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SOVEREIGN RULES AND REARRANGEMENTS: BANNING METHADONE IN OCCUPIED CRIMEA

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Abstract

In 2014, Russian authorities in occupied Crimea shut down all medication-assisted treatment (MAT) programs for patients with opioid use disorder. These closures dramatically enacted a new political order. As the sovereign occupiers in Crimea advanced new constellations of citizenship and statehood, so the very concept of "right to health" was re-tooled. Social imaginations of drug use helped single out MAT patients as a population whose "right to health," protected by the state, would be artificially restricted. Here, I argue that such acts of medical disenfranchisement should be understood as contemporary acts of statecraft.

Keywords

Ukraine; Russia; Medicalization; right to health; sovereignty; substance use

Dima called himself a *narkoman*, a Russian word which roughly translates to "addict." For years, if not decades, he injected pharmaceutical opioids and locally made poppy-straw solutions. These diluted opioids are not uncommon in Crimea, the southernmost region of Ukraine where he is from. Nearly 15,000 of Crimea's 1.9 million inhabitants inject such drugs (International HIV/Aids Alliance in Ukraine 2012). Beginning in 2008, however, Dima could no longer be counted among them. That year he enrolled in a methadone maintenance program in his region's capital city of Simferopol, where we first met; he had been actively engaged in treatment ever since. Methadone, a synthetic opioid-agonist medication, was the backbone of Dima's treatment for opioid use disorder. This approach, referred to as medication-assisted treatment (MAT) or, alternatively, medications for addiction treatment (Wakeman 2017), helped bring an end to Dima's daily cycles of craving and withdrawal. That stability, in turn, afforded him the mental and physical capacity to resolve the social and psychological challenges that pulled him into substance use in the first place. When I first met him in 2012, he had come a great distance both in his recovery from opioid use disorder and in strengthening his relationships with his wife and daughter. He was a happy man.

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Dima died from a fatal opioid overdose in 2014. That year, the Russian Federation invaded Crimea, illegally annexed the region (Brilmayer 2014), and permanently closed all of the MAT clinics there. These closures were politically motivated, undertaken by occupying forces as part of their efforts to demonstrate sovereign authority and secure political control. Crimeans treating their opioid use disorder through MAT suffered tragic but predictable consequences. Opioid overdose is a well-known hazard for those who abruptly cease treatment for opioid use disorder (Davoli et al. 2007). Those who leave treatment voluntarily are vulnerable to relapse, and those who were involuntarily discharged often turn to illicit drugs to manage their sudden withdrawal; in both scenarios, many return to previous habits of substance use with a dramatically lower tolerance for opioids. Of approximately 800 individuals once receiving MAT in Crimea, more than 100 were reported dead by the end of June 2014 (Kazatchkine 2014; Ingham 2015). Some, like Dima, suffered a fatal opioid overdose when they sought relief from methadone withdrawal with unsafe, unregulated narcotics; others took their own lives. Dima was among the first to die.

These administrative closures were less about drug use per se, than they were about Russia's claim to Crimea, which has long been of great political and military importance to the Russian state.[1] Crimea is home to Russia's Black Sea Fleet, for example, which maintains precious access to the open seas along its western border. The clinic closures also aligned with Russia's ongoing antagonism with NATO countries and the political trajectory of Ukraine under a new, emboldened, and decidedly pro-European government. Since November 2013, Ukraine had been rocked by massive public demonstrations in response to then president Viktor Yanukovych's decision to abandon an association agreement with the European Union under apparent interference from the Kremlin. In February 2014, amidst the strongest anti-government fervor yet, Yanukovych ordered police attacks against these protestors, resulting in the deaths of more than 120 civilians. As the death toll rose, institutional support for the president plummeted, spurring Yanukovych to flee the country and leaving Ukraine's pro-Kremlin government in shambles. Russia quickly moved to secure its assets in Crimea. Within 24 hours of Yanukovych's abdication of power, Russian soldiers set foot in—and effectively took control of—the Crimean peninsula.

More important than bringing the region into harmony with Russian foreign and domestic policy, however, was the need to produce and enact sovereign power over Crimea: the sudden, highly public closing of MAT clinics in the region served to do just that. On March 16, Russia staged a procedurally suspect public referendum on Crimea's cessation from Ukraine, which, according to Russian president Vladimir Putin, more than justified the rightful return of Crimea to its country of origin (Putin 2014).[2] On March 19, Russian

[1]The national status of Crimea has shifted several times over the past century. Originally part of the Russian Soviet Socialist Republic within the USSR, Crimea was not a part of Ukraine until 1954, when it was "gifted" to the Ukrainian Soviet Socialist Republic by Krushchev in celebration of the 300th anniversary of Pereyaslav, when Cossack leaders joined forces with Russia's Tsarist military forces in their uprising against the Polish-Lithuanian Commonwealth (Reid 1997).

[2]Beginning in 1991, Crimea existed as an autonomous region within Ukraine, retaining its status as a nearly exclusively Russian-speaking population with close historical ties to the Russian Orthodox Church and Russian cultural identity. Russian political rhetoric tends to frame Crimea as a fundamentally Russian place, drawing lines of distinction not between Russia and Ukraine, as world maps might have us imagine, but between a historically imagined "Russian world" and everywhere else. Historian Serhii Plokhy has described this contemporary model of Russian identity as on "which stresses the indivisibility of the Russian nation, closely associated with the Russian language and culture, [and which] poses a fundamental challenge to the Ukrainian nation-building project" (Plokhy 2017:350)

authorities began the process of distributing Russian Federation passports to the citizens of Crimea (Radio Free Europe/Radio Liberty 2014). On April 2, Viktor Ivanov, the head of the Russian Federation's Drug Control Service, publically announced his intention to shut down all MAT programs on the peninsula (Ivanov 2014); he did so on May 2, 2014. These were the acts that Russian leaders prioritized in the first ten weeks of the occupation, because they were acts that solidified their political control.

This rapid succession of adjustments posits MAT provision on a level of importance close to that of passport regulation, implying that such acts were prioritized for their optics as much as their practical necessity for governing. One simple explanation for this is the fact that social imaginations of "addicts" like Dima have long provided fertile soil for articulating social values and leveraging claims of political authority, especially during periods of rapid social change (Singer and Page 2013). The causes for this are myriad, yet frequently tied to cultural norms that bracket people who use drugs as social deviants of some kind, lacking in will, morality, or even common sense (Becker 1963; Spradley 1968; Bourgois and Schonberg 2009; Hart 2013). Today, growing clinical and anthropological literatures reveal drug use to be intimately shaped by factors such as built environments (Schüll 2014), local economies (Bourgois 2003; Mars et al. 2015; Carroll et al. 2017), and forms of physical or social control inflected upon drug using bodies (Garriott 2011; Carr 2010; Mimiaga et al. 2010; Beletsky and Davis 2017). Nevertheless, popular understanding in many parts of the world, including Ukraine (Carroll 2016), persists in categorizing drug use as a sign of personal, intellectual, or moral failure -- as a pathological behavior that violates the operant social norms in each new time or place (Valverde 1998; Garcia 2010; Carroll 2016; Carroll et al. 2017). These cultural constructs are what allow MAT programs (and other time-tested public health responses to drug use, like syringe access, naloxone distribution, and safe consumption spaces) to remain stigmatized, underfunded, even barred by public action despite the evidence supporting their efficacy in protecting public and individual health (Bazazi et al. 2010; Lopez 2017, 2018; Olsen and Sharfstein 2014).

In this article, by examining MAT clinic closures in Russian-occupied Crimea, I argue that the way a state responds to drug use and drug use-related social problems reveals much about foundational ideological objects like national identity, citizenship and citizens' rights as they are locally conceived. As Russia, the self-proclaimed sovereign authority of occupied Crimea, pushed forward new constellations of citizenship, nationality, and statehood, distinct from those that came before, so the state's biopolitics, the strategies used to manage the citizenry's individual and collective bodies, and the very concept of "right to health," were retooled as well. More specifically, fueled by Russia's adoption of a strictly punitive approach towards drug use, framing this behavior as a moral failing that requires a harsh, law enforcement response rather than treatment (Galeotti 2016), MAT patients in Crimea were singled out as a population whose access to essential medicines was restricted, redrawing the limits of the "right to health" that citizens would have fulfilled by the state. Further, I argue that the institutional abandonment of Crimeans receiving MAT does not simply reveal these values but is also constitutive of the sovereign authority that enforces them. I offer this argument as a counterpart to Stephen Collier's understanding of the Soviet government "as a distinctive form of biopolitics" (2011:19) that attended to the most fundamental questions of how a state should govern and how the balance between rights,

entitlements and prohibitions should be struck. By restricting the scope of citizens' "right to health." Russian authorities in Crimea established themselves as the "sovereign…who decides on the exception" (Schmitt 1985) through forceful administrative rearrangements.

Analyses of sovereignty, which center the citizen- and subject-making power of the state, have been aptly critiqued as "reinscrib[ing] the classic model of sovereignty as an actually existing relationship…rather than viewing it as a discursive figure produced through the colonial encounter" (Bonilla 2017). However, the act of declaring, re-declaring, and enforcing "correct" forms of citizenship through top-down proclamation by state authority, accomplished through the administrative restructuring of institutions that fulfill citizenship rights, is precisely the thing I mean to examine. Sweeping acts of inclusion and exclusion in Crimea—those in which Dima and his compatriots were repeatedly caught up—are worth investigating because they reflect so much of the ideological foundations, which have made possible the successful redrawing of national borders by force in post-WWII Europe. Especially when we consider sovereignty not as an abstract confabulation of power but as an "assemblage of administrative strategies" (Ong 2006:98), it becomes possible to scrutinize the biopolitical logic through which the sovereign is enacted by looking at the concrete policies and social divisions it seeks to and can successfully enforce. In Russian-occupied Crimea, the redrawing of citizenship boundaries was a crucial component of these state-forging exercises, as was the selective denial of rights to those assigned to delimited citizenship roles in the new sovereign arrangement.

MEDICAL SYSTEMS AND MAKING STATES

I came to know Dima and the other patients and clinicians presented throughout this article between late 2012 and early 2014, when I was engaged in long-term research on the implementation of MAT in Ukraine and the clinical trajectory of opioid users who sought out this mode of care. During this time, I regularly haunted MAT clinics in Kyiv, Kherson, Ivano-Frankivs'k, L'viv, Mykolaiv, Simferopol' and Sevastopol'. The latter two cities (Simferopol' and Sevastopol') are located on the Crimean peninsula. Some of these clinics were housed in tuberculosis hospitals or AIDS centers. Others were housed in freestanding narcological dispensaries. Still more were located in small rented basements and office spaces. Some of these clinics I was able to visit once or twice; others I visited on a daily basis for weeks at a time. I conducted formal interviews with 22 clinicians and more than 70 MAT patients. I also clocked hundreds of hours shadowing clinicians in MAT programs and outreach workers who moved through cities and the surrounding rural areas to provide medical and social services to individuals living with substance use disorders or engaged in commercial sex work. Many of the outreach workers I followed were MAT patients themselves.

These fledgling programs were a cornerstone of Ukraine's coordinated public health response to its significant (and synergistic) injection drug use and HIV epidemics. Injection drug use had been the primary driver of HIV transmission in Ukraine for nearly 20 years (Ministry of Health of Ukraine 2012). As recently as 2014, an estimated 1.2% of Ukrainian adults between 15 and 49 years of age were living with HIV (UNAIDS 2016), and, in 2009, the Ukrainian Ministry of Health estimated that nearly 25% of all Ukrainians who injected

drugs were living with HIV (Ministry of Health of Ukraine 2010). In certain urban areas, the estimate reached nearly 40% (Kruglov et al. 2000).

Historically, MAT programs in Ukraine have relied upon significant monetary support from international benefactors, with which the government of Ukraine has had something of a love-hate relationship. In 2014, Ukraine received a US $550 million grant from The Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund) to combat HIV (The Global Fund to Fight AIDS, Tuberculosis, and Malaria 2015); with these monies, the Global Fund supported MAT programs in Ukraine entirely and exclusively (U.S. President's Emergency Plan for AIDS Relief 2017). Though the number of persons actively receiving MAT remained small (3–4% of all injection drug users by 2015; Zaller et al. 2015), the political importance of these programs was just as significant, if not more so, than their epidemiological impact. According to the Ukrainian social scholar Viktoria Zhukova, "the topic of HIV/AIDS served as a tool for the state discourse on Western and European integration" (2013:85). In domestic politics, MAT programs have been a matter of some controversy in Ukraine. Clinics have been plagued by police harassment, occasionally culminating in the arrest of clinicians providing MAT on charges of "drug trafficking" (Cohen 2010); the clinics are often subject to strict regulatory controls that seemed designed to limit access to these essential services (Bojko, Dvoriak, and Altice 2013). Through significant external support, however, these programs have continued to survive.

The contentiousness of local discourse around MAT is due, in part, to the fact that notions of the "right to health" have long borne an intimate connection with tropes of nationalism in Ukraine and the body politic from which the nation was composed. In the late 1980s, for example, victims of the Chernobyl nuclear disaster wielded this political link as they chastised the Soviet government for failing to provide access to the health care they needed and which they felt they were owed (Petryna 2002). In the early 1990s, as Ukraine gained independence from the Soviet Union, the newly fashioned government took on the needs of Chernobyl victims as one of its banner issues, defiantly granting sweeping health care entitlements to those who were afflicted. These new entitlements for those injured by the disaster played a key role in separating the independent Ukrainian state from the Soviet socialist republic that preceded it, reconstituting Ukraine as a different—and different kind—of state. By taking such sweeping actions to "correct" the Soviet legacy of social abandonment following the Chernobyl disaster, the newly independent government of Ukraine was performing its distinction from the Soviet Socialist Republic that preceded it, establishing—and projecting globally—its newly achieved sovereign control. Similarly, the processes through which the systems providing the "right to health" of Ukrainians with opioid use disorder are today achieved can never be fully distinguished from the historical process of building the nation-state of independent Ukraine—both as an actor on the global stage and as a sovereign power set in structured relationships with its citizens.

Global health projects, such as Ukraine's internationally funded MAT programs, can also be understood as corrective interventions designed to deliver technologies that ensure health where the "right to health" remains unfulfilled. They become what medical anthropologist João Biehl has called "para-infrastructures:" "interstitial domain[s] of political experimentation that become visible in people's case-by-case attempts to 'enter justice'"

(Biehl 2013:422). Despite these benevolent intentions, however, these international "para-infrastructures" often create spaces wherein sovereignty is contested and struggles over regulatory control can play out in the infrastructures that fulfill citizens' "right to health"—one of contemporary statehood's key biopolitical terrains.

Petryna and Follis observe that "new post-Soviet countries [arrived] late to the game of nation-states," emerging concurrently with an international human rights apparatus that sought to implement concrete legal and institutional changes to across world regions to "secure the right of those whose 'right to have rights' had been denied" (2015:403–4). As noted by Viktoria Zhukova (2013), Ukrainian leadership has often engaged the so-called "universal moral code" (Morsink 1999; Petryna and Follis 2015) of human rights to position itself well in its relationships with powerful international actors. This has not been a flawless process. The Ukrainian government has occasionally pushed back against the Global Fund's demands, refusing to make purchases through Global Fund-specified vendors, for example (Berdychevskaya 2004). To the degree that the Ukrainian state has conformed to international expectations, however, it has done so by allowing international actors to influence administrative strategies within Ukraine's sovereign borders over which the state would typically have control. How the state chooses to welcome or reject these "para-infrastructures," therefore, can be crucial to certain elements of the state-building project.

THE CLINIC AS CORRECTIVE

I first met Dima at his clinic in Simferopol'. I have discussed this meeting in detail elsewhere (Carroll 2014). I was there with a colleague from Kyiv who was eagerly introducing me to Ivan and Pavel, the physicians running the MAT program there. We settled into Ivan's office, a comfortable room drenched in midday sun. I spent my afternoon overwhelmed by offers of tea, cookies, and *zefir*, a marshmallow-like confection for which I harbor a terrible weakness. It's a bit of a childish treat, but, as it would happen, I was not the only one with such enthusiasm for it. Dima, one of Ivan's patients, also adored eating *zefir*—so much so that he had made a habit of helping himself to Ivan's personal stash whenever he wished. As I was chatting with these new colleagues, the door to the office suddenly cracked, and the head of a young man popped in. He snatched several *zefir* from a dish sitting on a table near the door and squirrelled them away in his pocket. He paused to share some daily gossip with the physicians before taking notice of the unfamiliar woman in the room. He stepped in and took a chair next to me, curious to know who I was.

Dima was open about his past and his experience progressing from recreational opioid use to uncontrolled opioid use disorder. During one of our later interviews, when I asked Dima what had prompted him to join this MAT program in the first place, he replied simply, "I didn't think much about the bigger picture then." He continued:

> I came here to figure out more immediate problems. I had just met my girlfriend. I was always lying to her, telling her that I had some kind of job to get to. At eight in the evening, when we would be out for a walk, I would need to run off. I'd say I had some kind of job, as an excuse. But, she started to figure out what I was doing. And I thought -- I need to get on this program, first of all to save the relationship.

> First, my family started to suspect, she started to suspect that I was on drugs. And secondly, things had started to really break down at my work. I would come in for a half a day, leave for my lunch break, and never come back. I realized that I needed something in my life to change somehow, that I needed to start on this program.

He did. Two years later, Dima and his girlfriend were married. They have a baby girl who would, as this article comes to print, approach her seventh birthday. The direct link Dima drew between his access to methadone and his ability to fulfill his social and familial obligations harkens to the Marxist logics of the Soviet health care apparatus. In this view, the state of public health is a reflection of the political well-being of a nation (Field 1967; Virchow 2006). This view remains salient in the post-Soviet sphere today, but, as anthropologist Michele Rivkin-Fish has observed—and as Dima's narrative also reflects—the social and economic uncertainty experienced by citizens of post-transition independent states has helped raise the art of personal development, of "remaking themselves" (2005:31), as a key social value.

This same appreciation for MAT as an individual corrective (or, in Foucauldian terms, a technology of the self) was emphasized by two other people I met that day: Masha and Vova, a young, married couple who both also came to the same MAT clinic as Dima for treatment. Vova spoke explicitly about the limitations their previous opioid use had put on their ability to succeed as active, integrated, productive members of society. "When you're on that garbage on the street," Vova 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, Masha paced in slow, lazy circles around him, rocking their restless baby to sleep. Masha and Vova cite their infant daughter as the anchor holding their new life together. "We [Masha and I] just wanted to come back to life, to normal life," he said, "where there is work and a car and everything is fine…We have this great joy now." Vova gestured towards his baby. "There is no going back. We have a reason to build a life."

In addition to these philosophies of personal development, many MAT patients were keenly aware of the larger political significance of these programs. In the summer of 2013, when I was spending much of my time at a single MAT clinic in Kyiv, I came to know two women, Mariya and Alyona, very well. Both patents at the clinic, they generously spent numerous afternoons with me discussing news and politics. Alyona was a pessimist about the future of MAT. "The folks here, we have no idea what will happen tomorrow," she said, predicting that government interest in sustaining MAT would dry up in the near future. Mariya argued, in return, that MAT programs would survive, because they were inextricably tied to the ongoing praxis of statecraft in contemporary Ukraine. In her own words, she explained:

> Is [offering MAT] profitable for our government? It is. Not because the Global Fund pays for them, but because they want their citizens to be put on the right path. But it seems to me [they do it] only because they are getting paid, because they have to move closer to Europe, and if we didn't have it, Europe would say 'What kind of European country doesn't have these programs?

While it is hard to begrudge Alyona her pessimism, my analysis here aligns with Mariya's view. In the current geopolitical climate, which frequently requires Ukraine to pit itself against either western Europe or against the Russian Federation in order to secure beneficial diplomatic arrangements with the other (Yekelchyk 2014), the "para-infrastructures" that connected each of these individuals with daily methadone serve as a marker of fidelity to western European values, finances, and institutions. As the Kremlin has taken a hard line position against MAT, they may also represent, by contrast, a rejection of Russian values, institutions, and regional authority. Put another way, offering MAT can be seen as a very non-Russian—or even anti-Russian—thing to do. This is precisely what was at stake in Russian-occupied Crimea.

RIGHTS TO HEALTH IN THE POWER VERTICAL

Just to the east of Ukraine, the Russian Federation is also facing an HIV epidemic highly concentrated among people who inject drugs. Though sentinel surveillance mechanisms are poor, the Joint United Nations Programme on HIV/AIDS has endorsed estimates that put Russia's total HIV prevalence near 1.2 million cases and suggest that nearly 90% are not receiving proper treatment (UNAIDS 2013). Russia is also home to an estimated 8.5 million people who use drugs (Quinn 2014), many highly vulnerable to infection. Public health experts have estimated that the provision of MAT could cut the country's rate of new HIV infection in half (British Medical Journal 2010).

In spite of these troubling statistics—and in direct contradiction to the policies espoused by the Global Fund—Russian health care policies prohibit most evidence-based treatments for opioid use disorder, including MAT. Instead, the Russian government has consistently adopted policies of criminalization. It is even illegal to import the opioid medications most commonly used for MAT into Russia ("Rossiskaya Federatsiya Federal'nyy Zakon o Narkoticheskikh Sredstvakh i Psikhotropnykh Veshchestvakh" 1998). This is even true for methadone, which has numerous clinical uses beyond MAT, such as the prevention of postoperative pain (Murphy et al. 2015) and the treatment of peripheral neuropathy—even in pediatric patients (Madden and Bruera 2017).

The prohibition of MAT in Russia does the work of policing citizenship categories by virtue of restricting the institutions that would grant human rights in excess of the limits of that citizenship. Russian leaders, too, understand global health institutions as para-infrastructures designed to displace Russian sovereignty over its drug using population and insert the political logic of human rights, which Russian representatives have been known to rebuke (Borger 2016). In contrast to the "universal moral code" of human rights, which has become *lingua franca* of most international diplomacy (Morsink 1999; Petryna and Follis 2015), Russian president Vladimir Putin has sought to wield authority through a single "power vertical," a consolidation of control around a single axis of power: himself (Pertsev 2017). So-called "foreign agents," seeking to establish para-infrastructures and "chink the gaps" in the assemblage of administrative strategies engaged by the Russian state as it governs, therefore, constitute ideal targets for state-sponsored censorship under the aegis of that consolidation of power.

Russian authorities have also chosen to take an active, rather than passive, stance against entities that endorse or provide MAT and other public health services for people who use drugs. Russian physician Dr. Vladimir Mendelevich, who has long acted as a public advocate for evidence-based treatments for opioid use disorder in Russia, has been banned from working in the area of addiction medicine since 2006 for his outspoken views (Audoin and Beyrer 2012). The Russian government has also directly curtailed the activities of the Andrey Rylkov Foundation, a non-profit public health group founded in Moscow, for placing references to methadone on their website, citing the illegal "placement of materials that propagandize the use of drugs, information about distribution, purchasing of drugs, and inciting the use of drugs" (Human Rights Watch 2012) as just cause. In 2015, the Open Society Foundations, which have long advocated for more comprehensive harm reduction efforts in Russia, including MAT and syringe exchange services, were labeled "undesirable organizations," a Russian legal term applied to foreign entities accused of inappropriately meddling in internal Russian affairs (Walker 2015b; Open Society Foundations 2015).

The removal or oppression of groups perceived as para-infrastructures or other conduits of foreign control has not been limited to the territory within the Russian Federation. Elizabeth Dunn and Michael Bobick have argued that Russian military involvement in nearby 'breakaway' regions, for example, such as Trasnistria in the Republic of Moldova, South Ossetia in the Republic of Georgia, and Ukraine's Donbass region in the east, "serves the goal of reestablishing the sphere of influence [Russia] lost in the 1990s" (Dunn and Bobick 2014:407). In any of these breakaway regions, the praxis of sovereign "shock therapy," is likely to include the administrative upending of previously existing para-infrastructures such as that experienced by Crimea's MAT programs. New leadership may publically target these programs for the ways in which the global citizenship categories embraced by global health projects (Rees 2014) conflict with the conception of citizenship held forth by the newly configured state. Alternatively, these para-infrastructures could simply represent the unacceptable decentralization of sovereign authority away from the singular power vertical. Putin has referred sincerely to the collapse of the Soviet Union in 1991 as "the greatest geopolitical catastrophe" of the twentieth century (Osborn 2005), and the specter of this loss continues to haunt national discourse, especially insofar as Putin's rhetoric conflates Russian and Soviet state powers, framing contemporary Russia as unfairly denied its rightful place as a dominant world power. By this logic, expelling any foreign influence that may soften Russian's claim to sovereignty over the Crimean region seems only practical. Along with the potent rhetoric of dehumanization surrounding drug use in Russia, this placed MAT clinics right in the Kremlin's crosshairs.

DISMANTLING INSTITUTIONS

Russian authorities clarified the newly imposed boundaries of its citizenship in Crimea in shutting MAT clinics down. The political re-branding of Crimea as a territory that *is-and-always-has-been* a Russian place required that the region operate on Russian principles, be guided by Russian administrative norms, and ultimately produce Russian citizens who embody Russian values. So long as the "right to health" can be considered part of the assemblage of administrative strategies through which the state wields its authority over individual citizens, strategically denying certain groups access to available health care

technologies can effectively alter those citizens relationship with the state. Just as the annexation of Crimean constituted the redrawing of national boundaries through military might, so the closure of MAT programs reconfigured individuals' right to health through brute administrative force.

The substance of Russia's state-making activities involving MAT programs was not focused on their status as para-infrastructures per se. Rather, Russian authorities made claims about the appropriate relationship between a state and its citizens, dialing in on the ways in which the inclusion of MAT within the scope of citizens' rights perverted that relationship to the detriment of the citizenry. Viktor Ivanov, for example, supported the decision to shut down MAT programs through vague references to high crime rates, especially drug production and drug trafficking, on the peninsula. He referred to Crimea's MAT patients as "legalized drug addicts" and "a serious problem that must be dealt with;" he also characterized his desire to manage Crimea's drug addicts in eugenic terms, asserting that "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" (Ivanov 2014). The right to health afforded to these individuals, insofar as the right to health is the language that brings an enfranchised citizenry to life, was forcefully reconstructed for the purpose of disenfranchising Crimeans with opioid use disorder along this single axis of entitlement.

Ukrainian resistance to the administrative closure of Crimean MAT clinics took a similar form. Shortly before the clinics were shut down, as medicine supplies dwindled and fears about the future began to build, the Alliance, the non-profit organization serving as the primary recipient of Ukraine's Global Fund grant in support of MAT, produced a short video featuring patients and staff from Dima's MAT clinic in Simferopol' (International HIV/Aids Alliance in Ukraine 2014). In it, patients introduced themselves to the audience through reference to their status as biological citizens. "I have received many diagnoses," says one. "HIV, hepatitis, tuberculosis." "I was a liquidator [clean up professional] at the Chernobyl nuclear power plant," says another. "After that I…I've already had two different surgeries for cancer." After presenting the patients in the video, words flash across the screen:

> The longer MAT programs in Crimea operate, the longer these people will be able to live a normal life.
>
> They are not talking politics.
>
> They are not asking for much.
>
> They simply want to live.[3]

This rhetoric appeals not only to foreign actors and organizations supporting global health para-infrastructures in the region, but to Russian leadership as well, to acknowledge MAT patients as persons imbued with an inalienable right to health, framing the issue as a

[3]Original Russian: Чем дольше будит функционировать программы ЗПТ в Крыму, тем дольше эти люди смогуть нормально жить. Они не говорять о политике. Они не просять много. Они просто хотят жить. Translation by author: The longer MAT programs in Crimea operate, the longer these people will be able to live a normal life. They are not talking politics. They are not asking for much. They simply want to live.

question of basic rights—the universal moral code ambivalently tolerated by the Kremlin (Borger 2016; Pertsev 2017). The filmmakers urged audiences to focus on the human face of these programs, not the geopolitical influence of the health care institutions that supported them.

Any such appeals made to Russian authorities about the value of individual human rights, however, were vulnerable to the criticism that they had missed the point. The target of Russia's administrative policy was not people who use drugs but the institutions, which had fulfilled their right to health. This became especially clear in the subsequent months as Crimea's new leaders began performatively re-enacting the dismantling of these material infrastructures for wider audiences. In December 2014, for example, agents of Russia's Drug Control Service collected Crimea's remaining inventory of methadone, purchased with Global Fund grant monies and intended for distribution to MAT patients during the coming year, and tossed the whole lot into a furnace (Ingham 2015). Russian officers appeared grossly over-dressed for the event, weighed down by Kevlar body armor and large automatic weapons as they painstakingly lobbed hundreds of bottles of prescription methadone one by one into the modest but steady fire. Too many of these uniformed men were present -- more than were needed to guard the little hill of narcotics stashed by the fire and certainly more than were needed to control the furnace and ensure that all of the methadone made its way in there.

We are able to know what this scene looked like because photographers were kept on hand to record it. Photos of the incineration were published by media outlets world-wide: in English language media (Ingham 2015), in Russian language media (Kislyakova 2015), and, most importantly, in the emerging pro-Russian media outlets serving Crimea (Steglenko 2015). The message behind this performance was clear: there is a new political order in Crimea. The scene was both a statement about what types of persons were acceptable in Russian-controlled Crimea and a demonstration that the citizenship rights of undesirables could, at any time and as the sovereign saw fit, be revoked. In their efforts to re-boot Crimea as a place that *is-and-has-always-been* Russian, the closure of MAT programs and the death by flame of the remaining medications was also an attempt by Russian authorities to gain the trust and faith of the many by excluding a stigmatized few. In this light, the right to health begs to be interpreted not simply an element of human rights discourse or as an indicator of new visions of the nation-state, but as an effective tool of statecraft. It serves to situate sovereign authority, placing it in the hands of those who are successfully doing the administrative work of creating and annihilating spaces in which the right to health can be fulfilled by enabling or disabling the institutions that maintain them.

I have no way to know for sure what happened to this couple or to Masha and Vova who had introduced me to their family in the courtyard of their clinic so many years ago. Dima, I can say for certain, is dead. He had accepted the offer to transfer to a rehabilitation facility in St. Petersburg, Russia. He lost his life to an opioid overdose not long after arriving there. Much of the world came to know of the struggle these three and some 800 peers faced through mass media coverage that emerged in venues like *Slate* (Hyde 2017), *The Guardian* (Walker 2015a), *Vice* (Jesudason 2014), and *The Moscow Times* (The Moscow Times 2015), long after the closures took place. What pity, what compassion, what entitlements they received

came too late—if they came at all. Therein lies the greatest tragedy surrounding the death of Dima and others like him. Only by suffering the ultimate consequences of the abrupt removal of these institutional spaces were they able to signal that violence to the rest of the world.

CONCLUSION

Contention over what constitutes the correct institutional arrangement for the relationship between the state and its citizens has long been tethered to questions of health and health care. The expansion of MAT programs in Ukraine in the 2000s served to show that the country could muster an organized response to HIV worthy of international support. The sheer existence of these programs, which allowed Dima to reclaim his life, evinced Ukraine's ability to act rationally, to uphold international standards of health care, to support the right to health as a basic responsibility of the state. Dima's initial survival, therefore, was indicative of Ukraine's potential to rise to the status of a bourgeoning, if not yet thriving, democracy. Subsequently, following the Russian occupation of and consolidation of power in Crimea, the closure of MAT programs was similarly constitutive of a new political order. Since the object of Russia's administrative adjustments was the institution of MAT, not the patients themselves, it ultimately did not matter whether Dima lived or died; it only mattered that the clinic that served him ceased to exist. In a manner of speaking, however, it's just as well he's gone; by the time of his overdose in St. Petersburg, his expendable life had already served its purpose for the new state. In both the Ukrainian and the Russian context, the institutional empowerment or abandonment of people who use drugs served to reify new boundaries of the state, to articulate features in the new relationship between the sovereign and its citizens, and to craft a new nation out of that revised administrative arrangement.

Many more examples of statecraft through the selective "variegation" (Ong 2006) citizenship categories or restriction of citizens' rights can be found throughout the world. Even within the narrow realm of drug use and drug control policy, state manipulation of the right to health is prevalent. Consider, for example, the significant sentencing disparities which are still imposed upon individuals convicted of offenses involving crack cocaine versus powder cocaine (substances identical in every way except their physical form) which has resulted in the grossly disproportionate incarceration of men of color in the US (American Civil Liberties Union 2017). Consider, also, Filipino President Rodrigo Duterte's policy encouraging the extrajudicial killing of anyone suspected of using drugs (Domonoske 2017). Even US Attorney General Jeff Sessions' recent rescinding of Obama-era White House policies protecting low level, non-violent drug offenders—very likely individuals living with opioid use disorder and, therefore, in need of stabilizing medical or social support, not correctional supervision or incarceration—from harsh sentencing represents a new restriction on previously acknowledged right(s) to health for the purpose of sending, in Sessions' words, "[a] message to every last person threatening the peace on our streets and the safety of our police" (Ford 2017). These, along with Russia's abrupt health care policy reforms in Crimea, are all examples of a state power recasting citizens' right to health and determining, through the active stratification or de-stratification of society, who should or should not have access to it. In other words, these are all moments in which state authorities establish or reaffirm their sovereignty by doing what only sovereign powers can do: building

up or taking down the very institutional spaces where citizens can fulfill their "rights to health."

Rearrangements in citizens' "right to health," therefore, must be viewed not simply as a question of human rights but as potentially anti-humanist tools of statecraft. Through this lens it appears that defending the basic rights—right to safety, right to health, and right to life—of people who use drugs or seek to resolve their substance use through MAT in Crimea doesn't simply require the re-establishment of civil order. It would require a direct and perhaps violent military confrontation with Russia, because Russia has staked its legitimacy and the scope of its sovereign domain on its very ability to deny human rights in this way. That, I would argue, is what makes administrative acts like the prohibition of MAT in Crimea, the physical violence in the Philippines, and the blind prosecutorial fervor against everything drug-related in the US, particularly frightening. Such retooling of the shapes and capacities of state institutions (health care, police, courts, etc.) is rooted in social stigma against drug use and people who use drugs, and that stigma presents a social problem on its own. Yet, the stakes that are placed on these marginalized individuals who use drugs for the sake of consolidating administrative control are enormous. The violence meted out against them is nothing less than a demonstration of the state's ability to wield sovereign control over its own citizenry—simply to prove that it can.

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