was held up by many as an icon of the human dignity and sweeping social inclusivity that motivated the EuroMaidan movement in the first place.

The popular narrative of Liza Shaposhnik, which was printed and re-printed in countless newspapers and online venues, goes something like this. She was born in Siberia, the daughter of a Russian mother and a Ukrainian father. She grew up in Odesa, where her parents relocated when she was young. Since childhood, Liza's physical mobility has been limited by cerebral palsy. She suffered teasing and mockery from local children because of her disability and finally found relief from the stigma when she relocated to a special boarding school. As a young adult, Liza moved to the Donetsk region of Ukraine where she was able to rent a room in a hostel and support herself as a fruit vendor. Finally, in September 2013, Liza moved to Kyiv in the hopes of improving her situation. She rented her own apartment and again began working as a vendor.

Two months after she arrived, the EuroMaidan movement began to take shape in Kyiv's central square, the eponymous *Maidan Nezalezhnosti* (Independence Square). Liza learned that activists were protesting the suspension of the association agreement with the EU and decided to join the efforts (Gorskaya 2013). She was on the Maidan the night of November 30, 2013, a major turning point in the protests when Berkut officers stormed the area and violently scattered student protesters. Her presence during this terrible event afforded her narrative no small amount of legitimacy in the eyes of other protesters. Her story from this night is dramatic and harrowing. She reports sliding down the ceiling of the Globus mall, a terribly steep, two story incline made entirely of windowpanes, to escape the Berkut's truncheons and run to safety. Fortunately, she was able to escape without injury (Bereza 2013).

Soon after these events, Liza learned that volunteers were being recruited to assist with the management of the revolution. She immediately reported to the kitchens to see if there was something she could do. She was, at first, tasked with carrying trays of sandwiches to protesters

in the square. Liza has limited strength and mobility in her hands, and this job turned out to be quite challenging for her. She changed jobs a few times after that. For a short while, she sliced lemons for tea and garnish. Soon, she settled into her semi-permanent job: tearing the tags off of the strings of tea bags. This allegedly kept the tags from tangling and individual cups of tea from spilling as they were distributed (Gorskaya 2013).

Liza's hard work and dedication inspired such affection and respect from her coworkers that they decided to name the kitchens of Maidan in her honor (Gorskaya 2013). Thus, despite the arguably modest value of her work product, her role as a tea bag organizer seemed to be completely satisfactory to other volunteers who saw just as much, if not more, value in her *having* a job to do than in the work product that job produced. In other words, Liza was valued not simply for her work, but for the fact that she wanted to work, for the fact that she selflessly offered her labor without being told. In this action, Liza succeeded where OST patients had failed. She embodied the habitus of a "normal" person, achieving symbolic "normalcy," by insisting that she contribute to the collective effort, regardless of what product or benefit that work created. It was at her tea tag-tearing post, in fact, that the media discovered her and turned her into a celebrity, sitting stoically at a table with a moving box of tea bags to one side of her and a pile of torn tea tags on the other, working diligently, tirelessly, day in, day out.

The success of Liza's symbolic "normalcy" can be seen in the public's moral evaluation of her disposition and psychological state. For example, Liza was described by many EuroMaidan participants as humble, as a deserving person who wanted very little for herself. Many cited her statement, printed in the newspaper *Ukrainska Pravda*, that she longed only "to see a specialist once in [her] life…one who did not purchase their diploma…to have access to a health sanatoria, and to have a free massage" (Bereza 2013) as evidence of her enduring

humility. A popular website that chronicled the events of EuroMaidan listed Liza as one of the "True Heroes" of the revolution, along with the monk who rang the bells at St. Michael's Cathedral all night during the Berkut raid on December 11; the metro driver who, with horror, announced those same police attacks against protesters to metro passengers as the attacks were taking place; and two pensioners from Ivano-Frankivsk who spent their entire savings on a bus for transporting local people to Kyiv to join the movement. On this page, Liza is quoted as saying "I never imagined that I could be a needed and useful person. It's like I've been born again—not sick but healthy" ("#Євромайдан: Історії Справжніх Героїв – Inspired" 2014).

The public narrative into which Liza was woven reached its final denouement in May 2014 when she married a fellow EuroMaidan activist named Vitaly Popov. On her head, she wore a traditional halo of flowers, on her torso, brightly colored *vyshyvanky* [Ukrainian: вишиванки] (clothes decorated with traditional Ukrainian embroidery patterns). On her legs, she wore military fatigues and sturdy combat boots. Liza and Vitaly, along with a five-piece band and several armed militia members, were paraded down Kyiv's main boulevard, Khreshatyk, from the central Maidan to Kyiv City Hall atop an armored tank provided by the radical group Pravy Sektor. After the ceremony, the entourage caravanned down Shevchenko Boulevard then looped around to make a stop at the memorials for those protestors killed by police violence on Institutska St. There, the newlywed couple stopped to speak with reporters and showed off their wedding rings. Their matching bands were molded to resemble rubber car tires, the likes of which were burned by protesters along the barricades in the weeks prior (Makar 2014).

Liza's story is, above all, one of personal redemption, but it is one of bio-political redemption as well. She overcame disability, oppression, even a "backwards" thinking family,

as the story goes, to build an independent life for herself and contribute to an important social cause. She was viewed as "deserving," "humble," "the most important drop of water in the ocean" ("Ліза Шапошнік - Головна Крапля В Океані Євромайдану" 2014). Liza became a local hero, because she, despite the odds, achieved social acceptance and integration. She also, despite the odds, achieved the status of a married woman, finding deliverance from her former life of exclusion in this ultimate fulfillment of her gendered role as a Ukrainian woman. Liza became an icon for what Marian Rubchak called a return to "real Ukrainian-ness," a phenomenon accomplished by means of women birthing and raising "real" Ukrainians (1996, 318). As a married woman, Liza could not only be a part of the true *khoziaistvo*; she could also productively contribute to it, putting her successful social integration to work for the good of the country, the good of the collective. In sum, Liza was beloved because she overcame powerful obstacles to achieve not simply a life, but that fantasy-like "normal life," which was positioned at the center of the public's collective imagination—one of work, marriage, community, and home.

The great irony is that OST patients, who clearly harbor the same goals and values as many of those who gathered on the Maidan to protest government corruption, were not simply relegated to the margins of the revolution. They were explicitly prevented from entering the barricades that separated the Maidan from the rest of the city. Liza Shaposhnik became the celebrity sweetheart of Maidan for the way she represented and embodied the same, specifically Ukrainian form of "normalcy" towards which OST patients also claimed strive, yet, from the earliest days of the protests, signs were hung by the gates of the barricades indicating that alcohol and narcotics were unwelcome in the square. Not long after, these same notices announced that alcoholics and drug addicts themselves were not welcome. The social

dispossession and political disenfranchisement of drug users was not just tacitly maintained through the course of the EuroMaidan revolution. It was, in fact, deliberately perpetuated.

6.5 Slavery, Agency, and the Tautology of Social Exclusion

How then are we to explain Liza's resounding success in this regard in the face of the consistent failure of OST patients to achieve the same ends through demonstrably similar means? In answer to this question, I suggest that the discourse of dignity, which appeared on the Maidan, was the manifestation of a particular form of social exclusion that co-exists with the social imaginary of the *khoziaistvo*, which polices the boundary of the mono-social collective. Through assessment of drug users' internal states, and of the degree to which they are able to think freely, a clear determination is made as to whether such individuals can be integrated into the collective, can be situated within what Wynnyckyj has called dignity "in a relational sense…within [the] collectivity of persons" (2014).

The forms of social exclusion that addicts face in Ukraine are grounded in an ethopolitics (Rose 2007) that discriminates according to individuals' perceived mental freedom, according to their ability to act as agents of their own will. Those welcomed into the *khoziaistvo*, like Liza, are considered to be free, independent thinkers. They act with moral correctness and do so of their own volition. Those who are excluded, on the other hand, are thought to lack personal will. They do not possess the free-thinking abilities of truly independent social agents. In similar fashion, contemporary narratives about drug use in Ukraine deny addicts—whether or not they are in treatment—any claims to such personal agency (see Chapter 4).

In Ukraine, this idea of a person without self-knowledge or agency, the type of person described by Borys as having a disorder in the metaphysical connection between the will and the body (see Chapter 4), is expressed most forcefully through the word "slave" [Ukrainian and

Russian: раб]. As anthropologist Anna Fournier has observed, "[Ukraine's] new focus on the individual's 'inside' went hand in hand with the principles of self-knowledge, self-development, and self-realization" (2012, 41). "Slaves [*raby*]," Fournier counters, "[are] not people," and the term itself "denotes a lack of rights and the absence of agency" (2012, 70). Following Fournier's observation, it can be said that since self-knowledge and self-realization are characteristics of a "normal person," then their absence must be a key characteristic of abnormality, of personal or social pathologies that prevent one's social integration. Therefore, asserting oneself as an individual endowed with responsibility (as OST patients try to do, as Liza did) affects one's social subjectivity by allowing that person to be the opposite of a slave. It permits the humanization of the self.

Political discourse in and around the EuroMaidan revolution reveals these concepts in action. For example, the denial of this very form of personal agency was the intent of many smear campaigns launched against opposing political factions. Drug use was a common trope in those attempts. For example, many reports of drug use on the Maidan surfaced in Kremlin-controlled Russian media. One exemplary piece, published by *Voice of Russia*, recounted an apocryphal story of a young couple from Kyiv who went to Maidan to be revolutionaries. While inside the barricades, these two youngsters called friends and described the powerful emotions and euphoric atmosphere that surrounded them. Shortly after leaving the Maidan, the girl began to experience headaches, nausea, and high blood pressure. Her boyfriend fell ill with a similar malady soon after. They went to a hospital for treatment and were told by the medical staff they were suffering withdrawal from synthetic drugs—drugs that had been unknowingly fed to them through the soups and teas and other foodstuffs coming out of the Maidan kitchens. The *Voice of Russia* article also appealed to the allegedly drugged state of the Maidan protesters to explain

the violence that erupted on the 18th and 20th of February 2014 when nearly one hundred protesters were killed by the police. Viktor Ivanov, the head of the Russian Federal drug control Service, is quoted saying that "participants in the Maidan riot were under the influence of drugs, which resulted in 'an absolutely abnormal psychoactive condition'" (*Voice of Russia* 2014). From the point of view of the article, such behavior would only make sense if the actors involved were literally out of their minds due to the influence of drugs.

Accusations of drug-addled violence have continued even after Maidan and well into the military conflict that erupted in April 2014 in Ukraine's Donetsk and Luhansk regions (which continues even at the time of writing). Both sides in the war accuse the other of brainless, drug-addled behavior. In one such claim, a military aid group in Kharkiv offered evidence, by way of anecdotes from Ukrainian soldiers, that most of the separatists fighting against the Ukrainian military in the Donbas region are addicts. Soldiers allegedly reported that local separatists fighters were being drugged and "used as cannon fodder" by insurgent leaders. "Their blockposts are just littered with used syringes," the report reads. "Drugs are brought to them in large quantities from across the Russian border…They feel nothing when they are killed" (Hush 2014).

Attempts made during EuroMaidan to deny the agency or personal responsibility of others were not limited to those accused of drug use. Anti-Maidan activists (pro-government protestors who rallied in a different, nearby public park) were categorically turned away from the barricades just as drug users and alcoholics were. According to EuroMaidan protesters with whom I spoke, Anti-Maidaners represented a government that did not serve them and willingly did so for the sake of a few hryvnyas. EuroMaidan activists perceived them as weak in conscience, weak in spirit, willing to sacrifice their principles for almost nothing at all. People

called them cattle. People called them slaves. People called them prostitutes. I even heard the word "prostytushky" (a reference to *titushky* [Ukrainian: тітушки], the name commonly given to hired government thugs) used disparagingly against them. Similar epithets were launched against the Ukrainian polite officers who attacked protesters. Those people were brainwashed. They were zombies. They were animals, not even human. In sum, 'opponents' of the EuroMaidan movement were characterized similarly: weak in their moral constitution, surrendering their human values for meager incentives, as brainwashed or brain damaged, incapable of acting like humans, or, worst of all, as not even human to begin with. They were depicted as truly Pavlovian creatures, having little to no control over themselves, little-to-no control over their behaviors. They could not contribute to the collective, because they were spiritually empty vessels, tools to be manipulated by those in power for their own nefarious purposes.

These discourses were not a product of the specific events or politics of EuroMaidan. This mode of social distinction was prevalent during Ukraine's Orange Revolution in 2004 as well. At the height of these protests, signs could be seen around the Maidan that read, "We are not slaves [Ukrainian: ми не раби]." Anna Fournier interviewed a middle-aged political science professor at the Orange Revolution who elaborated on what this phrase meant:

> "What are slaves? A silent, amorphous mass. Slaves carry out the tasks [*vykonuiut zavdannia*] given to them, otherwise they know their heads will be cut off. Slaves are mute, but now, now we can already talk. We have freedom [*volia*]." (2012, 146)

Protestors in the Orange Revolution employed language like "slaves" and "cattle" to describe those who opposed the protests and even those who chose not to get involved. The supporters of presidential candidate Viktor Yushchenko, the opposition leader around whom the Orange Revolution protesters rallied, claimed that counter protesters who backed the Kremlin-endorsed

candidate Viktor Yanukovych were taking action "because they had been paid to attend" or had been "zombified [*zombovani*] brainwashed, or drugged" (Fournier 2012, 8). Many students defied parents and teachers by becoming active participants in the 2004 revolution, disparaging those who did not do the same. One student explained, "99 percent of people in our country are *bydlo* [lit. cattle, but meaning in this context, ignorant and destitute], they have no money, they don't know *anything*" (Fournier 2012, 86).

This history reveals that those individuals outside the *khoziaistvo* are perceived in both popular culture and clinic culture as quintessential examples of this kind of a-political, a-social, zombie-like individual, hopelessly lost to their wanton impulses. OST patients, in particular, become articulated in the popular imagination not simply through lay explanatory models of addiction but also through these locally salient theories of social subjectivity. Recall the complaint of the nurse in the tuberculosis hospital that her patients had no will to be involved in their own health or the lives of anyone else.

> Doctors tell them to come here [to this office to receive anti-tuberculosis pills], but they just hang out, they talk in the hallway, and then they leave. They are alcoholics, drug users. They have no desire. Maybe the wife already died, the daughter is already sick. It's all the same to them…That's addiction.

One could replace the word 'addiction' in this comment with 'slavery,' 'zombies,' or 'brainwashing' and render this complaint applicable to the Berkut, government titushky, or Anti-Maidan activists.

Though this mechanism of social exclusion is pervasive in contemporary Ukraine, the story of Liza Shaposhnik's revolutionary heroism in EuroMaidan's kitchens is evidence that exclusion from the *khoziaistvo* can be overcome. One would think that drug users should, in principle, be able to overcome this obstacle as well. This seems especially true given that Liza's formal status as a disabled person is parallel with the experience of drug users in treatment in a

number of key ways. Both groups are officially registered and classified as known entities to the state. Both conditions—disability and drug use—are subject to intense social 'othering,' fueled by the stigma attached to the outward appearance of both types of pathologized body. Even more importantly, both groups face significant limitations in their ability to find profitable work. Drug users are limited by the physical practicalities of their chemical dependence: the need to 'hunt' for drugs in order to avoid withdrawal and feel 'normal.' Those with officially recognized disabilities are given a meager amount of social security to live on each month. In exchange, they are largely prohibited from entering the formal job market[5]. Many, like Liza, are able to find work in low wage jobs that pay under the table, but the vast majority of occupations remain inaccessible.

The exclusion from the formal job market complicates the social intelligibility of addicted and disabled persons alike. The Soviet idea that one's social identity is directly link to one's labor towards the collective enterprise remains one of this era's lingering ideological legacies. As Hawkesworth has observed of the Soviet period, "the social significance of a person…the criterion of value of a person lies in her/her relation to work, in the socially useful work of the individual" (1980, 72: cited in Fournier 2012, 20). This explains Liza's ability to overcome social exclusion by simply performing work rather than producing a work product of meaningful value. However, the difference lies in the fact that Liza's exclusion from the labor force is ultimately out of her control (she did not *choose* to have cerebral palsy), drug users are frequently blamed for creating the situation that effectively removed their ability to work.

[5] There are several degrees of disability status in Ukraine. Group I is considered unable to work at all and in need of constant care. Group II does not need constant care, but only special cases are allowed to work. Group III is considered partially disabled and is allowed to work but only on a part-time basis (Phillips 2010, 51).

Discourses of 'wanting' (see Chapter 4) are used to place the responsibility for drug users' dispossession onto their own alleged psychological weaknesses.

The intentional refusal to work is deeply ingrained into the popular stereotype of drug and alcohol use (Fournier 2012, 95). This fact is well illustrated by an example from Anna Fournier's ethnography of high school education in Kyiv. One day, a teacher read the following passage from the Soviet constitution aloud for her class:

> Article 60: It is the duty of, and a matter of honor for, every able-bodied citizen of the USSR to work conscientiously in his chosen, socially useful occupation, and strictly to observe labor discipline. Evasion of socially useful work is incompatible with the principles of socialist society. (2012, 79)

The teacher then observed that citizens' right to work was also guaranteed by the Ukrainian constitution. When a student joked "or to not work!" she answered "Yes, of course, if you want to sit with a bottle [*sydity z pliashkoyu*] all day, you can!" "In this case," Fournier noted, "'sitting with a bottle' means doing nothing or being a 'lazy bum'" (2012, 79).

Put another way, Liza was able to fully and successfully embody the symbolic elements of "normalcy" because her work in the EuroMaidan's kitchens, irrespective of the practical utility of that labor, was an effort that she took up deliberately and intentionally despite the free pass from work that her disability afforded her. In this way, the labor that she performed was even more socially valuable than the product of that labor, because her work in the kitchens was, itself, an act of protest. Liza was perceived not simply as doing her part for the revolution, but as the personification of the agency and dignity that the EuroMaidan protests celebrated and sought to mobilize against the presidential regime.

Drug users, on the other hand, were viewed as the antithesis to Liza. They were unable to heroically overcome their social exclusion because they were believed to have forged that exclusion on their own. They were also believed to pose a particularly dangerous threat to

society. Their alleged mental weaknesses and chemical dependencies rendered them vulnerable to psychological exploitation. A cunning enemy could easily fill the crowd at a counter protest or a unit of government police officers or a brigade of separatist fighters, armed and unwieldy at a militia checkpoint, with such manipulable, zombie-like individuals. Thus, no matter what attempts OST patients made to assert their desire for social integration, to meet their social obligations, or to fulfill their proscribed roles as productive members of society, these efforts remained overwhelmed by a powerful, circular logic that rendered them less than human in the eyes of their neighbors. According to this logic, they became drug users because they had no will to be a part of the *khoziaistvo*, and so long as they are drug users, their alleged desire to reintegrate is simply impossible. The end result is that drug users find themselves locked into a place of social exclusion, unable to gain entry to "normal" society so long as any drugs, whether from the street or from the OST clinic, remain a part of their lives.

6.6 Conclusion

Part way through our walk together, after I had shut off the audio recorder and her formal narration had shifted into casual conversation, I learned that Alyona had walked through the park with me in order to speak privately about Anton, the OST clinic's social worker. She had unflattering things to say. "He should be defending us," she said, "but, you know, he's like that." I wondered how much her assessment of Anton's work performance was influenced by the fact that *she* had served the role of a social worker at this clinic before he arrived. Alyona believes her ability to council and guide others is one of her greatest gifts, and it's clear that she felt very much at home in that position. It gave her a sense of purpose and affirmed the most positive parts of her self-image. Now that she had been displaced and had

become just another patient at the clinic, Alyona needed a new opportunity for fulfillment. She was once again in pursuit of the same goals as her peers: work, purpose, a "normal life."

"I'm a very straightforward [Russian: прямолинейная] person," Alyona told me as we walked back towards the clinic gates. "Do you understand what that means? I was a healthy, *normal* person. I always helped everyone, you see. Fate saw to that. Our nurses here say to me 'Alyona, you must have had nine children in a past life. Maybe you had so many kids and now you need to use this life to relax…"

"What do you mean when you say 'normal person'?"

"Living like normal people? It's like, look, when people don't use drugs, they have something for themselves. They have a purpose in life. Some just want more money. They go crazy over trying to get more money. But there's still something else, you know? Those who seek out drugs, or who want to gather up things, they don't understand that each person has a purpose. Each person must be sincere in their heart and not do harm to anyone, not want harm for anyone. And living your life, being kind to others is the most important thing you can do."

Earlier in the week, Anton, the current social worker, had shared his frustrations with me over what he perceived to be a lack of purpose in his clients. He griped especially about amount effort put into job preparedness at the OST clinic, which ultimately had no effect. "We had a training one Saturday," he said. "We had 40 patients come and listen to someone give a presentation. They had help with resumes. People were here all afternoon, but zero people—zero, Jennifer—tried to find work after that. They all had excuses. No one wanted to do anything." I can't help but compare his version of these events with Alyona's: "The doctors tell us, so that people don't top off [their OST with street drugs], that they have to go on

methadone…They say it's better to go on methadone, take your pills, go to work, do something about it. We were all sent to the same employment center and we all tried to get work."

Caroline Humphrey has noted "…the dispossessed make mythicized image signs to the citizenry…We hear an endlessness in the narratives of the dispossessed, in their stories that keep starting up again each time they experience another disappointment or another rebuff," (2002, 33). OST patients are caught in a recursive loop of social marginalization that exists in a "blind spot" (Keshavjee 2014) of the Ukrainian health care and social service systems. However, the more time I spent in the physical geographies of the clinics and hospitals where these individuals are contained, the more I felt like that blindness was intentionally forged. OST patients often began this treatment program in the hopes of greater freedom and social recovery, but soon found themselves in a place with few options, no exit, nowhere to move onto. And no one, save the nurse who distributes their pills each day, bothered to see what became of them in the end.

If, as Humphrey suggests, "the narratives of the dispossessed only end when they are no longer dispossessed" (2002, 33), then the stories of OST patients in Ukraine are fated to carry on unchanged for a very long time. I found Alyona's final words to me particularly portentous in this regard.

"What do you want for the future?" I asked her , as we rounded the bend in the path and approached the clinic gates.

"To keep coming here for a while." She answered. "I'll be here for a while and I'll slowly lower my dose. I want to be able to work somewhere, to be needed, or helpful."

"Do you ever want to quit the program completely?"

"The folks here, we have no idea what will happen tomorrow. This program is in place [funds have been promised by the Global Fund] until 2017. After that, the AIDS Alliance in Kyiv won't sponsor us anymore, because the government won't offer any funds.

…But we're all staying here. All of us."

CHAPTER 7: CONCLUSION

The word "heroin" was once a trademark of the Bayer Corporation. From the 1890s to the 1920s, Bayer-brand Heroin was bottled and sold as an analgesic, a cough suppressant, and a mood regulator for children (Edwards 2011). Today, heroin manufacture is widely prohibited. This means the quality and safety of heroin and other illicitly produced opiates, which continue to be produced in massive quantities worldwide, exist outside the bounds of any health or safety regulations. The resulting products, whether made by unmonitored black market profiteers in South-Central Asia or by home chemists in Ukrainian apartments, are capable of providing the same effects as the commercial drug but do so at the expense of the personal safety of the user at every step, from production to purchase to preparation to use. Restricted access to sterile equipment for preparing and injecting drugs have compounded these dangers, leading to ethically unacceptable rates of HIV and hepatitis C infection among drug using populations, and forcing opiate users to make difficult choices concerning their personal welfare.

Rather than attempting to resolve upstream problems with narcotics production and supply, which produce the conditions for these devastating harms, the international public health community has chosen to target individual users, promoting interventions designed to change drug users' behavior by altering the calculus of their drug use-related choices. One of these interventions, OST, is endorsed by the WHO, UNAIDS, and UNODC as "an important treatment option in communities…in which opioid injection places [injection drug users] at risk of transmission of HIV and other blood borne viruses" (World Health Organization 2004). This medicalized approach has effectively reinforced the dominant moral that has framed addiction for much of the 20th century: namely, that compulsive substance use is caused by a deficiency of the will. As a result, the social imagination of drug use and addiction in many parts of the world

typically places blame for the myriad harms resulting from drug use onto individual users, selectively pathologizing those chemical management strategies that involve opiates or other illicit substances while ignoring many similar strategies for managing the body involving alcohol, sugar, caffeine, or nicotine, all of which are prevalent in contemporary society and put regular users at risk.

Within the realm of contemporary psychiatry, "addiction" is generally understood to be "a maladaptive pattern of substance use leading to clinically significant impairment or distress" (American Psychiatric Association 2000, 197); 'treatment-seeking' for drug addiction is likewise believed to hinge upon an addict's recognition of this maladaptive behavior as a problem that requires an immediate solution (Maddocks 2008, 3). This dissertation questions the utility of each of these premises. Instead, this research began with the premise that addictive behaviors may be integral parts of personal or collective strategies for such purposes as creating identity, generating social and economic power, or ensuring personal safety and welfare. The biomedical frame considers only a limited number of these factors, privileging physical and psychological symptoms located in the patient's mind and body over cultural considerations that inform how a patient will make sense of these symptoms, and the effect of social structures on the patient's behavior and choices. Alternatively, if we view drug use as a potentially purposeful activity, as a strategy for the chemical management of the social, physical, and psychological self, it becomes possible to see "addiction" as a set of behaviors simultaneously motivated by neurological processes, social structures, and the salience of the moment in which the drug user engages with the cultural and psychological idioms that shape his or her desire to use. This is what constitutes a neurochemical ethnography: a willingness to explore humans and the chemicals they interact with (opiates, amphetamines, antidepressants, mood stabilizers,

painkillers, etc.) in purposeful relationship with one another, and a refusal to privilege any psychological state (induced by the presence or absence of such chemicals) as more valid, legitimate, or 'authentic' than another. Such judgments are fundamentally cultural judgments, and the neurochemical ethnographer is obliged to treat them as such.

Armed with this theoretical standpoint, this dissertation sheds light on how and why adult opiate users decide to begin and continue receiving OST. This research demonstrates, first and foremost, that the attraction of this treatment program was not the allegedly therapeutic nature of a methadone or buprenorphine regime, but the practicalities of acquiring these drugs through the program. The predominantly middle-aged, long-term drug users I interviewed overwhelmingly named their desire to escape the *okhota*, the hunt, the constant scramble to find money and drugs, as their primary motivator for beginning OST. Secondary motivators included the desire to find work, to be healthy, to fulfill family or parenting obligations, or to live "normally." These goals were frequently linked with a patient's intention to continue OST for the long term, even after the time constraints of the clinic routine began presenting logistical difficulties of their own.

Unfortunately, not everyone has the privilege of making such choices. Some patients receive OST in an area where medically supervised detoxification is not available and clinicians strongly (if not coercively) deter patients from quitting OST on their own, effectively removing any option for ceasing treatment once it has begun. Many more live in rural areas where access to OST is limited by the sheer distance between most individuals' homes and the nearest dispensary willing or able to offer those services.

In his analysis of the politics of life in a medicalized world, Nikolas Rose has observed:

> On the one hand, our very personhood is being defined by others, and by ourselves, in terms of our contemporary understandings of the possibilities and limits of our corporeality. On the other hand, our somatic individuality has become opened up to choice, prudence, and responsibility, to experimentation, to contestation. This, then, is the problem space that defines the biopolitics of our contemporary emergent form of life. (Rose 2007, 76)

Following Rose's insight, I have argued here that the choice that Ukrainian drug users make to use OST drugs, or to use off-label pharmaceutical and black market drugs, or to use a combination of these substances, is representative of a locally-meaningful biopolitics. At a time when the need for quality health care and disease prevention services for injection drug users is extraordinarily high and the future of the scant services that have been made available is threatened by the global financial crisis as well as the ongoing military crisis along the Russian border, achieving a lucid understanding of this biopolitics is imperative for making the difficult decisions that lay ahead in a manner that is as informed and strategic as possible.

The Global Fund supports OST programs in Ukraine and elsewhere for the explicit purpose of combating the spread of HIV. In principle, this goal is accomplished in two ways: first, by diverting injection drug users away from injection practices through the provision of substitution drugs in tablet form and, second, by identifying HIV infected clients and connecting them with treatment, thereby controlling their infection and reducing the risk that they will transmit the virus by any means, injection or otherwise. Currently, Ukrainian OST programs simply do not have the reach or capacity to serve as an effective method of HIV control. At the time of writing, these programs had the space to enroll approximately 2.7% of Ukraine's estimated 310,000 injection drug users (Bojko et al. 2015). Obviously, a massive scale-up of OST programs in this region is needed.

Furthermore, OST alone is not a sufficient solution to the specific public health problems that the Global Fund seeks to address. The physical, social, and psychological needs

of patients on OST are incredibly diverse. Given this, and given the fact that few—if any—Ukrainians seek out OST strictly for its "therapeutic" capabilities, OST can hardly be expected to serve as a universal solution to problematic or long-term drug use. Support is needed to develop a robust diversity of services for drug users who are seeking to change their relationship with illicit drugs in some way. This means bringing about minor changes in existing OST programs, such as the procurement of additional pharmaceuticals, like Suboxone®, or the cultivation of different types of therapeutic milieus. It also means that the Global Fund and other international donors need to soften their stance on what constitutes an effective, evidence-based practice, thus allowing the clinical and therapeutic expertise that Ukrainians already possess to play a bigger role in shaping the spectrum of services available.

In practice, this means that "culturally competent" healthcare and HIV prevention interventions for drug users must include service options beyond the OST clinic. While their long-term efficacy is lower than that of OST (Ferri, Amato, and Davoli 2006), the cultural acceptance of programs like Alcoholics Anonymous and Narcotics Anonymous is growing in Ukraine. Either of these programs could provide viable support for some of those who, for whatever reason, are not interested in OST. Treatment options that align with local explanatory models of addiction are also needed, even if those options to not clearly harmonize with evidence-based approaches.

For example, this dissertation has shown that a lack of desire—specifically a desire to be treated, a desire to get better, a desire to live—is perceived to be one of the most destructive symptoms of drug addiction in Ukraine. This psychological profile of addiction is founded upon a unique, dualistic understanding of human consciousness, in which the connection between one's will and one's actions can become disordered, in which addiction is characterized by the

inability to act upon one's inner desires. According to this view, OST programs work thanks to the provision of psychological help that addicts need to overcome their acquired inability to act on their desire to change. If patients have no desire, their situation will never improve, but if they maintain an internal desire to change their lives, or if a skilled psychologist or social worker is able to light the fire of such desire within them, then drug treatment—including OST—is the last piece of the puzzle. It is the last necessary step towards realizing those desires, and it is a step that addicts must actively seek.

This explanatory model, dominant among Ukraine's OST clinicians, removes addiction from the biological, a-moral realm of medicine, where it is perceived to be a physical and psychological disease, and places it squarely back into the moral realm, where the decency, personal strength, and value of the individual are estimated according to the social acceptability of that person's behavior. In other words, the Ukrainian clinical model recasts (or, rather, re-centers) addiction as a problem of the will. If OST allows addicts to realize their inner desires to live, to leave drugs behind and regain their status as good people, then what does chronic substance abuse or frequent relapse say about the character of a person? To an experienced clinician, it may mean that they aren't good people. It may mean that their constitutions and desires are weaker than the desires of others. It may mean that they don't have any desire to live at all.

This tension in the patient-provider relationship could be attenuated by strengthening culture-bound, locally developed treatment options, which effectively neutralize these moral predicaments by putting the will of the patient at the center of the therapeutic intervention, like coding. Coding therapy presents some ethical dilemmas, as performance and deception are often integral parts of the treatment. However, these dilemmas are not wildly dissimilar from those

that that arise when patients' families request that a doctor conceal a diagnosis from an ill relative—a request that is common in some cultures (Muller and Desmond 1992). This issue has, in some cases, been resolved by shifting the agency of informed decision making from the individual patient to the family as a whole (Colclough and Young 2007). In other words, ethical dilemmas of consent and nondisclosure can be resolved if clinicians are willing to work towards resolving them. Furthermore, Eugene Raikhel's work on coding treatment in Russia reveals that patients are using coding therapy as a "prosthesis of the will" (Raikhel 2013), effectively revealing their complicity in the theatrics of the treatment and, perhaps, even a desire to be deceived, even if that desire is not explicitly stated. It would be appropriate, then, for entities like the Global Fund or UNAIDS to financially support coding therapy and increase Ukrainian drug users' access to this treatment option. Coding is not for everyone, of course, but neither is OST, and the research presented here indicates that greater access to coding and other locally meaningful tools for regaining control has the potential to improve many lives.

This may seem like a risky suggestion—one that, if adopted, could potentially compromise the efficacy of HIV prevention interventions or dramatically increase the opportunity costs of running those interventions. However, this research shows that such compromises to the integrity of evidence-based practices, as the Global Funds promotes them, are already being made in Ukrainian clinics. Specifically, two elements in the Ukrainian context enable local public health workers to resist and, in some ways, redefine evidence-based global health paradigms: the robustness of general uncertainty about the HIV and drug use epidemics in Ukraine and a flexibility in scientific discourse that is unique to the post-Soviet region. Bruno Latour has argued that scientific knowledge is believed to operate at a certain distance from the world, giving it the apparent ability to travel far without ever being far from home, without

sacrificing its relevance and its applicability (Latour 1987). Judy Clark and Jonathan Murdoch described this process beautifully:

> As scientific artifacts move 'through' the world they must reshape locales in a fashion, which allows these artifacts to 'work.' Herein lies the success of science and the basis of its universal claims. It remakes the world in its own image…" (Clark and Murdoch 1997, 41)

However, the discourse that I observed in Ukraine's OST clinics does not mirror that predicted by Clark and Murdoch, in which scientific ideas carve through local knowledge like an iceberg, remaking the world in its image. Rather, Ukrainian public health workers adapt scientific discourses to their own political purposes. *They* are the ones working towards a correspondence between local and scientific knowledge on their own. In other words, these compromises are already generated and managed by Ukrainian clinicians whether the Global Fund pays attention to them or not.

For OST patients, this means their clinical environments are shaped not by the protocols and standards of the WHO or the Global Fund but by a local culture in which only they and their clinicians are fluent. In light of this, efforts to develop "culturally competent" healthcare from the top down appear grossly underequipped, so long as health workers are actively adapting the entire ontological landscape in which the intervention takes place. Internationally funded HIV control efforts must find a way to productively co-exist with the worldviews that shape the lived experience of drug use and drug treatment in Ukraine and harness the power of those worldviews to positively impact people's lives.

In addition to these broad insights, this dissertation identifies a number of relatively minor changes that, if implemented, could increase the positive benefits of OST in Ukraine, as it currently exists. First, clinics need to be open for longer hours. Currently, the limited operating hours of most clinics hinder OST patients' attempts to find work and make other reasonable

improvements in their lives. This simple change would help patients procure their prescribed treatment in a way that does not conflict with their work, school, or caregiving schedules. Second, OST needs to be available in more places. It is appropriate for long-time opiate users on OST to be fully connected to treatment, to be seen and monitored by a physician. But, once a patient is enrolled in the program and regular contact with an appropriately trained clinician is established, why can't the task of providing the patient with daily methadone tablets be completed by a community nurse, a trained pharmacist in the local drug store, or a trusted parent or family member, as is frequently permitted in Ukrainian tuberculosis treatment (Carroll 2013)? Such options would provide significant logistical relief to patients who feel trapped by their clinical routine.

In Ukraine's current policy environment, methadone and buprenorphine are so strictly regulated that these alternative distribution methods are infeasible. Implementing any of the options proposed above currently constitutes criminal drug trafficking according to Ukrainian law. However, even methadone was classified as an illegal narcotic in Ukraine just one decade ago. The Ukrainian government is immune to neither influence nor reason. International actors need to advocate vigilantly for the practical revision of Ukrainian drug control laws.

Third, OST drugs need to be made available by prescription, allowing patients to acquire a supply of methadone or buprenorphine for one or two weeks at a time, thus severing the bio-chemical chain that shackles them to their clinic. Many OST patients expressed a deep appreciation of the structure and stability that their daily clinic routine afforded them when they were first entering treatment. Within a few months, however, this feature of the program—the daily jaunt to and from the clinic—turned from one of the most beneficial features of the program into one of the most burdensome. Patients who reach this stage in their treatment, who

have cultivated stability in their own lives and no longer need to rely on the clinic to provide that benefit, should be given the option of decoupling their daily treatment from the geography of the clinic. They should be able to take advantage of their hard-earned progress and begin moving on with their lives.

There is no policy in Ukraine that explicitly prohibits the provision of liquid methadone by prescription. The administration of each oblast in Ukraine is able to choose for itself whether their region will provide this service. Most do not. Prescription methadone was available in Dnipropetrovska and Ivano-Frankivska oblasts at the time of my research; however, the patients I interviewed from these regions complained bitterly about the implementation of the program. In Ivano-Frankivska oblast, for example, prescription methadone was only made available for those who could prove their need to travel away from their clinic (to visit family, for example) and only for short periods of time. The prescription option, then, was effectively unavailable even in regions where it was technically available. Therefore, an organized, targeted advocacy campaign designed to promote the reasonable availability of prescription methadone across Ukraine is desperately needed.

These are not the only programmatic changes, however, that could be made to improve positive benefits of OST *as patients perceive them*. Further adaptations that acknowledge how Ukrainian drug users typically interact with the drugs they consume are also merited. This dissertation shows that Ukrainian drug users interact with a spectrum of narcotic substances: *shirka,* codeine, Demerol, methadone, and buprenorphine, just to name a few. OST does not make sense as a technological or therapeutic intervention when brought into a social domain where multiple narcotic substances are already perceived to be acceptable substitutes for one another. For this reason, OST drugs like methadone and buprenorphine never achieve the status

of a medicine or a specialized therapeutic substance in the eyes of the patients who consume them. Rather, they are simply two more narcotics on this spectrum of narcotics from which opiate users can choose for managing their desires and dependencies.

Polydrug use in treatment, or the unapproved consumption of other drugs in addition to prescription methadone or buprenorphine, is common among OST patients world-wide (Lawrinson et al. 2008). In the Ukrainian context, where the interchangeability of narcotics is a prominent feature of drug-use culture, it is no surprise that polydrug use is prevalent. It may be appropriate, then, to explore ways of incorporating polydrug use into the service structure of OST programs. This would stop the erosion of OST's HIV prevention benefits caused by patients' return to unsafe injection practices with off-label or unregulated substances. It would also bring the explicit function of OST more in line with the purposes for which patients are choosing to use it. If drug users are not going to OST programs in order to quit using, OST programs should not be organized as a tool for ceasing use, exclusively. It should also be presented and implemented as a long-term option for individuals who use illegal drugs as part of their self management strategies, and it should be an option that provides long-term support for the *entire* scope of patients' chemical needs, including other illicit substances, not opiates exclusively.

Finally, as this dissertation has shown, the profound and negative impact that police corruption has had on the risk environment for drug users cannot be overstated. The use of more "traditional" narcotic substances, like *shirka*, presents a variety of health risks, such as (according to my interviews with clinicians and drug users) unsafe or unsanitary large-batch production, syringe back-loading, and even the use of human blood as a chemical buffer in drug preparation. However, it is undeniable that police control of the local drug market, despite

driving many users away from *shirka* and its problematic production methods, has nonetheless made drug users markedly less safe overall. Police corruption has put users at risk of extortion, imprisonment, physical assault, and extrajudicial harassment or injury at the hands of law enforcement. The pressures exerted by police control over the drug market have also pushed drug users to acquire narcotics in local pharmacies, where their vulnerability to immediate personal harm is much lower; however, this shift has increased the opportunity costs of drug use dramatically. People no longer need social connections to acquire drugs; they need cash. In other words, they need to learn how to hustle. This new economic structure allegedly drives numerous drug users towards deceitful or criminal activity that they would not have undertaken otherwise, and the desire to exit this dangerous social milieu, where their only options are to face police harassment or turn to criminal activity, is what drives many people to begin OST in the first place.

Under the presidency of Petro Poroshenko, who took office in June 2014, major efforts to reform the Ukrainian police are underway. Under the First Deputy Interior Minister, Eka Zguladze, legislation is being pushed through that seeks to replace more than eighty percent of the Ukrainian police force in less than five years, thus changing the entire culture of law enforcement in Ukraine ("Ukraine Seeks Foreign Help on Police Reform" 2015). The first section of law enforcement to undergo major changes within the framework of Zguladze's reform efforts is the road police, known for their trenchant corruption and exploitation of the public. Training for more than two thousand replacement officers was completed in Kyiv in May 2015 (McLaughlin 2015). So far, these efforts bode well for the future of Ukraine and the safety of its citizens. However, whether or not a hefty turnover in Ukraine's police force will bring an end to their complicity in the illegal drug trade or simply displace those officers

controlling the drug trade deeper into the black market remains to be seen. If the latter occurs, and those currently in control lose their social and professional protections, then the informal drug trade could become a much more dangerous and overtly criminal affair. If police pressure on the drug trade does decline, however, drug users may respond by pulling back from pharmacies and returning to the poppy-based narcotics that many prefer. This may change the attractiveness of OST for many users and could impact the number of individuals seeking this treatment. For all these reasons, the downstream effects of these national reform efforts need to be monitored closely.

Above all, and perhaps most tragically, this ethnography has shown that intense and pervasive social exclusion does much more to negatively impact the lives of drug users in Ukraine than any problem that OST or other clinical therapies could alleviate. Despite this, many OST patients still tried to alleviate their social exclusion however they could. Many said they were participating in an OST program because they wanted to live like "normal" people. They grounded their descriptions of this fantastic "normal life" in ordinary details. Normal people make a living wage. Normal people are able to receive good health care. Normal people are able to find work and raise their children. OST patients tried to manifest these characteristics in their own lives, using OST as a logistical support for reaching these goals. However, those who are able to achieve the status of truly "normal" people in Ukrainian society do not only outwardly manifest these symbolic characteristics of normalcy; they also succeed in positioning themselves with in the dominant socio-political structure so as to benefit from that structure, so as to be profitably entangled in that structure. Addicts were usually unsuccessful in their efforts to position themselves as "normal" people due to the psychological and spiritual pathology that was believed to lie beneath their continued drug use.

This exclusion does not simply tell us something about how addiction is viewed in contemporary Ukraine. It also reveals a broader pattern of social distinction grounded in sweeping acts of dehumanization and the wholesale rejection of alternative paradigms and points of view. By making claims about the liberty with which people are able to use their own minds, the degree to which they are able to think freely, a clear determination is made as to whether such individuals can be integrated into the collective. Interestingly, the "normal life" defined by these contemporary discourses deviates from the neo-liberal ideal in that self-determination and self-actualization alone are insufficient. To achieve a "normal life," one must also volley with a system of social distinction that that equates socially acceptable forms of sobriety and self-sacrifice with spiritual cleanliness and deservedness that renders those with socially unacceptable behaviors undeserving and even inhuman.

This stereotype is largely self-fulfilling. Marginalization assures that drug users are systematically stripped of the trappings of ordinary social life. Marginalization keeps drug users from finding jobs, from finding stable homes, from being at peace with their families, from achieving countless other forms of self-actualization that many of us take for granted. Marginalization is also fueled by an incredible ignorance of drugs, drug use, and drug users' lived experience that is widespread among the general population. Until more work is done to combat overt discrimination against drug users and to increase drug users' ability to speak of their own realities with their own voices, any assistance that support organizations can offer them will be palliative, not curative. The change that is needed is social, not clinical. That revolution is still to come.

EPILOGUE

A number of people who appear in this dissertation died as I was writing it. At least one (though there are likely others) died of a drug overdose. Another committed suicide. Both of these confirmed deceased were patients at Ivan and Pavel's clinic in Simferopol. It is largely due to the amount of care these two doctors took with their patients that there is confirmation that these individuals died. Their doctors were checking up on them. The fate of other OST patients in Crimea who had less diligent physicians (or who had their contact with health care providers severed by means outside of their control) remains murky. Both of these deaths were a direct result of Russia's military aggressions within the sovereign territory of Ukraine and the intensely negative effect that these actions have had on civilians both within and outside of the occupied territories.

One of the two men who have died (whose deaths have been confirmed by contacts at The Alliance) was named Dima. For years, if not decades, Dima injected pharmaceutical opiates and locally available 'street drugs' like *khimiya* and *shirka*. These drugs aren't that uncommon where he's from. The Alliance estimates that nearly 15,000 of Crimea's 1.9 million inhabitants inject drugs (International HIV/AIDS Alliance in Ukraine 2012a). For Dima all that ended in 2008 when he enrolled in an opiate substitution therapy (OST) program, operated out of the clinic where we met. In October 2012, at the time of our last meeting, it had been four full years since he started receiving OST. When his clinic shut down in May 2014, it would have been nearly five and a half.

Then, on February 24, 2014, Russian soldiers invaded the Autonomous Republic of Crimea and facilitated a military coup. The invading troops came dressed in Russian military uniforms, but displayed no name, flag, rank, or insignia, prompting the locals to refer to them

by the color of their uniform: “Little Green Men.” Less than one month later, on March 16, 2014, the Russian Federation staged a legally and procedurally flimsy annexation of Crimea. Anthropologists Elizabeth Dunn and Michael Bobick call this annexation a form of “theatre state” that “focuses on production of spectacle rather than economic development or the provision of social welfare” (Dunn and Bobick 2014). As they anticipated, the situation in Crimea quickly deteriorated following the invasion.

On April 2, the head of the Russian Federation’s Drug Control Service, Viktor Ivanov, publically announced his intention to close all OST programs in Crimea (Dunn and Bobick 2014). This announcement followed earlier promises that OST patients could continue receiving treatment through the end of 2014 (International HIV/Aids Alliance in Ukraine 2014). Ivanov supported this decision by citing high levels of crime related to drug production and drug trafficking on the peninsula. He argued that the level of drug use in the local population was twice as high as in Russia—a claim contradicted by available evidence[i]. He characterized his desire to manage Crimea’s drug addicts in eugenic terms, saying “the ‘rejuvenation’ of drug addiction in recent years and the increasing number of female drug addicts [in Crimea] is causing a rise in the number of births of children with various disabilities, which is a threat to the gene pool.” He called Crimea’s eight hundred OST patients “legalized drug addicts” and “a serious problem that must be dealt with.”

In spite of the promises made by Russian authorities to keep the programs open for at least another eight months, all OST programs in Crimea were shut down on May 1, 2014, under the authority of the Drug Control Service of the Russian Federation. More than eight hundred residents of Crimea were receiving OST when the shutdown occurred. The closure of these programs in Crimea has been nothing short of devastating. Since May, more than twenty of

Crimea's OST patients have reportedly died; at least three of those deaths were suicides (International HIV/Aids Alliance in Ukraine 2014).

These deaths were entirely predictable. It is well known that the risk of death from overdose increases significantly in the first weeks following the cessation of OST (Davoli et al. 2007; Cornish et al. 2010; Degenhardt et al. 2009). Speaking at a press conference on June 19, Pavlo Skala, a senior program manager for the International HIV/AIDS Alliance in Ukraine, announced that a few dozen methadone patients were sent to rehabilitation facilities in Moscow, but most were left to fend for themselves, with little medical support for managing their withdrawal. Skala also reported that, as a result of the shutdown, many former methadone patients in Crimea have returned to illegal drug use and several dozen had died in only a matter of weeks. "This is a form of execution," he said, "that constitutes inhumane treatment and torture according to international law…There will be [more] deaths. We expect increased rates of HIV and hepatitis infection. Russia will not record these statistics" (newsru.ua 2014).

In its own home territory, the Russian Federation is facing a massive HIV epidemic with virtually zero services in place with which to quell the tide of infection. Though surveillance mechanisms or poor, it is estimated that more than 1.2 million people are living with HIV in Russia. Furthermore, an estimated nine out of every ten of those HIV-infected persons in Russia are not having their treatment needs met (UNAIDS 2013). The HIV epidemic throughout Eastern Europe has, for more than two decades, been primarily driven by injection drug use, and Russia has consistently adopted policies of criminalization rather than offering evidence based treatment options ("Addicted to Crime: Russia Considers Jailing Drug-Users" 2014). Despite the demonstrable success of harm reductions like OST in Ukraine, and despite the presence of an estimated 8.5 million drug users in the country ("Experts Say Russia Not Ready to Fight HIV"

2014), methadone and buprenorphine, the two key drugs used in OST, are banned in Russia ("*Rossiykaya Federatsiya Federal'nyy Zakon o Narkoticheskikh Sredstvakh i Psikhotropnykh Veshchestvakh*" 1998), rendering these treatments entirely unavailable to the Russian population.

According to Michel Kazatchkine, the UN Secretary General's Special Envoy for HIV/AIDS in Eastern Europe and Central Asia, the closure of Crimea's OST programs constitutes "a blatant example of health policy being hijacked for political ends rather than being led by evidence" (Kazatchkine 2014). In this case, that evidence is predictive. At the time that the Russian Federation began its annexation of Crimea, the Ukrainian Ministry of Health reported that more than eight thousand residents of the peninsula, including Dima, Masha, and Vova, were living with HIV (Kazatchkine 2014). OST programs had been working successfully since 2005 to keep that number in check, but the unfortunate consensus among public health experts now is that rates of HIV, hepatitis C, and overdose will quickly rise in their absence (Grover et al. 2014).

Since the occupation of Crimea began, I have lost all contact with the OST patients on the peninsula who participated in this project, including Masha and Vova, the young parents I met at the Simferopol clinic. Back in 2012 when we last met, they presented as two strong, determined individuals. I have to hope that the instability and chaos they left behind has not re-entered their lives. But I know, in the back of my mind, that they live in a city that the Russian Federation now controls. They were thrown off of their chemical management strategy without medical assistance. Their support structure has been entirely dismantled. Statistics show that they are more likely to fall into harm's way now that their clinic has closed than they were before they even began OST.

My training in public health and medical anthropology has taught me to appreciate a variety of measures for assessing the quality and efficacy of programs like this one: average medication adherence levels; rates of recidivism; the number of incident infections. However, my time on the ground in little, forgotten clinics, like the one in Simferopol' where I met Dima, Masha, and Vova, have taught me to take note of many more. I recall how shamelessly Dima and his friends helped themselves to marshmallows from the plate on their physician's desk, revealing how comfortable and empowered the patients in this clinic were. I recall laughter from the courtyard, where nurses were chatting with young, opiate addicted mothers, revealing meaningful relationships between addicts and their care givers. This clinic offered a flourishing program that should have been used as a model to improve services elsewhere. I had, in fact, proposed to The Alliance that Ivan and Pavel be shadowed by health researchers trained in qualitative methods, so that their techniques and strategies could be better understood and reproduced elsewhere. Today, The Alliance is struggling to determine which of Ivan and Pavel's patients are still alive, let alone where any of them can currently be found.

The unfortunate truth is that every form of essential healthcare service in Ukraine—HIV-prevention, hepatitis screening, tuberculosis treatment, drug treatment, OST, etc.—is in a worse state today than it was two years ago as I was conducting my research. War has shattered Ukraine's economy and obliterated the infrastructures used for the delivery of social services and medical care across large portions of the country. Though this dissertation makes numerous contributions that could have been put to use improving and scaling up the OST services that existed in 2013, these goals are no longer feasible. The OST services that existed in 2013 no longer exist. Today, as certain regions of Ukraine are embroiled in humanitarian crisis and IMF-enforced austerity measures threaten to cripple health care funding elsewhere, it is absolutely

essential that the leadership of Ukraine and of the international organizations that are working to support Ukraine's fragile healthcare system understand the lived experiences of the country's most marginalized and at-risk citizens and the strategies they employ when engaging with healthcare apparatuses. This is the only way to keep these essential services—and the people they serve—alive as the world around them explodes.

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