Conclusion

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Conclusion

*Narkomania* is an ethnographic portrait of an “addiction imaginary,” a culturally contingent theory of socially marginalized people who use drugs that circulates through clinical spaces, legal discourse, public policy, public demonstrations, refugee crisis centers, popular revolution, and theaters of war. Across Ukraine, a localized “addiction imaginary” serves as a template for politically salient forms of distinction. It has given structure to emergent nationalisms. It has facilitated the mapping of social change onto the body politic. It has kick-started the political careers of new states, new sovereignties, and new forms of social order. *Narkomania* also follows this “addiction imaginary” into the mundane spaces of rural clinics and local hospitals, where small but occasionally fruitful efforts are made to extract opioid-dependent people from the hopeless subjectivities this shared imagination would sort them into. This analysis has been framed around several arguments, which I summarize below.

First, “addiction” is a social construct that fills the gap between locally meaningful theories of individual will and our ability to make sense of prob-
lematic substance-use behaviors through the lens of those theories. The
classic theories of critical medical anthropology suggest that the medicaliza-
tion of “addiction” might have stripped this condition of its moral connota-
tions, moving substance use disorder out of the realm of individual agency
and into the realm of purely biological phenomena (see Rhodes 1996). A
quick glance at contemporary media coverage of substance-use issues is suf-
ficient to demonstrate that this potential has not been realized. Public dis-
course continues to place personal blame on people who use drugs for the
injuries or consequences they sustain as a result of their drug use. This is true
in the United States, in Ukraine, and elsewhere. Narkomania suggests that
efforts to medicalize “addiction” have failed to strip away these moral values
because the very concept of “addiction” was generated, and is now insepa-
rable, from culturally driven understandings of choice and agency (Valverde
1998). Substance use disorder may be defined by a strict set of clinical crite-
rion, but “addiction” always has been (and likely always will be) modeled
around a pathology of the will, constructed to explain why some members
of society appear to be making habitual, destructive choices beyond the lim-
its of comprehension and the empathy of most other members of society. The
“addiction imaginary” is thus a construct created anew time and time again
as different societies chart a clearly defined pathology, which explains how
problematic substance use (or any other problematic, compulsive behavior)
arises in apparent contradiction to dominant theories of human will.

Second, the production of biomedically defined “Others” within a given
society can be equally constitutive of social order as is the creation of ideal,
governable subjects. The governability of citizens has long been a central con-
cern of anthropological studies of neoliberalism (Keshavjee 2014). Of note is
Stephen Collier’s critique of purely theoretical analyses of neoliberalisms,
which, he claims, fail to consider what may constitute neoliberalism as a prac-
tice and not simply as an abstract ideological arrangement (2011). The
analysis presented in Narkomania suggests that such practices of neoliberal-
ism can extend beyond the work of city planning, unbundling utilities, and
instituting new regimes of commodification (as Collier and others have de-
scribed) to include the production and enforcement of state policies on health
and welfare. Thus, the inequitable distribution of rights—including the
use of various administrative tools for the differential management of se-
lect portions of society, as seen in the framing of the 2012 version of MoH
Order 200 and the cumbersome reporting requirements given to MAT
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clinics—helps to settle the definitions and the limits of “Othered” social categories and allows state powers to enact their appointed role through the active management of these “Others” for the benefit of the rest of society.

Third, it is possible to establish new forms of sovereignty by enacting new administrative strategies, especially where those strategies are able to redraw the lines of social distinction and enforce new regimes of inclusion and exclusion. Indeed, the ability to create and enforce new categories of social exception was directly and purposefully engaged as a tool of statecraft in Crimea and in Donbas. Those making claims to sovereignty in these contested spaces had unequal access to resources and public platforms at their disposal; however, regardless of whether these proto-states’ new “Others” were produced through regulatory force or physical violence, public response both within and beyond their asserted geographic boundaries proves these strategies to be morally and politically compelling to wide swaths of society.

Fourth, both international global health organizations and the local entities they support are easily interpretable as troublesome foreign agents whose activities undermine the sovereignty of their host nations. Michelle Rivkin-Fish (2005), among others, has rightly pointed out the ridiculousness of considering global health, medicine, or even science to be apolitical endeavors. Enacting administrative strategies, establishing infrastructure, and even importing “para-infrastructures” (Biehl 2013) are inherently political projects, as is the choice of a state to accept or resist those projects when foreign actors are seeking to implement them. To this end, global health infrastructures are not only complicit in the reproduction of neoliberal forms of governmentality across global contests; they are also deeply entangled with the domestic struggles among (or between) state powers to produce subjects, produce “Otherness,” and enact sovereignty as it is locally conceived. Should state powers decide it is in their interest to contest the authority of that foreign influence the impediment or the outright removal of vital health-care services is an efficient mechanism for achieving this aim.

Lastly, “addiction imaginaries,” however they may be constructed, are able to provide symbolically rich and widely legible media to support a state’s core sociopolitical projects: the construction of “Otherness,” the legal or administrative organization of society around that “Otherness,” and the enactment of sovereignty through the violent enforcement of that “Otherness.” This is true precisely because the ways in which we formulate our understandings of “addiction” are so closely linked with hegemonic notions of agency, per-
sonhood, and the grain of the social fabric. Further, people who use drugs are not alone in their vulnerability to these strategies. In Ukraine, sexual and ethnic minorities are also very much at risk of discrimination and exclusion in nearly all aspects of their lives. In the United States, transgender and non-binary individuals have been similarly targeted by vicious campaigns of “Othering” and exclusion, especially through the sponsoring of so-called bathroom bills that would criminalize the use of a public toilet designated for use by a gender other than one’s gender assigned at birth (Kralik 2017). Parallels are readily apparent between “addiction imaginaries” and this “gendered imaginary,” which explains away those who do not conform to heteronormative standards of gendered identity as individuals who “refuse” to conform out of some kind of obstinacy or, worse, because they are inexplicable monsters who put the rest of society at risk.

In the final analysis, it becomes clear that these strategies of inclusion and exclusion do not simply tell us something about how “addiction” is viewed in contemporary Ukraine. They also reveal broader patterns of social distinction grounded in sweeping acts of dehumanization and the wholesale rejection of alternative paradigms that seem to contradict broadly accepted understandings of “human nature.” 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 considered fully fledged citizens and, subsequently, whether they should be afforded the rights they would be entitled to as such. To achieve full citizenship, people who use drugs and other populations bound by exclusionary “imaginaries” must contend with local ethopolitics (Rose 2007) that produce a sense of stability and order, enjoyed by the majority, by casting these members of “Othered” minorities as living emblems of the emergent social and political threats of the day.

What of Ukraine?

The analysis presented here reveals in stark terms that intense and pervasive social exclusion continues to negatively impact the lives of Ukrainians who use drugs much more than any clinical or individual problem that MAT or other therapeutic interventions can resolve. Despite this, Narkomania shows that many patients attempt to alleviate the social exclusion they are subject
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to in any way they can. Most told me they came to their MAT 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. MAT patients tried to manifest these characteristics in their own lives, using MAT as a logistical support for reaching these goals. Overwhelmingly, however, these individuals were unsuccessful in their efforts to position themselves as “normal” people due to the deeply rooted social stigma to which they are constantly subjected.

Recent changes in Ukrainian domestic policy allow for cautious optimism that the quality of life for those most marginalized in Ukraine will improve. Under the presidency of Petro Poroshenko, who took office in June 2014, major efforts to reform the Ukrainian police have been discussed. Under the first deputy interior minister, Eka Zguladze, legislation was proposed that would replace more than 80 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” n.d.). The first section of law enforcement planned to undergo major changes within the framework of Zguladze’s reform efforts is the road police, known for 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 actually come to pass—and whether such a transition will bring an end to police 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, participation in the informal drug trade, even as a consumer, could become a much more dangerous and more seriously criminal affair.

In late 2016, as the close of what was thought to be the Global Fund’s last active grant for the provision of MAT in Ukraine was just weeks away, the government of Ukraine voiced its commitment to fully finance this treatment program with funds from the national budget (UNAIDS 2016). As part of the “willingness to pay” provisions of its grant agreement with the Global Fund, Ukraine was obligated to begin allocating money toward MAT pro-
grams in 2016 and to establish dedicated lines of domestic funding in 2017 (Garmaise and Zardiashvili 2016). The government of Ukraine committed USD 31.7 million to the national HIV/AIDS control plan, which includes prevention for people who use drugs by means of MAT provision, in 2014. That amount dropped by approximately 50 percent in 2015 and 2016 due largely to the currency crash and financial drain that have accompanied the ongoing war in Donbas. Nevertheless, the Ukrainian government is on track to return to 2014 funding levels in 2017 and 2018 in fulfillment of the agreements made with the Global Fund and PEPFAR to continue providing supplemental funds to pay for essential HIV control programs (U.S. President’s Emergency Plan 2017). Historically, actions taken by the Ukrainian MoH—such as the artificially limiting provisions of the 2012 revision of Order 200—have long belied the government’s political will to take on the financial and administrative responsibilities of these programs. The post-EuroMaidan government, though subject to seemingly perpetual turmoil of its own, has nevertheless adopted a more cooperative stance with foreign donors of public health assistance.

This commitment to supporting MAT has arisen under the leadership of a new minister of health, Ulana Suprun, a Ukrainian-American physician who relocated from her home state of Michigan to Kyiv to take the position. The administrative changes undertaken by Suprun have been, in a word, sweeping. A new nationwide electronic medical records system was launched in April 2018, which will not only make health records accessible and transferrable in ways never before possible, but will also allow for public health authorities in Ukraine to conduct sentinel surveillance and understand the true nature of disease burdens across the country for the very first time. Many Ukrainians have also gained the ability to choose their own primary care physician, becoming effectively untethered from the polyclinic they had previously been assigned to according to their official residence (Kupfer 2018). The severity of this departure from Soviet approaches to health care cannot be understated.

When I began my research in Ukraine, approximately 8,000 people in Ukraine were receiving MAT. As of February 1, 2018, that number has risen to 10,252 individuals receiving services at 186 different sites. The Global Fund has set the ambitious goal of expanding available services for people who use drugs (including MAT and programs such as syringe access and disposal) to
reach 65 percent of the nearly 350,000 individuals in this population in 2017, 70 percent in 2018, and 90 percent by 2020. (U.S. President’s Emergency Plan 2018). Access to buprenorphine has also been expanded to primary care clinics, allowing patients to receive these medications from their personal doctor rather than from a narcological dispensary (Morozova et al. 2017).

These are important steps, but many potential obstacles remain. War and internal displacement continues to drain Ukraine’s financial resources, and experience of buprenorphine treatment in primary care clinics in the United States shows that increasing availability in this way does not guarantee that more people who need these medications will have access to them—or that doctors will be willing to prescribe them in the first place (Parran et al. 2017). Public statements from Ukrainian officials have reflected a clear understanding that the decision to support or reject essential HIV-control measures like MAT is an ideological one (UNAIDS 2016), and one hopes that the desire to conform to the international expectations held of modern democracies, if not genuine concern for the well-being of its population, will continue to shape the standards of public health and health care for Ukraine’s most vulnerable citizens.

What of Russia?

The deadly battles that have swept through eastern Ukraine have spurred new global interest in this region as well as a new wave of political thinking about foreign policies in the post–Cold War era. It is likely, for instance, that Russia’s military actions in 2014 made the very concept of Russian meddling in the 2016 U.S. presidential election, which has dominated the U.S. news cycle since, appear plausible to the American public in the first place. Though many violent territorial conflicts have taken place within the confines of Europe in recent years—including wars in Bosnia, Albania, Kosovo, Georgia, and Moldova—much of the Western world nevertheless seemed caught off guard when the territorial sovereignty of Ukraine was challenged by a foreign military. The Russian annexation of Crimea and, to a certain degree, the war in Donbas directly violate the most sacred tenet of the post–World War II European order: that international borders shall not be altered through violence or other means of force. Outrage at these events is fully merited on these grounds alone, and yet, it is difficult to defend the suggestion that this
pattern of events is somehow new. The world has borne witness to the military might of multiple nations pressing the boundary lines of European states in one direction or another since the collapse of the Soviet regime. A thoughtful consideration of what drives us to forget these realities again and again is long overdue.

For this reason, ethnographic investigations of post-Soviet modes of sociability, like this one, are desperately needed if our understanding of geopolitical conflict in this region is to improve. Despite (or perhaps because of) our well-developed political understanding of historical tensions between Russia and the European west, Cold War-era paradigms always seem to be coming out of retirement, supporting views of contemporary events that adhere too closely to the social realities of thirty years ago. Today, at a time when human rights has become the dominant language of personhood and now defines appropriate relationships between citizens and states, grounded analyses of medicine, the right to health, and other allegedly apolitical domains of contemporary life must continue to emerge if we are to move beyond obsolete modes of thinking that fail to illuminate anything new about the global political landscape of today.

What this analysis makes abundantly clear is the importance that Russian state authorities currently give to the consolidation of their political control of the former Soviet sphere. This is evidenced not only by the sheer number of soft military engagements and direct military conflicts in which Russia is currently engaged across Eastern Europe and Central Asia, but also the amount of human and financial resources its leadership is willing to sacrifice to territorial conflicts in its “near abroad.” Leaked reports indicate that the death toll among Russian ordinary and volunteer fighters in Donbas reached as many as two thousand in the war’s first year, alone (Segalov 2015). The human casualties are not limited to those engaged in physical conflict, however. No amount of politicking, diplomacy, or debate can change the fact that Russian authorities deprived over eight hundred people of essential, lifesaving health-care services, passively killing nearly one hundred of those individuals in the process, simply to prove that they could. Russia is actively engaged in the resurrection of its status as a formidable world power, and while many concerns and priorities inform the strategies they employ toward this end, the preservation of life is clearly not one of them.
What of Us?

While still in the process of writing this book, I began working with federal agencies in the United States to combat the ongoing opioid epidemic through the implementation of evidence-based strategies for the prevention and treatment of unintentional opioid overdose. Though I have been working in the fields of harm reduction and substance-use research for the better part of two decades, I still found myself unprepared for the depths and tenacity of the dehumanizing rhetoric used by state and local authorities across the United States to understand and talk about people who use drugs. The idea that living with “addiction” is a willful choice remains alive and well, and that view frequently leads otherwise reasonable people to the conclusion that the greatest U.S. public health crisis since the HIV epidemic of the 1990s is best solved by simply letting people die.

I have become habituated to the constant refrain of voices demanding that people who use drugs be stripped of their most basic civil liberties. Hardly a community meeting or town hall can be held without someone loudly proposing forced hospitalization, involuntary commitment, or compulsory treatment for those living with “addiction.” Compulsory treatment does not help. In fact, the science behind compulsory treatment was thoroughly adjudicated by a panel of experts at the National Institute on Drug Abuse (NIDA) in the 1980s. They concluded that compulsory treatment was inefficient, ineffective, and an irresponsible use of public resources (Leukefeld and Tims 1988). NIDA’s position on compulsory treatment and involuntary hospitalization has since been reevaluated but has never changed. The evidence continues to tell us what we already know. In the world of clinical research on substance use disorders, this question has long been settled. It is, therefore, incredibly disorienting to be asked to provide expertise on a public health issue, only to be repeatedly contradicted by non-experts who insist that the correct way forward centers around a strategy that has been scientifically disproven for more than thirty years.

What is it, then, that makes us so consistently impervious to evidence-based solutions to our own opioid crisis? What makes us treat people who use drugs with so much ire that we are comfortable stating out loud that their lives are worthless? What is at stake for us when our most deeply held imaginations about substance use in the United States feel challenged? What do
our viewpoints about what “addiction” really is accomplish for us, symbolically or ideologically? In the introduction of this book, I asked what social or personal ills in contemporary Ukrainian society MAT seems poised to repair. I asked how the meanings applied to “addiction” and “treatment” in this setting are entangled in broader discourses about power and sovereignty; how these meanings are mobilized in efforts to construct national identity; how the elite subject people who use drugs to selective policing, rights violations, and other delimited forms of citizenship in an effort to exact or consolidate social power. Shouldn’t we be asking ourselves these same questions?

A thorough reckoning with our own “addiction imaginaries” is needed if we are to have any hope of quelling the tide of opioid-related deaths across the United States. This is largely because the stereotypes that situate people who use drugs as toxic “Others” are largely self-fulfilling. Marginalization assures that they are systematically stripped of the trappings of ordinary social life. Marginalization keeps them 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 and widespread ignorance about drugs, drug use, and the lived experience of those whose lives have become caught up in these practices. Until more work is done to combat overt discrimination against people who use drugs and to increase their ability to speak openly of their own realities with their own voices, any form of social and clinical support will be palliative, not curative. The change that is needed is social, not clinical. That revolution is still to come.