Methadone as indiscipline: The making of the virtuous subject in Kyrgyz prisons

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Abstract

At the core of this PhD is a critical engagement with the project of translation. Methadone treatment, promoted within public health as an essential way to treat opioid addiction and prevent HIV infection among people who inject drugs, presents difficulties for translation into new settings. Post-Soviet prisons, where methadone uptake remains low despite an expanding HIV epidemic, are a particularly challenging, yet important, site for the implementation of methadone treatment. In this thesis, I treat the unique availability of methadone treatment in prisons in Kyrgyzstan, where informal prisoner governance prevails, as an opportunity to scrutinize how Western medical technologies travel. I mobilize materialist readings of governmentality, which provide a powerful conceptual lens for theorizing methadone as a form of, and resource for, governance. This mode of analysis marks a fracture from 'evidence-based' medicine—which treats methadone as a singular pharmacological object acting on a human body—to explore, instead, the relational and situated production of substances and bodies. Drawing on fieldwork from three Kyrgyz prisons for men, I argue that methadone, rather than having a presumed entitative status, is enacted through its environment, including the practices of informal prisoner governance. This produces methadone objects and subjects that depart sharply from those proffered by the global evidence base. I demonstrate how an assemblage made up of the prisoner code of conduct, the architecture of prisons, prisoner relations with state governance, and the relations between methadone and other drugs, produces a methadone of ill health and (un)virtuous methadone subjects. I conclude by reflecting on how this research itself is an intervention with onto-political effects, working to challenge mainstream conceptualizations of intervention translation in public health. These findings erode monopolistic assumptions of the dualism between evidence and practice to open up space for new interventions to be noticed and made through practice.

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When you reproach and reprimand anyone caught in…drunkenness, place him before the face of God and not before your face; show him that he sins against God and not against you. And do not reproach him alone but summon his wife, his family, assemble the neighbors. Reproach his neighbors because they have allowed their brother to live like a dog in their midst and…ruin his soul; prove to them that they will all give an answer to God for that. Arrange it so that the responsibility may lie on everyone and so that everyone who environs the man may be reproached and be he not be too much undone. Give the strength of authority and responsibility to the model managers and better peasants. Shake them up, so that subsequently they may not only live well themselves but so that they may teach others the good life, so that drunkard may not teach drunkard…Assemble the scoundrels and drunkards, so that they may be shown who is to be esteemed…but whoever makes bold to show him [the model peasant] some disrespect or does not listen to his sensible words, give a good scolding in front of everyone; say to him: "You, you unwashed bum! You have always lived in such grime that your eyes no longer see! Down on your knees and beg that he bring you to reason; he who does not call on reason dies like a dog."

Nikolai Gogol (1847)
Selected Passages from Correspondence with Friends

Contents

Figure list

Chapter 1—Introduction

In this thesis, I take up a central problem in public health from a critical sociological perspective: the challenge of translating treatment from one context to another. The translation of addiction treatment from its evidencing in research into the prison context is a task of particular challenge and importance. HIV and opioid injection intersect in a mutually reinforcing fashion in prisons due to the sanctioning of drug use and the risk of HIV transmission posed by the sharing of injection equipment (Degenhardt et al., 2013). The implementation of opioid addiction treatment in prisons, by reducing injection, is evidenced in public health research as key to turning the tide of the HIV epidemic worldwide (World Health Organization, 2012), but implementation efforts have been fraught with challenges (Stover and Michels, 2010).

Methadone treatment—prolonged treatment with an opioid agonist for patients diagnosed with opioid use disorder—is promoted within 'evidence-based' research as the most effective way to treat addiction and prevent the transmission of blood-borne infections such as hepatitis C and HIV among people who inject drugs (MacArthur et al., 2012, Platt et al., 2017). Methadone's global promise hinges on sufficient coverage among people who inject opioids to significantly reduce HIV transmission on a population level (Larney et al., 2017).

Yet, methadone treatment is unavailable in most prison systems worldwide due to its political unpopularity; when available, coverage among prisoners who use opioids is low (Stover and Michels, 2010). In public health research, this is described as a problem of 'barriers,' including resistance among politicians, prison staff, and potential patients (Polonsky et al., 2016a, Polonsky et al., 2016b). The 'ineffective' translation of 'evidence-based' addiction treatment into the prison setting is presented within research as one of the major barriers

to improved health outcomes among people who inject drugs (Azbel et al., 2013a, Morozova et al., 2013, Bojko et al., 2015, Go et al., 2016).

The post-Soviet prison is a setting both of great importance and of great challenges for the translation of addiction treatment. The HIV epidemic in post-Soviet countries, unlike elsewhere in the world, continues to expand (Joint United Nations Programme on HIV/AIDS, 2016). Driven by injection drug use, HIV is concentrated in prisons due to proscriptive government drug policies (Rubenstein et al., 2016). As a primary response, international agencies and public health researchers have focused their efforts on translating methadone treatment into post-Soviet prisons. Mathematical models project high coverage of prison-based methadone treatment as key to reversing the epidemic in the region (Altice et al., 2016). However, methadone programs are available in only three post-Soviet countries and, in each case, have achieved very low coverage (Altice et al., 2016). The Kyrgyz Republic (hereafter, Kyrgyzstan) is lauded as a global outlier in its implementation of methadone treatment within prisons. Yet, the program, plagued by low uptake, has not fulfilled its promise to reduce HIV incidence (Azbel et al., 2018).

I became well acquainted with this problem over the course of the eight years I spent researching the implementation of biomedical 'evidence-based' interventions in prisons in Eastern Europe and Central Asia. The discourse of 'evidence-based' intervention promises universal effect potential in terms of clinical outcomes, albeit shaped by social environment (Rhodes et al., 2016, Rhodes, 2018). A guiding question in my prior work was how to moderate the context to decrease the gap between *a priori*-evidenced methadone and its performance in practice. The answer to this problem turned out to be more complicated than I had expected because the methadone subject that emerged through local accounts in Kyrgyz prisons was not the patient with improved criminal justice, HIV, and addiction outcomes I was familiar with from peer-reviewed literature. Via my engagement with prisoners' accounts of methadone

use, I became aware of a *harm*-producing methadone. Prisoners told me that the methadone they used made people sick; methadone users were, according to them, "zombies rotting from the inside."

To gain an understanding of what was accounting for these different manifestations, I turned to a poststructuralist perspective. This lens opened up new avenues of questioning that were productive for illuminating a methadone that is altogether different from the one evidenced in public health research. This was a methadone inextricably tangled up with local practices to the extent that it was produced *within them*, making its extraction from these practices impossible. Accordingly, this methadone object produced different effects on the body. I redirected my questioning at the everyday practices of prisoner life to see how a local methadone was being produced.

The significant implication of this theoretical shift was that, unlike within public health, there was no methadone 'out there' that could be uncovered by the removal of 'barriers' to its translation. Context was, rather, an active participant in the making of local methadone and its effects. Given a different context, then, the methadone performed would also be *different*. In this thesis, I depart from the imagined stable methadone of public health to challenge the very notion that the methadone object, translated to a different place, should, given ideal circumstances, produce the same health outcomes. Indeed, in my search to translate an 'evidence-based' methadone into Kyrgyz prisons with the same effect potential, I had been trying to perform a methadone that could not exist.

With this insight, I turned my analytic lens to the mechanisms through which the Kyrgyz prison environment interacts with methadone to produce the particular methadone subjects and objects I was encountering. 'Informal governance' practices, or prisoner-run extralegal governing mechanisms that have deep roots in Soviet prison history, emerged as particularly important in shaping drug-using subjects. Although self-governed prisons are dominant in Southeast and Central Asia, Africa, Eastern Europe, and Latin America, the relations

between informal governance and health in a non-Western context is rarely studied (Butler et al., 2018).[1]

To understand methadone's alternative enactments beyond those proffered by global health, I trace the methadone object as a disciplinary force inside prisoner society. I argue that methadone becomes a site of governance in relation to how power is 'done' inside the prison. It interacts with the practices of informal governance to produce a toxic methadone object and subject, at odds with those performed by 'evidence-based' medicine.

In what follows, I situate this thesis in the extant body of public health and social studies literature to help readers understand the prison space as it relates to HIV, injection drug use, methadone, and criminal subculture, specifically within Eastern Europe and Central Asia.

Prison as harm

Globally, more than 30 million people enter prison each year and many more are detained (Institute for Criminal Policy Research, 2016). Prisoners have a higher prevalence of infectious diseases, substance use disorders, and mental illness than the general population, necessitating greater healthcare needs (Fazel and Baillargeon, 2011). Drug use among prisoners more commonly than not meets The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association, 2013) criteria for a 'substance use disorder,' defined as exhibiting recognizable symptoms resulting from a substance that people continue to use despite the resulting problems (Lintonen et al., 2011). A recent systematic review estimates a 30% prevalence of substance use disorders among male and 51% among female prisoners

[1] Frédéric Le Marcis tangentially explores the influence of informal governance in prisons in Ivory Coast on access to the infirmary (2012: 11-12). There is also a historical exploration of healthcare administration in the Gulag, which outlines prisoners' roles in the provision of healthcare (Healy, 2015).

worldwide (Fazel et al., 2017). The disproportionate prevalence of people with a history of substance use in prisons can be ascribed to punitive policies towards drug possession and drug-related crime (Bean, 2002).

In turn, people who use drugs, particularly via injection, are at elevated risk for the transmission of blood-borne infections (Altice et al., 2016). Drug injection, and injection of opioids in particular, is associated with the fastest growing HIV epidemics worldwide and concentrated in prisons (Dolan et al., 2015). Public health research, which dominates investigations into prisoner health, describes the prison as a 'risk environment' in relation to drug-related harm (Altice et al., 2016). Despite housing a population with greater healthcare needs than the general population, prison conditions are poor and resources to support effective healthcare delivery are inadequate (Jurgens et al., 2011). Epidemiological studies emphasize the prison as a place where multiple co-morbid health and social conditions come together to exacerbate the risk of blood-borne infections, evidenced by elevated prevalence of drug injection-driven hepatitis C and HIV infections as compared to community settings (Altice et al., 2016, Azbel et al., 2016b, Azbel et al., 2014, Azbel et al., 2015, Moller et al., 2008).

Incarceration, substance use disorders, and infectious diseases are in some studies presented as 'syndemics,' interacting in a mutually reinforcing, deleterious fashion to exacerbate the burden of disease (Altice et al., 2010). An example is the increased risk associated with drug injection within prison (Dolan et al., 2015). One study demonstrated that incarceration is associated with sharing used syringes, providing a pathway for increased hepatitis C and HIV transmission (Milloy et al., 2011). Worldwide, in the general population, the hepatitis C prevalence is 1%, but it is 15% among prisoners (Dolan et al., 2016). The time immediately after release from prison is especially dangerous for prisoners whose risk of death during this time, primarily due to overdose, is 12.7 times that of the general population (Binswanger et al., 2007).

Public health literature emphasizes the coming together of most-at-risk populations, addiction, infectious diseases, and insufficient treatment to produce the prison as a "global crisis" (Jurgens et al., 2011: 1), an "HIV hotspot" (Thorne et al, 2010: 482), and a "perfect storm" (El-Bassel et al., 2013), posing a threat to the community through further disease propagation after release. Yet access to HIV and hepatitis C treatment and prevention within prisons is severely limited, falling far below coverage levels within the general population (Fazel and Baillargeon, 2011, Dolan et al., 2016). For example, up to a third of prisoners in the United States living with HIV do not report taking antiretroviral therapy (Maruschak et al., 2015). Despite staggeringly high hepatitis C prevalence among prisoners, highly effective treatment with direct acting antivirals are unavailable to most prisoners (Rich et al., 2016, Rich et al., 2014). Thus, the prison becomes a place where risk is created, concentrated, reinforced, and exported.

Prison as care

Public health literature describes the prison as an insufficiently harnessed but key site for the introduction and scale up of health interventions (Dolan et al., 2016). Despite the increased need, prisons fall short of international standards for quality healthcare delivery as compared to the community setting (2016). Initiatives to decrease the gap between prisoner health and that of the general population are a top priority for international agencies and public health researchers. A paradoxical and complex relationship emerges wherein prisons act at once as a site of healing and a site of harm.

International agencies and research into prisoner health often perform a delicate balancing act of emphasizing prisons as inimical to health while advocating for prisons as opportune sites of treatment:

> Incarceration is detrimental to disease control programs for HIV-infected drug users, particularly through increased transmission of drug-susceptible and drug-resistant tuberculosis. It can also serve as a point

of entry to care. (Altice et al., 2010: 12)

Prisons are evidenced as "problematic for HIV prevention and control" and as "places for detection, treatment and the initiation of continuous care for medically and socially marginalized persons, including for HIV/AIDS" (Fazel and Baillargeon, 2011: 960). Likewise, the World Health Organization treats prisons as "inappropriate receptacles for people with dependence" (World Health Organization, 2007: viii). But, at the same time, it regards prisons as place which "can help to improve the health status of communities, thus contributing to health for all" (World Health Organization, 2007: viii). These productions of the prison space—as healing yet harmful—set the stage for the implementation of methadone treatment and other biomedical intervention for the treatment of substance use disorders within prisons.

Descriptions of the prison space as both harmful and healthy for people who use drugs rest on the fact that up to 90% of people who inject drugs, an otherwise difficult-to-access population, pass through the prison system at some point in their lives (Jurgens et al., 2009). Public health studies often point out that people who inject drugs seldom access health care services in the community, because of barriers to accessing care, such as cost and stigmatization of drug users, and/or the potential legal repercussions for disclosing substance use (Rubenstein et al., 2016). For many people who inject drugs, incarceration provides an opportunity for their first interaction with healthcare services (Massoglia and Pridemore, 2015).

An ever-growing field of research that examines the intersection of incarceration, HIV, and drug injection promotes imprisonment as an opportune time for biomedical intervention to improve health outcomes of people who inject drugs (Dolan et al., 2016, Dolan et al., 2007, Fazel et al., 2017, Jurgens et al., 2009). Such studies accomplish a delicate balancing act between the healing and harmful effects of prison:

> For people with HIV who are marginalized from care because of sub-optimally treated substance use disorders, psychiatric disorders, and other health disparities, incarceration could enable individuals to access HIV testing, ART, and general health care. (Rich et al., 2016: 1105)

Public health research into the implementation of addiction treatment in prisons are underpinned by the logic that since prison produces harm, medicine can reduce it. Thus, the cordoned-off walls of prisons perform a service essential for public health research into HIV and addiction: through their interaction with medical interventions, the otherwise hidden population of people who inject drugs becomes visible (Rhodes et al., 2007). And these interventions, intended to correct harmful drug use, become embedded within the same system that the literature portrays as harmful to health. Incarceration becomes a time for managing drug use in biomedical terms.

Methadone treatment

There are an estimated 15.6 million people living with opioid use disorders worldwide, a number that increases every year (United Nations Office on Drugs and Crime, 2012). Opioid injection is a major cause of mortality due to overdose and to its transmission of HIV and hepatitis C through injection equipment. Among global health networks, the medicalized model of opioid dependence as a pathological, diagnosed as 'opioid use disorders,' hinges on the understanding of addiction as a chronic, relapsing disease of the brain characterized by a loss of control (Moore, 1992). For over 45 years, the primary treatment model promoted by international agencies and clinical guidelines—the treatment of addiction with opioid agonist treatment—has correspondingly been pharmacological (World Health Organization, 2009).

Opioid agonists, most commonly methadone or buprenorphine, are prescribed under medical supervision to replace illegal and off-label opioid use. They work to reduce withdrawal, cravings, and the euphoric effects of opioid use (Mattick

et al., 2009, Mattick et al., 2014). While methadone is most commonly administered in liquid form, buprenorphine comes in the form of a pill that is absorbed under the tongue. Both are prescribed as a single daily dose. Methadone costs less while buprenorphine is considered to have a superior safety profile (Nosyk et al., 2013). In this thesis, I focus on methadone since it is more widely available in prisons.

Global health literature presents methadone treatment as one of the best-evidenced HIV prevention and addiction treatment interventions for people who use opioids (Wolfe et al., 2010, MacArthur et al., 2012, Alistar et al., 2011). A growing body of research (the 'evidence base'), including randomized controlled trials, meta-analyses, and systematic reviews, shows methadone treatment to be significantly more effective at treating opioid use disorder than detoxification and abstinence (Amato et al., 2005, Faggiano et al., 2003, Nosyk et al., 2009, Mattick et al., 2014). This research measures effectiveness primarily in terms of criminal justice, drug use, and infectious disease outcomes.

Because methadone is not injected, it reduces the risk of blood-borne infection transmission as well as skin and soft tissue infections. Systematic and meta-analytic reviews of global evidence, for instance, link methadone treatment to reductions in drug injecting risk practices and in the incidence of HIV transmission (MacArthur et al., 2012). Research from outside the Eastern European and Central Asian region demonstrates that methadone treatment leads to improved health outcomes, including decreased HIV transmission, opioid injection, overdose, and death (Wolfe et al., 2010, MacArthur et al., 2012, Alistar et al., 2011). Researchers have also found synergistic effects of methadone treatment with HIV outcomes, facilitating access for prisoners living with HIV to antiretroviral therapy (Volkow and Montaner, 2011, Low et al., 2016).

Methadone's effects are not limited to medical health outcomes. Because methadone is legally prescribed in many settings and reduces cravings for other opioids, it is associated with reduced property- and drug-related criminal behaviors as well as reduced recidivism (Marsch, 1998). This is because, no longer experiencing opioid cravings or withdrawal, methadone patients are more likely to decrease their use of illicit opioids, which pose criminal sanctions (Mattick et al., 2009). Many studies, however, stress the importance of high methadone dosage (greater than 100 mg) to suppress heroin use (Donny et al., 2005). Global estimates posit methadone as effective if adequately translated and scaled up (Kim et al., 2014), requiring at least 40% coverage in predominantly injection drug use-driven epidemics to substantially decrease HIV morbidity and mortality (World Health Organization, 2012). This sets the stage for a particular set of programmatic factors (e.g. dosing or coverage) that need to be met in order for methadone treatment to have the desired effects.

Methadone treatment in prisons

The promotion of opioid agonist treatment has been the primary policy adopted by international health agencies, such as the World Health Organization, to combat the twin epidemics of addiction and associated HIV concentrated in prisons (World Health Organization, 2007). Methadone treatment within prisons, similar to community settings, has been evidenced to have potential to treat addiction and prevent HIV and hepatitis C transmission (Boucher, 2003). The implementation of methadone treatment is therefore part and parcel of the worldwide response to HIV. The World Health Organization recommends maintenance treatment with opioid agonists to be available to all prisoners (United Nations Office on Drugs and Crime, 2009). Prisons are also a primary target for the UNAIDS goal to eliminate new HIV infections by 2030 (UNAIDS, 2014).

There are several programmatic factors that delineate how methadone treatment should be administered to improve health outcomes for prisoners

who use drugs. Randomized controlled trials from prisons evidence the effectiveness of methadone treatment in reducing opioid injection, especially when initiated before release from prison (Kinlock et al., 2009, Kinlock et al., 2007). There are coordinated efforts among international donors, organizations, and researchers to ensure the availability of methadone treatment programs within prisons. Research and public health promotion efforts strive to translate programs which involve few programmatic restrictions, high dosage (Wickersham et al., 2013), and uninterrupted treatment throughout the cycle of incarceration, release, and re-incarceration (Rich et al., 2015).

Yet, despite this targeted promotion, prisons remain some of the most challenging places for the introduction and expansion of opioid agonist treatment (Hedrich et al., 2012). Globally, methadone treatment is rarely implemented during incarceration. Rare exceptions include some countries in the European Union, Australia, China, Iran, Armenia, Moldova, and Kyrgyzstan (Sharma et al., 2016). A review found that, of the 66 countries that provide opioid agonist treatment in the community, fewer than half extend these services to prisons (Boucher, 2003). Indeed, opioid use disorders remain largely untreated within prison (Galea and Vlahov, 2002). This review, in a similar vein to other such research, attributed implementation challenges to underfunding, stigma towards prisoners and people who use drugs, and the tendency to equate methadone use with heroin use (Larney and Dolan, 2009).

HIV, opioids, and incarceration in Eastern Europe and Central Asia

Public health research at the intersection of HIV, addiction, and incarceration directs particular attention to the 15 UNAIDS-designated countries of Eastern Europe and Central Asia (Azbel et al., 2016b, Altice et al., 2016, Azbel et al., 2013a, Azbel et al., 2013b, Bojko et al., 2016, Makarenko et al., 2016). While HIV-related morbidity and mortality is decreasing throughout the world, Eastern Europe and Central Asia remains the only region where both continue

to increase (DeHovitz et al., 2014). Public health studies commonly explain the unique rising HIV incidence in the region as a problem caused by the major political, social, and economic changes that ensued after the fall of the Soviet Union (Latypov, 2014, Latypov et al., 2014, Vickerman et al., 2014, El-Bassel et al., 2013). Beginning in the mid-1990s, drug markets in the region were flooded with heroin, leading to a sharp rise in drug injection and, consequently, HIV transmission (Zabransky et al., 2014, Beyrer and Celentano, 2008).

While the countries of Eastern Europe and Central Asia have taken diverse political, economic, and social paths after their independence, they are bound by similar public health trends characterized by high levels of HIV, opioid use, and incarceration (Altice et al., 2016, Azbel et al., 2016b, Azbel et al., 2014, Azbel et al., 2015, Moller et al., 2008). In the first five years of the 2010s, the number of HIV cases in the region increased from 1 million to 1.5 million (UNAIDS, 2016). Drug injection remains a critical driver of HIV transmission, accounting for 25% to 51% of new cases (LaMonaca et al., 2019). Indeed, levels of drug injection in this region, mostly opioids, are among the highest in the world (Degenhardt et al., 2017). The proportion of HIV cases attributable to injection drug use, however, has decreased over the past five years in all countries in the region, as more cases are transmitted through heterosexual transmission, primarily to sexual partners of people who inject drugs (LaMonaca et al., 2019). This epidemiological trend poses a threat of a generalized HIV epidemic. Data from Ukraine, however, casts doubt on this trend, suggesting that there is misclassification of modes of transmission and that the majority of new HIV cases do indeed remain among key populations such as people who inject drugs (Cakalo et al., 2015).

Five of the 15 former Soviet countries are among the countries with the highest ten incarceration rates in the world (Walmsley, 2014). Proscriptive policies towards drugs result in the concentration of people at higher risk for infectious diseases in prisons. HIV, tuberculosis, and hepatitis C epidemics converge in

prisons. Ushered in by the Global Fund, opioid agonist treatments and needle and syringe programs have been available as a response to these epidemics, with varying coverage, for over 15 years in the region. But the local responses to these epidemics are described as inadequate by key public health studies (Altice et al., 2016, Antoun et al., 2011, Beyrer and Celentano, 2008). The scale-up of harm reduction services among people who inject drugs fails to reach levels necessary for reducing HIV incidence (Altice et al., 2016). Coverage of antiretroviral therapy in the region falls below 10%, for example, despite the updated World Health Organization guidelines calling for antiretroviral therapy for all people living with HIV (World Health Organization, 2013).

Situating HIV transmission within a global context, a body of public health literature shapes the task of turning back the tide of the HIV epidemic in Eastern Europe and Central Asia into a *global* problem. If it can be tackled here, where the epidemic is most severe, the implication is it will turn the epidemic worldwide, helping to reach UNAIDS 90-90-90 targets (Mazhnaya et al., 2018). As my co-authors and I wrote in *The Lancet*, "The 90-90-90 UNAIDS HIV prevention and treatment goal to diagnose, treat, and achieve viral suppression in 73% of all people living with HIV should be extended to prisoners where the HIV continuum of care in EECA [Eastern Europe & Central Asia] is poorly characterized" (Altice et al., 2016: 17). Opioid agonist treatment, evidenced as the single most cost-effective method for achieving this goal (Kim et al., 2014), is the key to achieving these outcomes. Let us take a look at the context of its implementation.

Methadone in Eastern Europe and Central Asia

The coming together of epidemics of mass incarceration, HIV, and substance use disorders gives traction to the argument that, to turn the tide of the HIV epidemic, opioid agonist treatment should be directed at its epicenter: the prison population of Eastern Europe and Central Asia (Mazhnaya et al., 2018). Several key epidemiological studies make prison-based, high-coverage opioid

agonist treatment a key element of effective HIV prevention and addiction recovery (World Health Organization, 2012). Using Ukraine as a case, mathematical models predict the impact of scaling up methadone treatment in the region (Altice et al., 2016), including to prisons (Larney et al., 2017). People who inject drugs in prison transmit HIV to the general population after release by sharing non-sterile injection equipment. But transmission can be prevented by decreasing injection through increased uptake of opioid agonist treatment in prisons and after release. Modeling analyses from Ukraine project that coverage with opioid agonist treatment of half of all people who inject drugs in prisons, with retention in care after release, would avert 20% of new HIV infections nationally over the next 15 years (Altice et al., 2016: 7). Intervening at the prison level becomes a methodology for affecting health beyond prisons.

Nearly all studies addressing HIV in Eastern Europe and Central Asia point out insufficient coverage of opioid agonist treatment as a major barrier to achieving improved health outcomes among people who inject drugs. Methadone treatment is rarely available in the community where coverage of methadone among people who inject opioids is estimated to be below 5% (Degenhardt et al., 2010). Studies draw attention to how this level of coverage is contrary to the evidence base: "Despite the mounting evidence of harm reduction's effectiveness, the scope of harm reduction coverage in Central Asia remains low" (El-Bassel et al., 2013: S3). Within prisons coverage is also low. Only Armenia, Kyrgyzstan, and Moldova offer opioid agonist treatment in prisons; of the estimated 4,000 prisoners who have injected opioids in Kyrgyzstan, for example, only 400 were receiving methadone in 2015 (Azbel et al., 2016b). Within a grant application to the National Institute on Drug Abuse, my colleagues and I draw attention to the gap between evidence and policy: "Despite unambiguous evidence supporting opioid substitution therapy…it is *practically absent* from prisons" (Altice, 2015).

In Eastern Europe and Central Asia, 90% of HIV infections are in Ukraine and Russia but Russia bans any form of opioid agonist treatment (European Centre for Disease Prevention and Control, 2018). Studies point to the negative influence of Russia's policies on addiction legislation within the region (Colborne, 2016). In most countries in the region, even when available in the community setting, methadone treatment is absent from prisons. Armenia, Moldova, and Kyrgyzstan are exceptions, but even in these cases, rates of enrollment are low, treatment disruptions are common, attrition is high, and patients are often stigmatized by other patients, peers, and providers (Altice et al., 2016).

Numerous studies take up the problem of translating methadone treatment in Eastern Europe and Central Asia (Azbel et al., 2016b, Azbel et al., 2018, Azbel et al., 2015, Makarenko et al., 2016, Polonsky et al., 2016a, Azbel et al., 2013a). These studies attempt to understand why, despite an 'unambiguous evidence-base' attesting to the effectiveness of opioid agonist treatment, it continues to be under-utilized. Quantitative and qualitative research, including my own, outline a number of context-based 'barriers' to effective translation primarily linked to attitudes towards treatment underpinned by insufficient knowledge about addiction and motivation to initiate treatment on the part of both prisoners and staff (Boltaev et al., 2013, Boltaev et al., 2012, Subata et al., 2016).

Several quantitative studies administered surveys among prisoners and staff and identified "negative attitudes" toward opioid agonist treatment (Polonsky et al., 2016a, Polonsky et al., 2016b, Polonsky et al., 2015). My previous research delineated the local misunderstandings of methadone treatment. One study, in which I am a co-author, identifies negative attitudes among Ukrainian prison staff and concludes, "In Ukraine, adoption of opioid substitution therapy is more influenced by myths, biases, and ideological prejudices than by existing scientific evidence" (Polonsky et al., 2015). In another study, my co-researchers and I found an example of such a myth among prisoners in Ukraine who

considered treatment with methadone to be mutually exclusive with addiction recovery (Polonsky et al., 2016b). In Moldova, my colleagues at Yale University and I found that prisoners accessing methadone were commonly harassed by other prisoners. We concluded that prisoners are opposed to methadone because they are "embedded within a stigmatizing prison culture…[that] endorses negative myths" (Polonsky et al., 2016a: 94). Such studies explain the barriers to effective scale-up as emanating from insufficient knowledge about methadone's benefits, resulting in a lack of motivation on the part of potential patients to initiate treatment (Altice et al., 2016: 18). The underlying assumption in these statements is that the nature of opioid substitution therapy is locally misunderstood and that this lack of understanding contributes to incorrect treatment translation.

Accordingly, implementation science studies suggest interventions to increase knowledge and motivate treatment as a solution. An example is the 'evidence-based' motivational interview strategy called Screening Brief Intervention and Referral to Treatment, wherein potential patients are screened for substance use disorders, informed about treatment options, and motivated to initiate care (Young et al., 2014). My colleagues and I proposed this type of intervention with the aim of increasing uptake to methadone treatment within prison and after release in Moldova, Kyrgyzstan, and Armenia—the three countries in the post-Soviet region that offer opioid agonist treatment in prisons. This intervention targets the individual level, but there are some key structural factors that studies present as impeding efforts at methadone treatment introduction and expansion in the region; I explore these in what follows.

Soviet legacy as a 'barrier' to methadone implementation

Soviet legacies of addiction medicine are repeatedly invoked in public health studies as a major barrier to the effective implementation of methadone treatment in the 'post-Soviet' space (Latypov et al., 2014, Jolley et al., 2012, Latypov, 2011). The collapse of the Soviet Union left a vast prison system with a

crumbling public health infrastructure in its wake. Driven by the injection of heroin arriving from Afghanistan through the newly opened borders of Central Asia, into Russia, and Eastern Europe, HIV transmission began to increase rapidly, especially within prisons (Thorne et al., 2010, Azbel et al., 2013a). The public health system indebted with treating the region's rising HIV epidemic, including in prisons, was based on the Soviet discipline of 'narcology,' and goes by the same name today.

In the Soviet Union, the management of opioid addiction, under the auspices of 'narcology,' a sub-specialty of psychiatry established in 1975, consisted of treatments emphasizing detoxification, a strong reliance on antipsychotic medication, and compulsory hospitalization or incarceration (Latypov, 2011). Dehovitz et al. describe the stagnating influences of narcology on the treatment of addiction today:

> The highly structured public health system rooted in the Soviet tradition has been unable to effectively transition to meet post-Soviet challenges. The Soviet model was based on a highly centralized and hierarchical sanitary-epidemiologic system, which was characterized by a large labor force and minimal emphasis on technology…there was minimal attention to feedback and quality improvement. (2014: 168)

The guiding premise of narcology was the recognition of illicit drug use as a social problem and addiction as a quasi-psychosis (Babayan and Gonopolsky, 1985), characterized by "pathological craving" [*patologicheskoe vlechenie*] (Altschuler, 1994, cited in Raikhel 2016: 5) and therefore warranting similar treatments to schizophrenia (Mendelevich, 2013, cited in Raikhel 2016: 7). Narcology "depicted patients under the influence of narcotics as lacking self-control and awareness of the danger they pose to self and society or the state" (Lovell, 2013: 139). This premise justified narcology's role as a vehicle for state surveillance of citizens diagnosed with addiction in an effort to discipline social deviance and instill a set of moral ideals (Raikhel, 2016).

Currently, public health research cites the narcological model of addiction treatment as the primary structural barrier to effective methadone translation (Elovich and Drucker, 2008). Such studies position 'evidence-based' addiction treatment in stark contrast to narcology:

> Treatment of SUDs [substance use disorders] in EECA [Eastern Europe and Central Asia], mostly as vestiges of antiquated influences from the former Soviet Union, has been restricted more by moral biases and prejudices than by scientific evidence. (Mazhnaya et al., 2016: 2)

This dichotomization underpins the reasoning behind the translation of opioid agonist treatment into Eastern Europe and Central Asia, including into prisons. Legalizing opioid agonist treatment is a way to introduce policies underpinned by science rather than bias, the antiquated knowledge of narcology representing the latter. As Eugene Raikhel notes in his study of narcology, critics of the discipline construct their argument to

> link the bioethical principles…and epistemic practices of 'evidence-based' medicine with medical modernity and…characterize narcology's failure to properly enact these ethical principles and epistemic practices not simply as paternalistic or outdated but as a sign of backwardness and its distance from the global biomedical ecumene. (2016: 5)

Treating addiction to turn the tide of the HIV epidemic becomes intertwined with righting the wrongs of Soviet ways of treating addiction. The case of Kyrgyzstan has emerged as key to this re-writing.

Kyrgyzstan as an exception to the rule

Given the challenge that implementation of methadone treatment into prisons presents from the public health perspective, Kyrgyzstan provides a unique case. Lacking natural resources or a well-developed industry and infrastructure (Oraz, 2013), Kyrgyzstan, a middle-income country and the second poorest in Central Asia, relies heavily on foreign aid. Following independence in 1991, Kyrgyzstan suffered economically, faced political instability, and weakened

state capacity (The World Bank, 2018). Relative to its Central Asian neighbors, the Kyrgyz government has been more open to international cooperation. Initially attracted by the liberalizing and pro-democratic policies of the 1990s, international donors flooded the scene (Pomfret, 2006). These initial reforms were, however, followed by periods of instability, corruption, and political upheaval, giving rise to a further weakened state, misappropriation of funds, and lack of sustainability (Cummings, 2012).

Today the country continues to face corruption, poverty, and the fallout from the breakdown of health infrastructure, creating a challenging environment for the treatment of infectious diseases, including HIV/AIDS (Donoghoe et al., 2005, Thorne et al., 2010). Kyrgyzstan has a 'concentrated HIV epidemic;' prevalence among the general population is relatively low at 0.2%, but it is among the top seven fastest-growing HIV epidemics in the world (Joint United Nations Programme on HIV/AIDS, 2018, Kadyrbekov, 2016). Incidence continues to rise, new HIV infections having increased by 21% since 2010 (Joint United Nations Programme on HIV/AIDS, 2018). Injection drug use is still a major driver of new infections, but the proportion of people who inject drugs among all HIV-infected individuals is decreasing as HIV becomes more commonly transmitted through heterosexual sex (Kadyrbekov, 2016).

HIV treatment and prevention is directed by national legislation—the national HIV/AIDS strategy—devised along with non-governmental organizations (NGOs) and international agencies, and signed into law by the Ministry of Health (Ministry of Health of the Kyrgyz Republic, 2012). Currently, Kyrgyzstan boasts one of the most progressive HIV management policies in Eastern Europe and Central Asia (Ancker and Rechel, 2015b). Using heroin, for example, is not a punishable offense (2015b: 824). International donors play a decisive role legislating and carrying out HIV/AIDS-related policies as well as financing Kyrgyzstan's HIV/AIDS programs as compared to the role of international donors in other Central Asian countries (2015b: 824). Kyrgyzstan pioneered

harm reduction programs in Central Asia with the first needle syringe program in 1999, followed by a methadone treatment program in 2002. The latter is coordinated by the Republican AIDS Center and the Ministry of Health as well by local NGOs and international donors, but funded exclusively by international donors, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

The prison-based methadone treatment program, introduced in 2008, marked an exception in the region—making Kyrgyzstan the only country in Central Asia and one of a handful in the world to offer methadone treatment in prisons (Bielen et al., 2018). This policy move is celebrated within global health networks, which highlight Kyrgyzstan as yielding particular promise in implementing 'evidence-based' interventions (Ancker and Rechel, 2015a, Latypov, 2011). In a region which is described in public health research as particularly problematic in regard to addiction treatment policies, the implementation of methadone treatment in Kyrgyz prisons constitutes an instance of exception and success. As Tomas Zabransky et al. (2014) point out, opioid agonist treatment is "somehow higher and more firmly established in Kyrgyzstan" (1189). Frederick Altice et al. (2016) elaborate that, "[Kyrgyzstan] has emerged as a welcome beacon in the region" due to the way they have "boldly overcome regional pressures to ban these HIV prevention strategies [methadone treatment and needle syringe programs]" (12). The case of Kyrgyzstan attracts a great deal of research interest because it constitutes a significant departure from narcology and provides a rare opportunity to see what methadone treatment can become in practice in a post-Soviet prison setting (Ancker and Rechel, 2015a, Latypov, 2011).

Despite championing methadone treatment in Kyrgyzstan as an outstanding achievement, researchers and international policymakers are concerned that performance indicators (e.g. uptake) are not being met by local implementers (Larney et al., 2017). As of January 2018, there were 11,100 people in prisons and jails (called SIZO) in Kyrgyzstan, including 6,800 prisoners. Of these

prisoners, 314 were registered as opioid-dependent with the narcological registry. The nationally representative biobehavioral study I coordinated in 2014, however, suggests this is an underestimate, considering that a third of prisoners report a history of injection drug use (Azbel et al., 2016b). One can deduce that, given that I measured a 50% prevalence of hepatitis C, the actual number of people who have injected drugs can be presumed to be even higher: more realistically, more than half of the entire prison population (2016b).

Nationally, following initial growth in methadone treatment uptake, the number of methadone patients has remained stable over the past five years (around 1,200 in the entire criminal justice system including prisons and jails) (Borisova, 2018). This amounts to 476 people in six of 11 prisons. To reach the standards of coverage of the World Health Organization, 1,224 prisoners would have to receive methadone. But treatment uptake is low and prison-based opioid agonist treatment highly unpopular: in 2014, 7% of the prison population was enrolled in methadone treatment, while 19% reported currently injecting drugs (likely an underestimate) (Azbel et al., 2016b, Azbel et al., 2018).

As a response, the Global Fund to fight AIDS, Tuberculosis, and Malaria sets targets for methadone treatment uptake in Kyrgyzstan, which includes reimbursement to local providers for increased retention in care and number of new patients accessing treatment.[2] Policy scholars, on the other hand, have pointed out that the race to meet indicators brings "unintended consequences" such as the promotion of increased methadone coverage at the expense of program quality (Ancker, 2015: 517). They caution against the move by international agencies to translate "ready-made recipes" of biomedical interventions that bypass local governing bodies (2015: 517). The problems of implementing medical technologies within new contexts have been explored extensively within social science literature.

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[2] Field notes, May 6, 2017

Social science studies of methadone treatment translation

The study of how medical technologies travel has been tackled from a number of theoretical traditions within social science studies. Differing approaches—including a focus on (a) structural factors, (b) post-structuralist analyses of governing practices, and (c) ontological analyses of objects in translation—are important to consider because they inspire different modes of inquiry and therefore different insights into how medical interventions translate from one context to another. I will briefly explore all three approaches here by outlining how each has dealt with the implementation of methadone treatment into new settings.

Social epidemiology of methadone treatment

A social ecological model is used within social epidemiological research to move beyond solely concentrating on individual-level risk and explore the multiple higher order factors shaping health behavior (Latkin and Knowlton, 2005). This includes influences from the individual, interpersonal, and socio-structural levels that continually interact to determine individual decisions regarding health (Larios et al., 2009). Individual-level factors can be operationalized as drug use history or gender, interpersonal can include the influence of peers and their drug use behaviors, and socio-structural can include drug policies and infrastructure. This framework has been applied to locate decisions surrounding methadone inside its social and policy environment with the aim of optimizing methadone treatment programs (Tran et al., 2018). In a study of the factors influencing access to methadone upon release from prison in Appalachia, for example, rural infrastructure and a dearth of education were identified as primary barriers (Bunting et al., 2018). For those already on methadone, studies applying this model have identified the importance of social support (Shen et al., 2018) and a consideration of methadone's interactions with other medications (e.g. antivirals) (Tran et al., 2012) to improve treatment outcomes (in these cases, the reduction of concomitant drug use). As a

response, interventions to increase methadone treatment uptake and quality are correspondingly targeted at multiple levels to inform combination behavioral risk reduction approaches (Latkin and Knowlton, 2005).

Qualitative implementation science of methadone treatment

Implementation science research posits that the implementation of methadone is sustained by social processes, including through situated meanings and context-dependent factors. Situated within an 'evidence-based' framework, which works with the understanding that the target intervention has been proven to be effective in previous studies, the aim of this research is to understand how to deliver the evidenced intervention with the same effect potential into a new setting (Cunningham and Card, 2014). Studies within this tradition most commonly use semi-structured interviews to delineate the context-dependent 'barriers' to the effective delivery of an *a priori*-evidenced methadone. Global examples of barriers to methadone treatment delivery include cultures of punishment in Thailand (Hayashi et al., 2017), the fear of being addicted to "just another" drug in China (Lin et al., 2011), and concerns about side effects in Iran (Zamani et al., 2010).

As a corrective for the gap between evidence and practice, implementation science has emerged as a field that seeks to navigate the complexity of these contingent meanings by optimizing the delivery of interventions into real-world contexts (Rhodes and Abdool, 2016). Concerned with how the technology of methadone can be replicated given regional conditions, implementation science studies are particularly troubled by the failure of methadone treatment in Eastern European and Central Asian prisons to reach targets (Rhodes et al., 2019). An implementation science grant application I helped put together to the National Institute on Drug Abuse read:

> The proposal is embedded with an implementation science framework that focuses on introduction and expansion of OST [opioid substitution therapy], an 'evidence-based' HIV prevention intervention, in prisons

> and communities in CIS [Commonwealth of Independent States] countries. Because Russia continues to influence policies in the CIS, OST is sometimes seen as a corrupting Western influence and is not endorsed by prison medical and custodial staff. The Not-Invented-Here syndrome, defined as an inclination of a stable group to reject new ideas from outsiders, is a relevant term that describes a stigma attached to outside (Western) ideas, even when they are beneficial to its performance. (Altice, 2015)

In this application, my colleagues at Yale University and I considered the implementation of methadone treatment into new settings as an effect of delivery systems and cultural understandings, wherein interventions adapt to new networks but retain their overall purpose and effect (May et al., 2016). In the example above, social and structural factors, including Russian-backed narcology, shape the delivery of a methadone with the transportable effect of preventing HIV. What follows is a call for implementation science methods to optimize methadone delivery by addressing Russian-backed suspicion of Western medical technologies through piloting 'evidence-based' interventions such as motivational interviewing through Screening Brief Intervention and Referral to Treatment (Agerwala and McCance-Katz, 2012).

As we can see, within implementation science, the translation of globally evidenced interventions into local settings presumes a singular intervention which is shaped differently in its translations according to time and place (Rhodes et al., 2016). Qualitative inquiry, used to assist implementation, is directed at unpacking the context-dependent factors that act as 'barriers' to effective intervention translation. A qualitative study explored the barriers to translating opioid agonist treatment into Ukraine where it has been available since 2004 but enrollment remains low and attrition remains high (Mazhnaya et al., 2016). The researchers held focus groups that identified several programmatic and structural barriers including difficulties with dosing and dispensing and mistreatment by medical staff. As a solution, they recommend legal and policy level changes to dispensing legislation, patient education and staff development, and community awareness campaigns to address myths

about opioid agonist treatment (Bojko et al., 2015). This approach acknowledges that context mediates the success of an intervention but holds on to the idea that problems with implementation are contextual—a matter of structure—rather than located in the object of translation itself (Rhodes et al., 2016). Solving these problems becomes a matter of undoing structural barriers to arrive at a smooth translation.

Critical social science of methadone treatment

Critical social science studies of methadone treatment, on the other hand, move beyond the 'evidence-based' framework, to open up space for a critical analysis of how medical technologies travel. This approach does not take for granted that the evidencing of intervention is fixed and transportable to the same effect potential across contexts (Rhodes et al., 2016). Researchers working in this tradition have examined the different ways that methadone has been evidenced, and why it can produce unexpected effects.

Methadone as discursive governmentality

Several critical drug studies investigate how opioid agonist treatment normalizes a certain conduct (Keane, 2009, Moore and Fraser, 2006, Frank, 2018, Harris, 2015, Bourgois and Schonberg, 2009). These studies draw on Foucault's concept of 'governmentality' (Foucault, 1991b)—a mode of inquiry into how governable subjects and domains are formed. Drawing attention to forms of power outside of the apparatus of state politics, Foucault uses the term 'government' in a broader sense to refer to indirect techniques that establish limits on possible ways of thinking and being. He refers to such techniques as "technologies," or "the more or less systematized, regulated…modes of power…following a specific form of reasoning (a 'rationality')" (Lemke, 2011: 5). Foucault's concept draws our attention to the mundane practices, outside the apparatus of state politics, which work to regulate the behavior of a population (Rose et al., 2006a). Discipline is a technology of government which is diffuse, pervasive, and hard to locate, working to invisibly shape the conduct

of a population, as individuals begin, with time, to govern themselves against a perceived norm (Lemke, 2011).

Critical drug studies have taken a Foucauldian understanding of government to investigate how the everyday practices—such as medical discourses surrounding opioid agonist treatments—discipline, or produce, subject positions in line with particular ideas of 'patienthood' and 'conduct.' Shana Harris (2015) outlines the way discourses of 'freedom' surrounding buprenorphine treatment govern patients' experiences of treatment and understandings of themselves (or their 'subjectivity'). She explores how the liberalized modes of dispensing buprenorphine (as compared to methadone) affect patient desires and behavior to be independent. These subjectivities are thus aligned with neoliberal discourses of freedom and individual autonomy. The regulated treatment space of the methadone clinic and its regimented treatment-dispensing scheme instill a different kind of subjectivity. Methadone treatment, in contrast to buprenorphine, has been explored as a regulatory technology conferring patient obedience, productivity, and reduced autonomy (Keane, 2009). Philippe Bourgois argues that methadone treatment acts as a product of morally driven imperatives to control pleasure. By enabling productivity, methadone plays a normalizing role in its users lives by rendering their bodies fit for the labor force (Bourgois, 2000).

Medical discourses do not only produce knowledge and meaning about subjects, but also about substances themselves. The evidencing of methadone in the biomedical sciences has been characterized by a move to tease it apart from illicit opioids as a way of drawing out the therapeutic qualities of the former (Acker, 2004a). Such discourses commonly draw a distinction between a drug of addiction, characterized by compulsive use, and a treatment, characterized by stabilizing effects (Keane, 2013). Research on methadone as a form of governmentality has complicated these categories. As Helen Keane (2013) writes in her study of the complex identity of methadone:

> It [methadone] is both like and unlike heroin, it is both addictive and a treatment for addiction. It is stigmatized through its association with addicts but it is valued for its ability to produce normality and stability. (2013: 24)

These conflicting discourses about methadone alert us to the role of discourse in challenging taken-for-granted bifurcations between what makes a drug and a treatment. David Frank explores how discourses of methadone-as-recovery from addiction, which has recently gained momentum in the United States, make particular ways of knowing drugs possible (Frank, 2018). By positioning methadone as "a pragmatic strategy to mitigate harms produced structurally by criminalization" (2018: 317), the criminalization of drugs, he argues, becomes legitimized. Methadone treatment as a solution to the dangers of other drugs, produces them as a dangerous and harmful activity. These critiques of the governing discourses of medicalized methadone complicate the prevailing representations of methadone and alert us to alternative representations.

Methadone as material practice

Moving beyond studying substances as they are constructed in discourse, a conceptual shift in critical drug studies investigates substances as 'a matter of materiality.' To understand drug effects, researchers within this tradition move away from studying substances as self-evident objects with inherent properties whose representations are affected by discourse. Rather, they emphasize the way that material, social, cultural, and discursive elements—such as the instruments used to administer drugs and the processes of drug administration—come together to *produce* substances and their effects (Duff, 2013, Moore, 2018, Dennis, 2016a, Lancaster et al., 2017a, Keane, 2018). Such studies lend scrutiny not only to the way drug-objects, but also drug-subjects, are constituted by—rather than pre-exist—the way that we, as researchers and policymakers, intervene to address drug problems (Fraser and Moore, 2011, Lancaster et al., 2017b, Bacchi, 2017). Schlosser's (2018) ethnographic study of clients' experiences at a rehabilitation center in Ohio examines the way that

practices of treating addiction as a biological disease, to be managed with pharmacological intervention, reshape the condition they are meant to address. She explores how the bodily routines of accessing pharmacological addiction treatment alter clients' experiences of addiction. The mandated practices of adherence to methadone and attendance of the methadone clinic produce addicted bodies that are stripped of the control they established through bodily connections with illicit drugs; for them, addiction becomes a bodily alienation.

Studies have also investigated methadone intervention and effect as a product of material practices. Methadone, they posit, is not merely made in discourse— in the linguistic sense— but becomes a product of its material implementation practices, including the objects used to dispense it, the space of the methadone clinic, and the bodies of its users (Fraser and valentine, 2008, valentine, 2007, Gomart, 2002, Rhodes et al., 2019, Rhodes, 2016). These elements act in relation to each other and change over time to co-constitute the methadone object. The implication is that methadone, in turn, also changes over time and according to place. The object of methadone is thus *opened up for contestation*.

Rather than a singular evidenced-methadone, these studies describe methadones of pain relief (Keane, 2013), addiction recovery (Berridge, 2012), and, in Ukraine, a means of disciplining the subject (Carroll, 2016). Emilie Gomart, in her seminal study of the object of methadone within drug trials, provides an account of how the different methadones produced through the inscriptions of the trials (Gomart, 2002). Through the processes of two different clinical trials, the same apparent substance produces fundamentally different material effects. She observes that methadone is a series of "effects in search of a substance" (Gomart, 2002). The performance of a substance does not precede but is *made through* its implementation events. Tim Rhodes' studies of methadone in Kenya draws attention to how the methadone-in-practice, a methadone of recovery hope, is distinct from the methadone-in-policy (Rhodes, 2018), a solution to HIV-linked drug injection. This methadone is evidenced as

enabling normalcy through its dynamics of delivery, including the witnessing of bodily-material change among its users towards a recovered-body. Rhodes concludes, "Methadone treatment is far from a singular evidence based intervention translated into multiple settings, but a local practice of emergent 'evidence-making' interventions" (Rhodes, 2018).

These investigations into the making of methadone subjects and objects trouble the notion that a stable entity pre-exists its social constructions. Underpinning this mode of inquiry is a philosophical move away from the dichotomization of the material and the social, to a recognition of their co-constitutive relationship (see "approach" section of Chapter 2, Approach and Methods). In their study of the daily experience of accessing methadone treatment in Australia, Fraser and valentine (2008) draw attention to the human and non-human actors that constitute the methadone subject. They highlight the conceptual limitations inherent in the separation of medicine from morality, and body from mind:

> Arguments that medicine liberated drug addicts from social prejudice are at best naive about the social worlds of drug treatment. More fundamentally, they neglect the mutual constitution of the social and medical. Just as critiques of drug treatment sometimes represent biomedicine only as political repression, heroic accounts of medicine doing battle with the social also misrepresent the nature of each. As contemporary studies of science and technology emphasize, the social and scientific are not distinct in this way. (2008: 25)

They redirect inquiry, rather, to the relations and practices that make objects and subjects. They argue that relations between human and non-human actors work to materialize a particular kind of subject. In their example, the arrangement of the methadone dosing point, which necessitates the line of clients to wait outside of it, creates a 'methadone client' who is most commonly "considered undesirable in modern liberal societies" (Fraser and valentine, 2008: 92).

The role of prisoner subculture in governing prison life

Studies of drug use and addiction treatment among prisoners in Eastern Europe and Central Asia have been dominated by quantitative analyses such as those described in the "Methadone Treatment" section above. Qualitative studies addressing methadone implementation in Eastern Europe and Central Asia are sparse, mostly adapting an 'evidence-based' medicine framework, and none have been carried out in prisons (Bojko et al., 2016, Marcus et al., 2018, Mazhnaya et al., 2016). Despite the persistent influence of informal governing systems, previous research into healthcare delivery in post-Soviet prisons, and even prisons worldwide, largely bypasses these. The implications of informal prison governance for any health treatment, let alone methadone, have to date, not been considered. A line of inquiry emerges as to which governing practices are significant in the shaping of the methadone object and subject in contemporary post-Soviet prisons.

Underpinning the social order of prisons globally is a tension between allegiances to prisoner-run structures and to the prison administration (Ricciardelli, 2014, Kupatadze, 2014b, Slade, 2013, Crewe, 2009), with the center of gravity shifting toward the former where a void is left by ineffective formal institutions (Varese, 2001, Gambetta, 1993, Wang, 2014). Prisons throughout the world differ in terms of to what extent power is practiced through formal or informal relations. Recent contributions to the sociology of prisoner subculture expose the range of self-governing possibilities, from the assignment of some administrative tasks to prisoners by over-burdened guards in Cameroon (Morelle, 2014), to the relative influence of competing gangs in the United States (Skarbek, 2014), to the shared governance of prisoner life in the Philippines (Narag, 2017) and the full prisoner-led governing structures in Brazil (Nunes Dias and Salla, 2013, 2017).

There is a paucity of ethnographic fieldwork examining prisoners' lived experience from *within* prison, however (Simon, 2000, Wacquant, 2002). Few

scholars have written on informal governance in post-Soviet prisons in particular. Some notable exceptions work both to tie Soviet penality to its post-Soviet incarnation as well as position the locus of power among the prisoners themselves. These include studies on the function of informal practices within prison and greater post-Soviet society (Oleinik, 2003), economies of the *vory v zakone*[3] (McDonnell, 2013), the resilience of organized crime in Georgian (Slade, 2013, Slade, 2017) and Kyrgyz prisons (Kupatadze, 2014b), the carceral geography of the Russian prison system (Piacentini and Pallot, 2013, Pallot and Piacentini, 2013), and prisoner hierarchy in Ukraine (Symkovych, 2017b, Symkovych, 2017a). These studies highlight the extent to which key features of Soviet prisons, such as self-governance through a tightly regulated prescriptive criminal subculture with hierarchical divisions, have remained resilient in post-Soviet prisons today.

While the extant literature touches upon top-down directives from informal prisoner leaders (Varese, 2001, Kupatadze, 2014b, Skarbek, 2014), a closer examination reveals that it obscures the complex disciplinary apparatus that lends legitimacy to this form of governance—an imperative focus of analysis given the threat that prison reforms pose to informal social norms (Slade, 2015, Oleinik, 2006). In their analysis of everyday penal practices in post-Soviet prisoner society, Piacentini and Slade (2015) flesh out elements of a disciplinary apparatus through their concept of "carceral collectivism," a collectivist culture of punishment that is undergirded by the terrain of the

[3] The Russian word for the national leader of organized crime (can also be written as *vor*). Commonly translated into English as thief-in-law, although this is a literal translation and can be misleading. In Russian, the term means "a thief bound by the code," as in the criminal code (Slade, 2013: 1).

prison. They argue that a disregard for the resilience of informal governance is a leading reason for the failure of prison reforms in the region.[4]

While some authors have claimed that prisoner self-governance has dissipated in the post-Soviet prisons and is merely an "anachronism," an "empty honorific," and largely, "faux" (Galeotti, 2018: 119-120), cultures of prisoner self-rule continue to be a critical dynamic in the lived experience of prisoners today, especially in Kyrgyzstan (Kupatadze, 2014b). "With state capacity limited, law enforcement inefficient, and corruption pervasive, the Kyrgyz prison is a stronghold of organized crime, a legacy of Stalin's Gulags, where prisoners themselves prescribe punishments, police hierarchical boundaries, disseminate rules, and function as guarantors of justice (Azbel et al., 2019, Kupatadze, 2014b, Cheloukhine, 2008, Kupatadze, 2012). This informal governance, institutionalized through criminal organization, enacts a disciplinary power in relation (and opposition) to those of the prison administration and state."[5] (Rhodes, et al., 2019: 4) It is further undergirded by the presence of an illicit drug-based economy in which heroin is a key actor (Rhodes et al., 2019). Through my fieldwork, I began to follow the relations of informal governance with methadone treatment; this line inquiry led me to the following analytical objectives.

Analytical objectives

In this thesis, I take methadone treatment in Kyrgyz prisons as a case study to investigate the practice-based dynamics of health intervention translations. To

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[4] The previous three paragraphs are adapted from an earlier draft I wrote of our manuscript, The collective body: Legacies of monastic discipline in the post-Soviet prison (Azbel et al., 2020, under review at *Theoretical Criminology*).

[5] I am reproducing this here because I wrote these two sentences for our manuscript, *The becoming-methadone-body: On the onto-politics of health intervention translations* (Rhodes, Azbel et al., 2019).

make noticeable the processes of methadone's making, I ask, how is methadone materialized as an object that is *governed* as well as an object *of governance* and with what subjectification effects? To do so, I treat the disciplinary practices of informal prisoner governance as an actor in the assemblage that produces particular kinds of methadone-objects and methadone-subjects. My objectives for this analysis are:

- To provide a comprehensive account of the disciplinary apparatus of informal prisoner governance;
- To trouble the taken-for-granted 'evidence-based' medicalized methadone by unpacking the relations involved in methadone's local becoming, including the discourses of national stakeholders and the embodiments of drugs; and
- To explore how this local methadone makes up prisoner subjects through its interplay with the disciplinary practices of informal governance.

Thesis outline

This thesis is comprised of seven chapters. In Chapter 2, I present the methodology, including the theoretical approach that informs it, and reflect critically on the simultaneous processes of data generation and analysis that I have carried out.

Together, the four empirical chapters that follow trace how knowledge about methadone objects and subjects is made locally through its implementation practices in national stakeholder discourse (Chapter 3), the embodied practices of drug use (Chapter 4), and the disciplinary practices of prisoner governance (Chapters 5 and 6).

Different environments *make* different methadones. In Chapter 3, I map how a methadone emerges, through the governing practices of Kyrgyz national policy

documents and stakeholder accounts, which is alternative to the methadone of global public health. In Chapter 4, I attend to prisoners' accounts of drug use and drug embodiment to describe the features of these alternative enactments of methadone.

Different methadone objects produce different material effects. Accordingly, in Chapters 5 and 6, I reverse my analytic lens to attend to how methadone *makes* its environment, particularly in relation to the kinds of subjects it produces. To set the stage, in Chapter 5, I explore how subjects are governed within prison by outlining how key disciplinary practices constitute the healthy prisoner subject. In Chapter 6, I pivot to methadone's entanglements with these practices to consider how this interaction produces the unhealthy methadone subject.

Chapter 7 concludes this analysis by considering how to implement reform via medicalized interventions in prison settings and beyond.

Chapter 2—Approach and Methods

Summary of chapter

The approach and methodology of this thesis are propelled by the transformation in the manner in which it was theorized. This chapter proceeds in two parts to trace first the theoretical and then the methodological movement of my research. Rejecting any clear division between theory and practice, however, I take my theoretical approach to be a methodological practice. In what follows, I describe the shift from studying methadone as a technical solution within a realist implementation science to studying methadone as an enactment of discursive-material practices. I elaborate on how this transformation was entangled with my own parallel trajectory towards a more relational material approach to governance. I describe how I adopted a mode of analysis that disturbs the natural/social dichotomy in order to be able to re-conceptualize methadone's effects in Kyrgyz prisons from simply shaped by social context to situated within a web of shifting, mutually constitutive relations between methadone the technology, the methadone subject, and the disciplinary apparatus of the prison.

Theoretical approach

Towards a defamiliarization with public health

This PhD, my place within it, and its theoretical trajectory is a 'movement' that has enabled different methadones to become noticeable. The three have shifted, in relation to each other, over the past four years. Together, they tell a story of a shift in epistemological and ontological framing from a study of methadone as an implementation *into* practice, to methadone as an effect *of* practice. In this section, I relate the analytical process of this thesis by tracing how I, my use of

theory, and this PhD have moved from seeing methadone as a complex intervention, to a discursive construction, to arrive at the relational thinking that has enabled noticing methadone as a material enactment.

The turning point in my approach to the study of methadone implementation in Kyrgyzstan was sparked by training sessions I led with research assistants at my partner NGO in 2016. The aim of this initial training was to prepare research assistants to carry out an implementation science study (unrelated to this thesis) aimed at increasing methadone uptake in prisons through motivational interviewing with prisoners who inject opioids. I describe an incident in my field notes from February 19, 2016 where I observed a research assistant run a mock motivational interview with a study participant:

> Instead of emphasizing the chronic, relapsing nature of the participant's opioid use disorder, the RA [research assistant] focused on social factors and supported his hopes for a life free of drugs. He informed the participant that methadone can be an option only in case of relapse. This was against protocol. "I have to correct this," I thought. We need to train the RAs to follow the guidelines of the DSM-V, which defines the criteria of opioid use disorder. We drove back to the NGO headquarters and debriefed for the day. The RAs were all in agreement that motivating someone to go on methadone who was in remission would be gravely unwise, putting them on a dangerous drug when there is hope they "go clean." I told the RA that non-injection does not mean that their disease is cured: "that's the whole nature of addiction that we had reviewed; it's like diabetes. You wouldn't recommend a patient to go off insulin, would you?' The RAs went on pressing their point. "You don't know what methadone is in Kyrgyzstan," exclaimed an RA who had formerly injected drugs and had been abstinent for ten years without the help of methadone…We got nowhere with this back and forth. The room got hotter and hotter. People's voices louder and louder. Finally, one of the RAs finished the conversation off: "Alright, if you want us to play your game, we'll advise people to take methadone; but you have no idea what methadone is in our country."

Looking back on these field notes now, I see that the notions of 'addiction,' 'recovery,' and 'successful' treatment, inherited from biomedicalized global health, and the local manifestations rooted in the particularities of life in Kyrgyzstan, were at odds with each other.

I was, however, unwilling to trouble a reality in which context was a 'barrier' hindering methadone from behaving like it 'should.' My colleagues at the Yale School of Medicine, during our bimonthly analytical meetings via GoToMeeting, drew out the implication of this rationality: "We know methadone is the answer, it's just a matter of how to implement it."[6] Methadone, in the context of Kyrgyz prison, was, for them, subject to multiple context-based meanings. They saw a barrier to methadone's effective translation, located in the stigmatization of methadone patients by the informal prisoner authorities, which they regarded as a strategic tactic to reduce competition to the informal heroin trade. The implication here is that, while the context of implementation makes intervention translations complex, with the proper tools, this barrier could be overcome. The entitative status of methadone and its subjects, however, need not be troubled.

Such moments of tension, arising from my relations with local partners, study participants, and colleagues—each with their own relations to methadone—guided me toward a poststructuralist theoretical approach that enabled alternative enactments of methadone to become noticeable. These processes—methadone's emergence and my theoretical reorientation—were co-productive and simultaneous, developing into an interplay where one enabled the other. Through this critical interrogation, I came to see the limitations of the dominant public health approach in explaining why interventions may behave in unexpected ways in different times and places. The defamiliarization with taken-for-granted knowledge was not a smooth process for my colleagues nor for me. The frustration it continues to elicit, however, "makes it possible to reflect on the limitations and possible deleterious consequences of well-established frameworks of meaning and the conceivable need for alternative

[6] Field notes, December 1, 2017

problematizations. In this way, space is opened up to think differently" (Bacchi and Goodwin, 2016: 94).

A poststructuralist challenge to implementation science

Mainstream public health approaches posit a separation between evidence (the natural) and practice (the social) (Mol, 2002). This serves as the driving principle for implementation science, which strives to bridge the gap between an intervention's (e.g. methadone's) performance in research with its performance in new contexts (e.g. Kyrgyz prisons) (Rhodes et al., 2016). The underlying assumption of this mode of inquiry is that a stable pharmacological object, transferred to a new environment, is inhibited by social systems, preventing the object from behaving as previously evidenced in research (Wood, 1998). This is indeed how I posited social practices, including informal governance in Kyrgyz prisons, in my publications: a social barrier, limiting methadone's performance, to be overcome (Azbel et al., 2017, Azbel et al., 2016b, Azbel et al., 2018).

Critique has been leveled at implementation science for its overly deterministic approach to evidencing (Rhodes et al., 2016). By positing the constitution of interventions as fixed and stable, such 'evidence-based' intervention approaches overlook how intervention objects are made up, or governed, in particular ways through a contingent set of interactions (Law, 2004). Deleuze and Guattari (1987) describe these interactions as an 'assemblage' of relations between heterogeneous elements (both human and non-human) that come together to affect the capacities of objects to act. By highlighting the capacity of objects to affect and be affected by other objects, assemblage theory is attuned toward noticing the emergent and contingent status of social formations (Deleuze and Guattari, 1987). Seeing objects through their assemblages of relations re-directs focus from interior essential structures to "relations of exteriority" that have the capacity to reassemble new objects (DeLanda, 2006: 10-11).

Foucault draws attention to how the relations between elements, calling them "discursive practices"[7] (Bacchi and Bonhamn, 2014: 177) are involved in the governing of objects, domains, and people (Rose et al., 2006a). Carol Bacchi and Sarah Goodwin explain the political implications of this understanding of governance:

> Countering the commonly touted view that "objects" are clearly "objects", people are just "humans"…attention shifts to considering how these "things" have come to be and continue to be "done" or "made" on an ongoing basis. Since "things" are not "natural", since they are made to be, they involve politics. This expansive understanding of politics extends well beyond political institutions, parties, and so on to include the *heterogeneous strategic relations and practices* that shape who we are and how we live. (Goodwin and Bacchi, 2016: 14)

In this vein, I treat 'practices' as "the routine enactment of relations between things" (2016: 114-115).

Attending to the politics of governing put the futility of picking away at the sociostructural barriers to 'uncover' a health producing methadone into view. There *was no methadone* outside of discursive practices. Correspondingly, my task as a researcher shifted from exploring "how implementation science constitutes 'evidence-based' intervention to tracing, empirically, an intervention's evidencing and knowing as an effect of its implementation" (Rhodes, 2018: 72). Drawing on materialist readings of Foucault's theory of governmentality (Bacchi and Bonham, 2014, Lemke, 2014), I sought to restage context, including the non-human, as an active agent in the making of subjects and objects. This opens up a field of empirical analysis to unpack the dynamic, iterative processes through which matter and the social entangle to produce each other.

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[7] Drawing on materialist readings of Foucault, I use discursive practices to indicate material-discursive practices. See Lemke, T. (2014) and Bacchi, C. and Bonham, J. (2014).

I want to underscore that doing science in a way that exposes matter as continuous with culture, rather than dialectically opposed (Braidotti, 2013: 35, Haraway, 1991b: 11), is a political act. As Donna Haraway notes, such dualisms are not neutral but grounded in "a supremacist politics of sexualization, racialization and naturalization of the West's Others" (Haraway, 1991b, cited in Fox and Alldred, 2016: 44). As Rosi Braidotti writes, this 'new materialist' form of science actualizes that which was empirically missing, giving us "a frame for the actualization of the many missing people, whose 'minor' or nomadic knowledge is the breeding ground for possible futures" (Braidotti, 2013: 23). Allowing for resistance to the forms of knowledge that come to dominate by opening up silenced discourses (Bacchi, 2009), this investigation is politically efficacious, accentuating otherwise unnoticed, beyond scientific, ways of being and knowing.

Theorizing methadone as a force of governance

This thesis is undergirded by a theoretical reorientation toward materialist readings of governmentality. This theoretical approach enacted a different methadone into view—one that was inextricably tied up with the practices of governance within the prison. I turned my analytic lens to the relations between heterogeneous elements (i.e. objects, subject positions, words, gestures, architecture) to observe how methadone was produced *through* them and what effects flowed from this production. To my surprise, this methadone produced different effects from those proffered by 'evidence-based' intervention. The methadone emerging from the practices of national stakeholder discourse (Chapter 3) produced *harmful* drug (Chapter 4) and subjectification (Chapter 6) effects. The question became, *why*? To understand why methadone in Kyrgyz prisons does not produce the healthy patient-subject prescribed by 'evidence-based' medicine, I responded to the theoretical call

described above by carrying out an analysis of methadone in relation to governance.

To account for the different materializations of methadone I was encountering, I wanted to present an explicit challenge to positivist tendencies to treat methadone as a self-evident singular object existing 'out there' in the world. To unpack how 'truth' about methadone and methadone subjects is produced in the Kyrgyz prison, I was concerned with how socially produced forms of knowledge establish authority by setting limits on what is speakable and thinkable (Foucault, 1991c). Put otherwise, I sought to understand how discursive practices govern.[8] I turned to Foucault's work, which teases apart the power relations undergirding knowledge (Foucault, 1980), to expose the politics underlying 'legitimate' knowledges—in this case, 'evidence-based' methadone. Foucault coins the term "governmentality" to refer to the logics of regulated, systematized modes of power that make certain knowledges possible (Foucault, 2009).

There are three key takeaways from this for my study of methadone as governance. The first is that power relations—not simply techniques of control—are productive; they "have a directly productive role, wherever they come into play" (Foucault, 1988b: 94). That is, power relations *enact* reality. Secondly, rather than being situated solely in top-down edicts of the state, power is exercised through fluid, dynamic techniques (relations between people and objects) that constitute accepted forms of knowledge. And third, these techniques, which Foucault called "discursive practices" (Foucault, 1972: 41), or *dispositifs,* are heterogeneous networks of relations which produce "regimes of truth" (Bacchi and Bonham, 2014: 177). Following a materialist reading of Foucault (Bacchi and Bonham, 2014), I take discursive practices to

[8] Sometimes called material-discursive practices to draw attention to the role of the non-human; I use the terms interchangeably.

involve an array of relations beyond just language, such as the interactions between materials, research practice (Rose and Peter, 1992, Foucault, 1988b, Foucault, 1995), gestures, actions, and subject positions (e.g. a person's disposition or health) (Bacchi and Bonham, 2014: 186). As Bacchi and Goodwin indicate, "it is through the ongoing enactment of relations within discursive practices that 'subjects,' 'objects,' and 'places' are in continual formation" (Goodwin and Bacchi, 2016: 117).

This thesis is undergirded by a materialist reading of governmentality. To think through the role of the non-human in enacting realities, I synthesize theories of governmentality from feminist technoscience and ritual studies in the anthropology of religion. In what follows, I demonstrate how different theorists in these traditions have conceived governance and governing practices. I describe the materialist readings of Foucault's work that underpin the theoretical framework of this thesis. I describe how I mobilized these theories to investigate methadone governed by discursive practices (Chapter 3), embodied drug effects (Chapter 4) and the methadone subject governed by disciplinary practices (Chapter 5) and methadone itself (Chapter 6).

Theories of governance

Discourse as governance

Drawn by tensions between the methadone I knew (or thought I knew) and the one I encountered on the ground, I aimed to unpack the materializations of local methadone to see how it may emerge differently. I was familiar with 'evidence-based' methadone within *global* public health, so I turned to the role of *national* stakeholder discourse—policy documents and interview accounts from local implementers—in making methadone. In Chapter 3, I ask, how is the object of methadone produced as a particular kind of object through the governing practices in Kyrgyz national policy documents and national stakeholder accounts?

To answer this question, I turn to Bacchi's poststructural analysis of policy, which builds on Foucault's theories of discourse, to explore the governing capacity of discursive practices (Bacchi and Bonham, 2014). In particular, Bacchi focuses on the 'making' of objects, subjects, and places within policy proposals (Bacchi and Goodwin, 2016). This form of analysis treats policy proposals as *productive* of realities. It therefore teases out how the "processes of studying, treating, and otherwise responding to entities such as drugs and their effects do not simply 'map,' 'reveal,' or 'deal with' them; they enact or constitute them as realities" (Moore, 2018). For example, a policy responding to addiction may constitute certain patterns of drug use as chronic relapsing medical conditions. Through a series of questions, Bacchi's poststructural analytic approach, "What's the problem represented to be?" (WPR), interrogates modes of governing by examining the way that policy proposals, through their representation of certain problems, profoundly impact what we and the world around us become. For example, drug policy proposals advocating pharmacological solutions do not simply respond to problems of addiction; rather, they produce addiction as a particular kind of problem as a chronic and relapsing disease of the brain. Most commonly applied to policy, the WPR approach can also be leveraged to understand the effects of a wide range of governing practices (Bacchi, 2017).

To unpack how certain truths about methadone stick and others fall apart, I mobilize the WPR approach to bring the contingent relations of methadone into view by analyzing methadone as an effect of policy proposals. In other words, I treat the production of the object of methadone as a contingent outworking of the 'proposal' of methadone treatment as a solution. To do this, I ask, what policy practices require repetition on a regular basis for methadone to be made into a particular kind of object? The proposals I turn to are within two sources of local stakeholder discourse on methadone implementation in prisons: national methadone policy documents, and interviews with medical staff, advocates, and policymakers working in the field of methadone implementation

(see "Stakeholder interviews" section well as the "Coding" section for interview analysis methodology). Bacchi and Goodwin (2016) treat such proposals as "practical texts" (Bacchi and Goodwin, 2016: 115) in that they contain the regulatory power to instill "programs of conduct," (Foucault, 1991: 75). According to Bacchi and Goodwin (2016), interview transcripts also comprise such practical texts.

Different methadones can be seen as produced through and by practical texts rather than preceding them. To interrogate what kinds of methadones these practical texts produce, I systematically take up Questions One, Two, Three, Four, and Five within the WPR approach. First, I ask, "What's the 'problem' represented to be in a specific policy?" To unpack the assumptions underlying these productions, I ask, "What presuppositions or assumptions underlie this representation of the 'problem'?" With Question Three, "How has this representation of the 'problem' come about?" I trace the contingencies of methadone's emergence, opening up space for it to be produced differently. These questions lay the groundwork for Question Four, "What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?" I end with Question Five, "What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?"

I address each of these questions through a critical analysis of the relations involved in methadone's becoming in the aforementioned practical texts. Specifically, I structure my analysis around a key policy document for methadone's implementation in Kyrgyzstan, the "Government Program for the Prevention of the HIV/AIDS Epidemic and its Social and Economic Consequences in the Kyrgyz Republic" (hereafter, "The Government Program") which introduces methadone treatment as part of the national strategy to prevent HIV in Kyrgyzstan (Government of the Kyrgyz Republic, 2006). This national HIV/AIDS program outlines the directives for harm reduction

programs in the country, including for prisoners. The document is released every four years. I focus on the 2006 version because it encompasses the period when methadone was introduced into prisons. Additionally, I analyzed documents related to the execution of the Government Program such as internal Ministry of Health and Ministry of Justice documents, such as PowerPoint presentations outlining methadone's initial pilot project in prison, updates on the program's development, and meeting minutes (Akmatova, 2008). These documents provided a 'behind-the-scenes' view into methadone's production.

My analysis of the Government Program as well as related policy texts brought methadone objects into view that were particular to the local national policy discourse in Kyrgyzstan. This set the stage for understanding how locally produced methadones came overlappea and contrasted to those produced within global health discourse.

Embodied drug effects as governance

During my fieldwork, I came to realize that I was expecting certain materializations from methadone that were not to be found in the Kyrgyz prison space. In my 2016 paper on the prevalence of infectious diseases in Kyrgyz prisons, I write, "Given the chronic relapsing nature of opioid use disorders, opioid agonist therapy should be offered to all prisoners with opioid use disorders entering prison and continued throughout imprisonment and after release" (Azbel, 2016b: 14). My underlying assumption here is that methadone is a singular pharmacological object acting causally on an individual body to treat a lifelong brain disease. This assumption hardens a social/natural dichotomy by presuming a neat division between an 'out there' pharmacological object, stable in essence, and a social world, which may variably interpret it. If this object does not produce expected effects, such as the case in Kyrgyz prison, it is considered a symptom of the social world, not the object itself. The natural remains untroubled.

But my engagement with prisoners' accounts and poststructuralist theory worked to dissolve the boundary between the natural and social in a way that was productive for understanding alternate materializations of methadone. The theoretical underpinning of this approach has a long history in philosophy (see Spinoza, for example),[9] but I came to it through feminist theorists working in the poststructuralist tradition (Bell, 1992, Haraway, 1991, Coleman and Ringrose, 2013, Hollywood, 2004, Butler, 1990). These theorists have taken aim at empiricist notions of linear causal effects between a stable object and subject, to interrogate the power structures that tacitly govern 'scientific fact.' In *Gender Trouble*, Judith Butler broke new ground with her interrogation of the interplay between biological essence and socially constructed categories by arguing that sex, like gender, is socially constructed (Butler, 1990). She argues that sex is enacted through performativity, "a stylized repetition of acts" (1990: 140), such as speech acts, that produce a normalized and naturalized network of binary oppositions, instilling hierarchical divisions. I began to reflect on how the object of methadone is also governed through its performances, including discourse about it, which produces "reality-effects that are eventually misperceived as 'facts'" (Butler 1990: 115).

I wanted to leverage this theory to trouble a taken-for-granted methadone, but I found Butler's solution here lacking because it seemed there was no way out of the hegemonic weight of a public-health produced methadone object. As a path towards radical change, Butler proposes undermining categories by publicly and intentionally subverting dualities through acts of "subversive repetition" (Butler, 1990: 148). Her example of this is performing in drag, where the normative trope of gender is imperfectly repeated to produce resistance. But critique has been leveled at the self-reinforcing nature of Butler's paradigm, wherein binary oppositions can only be broken by working within the very

[9] Spinoza writes: "the mind is united to the body because the body is the object of the mind" (Spinoza, B. 2018).

system we seek to subvert (Benhabib, 1995). Butler's solution, occupying the social constructionist tradition, leaves us in the same web of meaning we are trying to subvert with no way out (Hacking, 1999). The representations of methadone may change, but its substance stays the same. Again, the natural remains stubbornly intact.

The "ontological turn" in social science, accentuating the interplay between the social and the material, opens up opportunities for radical change where social constructionist frameworks fall short (Barad, 2007, Darke and Garces, 2017, Lemke, 2014, Bennett, 2010, Fox and Alldred, 2015). This movement draws a distinction between attending to how meaning is made in relation to an object given its context, and a whole ontological approach that troubles whether objects can ever stably be. It has diverse roots, but I turn to Donna Haraway's (1991a) feminist technoscience work on the cyborg—a hybridized posthuman metaphor that challenges unified organic subjects—as a corrective for Butler's impasse on social change. Haraway's work is a non-naturalist example of the coming together of human and non-human elements to dissolve and transgress essentialist binaries. The cyborg, a hybrid of human and animal, man and machine, presents a challenge to traditional dichotomies.

The object of methadone, too, directly confronted the distinctions between a social and natural world. It did not exist separate from, but was being *made* within, the social relations in the prisons where I was working. I began to notice how methadone's relations with other substances made it something different than the 'evidence-based' methadone I expected (i.e. how methadone's unexpected effects were a product of its use alongside some substances as well as its non-use with other substances). For my analysis into methadone's materializations through its relations with other substances (see Chapter 4), thinking through Haraway's cyborg was productive for three reasons.

First, new objects become possible. The cyborg is a new kind of body, transgressing boundaries through its hybrid machine and organism

constitution. Located in a network of relations situated outside of gender, the cyborg's boundaries are in flux in the here and now. There is resonance here with the linked analytical tools of assemblage and actor-network theory, which draw attention to the practices of human and non-human actors that come together differently at different times to produce different interventions (Deleuze and Guattari, 1987, DeLanda, 2006, Latour, 2005, Law and Hassard, 1999). New objects are made through an assemblage of relations where all the component planes are shifting including humans, animals, things, and matter (Bennett, 2010).

Secondly, the non-human becomes imbued with the capacity for agency (Coole and Frost, 2010, Bennett, 2004, Alaimo and Hekman, 2008b). For Haraway, there is a generative power to the material world itself. The machine elements of the cyborg are not only made by, but are making the human experience: "Matter as an active force is not only sculpted by, but also co-productive in conditioning and enabling social worlds and expression, human life and experience" (Sencindiver, 2017: 6). Discursive-material practices are not mimetic in that they represent the world; rather, they constitute what is real (Mueller, 2015). The way that prisoners move through the prison space, the ritual distribution of drugs, and the ways their bodies smell and feel interact to make a particular kind of methadone object and subject. The body too is "no longer taken to be given and waiting for the medical gaze to discover it, but is studied as it interacts with medical technologies, while thus being performed in quite particular, varying ways" (Mol et al., 2010: 21).

Thirdly, Haraway's work is inherently political, creating the possibility for *things* to be made differently. The image of the cyborg opens up the possibility that the building blocks of reality, congealed through unequal power relations, or politics, are mutable: "The cyborg is our ontology; it gives us our politics… This essay is an argument for pleasure in the confusion of boundaries and for responsibility in their construction" (Haraway, 1991: 7). It follows that the way

that methadone is held together is a product of power relations[10] and we, as researchers, are obligated to reflect on our role in these.

I mobilize the image of the cyborg to trace the mutability and interconnectedness of material substances by following how different drugs and bodies entangle and merge in a web of relations to make a particular kind of methadone. Rather than focusing on a simple drug-human interaction, I consider the complex negotiations that happen in relation to a 'drug assemblage' that is comprised of non-human elements including methadone's 'embodied effects' (see Chapter 4). In Chapter 7, I draw out possibilities for change that follow a recognition of this mutability.

Disciplinary practice as governance

Throughout my fieldwork, the informal governance of the prison was visible at every turn. The starkest example of this was the prisoners' hierarchical divisions. Each prisoner moved through the prison space in ways that were dependent on, and productive of, his subject position; the lower the *mast'*[11] the more limited the movement. I became interested in not only how discourse (Chapter 3) and drug effects (Chapter 4) produced methadone but also the constitutive effects of informal governance (Chapter 5) and methadone itself (Chapter 6) on the prisoner subject. This is where theories of ritual in the anthropology of religion became useful, transforming my understanding of the complex ways that methadone entangles with the power relations of the prison to produce health and virtue.

I theorized power, from my readings of Foucault (Foucault, 1988b), as an assemblage of heterogeneous strategic relations that are *productive* in that they

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[10] I take power to be "the name that one attributes to a complex strategical situation in a particular society" (Foucault, M, 1988b).

[11] A prisoner's status in the hierarchy. In Russian, the word literally means suit, as in the suit of a playing card.

bring subjects into existence by actively setting limits on what it is possible to be. But this was not an easy concept to apply to an analysis of power relations within prison. Given my public health training, I erred rather toward seeing the practices of informal government as representational: for example, I saw prisoners' sharing of communal resources in a way prescribed by informal governance as an expression of their desires and values—such as, perhaps, a sense of community. Prompted by participants' use of religious language to describe the rituals of informal governance, I turned to works in the anthropology of religion for a reading of ritual—or, disciplinary practice—as *productive*. Ritual, according to Talal Asad, is a form of practice that is not to be treated as symbolic action; rather, it is prescriptive and effective, with tangible effects for how we live and who we become. Asad's work on the ritual of medieval monks demonstrates how practices, such as the liturgy, are not detachable from an essential self; rather, ritual is technically effective in that it *forms* the self (Asad, 1993, Asad, 1987). He writes, "The liturgy is not a species of symbolic action to be classified separately from activities defined as technical, but a practice among others essential to the acquisition of Christian virtues" (Asad, 1993: 80). He argues that it is particularly modern to see ritual as symbolic; such tendencies are a product of post-Enlightenment western conceptions of the self which drew a boundary between the social, public, and the individual, private, self. Saba Mahmood, in her ethnography of women in Egypt during the Islamic Revival, makes a key distinction between symbolic and productive readings of power:

> The "how" of practices is explored rather than their symbolic of hermeneutical value…In this view, the specific gestures, styles and formal expressions that characterize one's relationship to a moral code are not a contingent but a necessary means to understanding the kind of relationship that is established between the self and structures of social authority, and between what one is, what one wants, and what kind of work one performs on oneself. (Mahmood, 2012: 53)

For these women, religious practices, like veiling, are not merely a matter of cultural custom, they are *technically effective*, working to develop modesty. I came to see that walking down a certain path in the prison yard or drinking from a specific cup was not just a matter of symbol; these practices were instilling moral sensibilities and creating moral bodies. Bodily ritual practices were governing what it was possible for prisoners to become—they were *disciplinary*.

Following the ontological turn I describe above, I came to Catherine Bell's study of ritual (1992), which takes a materialist reading of Foucault to formulate ritual as a technically effective form of material practice, which disciplines subjects and objects in particular ways. She delineates the processes through which embodied effects and materials produce subjects through their interrelations with humans, and the processes through which some relations come to be authoritative—or, to use Bell's term, "special"[12]—over others (Bell, 1992: 220). She writes of the 'ritualized body,' where the subject becomes the object, produced through interactions between the body and a structured material environment:

> It is a major reversal of traditional theory to hypothesize that ritual activity is not the 'instrument' of more basic purposes, such as power, politics, or social control, which are usually seen as existing before or outside the activities of the rite. It puts interpretive analysis on a new footing to suggest that ritual practices are themselves the very production and negotiation of power relations…Ritualization as a strategic mode of practice produces nuanced relationships of power, relationships characterized by acceptance and resistance…of the hegemonic order. (1992: 196)

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[12] Bell (1992) expands on what triggers certain practices as "special" to note that, whether formalized or not, ritual acts are bestowed with a social significance when they are set apart from all other acts—by limiting them to certain places and time. It is this form of "special" that I looked to highlight the rituals with a significant in the making of the methadone subject (Chapters 5 and 6).

For Bell, the material of the body cannot be peeled away from notions of power; the body is the very centerpiece of negotiations of power. What is striking about her approach is that bodily practices in and of themselves generate and regulate power. Amy Hollywood, in her work on the feminist philosophy of religion, expands on this to point out that, "through the bodily practices of ritual life, social subjects and their relations are performed and engendered" (Hollywood, 2004: 75).

Against this theoretical backdrop, the empirical weight of my analysis shifted away from the meanings the practices represent to their materiality. Chapters 5 and 6 are undergirded by the understanding that ritual practice is the very material through which power is negotiated, virtue is developed, and bodies are made.

Fieldwork and data generation

Partners at the Yale School of Medicine

This research is part of a broader collaboration, funded by the National Institute of Drug Abuse, between research teams led by Drs. Frederick Altice and Jaimie Meyer at the Yale School of Medicine, and local partners in Eastern Europe and Central Asia. The data I call upon here is funded by two interrelated research projects. The first, Project PRIDE (R01 DA029910; principal investigator: Dr. Frederick Altice), is aimed at integrating 'evidence-based' addiction medicine with local prison policy in prison systems throughout Eastern Europe and Central Asia. I joined Project PRIDE as a coordinator in 2011 in Kyiv, Ukraine, where I led the first nationally representative epidemiological biobehavioral survey among prisoners. This was my first exposure to the prison environment. I visited diverse facilities throughout the country, including prisons in the now Russian-occupied Donets'k region. The results were unprecedented—our research team documented among the

highest prevalence of blood-borne infectious diseases among prisoners worldwide. HIV prevalence was 19.4%, with only 6.5% of those infected receiving antiretroviral therapy, and hepatitis C prevalence was 60.2% (Azbel et al., 2013b).

We zeroed in on the absence of methadone treatment as the major factor contributing to the growing HIV incidence in prisons throughout the region. My publications from the time highlight 'barriers' to the effective implementation of methadone treatment, particularly 'myths' propagated by "negative attitudes on the part of implementers and potential patients" (Polonsky et al., 2015, Polonsky et al., 2016b, Rozanova et al., 2018, Polonsky et al., 2016a). Conducting surveys in the post-Soviet prison environment, a notoriously closed and secretive system, was incredibly challenging, particularly in terms of securing entry into the facilities and support from the prison department (Azbel et al., 2016a). I replicated these surveys in Azerbaijan and Kyrgyzstan. In Kyrgyzstan, the prevalence of blood-borne infection was also high (HIV: 10.3%, 34 times higher than in the community; hepatitis C: 49.7%) (Azbel et al., 2016b). But the work in Kyrgyzstan differed in two significant ways from that in other countries: prisoners and authorities were open about drug use within the prison, and, unlike anywhere else I had been, methadone treatment was made available to prisoners. For the first time, I could ask prisoners questions about injecting drugs in prison. The results were unexpected: more than a third of the prison population reporting having injected drugs and almost all of them had injected in prison (close to 90%) (Azbel et al., 2018). Even more surprising was that, despite the availability of methadone treatment in most prison facilities, only 11% of prisoners who had injected drugs were accessing methadone (Azbel et al., 2018).

The five-year collaboration through Project PRIDE culminated in a publication in *The Lancet* in which my co-authors and I summarized our findings. We included mathematical models projecting that methadone coverage of half the

people who inject drugs in Ukrainian prisons would result in a 20% decrease of new HIV infections over the next 15 years (Altice et al., 2016). We held Kyrgyzstan as an exception in the region, calling it one of the lone "candles burning in the night" for having "prevailed over the misaligned ideological policies espoused by Russia" (Altice, 2016: 12).

I became interested in why the most effective opioid addiction treatment was largely unwanted by the prison population. It seemed to me that my previous work was unable to fully answer this question, given the exclusive use of quantitative methods. To gain better insight, Drs. Altice, Meyer, and I secured funding for a qualitative study in Kyrgyz prisons (R21 DA042702; principal investigator: Dr. Meyer, including a research team from Yale University, University of Illinois, and Tim Rhodes, my PhD supervisor). I led this study, called MAK (the word for poppy in Russian) and developed the concept, protocol, data generation, and analysis. I was also employed part-time on Project PRIDE throughout the course of my PhD. I also spent a year working full-time on PRIDE during an interruption of studies, from 2017 to 2018.

Initially, my engagement with MAK followed the trajectory of my previous research: it was centered around "environmental barriers and facilitators to methadone treatment during community re-entry" (Meyer, 2017). The emerging data, however, have radically reshaped not only my research questions but also my ontological and epistemological approach to research (see "Analytical process" section). The data I use in this thesis is constituted by portions of the qualitative interviews I conducted under the auspices of MAK that most directly touch upon the intersection of informal governance and methadone implementation within prisons. As such, it is limited to only those interviews I conducted within the men's colonies, where informal governance and methadone use are most prevalent (I analyze the interviews with women as part of a separate analysis outside the scope of this thesis).

Partners in Bishkek

I carried out the fieldwork with the support of local partners at the AIDS Foundation East-West (AFEW) in Kyrgyzstan—an NGO working in the field of HIV/AIDS. This organization was an easy choice given my collaboration with them through Project PRIDE since 2012, when I began visiting prisons in Kyrgyzstan. When funding was secured for PRIDE II in 2015, I began putting together a research team, training them, and setting up a study protocol. Between that time and the completion of data generation in October 2018, I visited Bishkek three times a year for a total of six weeks each year, spending as much of that time in the prison facilities as possible.

I led two-day trainings in person upon visiting Bishkek, and monthly trainings over GoToMeeting, throughout the period of data generation. I led initial trainings in February 2015 on qualitative methods, first with my co-researcher and AFEW's director, followed by training on the protocol, ethics, and qualitative research methods with the extended local study team. These initial, more comprehensive trainings focused on study protocol, interviewing skills (verbal and visual cues, note taking, listening, clarity, demeanor, follow up questioning), ethical integrity, reflexivity, safety, and developing the further direction of the study. As most of the research assistants were trained in quantitative interviewing, it became very important to outline the differences inherent in a post-structural qualitative approach that seeks to understand the social world of prisoners. Here, it was helpful to team up and roleplay mock interviews that the co-interviewers then critiqued as a group. These interviews were also useful for developing initial interview guides (see Appendices C and D).[13] The research team consisted of two peer research assistants (with

[13] The first iterations of the interview guides, included in the appendices C and D to this thesis, were much more structured than the modes of questioning I employed in the later interviews. I am also including a later version of a topic guide in Appendix C to show how the questioning developed into a more flexible, open-ended form involving

experience injecting drugs and/or having been incarcerated) who were employees of public health NGOs in Bishkek. Hiring peer research assistants allowed me to access inside perspectives. My co-researcher, Ainura Kurmanalieva, an employee of AFEW, ran on-the-ground logistics of the study and carried out interviews.

Getting to know the field: sites and potential participants

It was during these initial trips to Bishkek to train research assistants for Project PRIDE in the winter of 2015 that it became clear to me that informal governance within prison plays a much larger role than I had previously imagined. It was through the mock interviews with research assistants who had experience working with prisoners that I learned that informal prisoner governance was crucial to the functioning of all aspects of prisoner life, including drug use. This shaped the course of the study procedures.

Following the initial training and pilot interviews, I further developed the study protocol. The first step was to identify research sites. The Kyrgyz research team and I were interested in exploring relations between drug use and methadone, so we turned to prisons that, according to the national biobehavioral survey we conducted (Azbel et al., 2016b), had the greatest proportion of self-reported injection drug use and the highest uptake of methadone treatment—prisons 1, 3, and 16. This 'sampling' strategy allowed us to cover participants with a broad range of experiences with heroin and methadone use. Although focusing on three male prisons limited the ability to compare data across a wide range of facilities, I opted for a more in-depth, rather than nationally representative analysis, within limited facilities. Until beginning data generation in October 2016, I continued visiting these facilities, observing the surroundings, and

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individualized notes to guide conversation flow (see "Interview encounter" section for more details).

speaking to prison and study staff as well as prisoners informally with an eye to understanding how the space was governed with the purpose of organizing qualitative interviews.

Through informal conversations with prisoners, staff, and research staff, I learned that the prisons are informally governed by the prisoners themselves, with centralized structures of government and a rigid hierarchical structure called *masti*. The head of the prison, the *polozhenets*, is a prisoner within each facility appointed by the *vor v zakone* (the thief-in-law) of the country, Kamchy Kol'baev. With the participation of the *poriadochnye* (literally, "decent" prisoners, the middle and largest *mast'*), he is responsible for appointing overseers (*smotriaschie*), settling disputes, managing the *obshchak* (an informal fund of pooled resources), and making informal law (*progony*). The extent to which informal governance disciplined methadone, and methadone disciplined the prisoner, varied between the facilities as a function of the *progony* issued by the *obshchak* (it was most strict in Prison 16 and least in Prison 3). In the context of the Kyrgyz prison system, these three prisons were known by prisoners, medical staff, and government prison officials as the "most welcoming" to methadone in the country, as well as the least strict in terms of the enforcement of the laws of informal governance. This provided an interesting contrast to Western researchers' perspectives of the low uptake and stigma surrounding methadone in these facilities.

These facilities do not resemble what we imagine in the West when we say "prison" in terms of their appearance and architecture. Locally, the prisons are known as "colonies." They are large, open-air camps surrounded by a wall, and with a material divide between the administrative and prisoner portions of the facility—in contrast to "prisons," which contain prison cells and do not allow for free movement. The *zhilaiia zona* (literally, the living zone) is divided via walls and doors into "local sectors" (*lokalki*). These material divides can be locked to 'localize' prisoners within them. In Kyrgyzstan, prisoners' ability to

move between local sectors is essential to the functioning of informal governance (Piacentini and Slade, 2015).

Linguistic considerations

To conceptualize the translation of methadone from one setting to another, this research worked through many other translations, such as that of texts and conversations from Kyrgyz and Russian into English, and from the concepts available locally to those used by the international community of scholars. As Jacques Derrida, lecturing to a French translator's association on the social effects of translation strategies said, every translation participates in an "economy of in-betweenness" positioned somewhere between "absolute relevance, the most appropriate, adequate, unequivocal transparency, and the most aberrant and opaque irrelevance" (Venuti, 2004: 331). Similarly, I saw every translation—whether of a word or a technology—as positioned somewhere in between a near one to one reproduction of the original or the creation of something completely new. Generally, in attempting to translate the practices of the Kyrgyz prison space, both linguistic and material, into words, I tried to stay as close to the original as possible.

The preferred language among prisoners was Russian (94% of randomly sampled prisoners chose Russian as their preferred language) (Azbel, 2016b). The research assistants were native Russian and Kyrgyz speakers. I am also a native speaker of Russian—although most native Russian speakers can tell that I am not 'fully' native—and I have worked in Russian in prisons in Ukraine, Armenia, Azerbaijan, and Moldova. I had never done qualitative work in these prisons, however, which meant I had not engaged with the very particular language of post-Soviet prisons. Criminal slang, emanating from the subculture of the Gulag, permeated greater Soviet society—a testament to the influence of prisons on society as a whole (Oleinik, 2003). Criminal slang is so rich that it can be argued to be a language in its own right with particular words for money, food, pills etc. Today prison terminology is a stable part of post-Soviet

popular culture, with Vladimir Putin (in)famously using criminal slang publicly (Galeotti, 2018). I was not at all familiar with the lexicon and it took time for my ear to adjust. I developed a glossary with terms of particular relevance to the interviews at hand; these also aided in transliteration and translation processes. I have reproduced the glossary here; it is the first of its kind for contemporary Kyrgyz prison slang and will be useful for future studies (see Appendix E).

In the thesis, I generally try to revert to the terms used by prisoners in their transliterated form (using the Library of Congress transliteration system) when I feel a close enough English translation is lacking. I argue that staying close to the words of fieldwork enables a closer understanding of the local terrain, through its original linguistic manifestations. Finding the appropriate terminology, balancing both scholarly and prisoner lexicon, was sometimes a challenge but, more often than not, a theoretically illuminating process. The theoretical turn towards material practice in the social sciences that I am pursuing, is, at first glance, at odds with the focus the participants place on their "soul" and its "virtue" and "decency." But, for prisoners, inner virtue was equivalent to outer practice in a way that I had not experienced before: a virtuous prisoner was a healthy prisoner. This tied directly into my theorization of the prisoners' use of drugs as fused together with the self; I opted for using these terms in place of citizenship (the sociological term).

The public health and criminal justice terminology presented particular challenges. There has been a turn recently in public health research toward employing the term "people in prison" instead of "prisoners," as a move towards more humanizing and neutral terminology, echoing the widely used "people who inject drugs" (Kinner and Young, 2018, Kouyoumdjian et al., 2018). While I recognize the attempt to retain dignity inherent in this attention to terminology, the picture, at least in regard to my fieldwork, is more complex. In Kyrgyzstan, a "prisoner"—the term used by study participants is *zek*, a

shortened form of prisoner in Russian—can be dignified or not, and this decency, as its locally called, is not a function of incarceration status. Rather, it is a function of one's *mast*', which is determined communally through a lifetime of deeds according to the *poniatia*—a set of informal unwritten laws that guide all aspects of prisoner conduct. Some prisoners are indeed eminently decent and humanized, more so than some non-prisoners, such as the formal prison administration. Cognizant of these nuances, I have stuck to the local term *zek* or prisoner.

Methadone is signified with myriad terms in peer-reviewed literature (opioid substitution therapy, methadone maintenance treatment, opioid agonist therapy to name a few). These terms are not neutral; I hold that they speak to the differing manifestations of methadone in different discourses, times, and locations, which I explore, in part, in Chapter 4. I chose to use methadone when referring to the substance and methadone treatment. Interestingly, one of my biomedically-oriented colleagues pointed out that even "methadone treatment" can be problematic given that "methadone is already a treatment and the term is redundant."[14] Furthermore, the use of the term "uptake" for methadone and "use" for heroin point to the dichotomization of one as a medicine and the other as a drug. Similarly, methadone users are clients or patients and heroin users are just heroin users. This dichotomy—along with many others—breaks down in the Kyrgyz prison context in practice and through language. I therefore strove to employ "use" and "users" for both substances to position them on more even playing fields. Otherwise, when referring to the prisoners who took part in this study, I opted for "participants" as opposed to subjects (the more biomedicalized term) or interlocutors (more common in anthropology) as a way of highlighting the active role of those who shared their story.

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[14] Field notes, November 17, 2017.

Interview procedures

Between October 2016 and September 2018, the research team at AFEW and I carried out interviews with 40 prisoners and 22 stakeholders. Of the prisoner interviews, 35 interviews were carried out within prison and 25 interviews after release (some participants were interviewed more than once; see Figure 1 for interview procedure details). Due to the unpredictable nature of the work in Kyrgyzstan, most interviews could not be planned in advance, as they depended on uncertain access to the prisons and the equally uncertain availability of the participants. When these opportunities coincided with my time in Bishkek, I carried out as many interviews as I could (35 interviews). When opportunities arose in my absence, the research team at AFEW, primarily the co-researcher, led the interviews. All interviews were conducted in the language that was most comfortable for the participants (the majority in Russian, three in Kyrgyz).

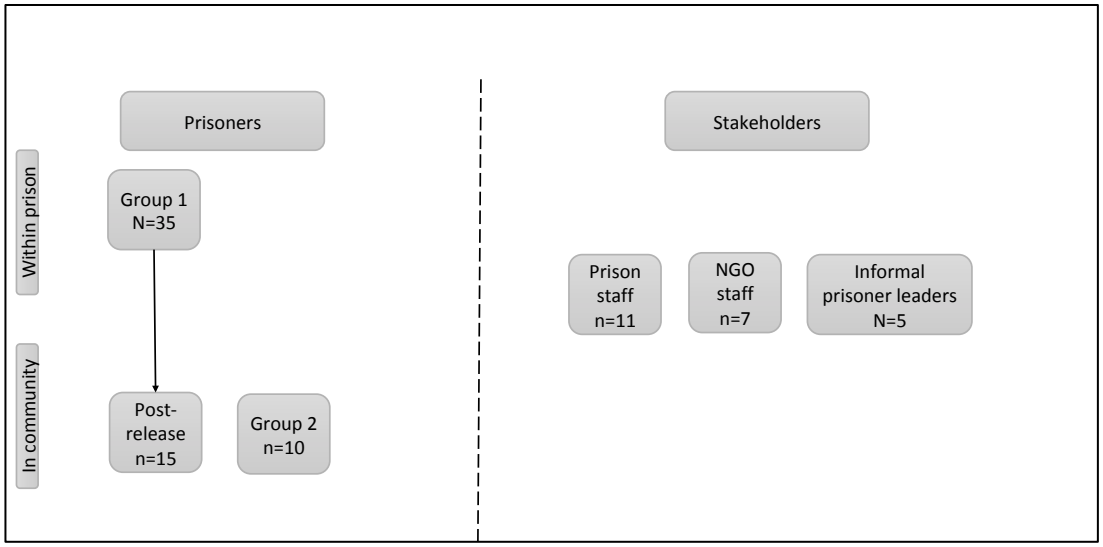

Figure 1—Interview Procedures.

Number of interviews conducted within prison and in the community with prisoners and stakeholders; Group 1 = prisoners from general population; Group 2 = former prisoners in community. Adapted from Meyer, J. et al. (2019), "A qualitative study of diphenhydramine injection in Kyrgyz prisons and implications for harm reductions efforts," to be submitted to the Harm Reduction Journal.

Entry and access to the facilities

AFEW is a well-established partner of the Prisons Department, and I had been visiting the facilities since 2012 as a Yale researcher, which secured me with a pass to enter the facility. But while the local research team had passes to enter the prison for an extended period of time, mine, a foreigner's, had to be issued only for a specific day and requested months in advance. On the appointed day, I would enter the prison, usually with my co-researcher, through the main checkpoint, a set of imposing doors on one side of a small passageway with a gate on the other. In between was a prison official who checked my entrance permit and took my passport in exchange for an entry pass. The administrative and safety procedures that ensued varied among the three prisons from quite formal (checking my belongings, taking away my phone, having a security officer follow me throughout the facility) to very informal (no checkpoint, no security officer). Bearing in mind the role of the interview space in constituting

participants' accounts in particular ways, it became important to locate facilities that were aligned neither with the formal nor informal prisoner administration to carry out interviews. I found such a building in each facility, usually located between the prisoner and administration territories of the prison, affording a 'neutral' governing boundary.

Interviews with prisoners

Process of recruitment

Participant recruitment, or 'sampling,'[15] for this study was purposive (Corbin and Strauss, 1998). At the beginning of the study, I was not sure what types of respondents or interactions would produce theoretically grounded data on drug governmentality, so I decided to cast the net wide. Originally, the study set out to understand the socio-structural context of prisoners' relationship to methadone. I therefore sought to recruit participants who had injected drugs with a relevant range of substance use experience (heroin, methadone, and Dimedrol emerged as the three prominent actors in this regard). I also recruited participants with diverse incarceration experience, age, *mast'*, HIV status, and ethnicity.

Guards or prisoners who worked in the interview facility would organize for potential prisoner-participants to join us for voluntary interview participation. These would be, at first, chosen randomly from a list of prisoners within six months of release (to ensure the possibility of follow up after release). Since the prison is a large open-air space, their names would be called over the loudspeaker with a request to report to the building where an independent research team was located for voluntary and anonymous interview participation. With time, however, potential participants approached us

[15] 'Sampling' is not the most appropriate term given that this study focused more on process rather than attaining a specified end result, including in number of participants.

without being called, having heard of the study or been referred to us by fellow prisoners. While not everyone who was called arrived at the facility, information gets around the prison quickly and, even before my co-researcher and I began generating data, our presence and purpose in the facility was well known throughout the prison. Upon meeting potential participants face to face, we explained that our purpose was to understand the experiences of using methadone and other substances inside the prison. I would explain that I was an outsider—a sociologist studying health, especially in relation to drug use. I informed the participants of the names of the professors supporting my study. I explained that, for the purposes of the study, it would be most helpful to talk to people who had experience with either methadone or other drugs. I clarified that I was in no way affiliated with the Prisons Department or with other studies being conducted in the prison, that the interviews would be confidential, and that participants would not be required to answer any question they did not want to. Most responded positively, and those who stated that they had no experience with methadone or drugs, decided not to participate (38 of the 78 screened). Otherwise, 40 participants took part.

As the initial data was generated, informal governance emerged as a key factor that reshaped the line of inquiry, focusing it more broadly on practices of governmentality in the making of the methadone subject. This had implications for recruitment. The rationale was to seek out participants who could provide a window into the power relations embodied in the ritual practices of informal governance. To follow this thread, my co-researcher and I began to recruit participants from each *mast*'. This methodology fed directly into Study Aim 2 (see Chapter 1) and produced for us a map of relations that make up power within the prison, enabling us to understand how different relations to drugs are variably located within different elements of government (see Chapter 5).

Although the original recruitment strategy included interviews only within prison, I found that interviews with released prisoners yielded useful data in

two respects. Those accounts of the participants whose within-prison interviews were particularly rich often generated more questions upon debriefing and analysis. It was useful to follow up after release to engage with these key informants on these issues in a more in-depth manner. Time and logistical constraints within the prison environment limited the scope of the within-prison interviews, and I found that this could be avoided in a more relaxed post-release environment. See Appendix B for a list of participants from each study group as well as their pseudonyms and demographic information.

Consent procedures

Work with participants interested in the study began with consent procedures (see "Ethics" section below). These involved an information sheet about the study and the consent form, requiring a signature (see Appendix A). I asked participants to read the information sheet and confirm they were interested in participating. In the few cases in which participants could not read, I read the sheet out loud. Participants were provided with the contact information of AFEW representatives in case they had questions about the study (we had a cell phone and SIM card exclusively for study-related calls). If they agreed to take part, they signed the consent form. Afterwards, I filled out a short questionnaire with basic demographic information to contextualize their narratives. Interviews followed an interview were recorded using an Olympus digital voice recorder and lasted 58 minutes on average. After completion, participants were reimbursed for their time with a package of hygienic goods (containing toothpaste, soap, shampoo, etc.), totaling eight dollars, commensurate with other studies in public health carried out by AFEW. They were also provided with a list of organizations AFEW compiled working with released prisoners in need of housing, medical services, and bureaucratic services such as passport and housing registration.

Stakeholder interviews

Additionally, my co-researcher and I carried out 23 interviews with key stakeholders, professionals working with current or former prisoners who use drugs. In pursuing these additional interviews, I wanted to engage with administrative accounts into the implementation of methadone treatment and the management of addiction. Participants included seven NGO employees, four informal prisoner leaders, and 11 medical and non-medical prison staff. The study procedures were similar to those with prisoners but followed different interview guides (see Appendix D). Interviews lasted, on average, 55 minutes and took place in a setting of the participants' choice: either AFEW's office or participants' offices or clinics in the prison facility. I anticipated fewer difficulties in approaching drug use and governance issues in my discussions with stakeholders. However, the prison staff was sometimes reluctant to discuss these issues, especially the non-medical staff (such as the prison security personnel). When I sensed discomfort, I would move on to a different topic. It was my sense that issues of governance were particularly difficult for prison staff to discuss because they were often not the ones in control of the prison. Issues of drug use also traversed a difficult field given that the staff was often involved in bringing drugs into prison. Four of the 15 prison staff approached did not consent to participate without giving a reason (all other categories of stakeholders approached consented).

Participant observation

During interview encounters, participants drew my attention to the way the methadone-body looked, felt, and smelled as it moved through different spaces and consumed different substances. This attention to the materiality of the body worked to highlight the role of spaces, rituals, and drugs in forming prisoners' bodies. During one of my team's prison visits under the auspices of Project PRIDE (a project separate to MAK), my colleagues at Yale University and I met with the informal leader of the prison to discuss methadone

implementation. We made an argument for the medicinal effects of methadone by describing its stabilizing effect of methadone on the brain. He looked at the graph of brain activity we sketched (see Figure 2) to aid this description and then looked away, pointing to methadone patients in the prison yard: "Yes, but look at them! Look at them walking around like zombies with rotting flesh!" The contrast between our sketch and the bodies walking through the prison yard provided a corrective for the positivist-inspired theoretical position we were taking within evidence-based medicine. Indeed, this position"framed, fixed, and rendered inert all that should be most lively" (Lorimer, 2005: 84-85). The 'real' methadone didn't exist only in the sketch, but was simultaneously being made through the interactions between the materials in the environment, including the materiality of these bodies (Rose, 2002). My impulse had been to flatten out the terrain of the prison and its ritualized practice, while participants' accounts brought it to life.

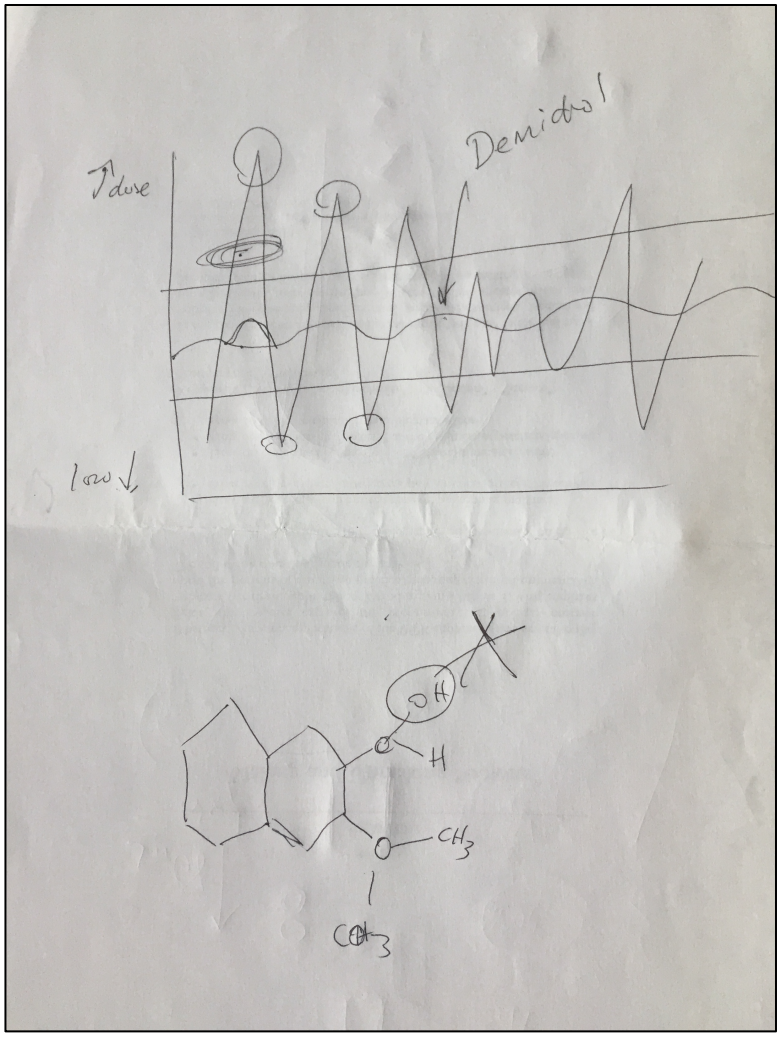

Figure 2—Sketch of methadone brain activity.

My research team's sketch to the informal leader of a prison my colleagues from Yale University and I visited showing methadone's effect on brain activity.

To revitalize the material, I decided to incorporate participant observation into my methodology. It was impossible to schedule interviews for a specific time, which meant that I spent close to half of every prison visit waiting for interview participants to arrive. This provided me with ample opportunity to observe the space, move around it as much as I could, and interact with the people around me. By using participant observation, I wanted to overcome the confines placed on data generation by the interview format, particularly its narrow focus on retrospective accounts and language (Bryman, 2001: 494). While ethnographic

study would have attended to ritual practice and its relation to drug use in greater detail, I was limited by the logistical and ethical constraints of embedding myself within the daily life of prison (see "Ethics" section). As a female foreigner who is not incarcerated, I was not, for obvious reasons, able to fully immerse myself in the lives of prisoners in Kyrgyzstan in a way that would warrant "becom[ing] a member of that world, to experience events and meanings in ways that approximate members' experiences" (Emerson et al. 1995: 35). Instead, I considered how my partial immersion contributed to shaping the data I was gathering. I began to see myself not as an independent observer of independent phenomena, but as a researcher with an active role in creating the very reality she was trying to describe (see "Observational encounter" section) (Coffey, 1999).

Analytical process

Noticing the material relations in data generation

Undergirding the analytical process of this thesis is a theoretical move away from the interpretive tradition in sociology, committed to unpacking the representation of a social reality made through research processes. Drawing on materialist readings of governmentality (see "Approach" section) (Lorimer, 2005), I sought to move beyond the *representation* of drug subjects and objects in participants' accounts, to a *relational* truth made by bodies moving through space. I adopt Jessica Ringrose and Rebecca Coleman's feminist Deleuzian methodology which maps the connections between different components to observe how new forms emerge through these relations (Coleman and Ringrose, 2013). Like other models of materiality in feminist theory (Alaimo and Hekman, 2008a, Åsberg, 2010), including Haraway's (Haraway, 1991a), it asserts that the way that these parts come into contact and hold together is never neutral, but rather produces coercive divisions and hegemonies (Coleman and Ringrose, 2013: 127).

This 'non-representational' theoretical approach regards the production of meaning as including not just human subjects and linguistic forms, but also non-human actors (see "Approach" section) (Lorimer, 2005). I was therefore not so much interested in human psychoactivity and its meaning generation or intentionality, as I was in mapping the "more-than-human, more-than-textual multisensual worlds" inhabited by the participants (2005: 83). Putting the concept of the cyborg and Deleuzian methodologies to work (see "Approach" section) meant looking beyond what was immediately uttered or visible in both interviews and observations, to trace instead how diverse and heterogeneous parts stick together to form new entities through their relations (Coleman and Ringrose, 2013). I turned my empirical analysis to the dynamic spatial relations between bodies and substances to trace how power flows through their components to produce mutable wholes.

Below, I describe my 'more than representational' approach to coding, and analysis of the interview and observational encounter.

Coding

Upon receiving the interviews files from the research assistants through Yale File Transfer, I forwarded them to the transcription and translation agency in Kyiv, Ukraine, that our team at Yale University had reliably worked with for six years. Using Dedoose (SocioCultural Research Consultants, 2018), the research team (three people) coded 22 interviews (all of which I reviewed), and I coded the remaining 61 interviews to shape the analytic frame that "generates the bones" of my analysis (Charmaz, 2006: 46). I opted for coding the Russian language transcripts to stay closer to the original.[16]

[16] For the Kyrgyz language transcripts, I coded the English translations.

To code the interview transcripts, I carried out a "Poststructural Interview Analysis" (Bonham et al., 2015). Drawing on Foucualdian concepts of governmentality, this methodology is useful for considering the production of subjects and objects through practices (see "Approach" section above). The relations between things in interview texts are treated as practices with governing potential. Take, for example, the relations between the length of a substance's withdrawal symptoms, the mode of its administration, the high, and the punitive consequences of its use. These elements in an interview text interact (i.e. the longer the withdrawal symptoms, the stronger the punitive response) to make a substance into a particular kind of substance. In this case: an illicit drug. Following this approach, I was not interested in arriving at a participant's access to an 'inner truth' about their intentions or experiences with drugs. I was, rather, interested in the politics of *what* is said, meaning, how things said establish normative *ways to be*. Accordingly, I used the coding framework as a form of analysis to map the entangled web of relations that set limits on the kinds of methadones and methadone subjects were possible in the Kyrgyz prison. This coding procedure was comprised of three non-linear and interrelated steps.

First, I looked to precisely *what* was said in interview accounts. These codes simply answer the question, "what things said have been noted?" (Bacchi and Goodwin, 2016: 116). I highlighted excerpts with taken-for-granted, common sense assumptions and assigned codes that summarized them. For example, I produced a code called "reasons for using heroin" that included excerpts with reasons such as "to avoid overdoses," "to relieve men of psychosis," "to prevent withdrawal," "it's purely for the sick," and "to help the user."

Second, I coded for the normative assumptions that made what was said "sayable" (Foucault, 1991a: 59). In other words, "what meanings need to be in place for particular 'things said' to be intelligible" (Bacchi and Goodwin, 2016: 117)? Continuing with the example above, I identified the intertwined practices

that make these reasons for using heroin legitimate or 'sensible.' I asked, "What discursive practices give rise to a heroin that is "purely for the sick?" (see "Approach" section for definition of discursive practice). A key practice emerging from the data was that of health producing informal prisoner governance. There were several key relations incorporated within this practice including what I coded as "communal property." This involved the distribution of communally owned heroin to all prisoners. The normative assumption here was that the materials owned and distributed collectively by prisoners to prisoners confer health.

And last, with a view of what "things said" *do*, I traced how these normative implications generate ways to be. Put differently, this form of analysis treats "things said" as productive since it is through the relations within discursive practices that subjects and objects are continually formed" (Bacchi and Goodwin, 2016: 118). As Bacchi and Goodwin emphasize, "hence, they [discursive practices] need to be studied in terms of what they produce, or constitute, rather than in terms of what they 'mean'" (Bacchi and Goodwin, 2016: 118). I examined the effects of privileging health within communal property on what objects and subjects can be and do. I coded for objects and subjects that fell within the confines of communal property vs. objects and subjects that fell outside of it. For example, methadone was excluded from communal distribution practices whereas heroin was included. The subject position that emerged was clear: the physically fit prisoner was someone who received heroin treatment while the ailing prisoner took methadone. In this way, "Poststructural Interview Analysis" allowed me to harness "*what* is said" to examine the processes through which heroin and methadone are differentiated.

The observational encounter

Following Rebecca Coleman's and Jessica Ringrose's feminist Deleuzian approach (Coleman and Ringrose, 2013), I treated "the capacity of affecting and

being affected as a series of relations" (2013: 126) that extend or limit a subject's becoming. That is, objects and subjects—including the prison space and prisoners' bodies—can constitute each other through their interactions. Given that I was now part of the prison space, my observations were not unidirectional but an 'affective analysis'—an actor in the participants' becoming. I was interested in how certain portions of the prison space made healthy, 'decent' (*poriadochnye,* to use the prisoners' word) bodies possible, while other portions at other times enacted unhealthy 'rotting' bodies, and how this related to what methadone became.

My interactions with participants entered this process of becoming. The prisoners belonging to the lowest *mast*', the *obizhennye*—those with the "rotting zombie" bodies—could not, according to the *poniatia*, enter my interview space until all other *masti* had been there first. Since only the highest and, by extension, physically and morally healthiest, *masti* could access the interview first, those coming in last were affected in specific ways: it made them into *obizhennye* and inscribed their bodies as broken. Conversely, my interview was also affected. It became an encounter warranting 'health' and '*poriadochnost*' (decency). As Deleuze writes, "a body affects other bodies, or is affected by other bodies; it is this capacity for affecting and being affected that…defines a body in its individuality" (Deleuze, 1992: 625). My interactions were therefore tied up with ritualizing practices of informal governance, and this had affective capacities on the prisoner body.

The interview encounter

Coming from a positivist biomedical tradition, I did not start out interviewing attuned to representationalist, let alone non-representationalist, methodologies. A few months into the analysis, I shifted gears to a representationalist approach. I began to analyze the ritual practices of informal governance as imparting symbolic meaning (see "Approach" section). For example, I analyzed prisoners' ritual distribution of heroin from the obshchak,

the common fund, as representing a value of sociability and shared hardship and representing the centrality of the group. Methadone distribution, too was, for me, a matter of representation. My mode of inquiry followed suit. I was interested in "attitudes towards" and "barriers to" methadone access. Such lines of questioning spoke to how I saw meaning as generated by a reference to external realities rather than being made through the action itself. I took the ritualized methadone distribution in the administrative—and not the prison-run—portion of the prison as a barrier to accessing methadone. This location imbued methadone with a symbolic meaning, associated with the formal prison administration, which made it unpopular among prisoners fighting for governing independence. In doing so, I emphasized the representative qualities of ritual as a stand-in for the 'real,' which was located elsewhere (like, for example, in our sketch of methadone's activity in the brain (see Figure 3) (Hollywood, 2004: 74).

But participants' emphasis on their own and others' bodies, coupled with my reading on ritualization in the anthropology of religion (see "Approach" section), led me to change my analytic approach and lines of questioning. As I drew the interview to barriers and attitudes, focusing on the meaning of methadone, participants repeatedly redirected me to the gestures, movements, wounds, and postures surrounding us. They pointed at their own body, drew attention to those of others; for them, methadone was something embodied. It was being made through its material embodiments. Through prisoners' accounts, the object of methadone came together with and drifted apart from other components, other drugs, material spaces within the prison, and always bodies, both their own and those of others.

To understand methadone implementation, it became essential to first understand the confines of their body—where it began and ended—and how it was formed. How the body was reconfigured was not something that could simply be immediately observed. As Elizabeth Grosz (1994) writes, in her

feminist Deleuzian analysis of the "volatility" of the body, "the body is thus not an organic totality but is itself an assemblage of organs, processes, pleasures, passions, activities, behaviors, linked by fine lines and unpredictable networks to other elements, segments and assemblages" (120). To get at this body, I could not observe or ask about what was immediately apparent, I had to map prisoners' relations with other bodies and substances (see Chapter 5) to unpack "what might be." As Coleman and Ringrose write, "mapping connections is not only a task of investigating what there is, then, but is also concerned with unpacking what might be. It is a methodology of looking differently at connections…a methodology of tracing how these connections might be made differently" (Coleman and Ringrose, 2013: 125).

I began to notice the material, including methadone-bodies, as products of the ritualizing function of informal governance. And I leveraged the interview encounter to explore how the "ritualized ways of acting negotiate authority, self, and society" (Bell, 1992: 8). My questioning changed accordingly: Where I would have previously drawn the interview back to the symbolic value of human behavior in constructing the meaning of methadone, I instead, drew it deeper into the minutiae of the body-drug-ritual practice entanglements. I was interested in how material relationships with and within the prison space were formed (Alaimo and Hekman, 2008a). The material relationships I was particularly interested in included the bodily practices surrounding heroin and methadone distribution as well as governing rituals. In the interviews, I questioned the "pervasive and mundane acts" (Mol, 2002: 39) of everyday life, including which path prisoners followed through the prison yard to obtain methadone and heroin, how methadone and heroin were administered, what it looked like when punishments or rewards were meted out, how their bodies felt and looked after taking the substances etc.

Ethical considerations

Ethical challenges such as issues of informed consent, voluntary participation, and the management of power dynamics, are exacerbated in the prison setting where power imbalances are sharpened and agency diminished (Schlosser, 2008). In my case, these challenges were made more pronounced by the lack of sociological work conducted within prisons to draw on (Wacquant, 2002), with none having been carried out within Kyrgyzstan. Important exceptions from other post-Soviet prisons, however, helped pave the way (Symkovych, 2017b, Symkovych, 2017a, Pallot and Piacentini, 2012, Piacentini and Slade, 2015, Slade, 2015). Key to managing ethical questions was to see ethical considerations, including consent, as a process, requiring constant re-assessment, negotiation, and discussion (Guillemin and Gillam, 2004). I proceeded carefully, spacing out the interviews so that no more than three were done per week. This schedule provided time for me to begin analyzing the incoming accounts and address ethical issues as they arose. The major ethical considerations prior to and during the study included finding an appropriate setting for interviews and observation within the prison (see "Entry and access to the facilities" section), providing the flexibility for interviewers and participants to raise concerns or opt out even after consent had been given (see "Consent procedures" section), and negotiating my place in the prison given the power relations implicated in my exchanges with participants (see p. 84 for interviewing the *obizhennye*).[17]

[17] The fieldwork was undertaken with ethics approval from Yale University Human Investigations Committee (IRB), including a prisoner representative, and from the Department of Health and Human Services, Office for Human Research Protections (OHRP). Additionally, we received ethics approval from the Committee on Bioethics under the Global Research Institute in Kyrgyz Republic.

All information supplied by the participants was kept strictly confidential and each interview was assigned an anonymous study ID. Upon leaving the prison, the researchers would upload the files onto a secure file transfer service (the Yale File Transfer). This service was password-protected and encrypted, and I could access it only by using my Yale NetID and password. Contracts were signed with employees doing transcription and translation to ensure confidentiality. The employees who transcribed the interviews replaced participants' names with pseudonyms and removed any identifying information such as location names. Upon receiving a transcription, I would read over it to make sure that all identifying information had been replaced or removed. Participants were informed that confidentiality would only be breached in the case that *serious potential harm* was reported following procedures set out by the ESRC (Economic and Social Research Council, 2010). (There was no instance, however, in which the researcher was obligated to file such a report.) The interviews covered topics of violence, exploitation, and corruption, which could have caused discomfort for both researchers and participants. The research assistants were trained to abort the interview and/or seek the help of security officers in case they did not feel comfortable. Upon completing the interview, participants were asked if they would like to make a post-release appointment to receive additional aftercare, such as treatment at the National AIDS Center, or referrals to NGOs working with released prisoners in Bishkek.

Indeed, observational research in prison poses more potential harm than interviews outside of prison because of the increased exposure of the participants (Mason, 2002: 100). To manage this, I attempted to always make my purpose clear (see "Getting to know the field" section). But the nature of this research was such that ethical decisions often had to be made on the spot. Our research team had a protocol in place for medical emergency and psychological distress referrals for both participants and researchers, and discussed the risks of recruitment based on a stigmatized category (Abrams, 2010). It was the more 'mundane' issues, however, that gave rise to most of the

ethical challenges I encountered. Most often, these took the form of a plea for aid. The majority of people I encountered in prison saw me as an aid worker, often calling my research team "the Red Cross." This conferred upon us a 'neutral' status, facilitating entry into some off-limits prison environments, yet also presented problems. For example, one day, at the checkpoint entering the prison, the secretary stated, "You're always coming and helping the prisoners. What about the staff? You know one of us was electrocuted to death yesterday upon changing the electrical wiring on the border fence of the prison. What are you going to do for us?"

Of course, these issues emerged from the inequality of the researcher/participant relationship. The very concept of doing research for an improved understanding of health did not sit well in a context where essentials were lacking. As one prisoner who came up to me said, "I need socks. You have socks, but you won't give me socks." Increased exposure to this environment equipped me with the skills to make more educated judgments on how to reduce harm in these situations while avoiding getting 'too' involved. I would usually respond by explaining my purpose in the prison—to understand the lives of prisoners and their health—in a way that separated us from charity organizations. At the same time, I gradually developed stronger relationships with some prisoners, who presented me with handcrafted gifts and other tokens of respect—circumstances that made it impossible to maintain the level of distance and disengagement common in biomedical public health research. Finding the appropriate balance between researcher removed from the setting and active participant was always the most challenging issue (Murphy and Dingwall, 2001).

Lastly, I realized that navigating a terrain of extreme poverty involves constant negotiation of one's role in and impact on the environment. Certainly, merely assuming that the participants are disenfranchised and lack agency is not productive to finding a platform to allow them to share their experiences. But

mobilizing their voices for academic purposes (this PhD) raises ethical concerns of exploitation and appropriation—a colonization that reinforces domination. Following a "situated moral practice" (Mason, 2002: 54) approach, I did not presume there was a cookie-cutter code of moral conduct. In pursuit of a more reciprocal research relationship, I attempted to address these concerns by exposing the dependent relationship between myself and the participant. In recognizing that their knowledge was greater than mine, I hoped to shift power to the participant (England, 1994).

My guiding principle became exposing the complexities of the researcher-participant relationship, including the moments of balance and imbalance, rather than smoothing them over. The research team and I discussed ethically challenging situations (such as those in the previous paragraph) and came to a consensus about potential ways forward on a case-by-case basis. The source and nature of my moral concerns was put to a critical test through conversations with my colleagues and supervisors.

Chapter 3—Drug treatment as formal prison governance: a critical examination of stakeholder discourse in the making of methadone objects

Summary of chapter

Fundamental to the poststructuralist policy analysis I adopt in this thesis is the understanding that objects are not stable but made through material-discursive practices. In this chapter I analyze the practices of policy discourse to get to the multiple 'objectivizations' of methadone; as Paul Veyne (1997; cited in Bacchi and Goodwin, 2016) writes, "there are no natural objects…there are only multiple 'objectivizations.'" This mode of analysis does not question the reality of objects, rather it argues that they are not made real, or "objects for thought" (Foucault, 1988a), until something is *done* to them.

The 'doing' that I focus on here is policy discourse (or 'practices') surrounding the introduction and implementation of methadone treatment into prisons in Kyrgyzstan. I adopt the view that policy discourse is not simply a tool for responding to problems; rather, it 'governs.' Following Carol Bacchi and Susan Goodwin's poststructural approach to policy analysis (Bacchi and Goodwin, 2016), I treat Kyrgyz national policy documents and methadone implementer accounts, which propose methadone treatment, as directly *productive* of methadone objects—the very thing that they seek to understand and manage. Starting from this premise, in this chapter, I examine how methadone objects are produced as an effect of the problem identified in methadone treatment policy proposals. In this way, I treat the making of methadone objects as an outworking of methadone treatment as a proposal (see Chapter 2, "Discourse as governance" section for more details on methodology).

To facilitate this analysis, I use Bacchi's poststructural analytic strategy, "What's the Problem Represented to be? (The WPR approach, described in detail in the methods chapter; Bacchi 2009)—a 'problem questioning' methodology. By answering a series of questions within the WPR approach, I scrutinize how policy proposals 'problematize' methadone objects into being; in other words, what problem is the policy proposal of methadone treatment purported to address and what objectification effects flow from this particular problematization? I take up questions one, two, three, four, and five within Bacchi's approach to ask: "What's the 'problem' represented to be in a specific policy?"; "What presuppositions or assumptions underlie this representation of this 'problem'?"; "How has this representation of the 'problem' come about?"; "What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?" and "What [objectification] effects are produced by this representation of the 'problem'?"

I address each of these questions through a critical analysis of the relations involved in methadone's becoming through a set of 'practical texts' (Bacchi and Goodwin, 2016: 33). Practical texts are policy texts that, according to Foucault, introduce "programs of conduct" (Foucault, 1991a: 75); they are texts, as well as interview accounts, that prescribe certain ways of being through programs and policies. For example, addiction treatment guidelines that call for pharmacological intervention are a practical text in that, through relating to, or 'problematizing,' drug use in a particular way (as a disorder warranting chemical changes to the brain through daily medication), they produce a way for drug users to be (patients with chronic, relapsing diseases of the brain).

I begin with two practical texts on methadone implementation in Kyrgyz prisons: a national policy document called the "Government Program," and interview accounts with local stakeholders (medical staff, advocates, and policymakers working in the field of methadone implementation; see Chapter 2, "Stakeholder interviews" section for stakeholder interview procedures). But

there is a broader context invoked by these practical texts, called the "hinterland"[18] of practices (Law, 2009). Using these practical texts as jumping off points, I draw on texts in the hinterland of practices surrounding the Government Program. Specifically, I turn to internal government PowerPoint presentations, put forward by the Ministry of Justice, on the cusp of the introduction of methadone treatment into prisons, because they produce methadone objects that are different to those produced within the Government Program.

Multiple methadones can be seen as being produced *through*—rather than preceding—these practical texts and their hinterland of practices. A medicalized methadone of HIV prevention emerges through national policy discourses; this methadone is mutually co-constitutive of and overlapping with the methadone proffered by the expert knowledges of 'evidence-based' global health. But, through the hinterland of practices in stakeholders' accounts and PowerPoint presentations, a distinct kind of methadone, hitherto absent in global health and national policy discourses, also emerges. Rather than the medicalized methadone of HIV prevention, contained in this distinct objectivization of methadone is the previously unexamined assumption that methadone is a particular type of governance. Through the historical contingencies of governance within post-Soviet prison and the discourses of 'practical texts,' a methadone object tied up with the shifting governing relations of the prison emerges. This methadone object is in line with the administrative goals

[18] John Law (2009) argues that objects do not take shape in a vacuum. He writes, "Realities…depend on practices that include or relate to a hinterland of other relevant practices." With "hinterland," I refer to the set of contingent relations that surround the practical texts in question. That is, I am not only interested in terminology but discourse: the attendant knowledge-making practices invoked by the practical texts, including representations of methadone within the texts, the instruments used to dispense methadone, the way knowledge about it is made, etc.—all these make of up the context surrounding the text or "the hinterland of practices."

of the formal prison administration, primarily the reduction of informal prisoner governance.

Legislating methadone into practice

Legislation granting methadone treatment legal status in Kyrgyz prisons plays a key role in the network of local stakeholder relations that produce knowledge about the object of methadone. Methadone treatment was signed into national law and called "substitution maintenance therapy with methadone" (*zamestitel'naiia podderzhivaiuschaia terapiia metadonom*; hereafter, ZPTM) by a joint order of the Ministry of Justice and the Ministry of Health in 2007 (Ministry of Justice of the Kyrgyz Republic, 2007), and introduced into criminal justice settings as a pilot program on August 12, 2008 (Ministry of Justice of the Kyrgyz Republic, 2007) .

There are several legislative documents that grant ZPTM legal status in prisons as well as regulatory documents and clinical protocols that govern its administration. Among them is the oft cited document, "Government Program for the Prevention of the HIV/AIDS Epidemic and its Social and Economic Consequences in the Kyrgyz Republic" (henceforth, "Government Program"), which was approved by the resolution of the Government of the Kyrgyz Republic in 2006 (Government of the Kyrgyz Republic, 2006). Marking a turning point in drug policy in Eastern Europe and Central Asia by introducing methadone treatment into the criminal justice system, the Government Program is an exceptional move in the region (Altice, 2016). The goal of this program is to increase the effectiveness of HIV prevention measures among "most vulnerable groups" and it includes support for prison-based ZPTM.

This document is particularly important because of its publication immediately preceding preparations to launch ZPTM into the criminal justice system. At the time, there was heated debate among politicians, activists, and international donors about methadone's acceptance. The move to initiate ZPTM into prisons

was not only exceptional in the region but the world, given the few prison systems providing opioid agonist treatment worldwide (Stover and Michels, 2010). The instability regarding what methadone would become after its launch—a dangerous drug of addiction, a treatment for addiction, prevention for HIV, a mode of pain relief or something else entirely—makes this document a key site of methadone-making. After ten years of implementation in prisons, methadone is less contested today, as it continues to factor prominently in the Government Program's current, 2017-2021, iteration (Government of the Kyrgyz Republic, 2017).

Methadone as a narcotic and a substitute for narcotics

Government program's definition of methadone

Within the Government Program, methadone is not a pre-existing object being described—the document's definition *makes it* a particular kind of object. The definition—as a form of proposal—constitutes the problem it purports to address. It accomplishes this by proposing methadone treatment as a solution to the problem of compulsive heroin use. This, in turn, makes different methadone objects through how they are put to use (Bacchi, 2017). In what follows, I explore how a network of relations (or an 'assemblage' of relations) intertwine within this definition to produce multiple contested methadones.

Methadone as a narkotik – like heroin

The Government Program defines ZPTM as "a synthetic narcotic [*narkotik*], taken orally to treat opioid (for example, heroin) dependence." While labeling methadone a *zamestitel'* (substitution), the Government Program also states that methadone is a *narkotik* (a narcotic substance). The co-existence of these usually polarized terms—a legal treatment substituting heroin and an illegal drug—is an example of the continued tensions surrounding methadone's implementation.

The tension within the Government Program's definition of methadone thrusts it squarely into the disputed territory surrounding drug versus treatment (Acker, 2004b), which underpins debates about opioid agonist treatment in Eastern Europe and Central Asia. Within the Government Program, methadone is a *narkotik*, a label that evokes the history of policies, spearheaded by the Russian Federation, banning methadone treatment (Colborne, 2016). Methadone, like heroin, motivates compulsive behavior while the 'Russian model' seeks to discipline and control drug-seeking behavior. As the Kremlin-supported research group concludes in a recent report, "harm reduction is inconsistent with the 'Russian model' of fighting HIV" (Colborne, 2016). Methadone here becomes a resource for negotiations between the values and politics of East and West (Rhodes, 2016: 20). Methadone, as a drug of the West, is merely a "replacement of one drug with another" (Latypov, 2010). The discourse of methadone as a toxic drug of the West creates a dichotomy between Western public health responses and Eastern punitive responses to the problem of addiction. As Rhodes et al. (2016) argue, "Methadone becomes a resource, a form of capital and performance…in the politics and values of the East and West, in which negotiating a dualism between public health and criminal justice approaches…is core."

The discourse of East verus West was leveraged by Kyrgyz policymakers to introduce methadone into prisons in Kyrgyzstan in 2008. Some local politicians and experts in drug treatment (narcologists) resisted the methadone lobbying efforts of international organizations and NGOs (World Health Organization, 2008). While the latter produced methadone as harm reduction—a substance reducing the harms of illegal drug use—the former called methadone a *narkotik*. Several government officials, without whose vote prison-based ZPTM could not pass, emphasized the narcotic qualities of methadone, claiming that it was simply a replacement of one drug for another warranting punitive

measures.[19] Through its associations with the compulsive use and loss of control of heroin, methadone becomes a substance to be controlled through criminal justice measures.

Methadone as addiction treatment – unlike heroin

Discourses of methadone as a drug and as a treatment inscribe a mutually exclusive dichotomy: a substance is either an illicit drug or a medication. As a counterweight to the discourses of methadone as a toxic drug of the West, international organizations and medical professionals expend much effort to emphasize the therapeutic qualities of methadone. Unlike Russian drug policy, which emphasizes the similarities between methadone and heroin, these discourses inscribe methadone's distinctions from heroin. The National Institute of Drug Abuse, for example, points out that methadone is different precisely because it does not bring about mood-altering psychoactive effects (National Institute on Drug Abuse, 2009).

The implication here is that a drug is euphoria inducing whereas a medication does not produce euphoric effects. Methadone is a medication precisely because it is not heroin. This calls to mind Law and Singleton's (2005) concept of an "absent presence" where one object relies on another to shape what it is and what it is not. Heroin, then, is necessary to make methadone what it is (i.e. *not* heroin). In this way, debates about methadone within biomedical discourse produce it as either an addictive object or a treatment for addiction (Keane, 2013).

The enactment of methadone within the Government Program breaks down methadone's dualism of drug versus treatment that Russian-led regional policy has pulled in the direction of the former and global health policy has pulled in

[19] Field notes, May 5, 2016.

the direction of the latter (Woods and Joseph, 2018). It is of note that a policy document instituting methadone treatment simultaneously invokes both sides of the debate; methadone is produced within the Government Program as both a *zamestitel'*—a superior replacement for heroin conferring stability—and a *narkotik*—a drug of compulsive use producing a lack of control. The Government Programs works to breakdown the hard-fought distinction of drug versus treatment, which is complicated by methadone's dependency-inducing qualities. This calls to mind Helen Keane's observation that methadone does not produce a high, unlike heroin, it remains an opioid, like heroin. As Keane notes:

> This distinction between good medicine and addictive drug is often mapped onto an opposition between analgesic effects and euphoric/rewarding effects, the latter being linked with the development of compulsive use. However, methadone, as a drug which is used in substitution therapy for illicit opiate addiction, blurs these distinctions. (2013: 23).

Within the Government Program, methadone is being put to use as a narcotic treating compulsive drug use by substituting heroin.

The discourse of *narkotik* and *zamestitel'* blurs a clean boundary between these dichotomies and invokes what Suzanne Frazer and Kylie valentine have called methadone's "double identity" (Fraser and valentine, 2008: 56). The object is constituted as a drug of addiction being used to treat addiction. And, given the divisiveness and mutual exclusivity of the debates between these two objects, methadone becomes particularly unstable. Methadone within Kyrgyz government policy shifts from one to the other, sometimes embodying both a drug and a treatment simultaneously.

Methadone as harm reduction

There is, however, a different enactment of methadone that, through its production within the expert knowledges of global health, works to lend it legitimacy by stepping out of the debates surrounding methadone as a *narkotik*

or a treatment for *narkotik* use. A particular stability is conferred onto methadone through its alignment with the global health methadone as a medicalized response to the HIV epidemic. In what follows, I consider how methadone as harm reduction materializes through a network of practices within Kyrgyz national policy documents that propose ZPTM.

A methadone of HIV prevention made within a discourse of public health urgency

Since the Government Program introduced methadone into prisons as a national response to HIV/AIDS, this enactment of methadone as HIV prevention continues to carry particular weight today. This is particularly evident in the objectification of methadone as HIV prevention within a hinterland of 'practical texts' instead of other methadones, such as that of addiction treatment.[20] These practical texts (in this case Kyrgyz national policy documents and stakeholder practices associated with the Government Program) propose methadone treatment as a response to a global health epidemic; the methadone of HIV prevention that flows from this problematization aligns with the expert knowledges of global health, lending this methadone object particular stability.

Methadone as a response to the HIV epidemic is held together through national policy documents including, but not limited to, the clinical protocol signed into law in 2015 and methadone's 2006 entry into the "List of Essential Medications in the Kyrgyz Republic" (Ministry of Health of the Kyrgyz Republic, 2015). Before the first prison-based methadone intervention was launched as a pilot program in 2008, government officials introduced the program to ministries.

[20] As Lamonaca et al. write, "In many EECA [Eastern European and Central Asian] countries, OAT [opioid agonist treatment] has been introduced as HIV prevention and supported by international funders, yet those who must provide this treatment are addiction treatment specialists who do not support OAT as an effective treatment for opioid use disorders. Consequently, these programs have remained 'pilot' projects to satisfy donors but have failed to gain widespread adoption." (Lamonaca, K. et al., 2019)

On the cusp of methadone's introduction into the first prison facility, official policy texts produced methadone in relation to global narratives of 'evidence-based' HIV prevention. A PowerPoint presenting an overview of the first prison-based ZPTM pilot program internal to the Ministry of Justice—the ministry responsible for instating ZPTM into prisons—lists reducing the transmission of blood borne infections as one of the major functions of ZPTM (Akmatova, 2008). Through its incorporation into the range of harm reduction solutions to the regional HIV/AIDS crisis, methadone is thus enacted as an essential strategy in countering the epidemic.

The HIV/AIDS epidemic is given particular urgency in the Post-Soviet region within public health policy documents. Among government agencies, there was a vociferous call for action in the mid-2000s when the Government Program was written and ZPTM was launched into the criminal justice system. The language of the Government Program brings this sense of urgency to the fore: "This [HIV/AIDS] is a global humanitarian crisis, which poses a threat to human life" (Government of the Kyrgyz Republic, 2006: 3). The prison setting provides an added layer to the health crisis given the increased likelihood of "HIV/AIDS quickly spreading in the criminal justice system, and the rapid progression of the disease and high mortality rate… and the spread of the infection to the general population" (2006: 28). This association with an out-of-control, accelerating threat to public health lends ZPTM legitimacy as a method of HIV prevention, inscribing the methadone object as an element of "harm reduction programs among drug users in Kyrgyz Republic" (2006: 10).

Local stakeholders harnessed the sense of public health urgency echoed in policy documents to enact methadone as HIV prevention through a network of practices. Sofia, an NGO employee, described the campaign preceding ZPTM's introduction into prisons:

> We worked a lot with MPs [members of parliament], because the MPs were shouting "how could this be? Not only can they not ensure that there are no drugs getting in there, into prison, they're trying themselves

> to give them drugs."…There were, you know, training meetings held, they were called seminars, with the support of various donors, and we also held trainings for staff…These were conducted as purely political meetings to raise awareness among the expert community, the specialists themselves, politicians, the Ministry of Health, those who determine that there is evidence that this is right, that this needs to be done if we want serious changes in the field of reduction of new cases of HIV infection.

Folded into this objectivization of methadone are stakeholder meetings, political gatherings, and applications for international donor financing—all practices that contribute to the enactment of globally-evidenced methadone treatment for the purpose of HIV control among the prison population. Assembling methadone as outside the confines of the moralizing debates on drugs that pervaded the political discourse at the time, this set of practices make the otherwise unstable object of methadone stable through its proposal as a solution to a crisis of dramatic urgency.

Discourse of 'evidence' makes methadone HIV prevention

The Government Program's departs sharply from the primarily Russian-led enactments of methadone treatment as a *narkotik* (Elovich and Drucker, 2008) towards the mobilization of 'evidence-based' discourse to produce methadone as HIV prevention. This move is underpinned by a range of assumptions. Methadone's initial enactment as HIV prevention entered ZPTM in Kyrgyzstan into broader discourses of 'evidence-based' harm reduction approaches—the framework underpinning harm reduction research (Birbeck et al., 2013). The underpinning assumption of this approach is its 'value neutrality,' wherein medical decision-making relies on the 'best quality' research on 'what works,' hinging on markers of 'effectiveness,' to improve health outcomes (Lancaster et al., 2017b). The knowledge, or 'evidence,' produced through 'evidence-based' research methods, with the randomized controlled trial as the gold standard, is taken for granted as rational and apolitical within 'evidence-based' discourse (Lancaster, 2016). It is "seen as uncontested, capable of being translated into

policy under the rubric of 'what works'" (Bacchi and Goodwin, 2016: 10). Promoters of harm reduction approaches to drug policy have voiced commitments to rationality and pragmatism aimed at exiting the moralized constraints of the drug debate, which they argue impedes improved health outcomes by invoking blame of people who use drugs (Strang, 1993, O'Hare, 1992). As Helen Keane writes, harm reduction's "professed value-neutrality can itself be seen as a powerful intervention in the moralized arena of drug debate" (Keane, 2003). This discourse of medicalized neutrality, embodied in evidence, is mobilized within harm reduction to buoy the legitimacy of drug policy decisions, rendering them 'objective' (Lancaster, 2016).

Additionally, the discourse of 'evidence-based' medicine and harm reduction features prominently in the hinterland of practices associated with methadone policy. This production of evidence-based methadone relies on a range of relations between local methadone treatment and global evidence-based medicine. Through these relations to expert knowledges within global health, the discourse of 'evidence' thus becomes part of the making of methadone as HIV prevention in Kyrgyzstan. This relationship is accomplished in a number of ways, primarily when local policy documents cite global health research on methadone's effectiveness. Here, I briefly explore how these practices intertwine to make the object and the goal of methadone as HIV prevention seem incontrovertible.

Methadone treatment is a staple of global health research on opioid addiction and HIV (Larney and Dolan, 2009, Low et al., 2016, MacArthur et al., 2012). In Eastern Europe and Central Asia, there is an urgent call to implement opioid agonist treatment as a response to the growing HIV epidemic in the region (see Chapter 1) (Alistar et al., 2011). The Government Program draws on a range of 'evidence-based' studies that establish methadone as a first-line response to the HIV-related harms associated with the injection of illicit drugs through its effect

on adherence to antiretroviral therapy (Low et al., 2016) and prevention of further HIV transmission (MacArthur et al., 2012).

The expert knowledges of 'evidence-based' methadone feature prominently in health policy in Kyrgyzstan; given the dominance of international donors promoting 'evidence-based' methadone treatment, such as the Global Fund, alternative enactments are financially unsupported and legally unrecognized (Ancker and Rechel, 2015a). By aligning ZPTM with the expert knowledges of 'evidence,' the Government Program mobilizes this 'value-neutral' approach to extricate methadone from the moralizing debates about the nature of methadone in relation to pleasure. Methadone as a response to the harms associated with HIV shifts discourse from the dichotomy of methadone as a *narkotik* (producing compulsive behavior) and methadone as a *zamestitel'* (producing no euphoria).

The enactment of methadone as an 'evidence-based' response to HIV infection, however, is a move away from the moralizing relations with heroin, entering methadone into relations with evidenced-based discourses of harm reduction. Both the *narkotik* and *zamestitel'* are made in relation to heroin. In other words, they become what they are—a substance to be banned due to similar drug effects as heroin or a substance to heal due to its ability to replace heroin's effects—through their relationship to heroin. Relations with heroin provide the basis for which methadone is banned in the East and promoted in the West.

This move, in turn, lends methadone the legitimacy needed to overcome its regional enactment as a drug used recreationally for euphoric effects. Neither replacing nor mimicking heroin, the methadone as HIV prevention attempts to de-pathologize the methadone user through particular formulations of health coherent with global health models of patient citizenship (Rance, 2009). Methadone use becomes sanctioned by aligning it with a purely medical practice aimed at returning to 'normality' through the prevention of new HIV cases and the improvement of HIV outcomes (Fraser and valentine, 2008,

valentine, 2007, Rhodes, 2016). Extricated from its relations with heroin, methadone is thus produced as a 'neutral' harm-reducing object of medicine, rather than a narcotic or a substitute for narcotics.

Methadone as formal governance

Methadone as governance begins to emerge within subjugated knowledges of local stakeholders

I have shown thus far that multiple methadones are made within the Government Program: methadone exists as a *narkotik*, a *zamestitel'*, and a response to HIV. The mobilization of 'evidence-based' discourse that gives traction to methadone as harm reduction raise questions about what knowledges are rendered legitimate and, by extension, illegitimate, in the production of methadone. As Lancaster et al. write, "The singular focus on producing evidence of 'what works' in drug treatment eschews a range of prior questions about how things may be 'known' and how the 'problem' to be 'solved' by drug treatment may be understood" (Lancaster et al, 2015: 623). What ways of knowing methadone as an object in Kyrgyz prison are silenced by the privileging of 'evidence-based' discourse in national drug policy? Though the majority of methadone's local materializations through the Government Program are mutually co-constitutive with those of global health methadone, there are also entirely different enactments at play on the local level.

Virtually absent from the formulations of ZPTM in policy texts (save the few examples I list above), but integral to its performance, alternative problematizations of methadone emerge from the "subjugated knowledges" of local stakeholders. Subjugated knowledges are made through discursive practices that "survive at the margins" (Bacchi and Goodwin, 2016: 22) of authoritative expert knowledges. In this case, as I have shown, the expert knowledges of 'evidence-based' medicine dominate the national discourse on

methadone, producing it as HIV prevention. To get beyond these knowledges in my fieldwork, I turned to the typically disqualified knowledges that emerge from the 'hinterland' of practices and run counter to the global 'evidence-based' consensus.

I found that methadone as formal governance emerges within the subjugated knowledges of local stakeholder discourse. As I mentioned in the section above, the Ministry of Justice PowerPoint presentation enacts methadone as HIV prevention, in line with global health discourses of harm reduction. There is another, more hidden, methadone within this presentation, however. The Ministry of Justice lists several aims for the program, which lie outside the confines of improved health outcomes for prisoners, including:

> Increased trust among prisoners (the clients of ZPTM) toward the staff of the Prison Service and the medical personnel; reduction in flow of illegal narcotic substances; and the development of communication skills among ZPTM clients. (Akmatova, 2008)

Within this text, methadone is being made otherwise. These aims depart from the legislative enactments of methadone as HIV prevention to produce a contrasting problematization and methadone object. The problem to be addressed within this presentation is the illegal heroin trade and its impact on relations with the prisoner population. Methadone, as a solution, then, becomes a methadone that is *more than medical*. It is a hope for improved relations of the formal prison administration with the informal governance of the prison. It is also a hope for a reduction in the heroin trade. We see that the methadone object that emerges from this problematization is imbued with the workings of power within the prison. It speaks to the complex interplay of formal-informal relations in the making of drugs.

While silenced in global discourses on methadone, local discourses constitute the problem to address with methadone as a lack of governance of the prison, brought about by the *obshchak*-controlled (or, informal governance controlled) heroin trade. This problematization is implicitly contained within the aims of the Ministry of

Justice. Within the proposal of methadone for "improved relations" lies the problem of prisoners whose allegiance lies with the *obshchak*,[21] outside of the formal administration. Within the proposal of methadone as a reduction in the drug trade of the *obshchak*, lies the problem that *obshchak*-run heroin trade exerts influence over prisoners' lives at the expense of the state government. And, lastly, within the proposal of methadone for developing prisoners' communication skills is the problem of prisoners, living under the auspices of the *obshchak*, who do not adhere to the disciplinary measures of formal governing structures.

A particular methadone object is constituted as an effect of the ZPTM proposal within this PowerPoint presentation. Acting as a response to a lack of formal state control of the prison, methadone as a mode of formal governance, or a methadone of the reds, materializes. A significant feature of this methadone is the hope for "increased trust among prisoners." In other words, therein lies a hope for the state to regain control of the prison population, as the allegiances of prisoners would shift from the *obshchak* the formal administration. The call for the development of "communication skills" further clarifies this. Implicit here is the call for prisoners to develop trust and communication skills with the *formal* prison administration at the expense of the *informal* (the *obshchak*) through the implementation of methadone. Increased communication and trust with the formal administration are desirable behaviors that methadone as a proposal is positioned to cultivate. Methadone of the reds is produced as a *governmental technology for societal administration*. It works to constitute subjects by eliciting normalizing practices, thereby rendering them *governable*.

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[21] The *obshchak*, used in this sense, is a term particular to Kyrgyz organized crime. In Russian more broadly, it signifies a common fund of pooled resources. While this meaning is also in use in Kyrgyzstan, the use of the term here signifies the elite leaders of organized crime who govern the prison. See Chapter 6 for the implications of the practices of the *obshchak* for health.

Through these aims, methadone folds into the shifting relations of formal and informal governance, becoming a way to govern in line with formal administrative goals. We see methadone-as-governance among the expected results of the program, which the presentation lists as "the improvement of the criminal situation in the facilities of the Prison Services which are involved in the project." Implied in the reference to the "criminal situation" is a reduction in governing power of those who run the drug markets, the *obshchak*. Through the historical contingencies of Post-Soviet Kyrgyzstan, informal administrative practices, rather than formal, have emerged as significant in determining the disciplinary regime of the prison. The *obshchak* has steadily increased its influence in the prisons through its handling of the heroin trade. Thus, methadone becomes an antidote for the power "congealed" (Foucault, 1987: 114) in the *obshchak,* particularly through its operation of the heroin market.

The historical contingencies of state power producing methadone as governance

Because the methadones otherwise produced within the Government Program are entangled with regional discourse of methadone as heroin and global health discourse of methadone as HIV prevention, both of which are more heavily intertwined with expert knowledges, the more local manifestation of methadone-as-governance features minimally (only in one sentence) in this document. The methadone of governance is silenced in global health discourse as well as national discourse heavily intertwined with global health (like the Government Program) so, to understand its making, I had to turn elsewhere. Since the Government Program offers ZPTM as a proposal to the problem of governing the socioeconomic status and security of the Kyrgyz state, it becomes significant to understand the historical contingencies that brought about this lack of governance. In other words, I wanted to delve deeper into the material-discursive power relations of prison governance.

Receding into the background of the Government Program is a manifestation of 'methadone as governance.' Because this mention is minor, consisting of just one sentence, I follow the hinterland of related practices (specifically, historical policy texts on methadone treatment implementation and stakeholder interview accounts; see "Discourse as governance" section, Chapter 2) to further unpack this enactment. With this genealogical analysis, I aim to bring the historical contingencies of methadone's making to the surface to reveal the conditions of its emergence as an "object for thought" (Foucault, 1988a: 257). In turn, this reveals the silenced enactments of methadone that stray significantly from those produced through 'evidence-based' discourse. Turning our attention to silenced methadones allows us to understand the way methadone translates in unexpected ways.

While national medicalized methadone is co-produced with global health methadone, the methadone produced through the local power relations of the prison strays significantly from this materialization. Within the Government Program, another, less visible and more local methadone is being produced. Rather than a methadone tied up with regional discourses of heroin addiction or global discourses of HIV, this is a local methadone entangled with the governing practices of prison. The Government Program states that implementing ZPTM in the criminal justice system is a response to the problem of an HIV epidemic that "impedes socio-economic development and threatens national security of most affected countries" (2006: 3). ZPTM here is a proposal responding to a national socioeconomic crisis. This produces a methadone that is no longer medical but concerns the stability of Kyrgyz nationhood. This is methadone-as-governance—a mode of reclaiming state socioeconomic control and national security.

Over the past 27 years since Kyrgyz independence, significant historical shifts in Kyrgyzstan's sociopolitical landscape have occurred that, rather than medicalizing methadone, have constituted it as state governing power. To

explain how methadone came to be constituted in this way, I first examine the history of the loss of state governance of the prison system. It is this loss that created a vacuum for methadone to be made into a mode of reclaiming state control of the prisons.

In the years of the Soviet Union, the prison system was a site of state control with a strong budget (the prison service was the fourth largest recipient of government funds) and industrial infrastructure (the criminal justice system housed 12 enterprises—a large number for a small country) (International Crisis Group, 2016: 8). Industry was a major source of income for both the Prison Service and the prisoners. The fall of the Soviet Union was followed by a breakdown of the Kyrgyz state apparatus, with the criminal justice system taking a particularly hard hit (International Crisis Group, 2016). A financial crisis following independence led to a general economic downturn that slowed state-run enterprises and affected the pay of prison staff and upkeep of prison infrastructure. Additionally, Kyrgyzstan's economy was affected by a cut of economic ties with other Soviet states, especially the Russian Federation—Kyrgyzstan's politically and economically more robust neighbor. The prison system, no longer providing resources for other Soviet states, lost its status as an economic stronghold of state-run industry. The loss of resources and state governing power after 1991 meant that the budgets decreased (financing in 2005 covered 26% of the Prison Service's needs), the factories fell into disarray, employment for prisoners disappeared, infrastructure crumbled (most prison facilities have not been renovated for 30 to 60 years), and the hold of the state weakened (as a prison doctor explained, "we don't have anything left, just prisoners sick with tuberculosis") (International Crisis Group, 2016: 9). After the collapse of the one-party political system, government institutions, including the criminal justice system, were newly weakened. Corruption flourished as individuals took state resources for personal gain.

Local stakeholders signify the weakening of state power as the collapse of the '*rezhim*.' *Rezhim* within prisons is a set of regulations, written into law, governing all aspects of prisoner life, including sentencing conditions, prisoner surveillance, and safety measures. As long as *rezhim* is maintained in the prisons, the government more or less has control of them. Due to a lack of resources (for example, employees of the Prison Service were some of the lowest-paid employees of the government security apparatus) (International Crisis Group, 2016: 1), the Prison Service could no longer supply prisoners with legally mandated *polozhniak* (prisoner slang for the array of legally mandated goods, such as hygienic and food products). This continues to be the case today and makes the case for *rezhim* moot: if the Prison Service cannot provide legally mandated goods, the prisoner-run informal governance, called the *obshchak* takes over.

The historical contingencies of the heroin trade producing methadone as governance

The collapse of the *rezhim* made way for a particular relationship between heroin and methadone that produced the former as informal and the latter as formal governance. A practical text invoked by the Government Program's proposal of ZPTM as a solution to a loss of state governance is a jumping off point for understanding how. The government legislation called "Anti-Narcotics Campaign of the Kyrgyz Republic" (Government of the Kyrgyz Republic, 2014), participates in the materialization of methadone as governance by invoking methadone's relations with the economies of other substances, namely heroin. The Anti-Narcotics Campaign states that ZPTM is a response to the illegal drug trade and adds that "the current program [of methadone treatment] is one of the primary means of counteracting…the illegal drug trade" (Government of the Kyrgyz Republic, 2014). This gets us underneath the Government Program's call to reclaim socioeconomic control by getting to the heart of the problem: heroin, the illegal drug with the greatest economic impact in Kyrgyzstan

(Kupatadze, 2014a). The introduction of a state-run ZPTM is a proposal that acts as a countermeasure to the heroin trade run by informal prisoner governance. This leads us to the question, what kind of methadone object flows from this proposal? To consider how it is possible for methadone to be produced as formal governance, I follow the discourse within practical texts to look at how heroin is intertwined with informal governance within the prison.

A series of political events made way for the entanglement of heroin with a lack of state control, eventually opening up space for methadone to manifest as a solution to this problem. After the fall of the Soviet Union and the economically turbulent 1990s, the financial crisis within the Prison Service, and the toppling of the regime of President Akaev following the Tulip Revolution in 2005, a power vacuum formed, which allowed criminal factions to regroup and affect politics. Political stability nationally is linked to power equilibria within prisons; political turmoil and regime transitions are associated with prison destabilization (Kupatadze, 2014b). The departure of President Akaev, coupled with the poorly financed and weakly controlled prison system, inflicted political turmoil. The *vor*, Aziz Batukaev, was living in one of the prisons near Bishkek and directed riots that led to the taking hostage and killing of a member of parliament by prisoners. Through this turmoil, the *obshchak* garnered a new status.

Governing power in the prison defines a prison as red, mostly governed formally by the state, or black, mostly governed informally by the prisoners themselves. Kyrgyz independence was marked by the end of the *rezhim* as informal prisoner leaders took the reins of governance within the prisons. And all the prisons in Kyrgyzstan turned black; as Vitalii, an NGO employee working with prisoners who inject drugs, explains:

> There's no *rezhim*. Before there was *rezhim*. Now there isn't. Now it's just, well, you know, the head of the prison and the *smotriaschie* [members of the *obshchak* who oversee governance], they come to an agreement. They sit there and decide what to do. I saw how they beat up

> a prison guard, a young guy, who wouldn't bring in heroin. That's how it is. [Vitalii]

Before, the employees of the Prison Service had been the *obshchak's* partners but now they were its subordinates (International Crisis Group, 2006: 15). Today, the formal prison administration retains some control of the prisons; primarily, they manage relations of prisoners with other state institutions and oversee the entry of goods and people into the prison facilities. But this is a *de jure* sort of governance. The majority of prisons are 'black' (governed primarily by the *obshchak*); significant financial resources, management of the economy, and decisions affecting the everyday lives of prisoners are made by the *obshchak*. And the heroin trade is their primary source of income—the lifeblood of informal prisoner governance.

It is not surprising then that policy texts invoke heroin—the problem to be solved by ZPTM—as a loss of state control. Heroin use and prisoner rule was strongest from the 1990s to the end of the 2000s. As Sasha, a former prisoner, who now works at an NGO for released prisoners explains: "There were no problems at that time. The Administration didn't watch over us. Every camp took care of themselves…The camps were black at that time. It was black rule." Bulat, a member of the *obshchak*, who was in prison at the time, explains:

> Every prison was surviving on its own. There was no control of the camps, everyone was stuffing their pockets. There were some resources allocated to every camp, like food…A van couldn't even make it to the camp with this delivery…bread, food…Half of it was already sold on its way [to the prison], by the prison staff themselves.

The biggest source of power and income for the informal leaders was heroin, which was sold through a *'bazaar'*—an open market of prisoner-dealers who sold heroin and gave a portion of their earnings to the *obschhak*. Heroin flooded the prison markets in the late 1990s. As heroin use increased with the onset of fiscal crisis, the influence of state employees decreased.

The state narcological system experienced significant budgetary contractions and the influence of narcology as a field declined (Raikhel, 2013: 86). Interviews carried out with prison staff from the mid-2000s to investigate the impact of political instability on prison life show that, confronted with a lack of resources and no longer able to provide necessary care, they sought support from the *obshchak.* A prison doctor noted, "We don't have our own ambulances and we don't have money to transport our patients to the hospital. So we go to the *obshchak* and ask them for money. We have to return the receipt of payment to them and they even complain that we spent too much money on gas" (International Crisis Group, 2006: 16). In this way, the *obshchak* stepped in to shape the course of medical care within prisons.

The formal administration's lack of economic resources meant that it was unable to address the rise in heroin trade and increase in HIV independently. It is this *obshchak*-controlled prison, with its management of drug sales and influence on medicine, which saw the entry of ZPTM. In 2008, ZPTM was launched as a pilot in Prison 47 and two jails (called SIZO in Russian). In the same year, the for-profit heroin sales through the bazaar were suspended by the *vor*. Individual prisoners could no longer sell heroin; this effectively incorporated heroin completely into the *obshchak.* No longer sold in exchange for money, heroin was, instead, distributed for 'free' by the *obshchak* to certain prisoners either in exchange for work or for celebrations, like the *vor*'s birthday and the New Year. At the same time, the formal prison administration began the 'free' distribution of methadone. As Daniiar, a prison doctor, explains:

> Why did they [the prisoners] quit it [heroin]? Because the head of the criminal world, the *vor*, he gave his word that heroin should be stopped in all the camps, to close down its sale [*zakryt' etu lavku*]. And they closed it, and those who had been using heroin for a long time, for them to quit, just like that, it's really hard. And it's not just one, not just two people, it's half the zone that started going crazy [*nachalo tam kryshu sryvat'*], getting sick from this heroin, from these withdrawals, yes. They switched right away to methadone, at this time, methadone arrived to help.

The monopolization of heroin into the *obshchak* and methadone into the prison administration entangled the two substances within the formal and informal relations of power of the prison.

Conclusion

I have shown that in Kyrgyz national policy documents, methadone is, in large part, holding together similarly to the medicalized methadones of global health. The global health-led proposal of ZPTM produced a new methadone object, generally in keeping with global narratives of a response to the problem of rising HIV incidence. This enactment is produced through the discourse of value neutrality within 'evidence-based' medicine; this discourse extricates methadone from the debates about its similarities and differences from heroin. Local legislative documents tease methadone apart from heroin by stepping out of regional debates that portray methadone either as a narcotic due to compulsive use (like heroin) or as a superior replacement due to the lack of euphoria (unlike heroin). The resulting object of methadone as HIV prevention is an effect of ZPTM as a proposal to curb an out-of-control HIV epidemic. This methadone object confers stability by relying on the expert knowledges of 'evidence-based' medicine, which carry more financial and political weight in the policy arena than local knowledges.

But the local methadone as formal governance, made through marginal policy and stakeholder discourse, is a silenced methadone. By unpacking the relations in the making of this methadone, I have directed attention to a methadone of governance that has not previously been discussed in global health publications. I have outlined how the shifting constitution of formal state power, underpinned by diminishing economic capital, the dwindling influence of narcology, and increasing dominance of *obshchak*-run heroin produce a set of circumstances that make a methadone of formal governance possible. This

methadone is inextricably intertwined with the strategic relations of prison governance.

Flowing from the local proposal to increase formal state governance of the prison by countering the *obshchak's* heroin trade, the methadone of formal governance is produced as a counterweight to the heroin of the *obshchak*. Historical contingencies of formal/informal governing relations have imbued heroin and methadone with a politics, or the "strategic," although unintentional, mechanisms that arrange things to converge in certain ways (Bacchi and Goodwin, 2016: 14). Local stakeholder methadone is predicated on the network of practices that inscribe a governing divide between the red, formally run, and the black, informally (or *obshchak*) run, territories of the prison. A dichotomy is thus produced between the heroin of informal state power relations with the methadone of formal state power relations.

This is where the local and global health-infused problematizations of methadone intersect: both are made in relation to heroin. While the methadone as HIV prevention in national policy texts relies on global health methadone to step out of its relations with heroin, the methadone of formal governance dives methadone back into the politics of heroin. Ironically, in their production as opposing governing bodies, methadone and heroin become intricately intertwined; the making of one cannot be done without the other.

Understanding methadone's local performances can expand the way we think about methadone delivery in the prison context beyond its 'evidence-based' enactments. To get at this performance, I explore the bodily effects that flow from the rendering of methadone as governance in the next chapter, particularly through its coming together with another substance, Dimedrol.

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Chapter 4—Methadone's embodied effects: The toxic methadone-Dimedrol complex

> Discipline is beautiful. Here two elements testify to it: clean children who march in orderly fashion through the city streets are more beautiful than a gang of sick, dirty street scum in libertine postures.
>
> (Anton Makarenko quoted in Kharkhordin, 1999: 104)

Summary of chapter

In this chapter, I take prisoners' accounts of drug embodiment as the unit of analysis to describe the features of the methadone *made* in this context and the kinds of subjects it produces. Drawing on new materialist ideas of drug effect (see "Embodied drug effects as governance," Chapter 2), I explore methadone's multiplicity through its practices of implementation, particularly its relations within an actor-network of other substances. I map the variability and multiplicity of three substances (methadone, heroin, and Dimedrol) as the prime actors in a drug assemblage, tracing the different ways they come into connection with each other, and with what effects.

Methadone: the anti-heroin object

Heroin as healing

The collapse of the Soviet Union was followed by an influx of heroin into Kyrgyzstan, including the prisons. Heroin use peaked in the late 1990s until it was incorporated into the informal governing body of the prison, the *obshchak* in 2008. Prisoners' accounts, offering a retrospective on this time, produce heroin as a substance of degradation, enacting political, material, and moral

chaos and disorder. Accounts work to weave heroin into the economic and governing upheavals of the post-Soviet period: "In the 1990s, when our country was falling into the heroin pit…everything started collapsing, everyone was buying [heroin], and a lot of it" [Yevgenii]. At this time, prisons had a 'free market' for heroin, called the bazaar, where anyone could buy or sell the drug. Participants associate the exchange of money for drugs with a degradation of the *poniatia*, a moral corruption: "When money started flowing, some turned a blind eye, let everyone go get it. As long as money is flowing, you understand? And that's it. Everything got mixed up with money. Everybody started going to buy." Correspondingly, the heroin of this time was a heroin of disarray, stripping prisoners of their 'decency': "The *poriadochnye* [literally, 'the decent ones'; the middle prisoner *mast'*] guys, who've never come across this, they started. Well it's prison, this and that, what do you do? Drugs are available and they start…they became weak in spirit" [Yurii]. Yurii continues that these heroin users could not "stay true to their word;" the act of staying true to one's word, or maintaining the community's trust, is essential to maintaining one's social status within criminal subculture. Even more than a bodily harm, the heroin of that time is enacted as a moral danger, destroying people's moral compass. The corruption of the *poniatia* brings a corruption of the soul.

In 2008, with the ascension of the new *vor*, Kamchy Kol'baev, the bazaar was closed, and the *obshchak* absorbed heroin. No longer sold by dealers, today heroin is exclusively distributed by the *obshchak*. This new drug policy ushered in a shift in the way that the substance of heroin is produced socially. A contingent of participants, lamenting this arrangement, constitute this new heroin, made available through the *obshchak*, as an insufficient substance. It is a substance lacking ("There's no bazaar, and this gram [mL] of heroin, what is it? Nothing"), of low concentration ("It's just that heroin is now weak"), or too sporadic ("There are disruptions. They shoot you up one day, and then there's no heroin for three days"). These accounts work to establish heroin as a substance requiring certain levels of supply and consistency in its quality to

fulfill its full potential. And the *obshchak* becomes a governing mechanism responsible for fulfilling this promise: heroin delivered through the *obshchak* at sufficient concentration, quantity, and timeliness is heroin done well. This heroin stands in direct contrast to the pre-*obshchak* heroin which was a heroin producing disorder and ill-health.

The demands that the *obshchak* sets on heroin distribution enable a heroin program ideal, and this ideal is one of *treatment*. The incorporation of heroin into the *obshchak* aligned heroin distribution with turning the tide of addiction. One participant called the closing of the bazaar "war with *narkomania* [addiction]." As a result, and in contrast to the times of the bazaar, heroin use today is a much smaller phenomenon: "It's just that now there are no more drug addicts in the prison. In the past, 70-80% of the prisoners used drugs. Everyone in the prison was on the needle. Now it is different" [Nursultan]. And the use that does occur is enacted as a form of 'harm reduction.'

The distribution of heroin by the *obshchak*, called the *razgon*, is carried out by the *smotriaschie* [prisoner-overseers] who do not do drugs themselves but oversee the procedure of the *razgon* to ensure its smooth function. The *smotriaschie* mix the solution in a 500mL bottle, test it for strength, and transfer a portion of this solution to a 20mL syringe. This solution is distributed into a smaller syringe by removing the plunger of the smaller syringe and squirting some of the solution from the bigger syringe into the smaller syringe. Participants describe the way that "they" (the *smotriaschie*) carry out the *razgon*:

> Each one comes with his own syringe and takes it…They pour it into his syringe and that's it…From another syringe. A big one. [Esenbek]

> When they pour, for instance, you're talking about the *razgon*. Thirty people, let's say, in the barrack, 30 people receive it. So the one who's receiving it, he goes with the syringes, he takes three 10-mil syringes with him. He doesn't do drugs himself. So, he takes from the common pot, so to say, takes it, and goes to the barracks, and then these 30 people go to him, each with his own syringe, he pours one mil into the syringe.

> That's how it is here. [Nurlan]
>
> They make a solution and for everyone, who does drugs, who's sick, they pour it for them… They boil the water, there are large bottles, they put in that powder, into the boiled water, and there are four or three of those [large bottles] for everyone, for a thousand people. One mL for each. How much do you get? If you calculate it. That's a lot. And from that they take 20 mL syringes, they draw up 20 [mL] and take some four or five twenties [20 mL syringes] and it's poured like that for everyone. One is done, another one, a new one…I come with my own [syringe] …Yes, yes, he pours in there [in the back of the syringe]…you have this thing [the plunger] that you take out…The syringe is mine. I come with my own syringe, they pour for me. I leave. Another person comes up with his syringe, they give it to him. [Chingiz]

This procedure is centralized such that it is only performed by authorized members of the *obshchak* and standardized throughout the entire prison system. As Chingiz points out, the solution is poured for prisoners who are "sick." This is an important point of departure for the enactment of heroin as treatment.

In contrast to heroin sold during the times of the bazaar (pre-2008), the heroin distributed through the *razgon* today, under the auspices of the *obshchak*, is a *different* heroin. Present day heroin emerges as a heroin of disease prevention via its contrasting with the harm of pre-*obshchak* heroin:

> Well, the brother, Kamchy [the *vor*], he announced a *progon* [a directive; in this case, ordering the closing of the bazaar in 2008], mainly because of drugs. There were many deaths, too many TB cases…Someone shoots up, the syringe is washed and left there. Another one comes: "Give me the syringe." They give it to him. Some give each other HIV/AIDS with the syringe.[22] [Mirlan]

[22] I have used this quote in a manuscript Gavin Slade and I prepared for *Incarceration* called, "Governing through Heroin: Drugs and the Resilience of Informal Order in Prisons in Kyrgyzstan."

Pre-mixed heroin from the *obshchak* today is an improvement to the pre-*obshchak* heroin: it is a heroin of safety, as compared to the heroin obtained through other means, often called "illegal." This enactment is grounded in four harm-reducing practices: clean syringes, management of withdrawal symptoms, decreased overdose cases, and the prevention of heroin initiation.

When receiving one's dose from the *razgon*, the overseer of the *obshchak* will make sure that each participant has a clean syringe, especially if he is aware they have HIV.[23] The *smotriaschie* sometimes ask participants in the razgon to unpack syringes in front of them to ensure that they are indeed uninfected.[24] Those participants without clean syringes, "they will stand to the side."

Given the low heroin concentration in the distributed solution ("Here [in prison], from such a dose… there's a high, but it's not the same effect as outside [of prison]") and the sometimes-intermittent access ("you're shooting up once every 10 days"), this is not a heroin of euphoria but of withdrawal prevention:

> It [the *razgon*] stops them [the prisoners] from going through withdrawal. If someone is an addict doing time there, because you know that the third, fourth day [without heroin] a person begins, he shakes terribly. Two days, you can still take it, right. And then suddenly, so you get the *razgon* and you feel better. [Alim][25]

Going through withdrawal is often called "being sick," and thus heroin is considered healing. Some accounts enact a counter narrative of an unhealthy heroin distributed through the *razgon*:

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[23] This statement is included in the manuscript "Governing through Heroin: Drugs and the Resilience of Informal Order in Prisons in Kyrgyzstan," submitted to *Incarceration*, (Slade and Azbel, 2019).

[24] Fieldnotes, September 20, 2017.

[25] This statement is included in the manuscript "Governing through Heroin: Drugs and the Resilience of Informal Order in Prisons in Kyrgyzstan," submitted to *Incarceration,* (Slade and Azbel, 2019).

> They take it out with a 20 mL syringe and start distributing. One person… the one who distributes…he pours for each person. It can happen that he pours more for one person, so he pours it back in [into the original 20 mL syringe]. And this, well it's mixed in with the common solution, and some don't know it, but they get infected. [Timur]

Crucial here is that even the accounts that enact an unhealthy heroin, do this in relation to a healing heroin ideal. This is a 'failed heroin,' a heroin not up to par with how it is 'supposed to be.'

Rather than the dry heroin that was sold by prisoner-dealers in the days of the bazaar, where the concentration was unpredictable, heroin is distributed today in pre-mixed liquid form, guaranteeing a safe concentration. This capacitates a predictable and, therefore, stable, heroin object. During the times of the bazaar, overdose was possible and imminent:

> Why do overdoses happen? Because he's shooting up with just heroin… He knows for sure how much to add, and then suddenly it's different, a different drug has come in, and he adds approximately the same number of spoonfuls. Well he can't see that it's like different, and he, well it's stronger, it just gets you, and so he shoots up, and it's really killer and that's it and that's how he overdoses. [Ibragim]

Currently the *obshchak* pre-mixes a "weak" solution before distribution: "in general, you see, they dilute one gram in 40 mL, about, sometimes it's 60 mL, it depends." This heroin is often invoked as 'safe' and 'harm reducing.' As Barat put it, "There's no danger from the *obshchak* at all, especially that the *razgon* is distributed to save people from dying, right?…They add more water, naturally, to avoid overdoses."[26] Sergei echoed this sentiment: "Yes, to avoid overdoses. That's a problem. It's a problem if a man dies" [Sergei]. Participants emphasized

[26] I wrote this statement for the manuscript "Governing through Heroin: Drugs and the Resilience of Informal Order in Prisons in Kyrgyzstan," submitted to *Incarceration,* (Slade and Azbel, 2019).

that overdoses from the *razgon* heroin do not occur because they "check the drug [*otravu*], so that overdoses don't happen" [Talgat].

There are accounts of overdoses, however. These are situated in the 'illegal' heroin use—the few instances of bazaar-like heroin that continue to exist outside the purview of the *obshchak*. When individual prisoners bring in heroin through their own channels, the unpredictable strength of the heroin, coupled with greed ("without trying it first, out of greed, for the high, to have a stronger effect"), can lead to overdose. The heroin that lies outside of the *obshchak*, in the hands of the estranged prisoner operating in the interest of individual desire, is a heroin reminiscent of the pre-*obshchak* 'heroin of chaos,' stripped of its healing properties.

Furthermore, heroin distribution is limited by the *razgon* to those who have injected previous to their incarceration—a practice that creates a group of 'diagnosed patients' deserving of heroin ("it's just purely for the sick"). The sanctioning of independent heroin transactions is further limited by the *progon* on initiating new prisoners onto heroin:

> If you've started injecting, let the *smotriaschii* [the overseer] know that you've started. And if an eighteen-year-old comes to him and says he's started injecting, he'll ask, "Who injected you? Where did you inject?" and even, "What time?" If it turns out that I'm his *seminik* ["family member"—a term used for prisoners who live together] and I've injected this eighteen-year-old, that's it, they'll break me to pieces for this. They won't even talk about it first. Because you never initiate a young person on heroin. This warrants a very serious punishment [*otvet*] according to the *poniatia*. [Nurlan]

Only those who are already 'sick' receive limited, regulated, and regular doses of heroin: "there were certain criteria set, only those who were already familiar with this [heroin] could come. Those, as they say, who have gone through this and weren't broken by it" [Bakyt]. That is, the heroin market is, in fact, not looking to expand. Only those who have been 'diagnosed' can continue to get 'treatment.' Much in the same way public health discourse constitutes

methadone (see "Methadone treatment" section, Chapter 1), heroin here is constituted as a treatment, heroin dependence as a disease, and its users as 'patients.'

The language employed by participants used to describe the *razgon* is one of either respect for the prisoners (given out "*na blago obshchestva*," or "for the good of society"), of medical treatment, or celebration ("When there's some important holiday, camp [prison] holidays in particular. Like New Year, birthdays, things like that"). Through this regulated and monopolized mechanism of the heroin *razgon*, heroin materializes as a medicalized or festive object, often called "receiving care," "helping," and intertwined with celebration, through its distribution on holidays. The distribution ritual of the *razgon* is sometimes cast as "paying attention to prisoners" [*udeliat' vnimanie*], which invokes an image of a doctor giving extra care to an especially sick patient. Dramatic social and cultural upheaval following the collapse of the USSR ushered in a heroin of chaos and disease. But the incorporation of heroin into the *obshchak* produces a heroin of healing. Heroin under different circumstances, affected by different practices, has different effects.[27]

Methadone as toxic

From the time the Kyrgyz government introduced methadone treatment into prisons with the support of international donors in 2008, the program has retained few patients and remained largely unpopular (Azbel et al., 2016b, Azbel et al., 2018). Nationally, following initial growth in methadone treatment uptake, the number of methadone patients has remained stable over the past five years (This amounts to 476 people in six of 11 prisons) (Borisova, 2018). To reach the standards of coverage the World Health Organization deems

[27] The previous three paragraphs are adapted from our manuscript "Governing through Heroin: Drugs and the Resilience of Informal Order in Prisons in Kyrgyzstan," submitted to *Incarceration,* (Slade and Azbel, 2020).

necessary to significantly reduce the number of new HIV infections, 1,224 prisoners would have to receive methadone (Azbel, 2020).

Study participants' accounts work to constitute methadone as a failure. Participants accounts produce methadone as a toxic technology, poisoning the body to the point of material and moral degradation:

> From what I understood, this methadone was introduced to fight heroin. But for some reason it didn't kill it [laughter]. On the contrary, it's just growing drug addicts, more and more. [Salamat]

Echoing Salamat's account, other participants' accounts cast methadone as *uncare* and bad health ("Maybe if I didn't have the health issues, maybe I would be continuing with it [methadone]. But since I have health issues, no;" "If not my health state now, maybe I would still be taking methadone. Until the very end. It's just that I have health problems now…so I stopped now"). Within the accounts, there is a strong sense of methadone inducing harm, a substance to be avoided in the case of health problems.

We can see that, in start opposition to the health-producing methadone within global health accounts (World Health Organization, 2012), local methadone disrupts the well being of the body in multiple distinct ways, with effects extending to the moral character of individuals and entire social groups. In what follows, I outline these local manifestations of methadone as they relate to heroin. Methadone's harms are made in relation to a local manifestation of heroin-as-harm-reduction, with the most pronounced effects of methadone being a dependence and, correspondingly, withdrawal, stronger than those induced by heroin.

Methadone in relation to heroin: an overpowering force

Within participants' accounts, methadone is made relationally to heroin; the two substances perform related work on the body. This 'work'—these material

effects—are emergent from the relations within a 'drug assemblage,' in which heroin is a key actor. Global health discourse presents methadone as distinct from heroin, a treatment rather than a drug (see "Methadone treatment" section, Chapter 1). Participants' accounts too make up the substance and effects of methadone relationally to heroin, but in the opposite direction: heroin through the *razgon* is necessary treatment, whereas methadone is a toxic drug. Key to these relations is methadone's 'neutralizing' effect on heroin: methadone messes with heroin's materialization as treatment. Methadone and heroin are linked in their materialization, the former working to erase the latter. Below, I unpack the relations of this assemblage.

There is an acute sense that methadone is a more potent substance than heroin ("Methadone has stronger cravings, it is stronger" [Viktor]). Methadone is constituted as a drug that, once started, is nearly impossible to discontinue, engendering a stronger dependency than heroin ("It is possible to give up heroin, but methadone addiction is much stronger, much worse" [Bashir]. "It creates stronger dependency than heroin…When you're taking heroin, if you quit, you're recovering for a month. Whereas with methadone, it took me six months to recover" [Zheenbek]).

And stronger dependence goes hand in hand with a more physically and psychologically intense, or 'stronger,' withdrawal:

> Last time I managed to stay away for seven days. But could not stand it anymore. The longer you stay away, the worse the withdrawals. When methadone is washed out of the system, I experimented, to see how long I would be able to stand it. It turned out, after heroin it gets better with every passing day, but after methadone…After methadone, ten days is not enough to fight physical withdrawals. Even with medicine. They gave me a drip here. They gave me Relanium. It was as useless as an udder on a bull. [Umar]

The fear elicited by even the thought of withdrawal is palpable. There is a strong sense of helplessness, with users succumbing to the power of the drug.

The body is talked of as being overburdened by methadone, its capacity overextended, caving to the lethal power of the substance:

> Withdrawal from methadone, a person can't get through it. If I was to just quit it cold turkey right now…as I quit heroin, where I'm sick for a week and that's it. With this, it won't work. I'll die. My body won't be able to take it…the methadone withdrawal. [Sergei]

Again, heroin is the point of comparison—albeit a point that is also shifting. On its own, and delivered through the *razgon*, it is a necessary treatment that can be overcome, if needed, bringing one closer to healing. In concert with methadone, however, this healing power is neutralized.

Methadone's strength is materialized through the 'overtaking' of heroin; there is a sense that methadone, through its power of acting, diminishes heroin. Repeatedly, participants recount the 'blocking' effects of methadone: those taking methadone are no longer able to experience heroin ("They cannot understand heroin, even when they use it, they cannot understand it… There is no effect. Methadone neutralizes, counter-balances it"; "Everybody knows full well that methadone knocks down the heroin concentration, you drink a sip and then you shoot up, useless, well useless"). What, then, are the effects on the body when methadone pushes heroin out of the way? In other words, what work does methadone, taking the place of heroin, do on the body?

Methadone as making up the body

The relationship of methadone and heroin is one of incorporation, with methadone swallowing heroin so that its effects are masked. I showed that heroin is enacted as a treatment. Methadone's effect of blocking heroin treatment produces a body bereft of healing. Accounts invoke methadone's potency through its mechanism of acting on the body, wherein methadone becomes entangled with the user's body.

Participants' narratives emphasize how the very material of one's body fuses together with the substance, becoming one: "First, it all builds up inside, right,

and the heart suffers, and the liver, and urine, and everything, basically it's the living dead, what's the sense?" [Aigul']. Methadone becomes a sort of entrapment. Longer-term users, unable to look back or quit, describe methadone as the building block of their bodies and bones: "I told them…I've been on methadone for 15 years, my bones are already made of methadone, I won't be able to quit, it's okay, you'll quit, he said, others in worse positions quit" [Timur]. Interview accounts constitute methadone as *seeping* through body, to the point that it is filled-up with it:

> When a person begins taking methadone, he gets a high. He's high from it, right, until his body is filled with methadone. It even has the property of filling up, right, methadone fills you up. He gets high, and the larger the dose, the more, basically, the better he feels. And then they don't understand themselves, i.e. they don't notice themselves how they end up, right? Drinking 300 grams, while he weighs 40 kilograms, 50 max. What's that? He can barely walk, and he's drinking 300 there. Basically, I know, I'm not stupid, I've read online what this drug is made of, and that people, if they abuse it, methadone, it really degenerates, they degenerate right before your eyes. They don't read, they don't develop, they, well, in general, they are aberrations. [Alim]

Methadone is described as "taking over" the body, transforming the healthy body into a *methadone-body*. The body becomes made of methadone.

But the interaction between the heroin and methadone objects and the effects they produce are not the only significant relations in the drug assemblage. Methadone is often taken together with another substance, an antihistamine called Dimedrol (generic name: diphenhydramine; Benadryl in the United States) that is available in pill form. In what follows, I explore the constitution and effects of the methadone object through its interaction with Dimedrol. Although emerging from accounts as the most significant player in the drug assemblage, Dimedrol use has not previously been explored in peer-reviewed literature. Below I explore how the methadone object is produced in particular ways through its relations with Dimedrol.

The methadone-Dimedrol object

A faint trace of 'solitary' Dimedrol

Today, Dimedrol is most commonly used in combination with methadone to achieve a high. Dimedrol is most commonly used in combination with methadone to achieve a high. Some time after drinking methadone (about 20 minutes), the pills are "crushed, shaken with water, drawn up [into a syringe]. Let's say, five tablets in five mL, and so you shoot up these five mL." Shooting up Dimedrol, rather than oral consumption, produces a much stronger high. Shooting up Dimedrol, rather than oral consumption, produces a much stronger high. While there are accounts of Dimedrol use predating the introduction of methadone into Kyrgyzstan, Dimedrol at this time was used sparingly and mostly to reduce nausea associated with heroin use.

Most, however, present Dimedrol use as a phenomenon that goes hand in hand with methadone. A cheaper alternative to heroin, it is precisely the *reaction* between the two that is the sought-after high. This connection is so strong that Dimedrol only registers as a substance in participants' accounts in concert with the introduction of methadone:

> Especially now that they've introduced methadone there. Now there's methadone and Dimedrol, it's such a mess with everything. [Taalaibek]

> Basically, Dimedrol was available before, but it wasn't the same consistency as now. Starting in 2010, when the methadone program was set up, the way methadone and Dimedrol interact, and this reaction created a miracle, it proved to be better than heroin. [Salamat]

> It's new, it's methadone and Dimedrol. I haven't noticed this before. Before there was just *khanka* [home-made injection opioid from poppy straw] and heroin, as far as I remember in all prisons, now there's this methadone. People are simply dying, after a while they pass away. I was offered to join methadone, no, I didn't agree to it and I won't. [Esenbek]

Some accounts go as far as to say that Dimedrol was ushered in by methadone. Prior to methadone, then, Dimedrol barely existed. A separable Dimedrol is a faint memory, currently non-existent, and exerting no work on the body.

Dimedrol: a way to re-enact the heroin experience

Unlike methadone's implementations elsewhere, and in contrast to its portrayals in policy as a solution to the problem of HIV (see "Methadone treatment" section, Chapter 1), I found that methadone in Kyrgyz prisons is often used in combination with Dimedrol. This is done to turn methadone, normally a substance providing no euphoria, into a high: "Methadone without Dimedrol doesn't get you high. It just takes away the withdrawal, stops you from being sick. But with Dimedrol, there's some kind of reaction that takes place" [Sultan]. Methadone patienthood without Dimedrol constitutes a dull 'robotic' existence. Adding Dimedrol re-ignites life: "I drink methadone, I'm going down a tunnel, I see nothing… I get Dimedrol, I shoot it up and I see a white light, birds chirping. It turns out I'm alive" [Kalmurat].

Methadone is enacted, in terms of the high it affords, in relation to both heroin and Dimedrol. Indeed, these substances interact. Methadone blocks heroin, eliminating the high. Dimedrol, on the other hand, provides an alternative pathway to the heroin experience by activating the high that methadone makes absent:

> They all do Dimedrol because methadone doesn't provide euphoria, no high. [Bakir]
>
> It seems the brain remembers that heroin trip, and Dimedrol gives this trip. But not for long. That's why the Dimedrol dose keeps growing. [Semen]
>
> It's like heroin, as though you've injected heroin [Sultan]
>
> Yes, and this [Dimedrol and methadone] is better than heroin, the high is stronger… You get this wave all over your body, that's twice as good as heroin. You drink methadone and you go and shake five pills, shoot them

> up, and there you go, the same as heroin. [Salamat]

Dimedrol, in a sense, works to restore the heroin that methadone erases.

Accounts often invoke the heroin experience as the ultimate goal. This heroin high, as articulated in Vitalii's narrative, is health producing:

> I injected opium, heroin, I tried pills, I didn't like them. I didn't like any of the pills. 'Cause I was a proponent of the sober high… this [preference] depends on how you were raised. First, second, third, fifth grade, I did sports, gymnastics, more sport.

Heroin is a "sober high," in its discipline, fitness, and morality. This high stands above the high afforded by other substances ("How can I explain it? Heroin has this tinge, this flavor, when the wave is about to start. It's our kind of high [*prikhod po nashemu*]. You can taste it. It's a completely different high, just completely different"). And Kyrgyzstan is the country with the best quality: "In the whole world, again, we have the best opium, again, we have the best marijuana. We have it here in Kyrgyzstan." But heroin is not regularly and readily available for all. (See Chapter 6 for a reading of informal governance in relation to heroin availability). Dimedrol becomes the surest path to this "sober" high ("[with Dimedrol] the brain starts to work faster. This feeling of reality, you get a crisper image. And then it ends, and you're not high anymore").

The entanglement of methadone and Dimedrol

The relative 'purity' of methadone is contaminated by Dimedrol, a banned substance which is even 'worse' than methadone in relation to the casting of moral position and administrative and bodily power. Methadone's entanglement with Dimedrol disrupts the notion of 'methadone as treatment' as proffered by global health, making it a drug. The narrative that cuts across participants' accounts is that of methadone's inextricability from Dimedrol. Daniiar, a participant on methadone, recognizing the problem with Dimedrol,

states that "the only way to get rid of Dimedrol is to get rid of methadone." This flips the traditional public health response to the problem on its head: instead of decoupling Dimedrol from methadone to preserve the purity of the latter, only with the full erasure of methadone can Dimedrol disappear.

Before turning to the bodily materializations of Dimedrol and methadone, let us first pause for a closer look at how these terms are used. Accounts oscillate between referring to the substances as going hand in hand ("if there wasn't methadone, he wouldn't be looking for Dimedrol" [Ali]) to attributing the same effects to both substances ("People die, right?…I don't know, as far as I understand it's from methadone. But they also take Dimedrol" [Kamal']) to fusing them together completely ("Those methadone-dimedrolers, it's just horrible!" [Kairat]). As Kairat explains, "Dimedrol or methadone, it's the same thing. This is the reason why I don't want to go on this methadone, because I know what happens… A person begins to transform from a human into an animal." The two substances are so intertwined that the words "methadone" and "Dimedrol" can be used interchangeably to refer to the same thing disrupting any clear demarcation between the two.

The shifting complexes of Dimedrol and methadone make it impossible to regard the methadone object as constant. Methadone, through its incorporations, becomes a different object, a Dimedrol-methadone object. Below I look at the practices of methadone-Dimedrol to outline how this object materializes. And the effects of engaging with this methadone-Dimedrol complex are dehumanizing: the self transforms into an animal.

Methadone-Dimedrol practices

The interaction between methadone and Dimedrol is inordinately powerful, described as both a "miracle" and a "poison," and evidenced by its practices of

administration, the high, and the body of its users. Let's take a look at each of these practices in turn.

First, instances of Dimedrol's use constitute a toxic drug of addiction. Dimedrol tablets are banned but available illicitly. They are crushed, dissolved in water, and injected around the time of drinking methadone; this injection process is repeated several times throughout the day. The procedure of Dimedrol use is repeatedly emphasized as unimaginable ("Can you imagine? Six pills at once into the vein, into the blood stream" [Kalmurat]; "You inject 40 pills a day. Can you imagine?" [Bakyi]; "They take dimedrol by the sheets" [Barat]; So from 9 a.m. to 5 p.m., it's 50 tablets, can you imagine what was happening? I don't even know how I'm alive still" [Rustam].) This excessive dosing denotes an unnaturalness; such large quantitates are not conducive to 'natural' human life. Those continuing to live while injecting are an abhorrent marvel.

Dimedrol promises a high stronger than heroin: "Experience has shown that it's even better than heroin. It's a very strong high" [Nikolai]. But this Dimedrol high has a flip side much like that of heroin: addiction: "first it's euphoria, then it's some kind of addiction to Dimedrol, too" [Zheenbek]. Addiction, here, is evidenced by an ever-increasing need for Dimedrol: "Because they also get addicted. Later, a tablet, two, it's too little, they start taking five tablets" [Mirlan]. Like with the high, the addiction is described as being even stronger than in the case of heroin. The overwhelming nature of Dimedrol addiction is repeatedly emphasized by users. When I asked Salamat what can be done to change the practice of combining Dimedrol with methadone, he responded with the following scenario:

> Well you'll have to say that it's the end of the world in an hour, maybe then something might happen [laughter]. Otherwise, they don't care, they wouldn't even care if it's the end of the world. I've seen a person who was on methadone, he was taking a large dose and decided one fine day to quit everything, on the spot in one day. I just saw his reaction, what started happening to him…He began losing his mind right away. Afterwards he was caught in the prohibited zone and was killed, that's

> that…Perhaps it's withdrawal, or something else, that a person begins losing his mind, he begins pouring soup on himself and so on, begins talking in a non-human tongue, well if, well I don't know what to make of it. [Salamat]

The force of methadone is beyond reason. The extreme practices of its use and effects have equally extreme consequences: loss of control, humanity, and eventually death.

To understand prisoners' decisions surrounding methadone, it is important to consider how the practices of methadone's use produce methadone-using subjects. In the next section, I explore the production of the dehumanized methadone-Dimedrol subject, focusing particularly on how practices of methadone-Dimedrol use make evidence about this particular subject.

The dehumanized methadone-mind

At the same time as offering a 'way out' of the banality of the methadone routine via a re-routed heroin experience, accounts equate Dimedrol to a complete loss of moral decency. We can glimpse this in the unpredictability related to the methadone subjects who are made-up through the accounts of prisoners with varying methadone experiences:

> It's like a monkey house. People are already not normal… It causes hallucinations, it closes up a person, he becomes crazy, delusions, hallucinations, talks to himself, doing things, this noise, that's it, he is lost. [Bakhtiiar, some methadone experience]

> They [methadone clients] would not answer your questions. Sometimes they would talk nonsense and gibberish. Their eyes are crazy. I heard someone say they would start going through garbage, or even put their hands in the toilet bowls. In a nutshell, people just become awful. [Sultan, no methadone experience]

These accounts of the psychology of the methadone subject work to constitute him as Other, as beyond knowability. No longer in tune with the 'normal' practices of daily prisoner life, the subject loses touch with reality. Defining this

Other in terms of an alternate reality, characterized by hallucinations and delusions, renders him unknowable. He occupies a different psychosocial space, and this space is grotesque.

But the effects of the methadone-Dimedrol object extend beyond the mind to the make up of the body. To further explore how subjects are governed through methadone's subjectification effects, let us reflect on how methadone constitutes the body as a particular kind of body (Bacchi and Goodwin, 2016: 69).

The dehumanized methadone-body

The extraordinary procedures of Dimedrol use and its psychological effects extend to its bodily-material manifestations, which participants' accounts emphasize as equally 'unnatural' and 'inhuman.' The user's body, having been 'filled up' with methadone, undergoes a transformation. Users of this substance complain of blisters; wounds; abscesses; bad teeth, lungs, and livers; an addiction worse than heroin; and unprecedented drug withdrawals. As Kalmurat notes, methadone users "degenerate right before your eyes." He continues:

> They disappear, the veins vanish. They're aware. They know that their veins are burning. They know about their liver. Their hearts grow weaker. They know and consciously do it. He gave up on himself. He just gets high. He needs nothing else. [Kalmurat]

Again, the substance of methadone-Dimedrol is powerful enough to take the will of the user hostage. The substance supersedes the body, leading to a loss of self and a loss of body. And when it overtakes the body, methadone-Dimedrol degrades. "I see them, those people who use 100 pills at a time. It's scary even looking at this person… Their legs are like my arm." The bodies of these users are literally deteriorating and disappearing:

> They have ulcers, all of them. All of them are rotting. And such a smell!

[Tursun]

> What person in his right mind, when he sees these zombies, excuse my language, all these people with abscesses. What person in his right mind would support this program? When doctors do autopsies on these methadone users they say they are all meat-jelly [*kholodets*] inside, they're like monsters. [Alibek]

These descriptions invoke the decay surrounding this methadone object—a new substance incorporating Dimedrol—which works to infect and break apart the body.

If methadone deteriorates the body, the logical end is that the body turns to nothing ("there is nothing but bones left in me"). The methadone body may end in "actual death," which is sometimes presented as rationale for resisting the introduction of methadone from the outside:

> Nothing will change for the better if I start taking methadone. That is the same drug [as heroin], but is killing people much faster than heroin. [Bashir]

> People die, right. Well, I already know many guys who used to take methadone, my acquaintances, die. Their livers give up, lungs… As far as I understand, it's from methadone. [Barat]

> We clearly realize it, that this is the killing of drug addicts, the methadone program…During [its] nine years, half of the population died. In nine years, half of them died!…It's slow death by methadone. [Sergei]
> I don't feel like it [taking methadone]. I still feel like living. [Kamal']

The association of methadone with death is so strong that some even see it as a conspiracy to kill prisoners who use drugs, or, as Talgat put it, "a legal way to kill people." As Salamat explains:

> The goal is just to exterminate the druggies, the thieves, and the killers. Many countries have said no to methadone. It's just our Kyrgyzstan that continues it. We have a lot of druggies. And I just see it, I see what's happening with this program, they're starting to die. At first, all's OK, he's blooming. And then one fine day, that's it, and he's a corpse…My bones started breaking, the joints were giving in, and I said, "No, that's

it." I'm still young, I have a life ahead of me. [Salamat]

Accounts often present Kyrgyzstan as an exception to the rule of banning methadone. Prisoners recounted rumors that Americans invented Dimedrol in order to combine it with methadone to kill the drug using population.[28]

The methadone body especially in light of its incorporations with Dimedrol, is enacted as a *less-than-human* body. The terms used to describe methadone users ("zombies," "monsters," "animals,") render them inhuman. The ill health brought about by methadone is evidenced in the visible physical degradation. This degradation is present in the personal narratives of users ("I lost my teeth to methadone"; "I drank it and half an hour later it all comes back out") as well as in the observations of non-methadone users ("They have sores and blisters… they have wounds"). In both cases, bodily ailments are directly attributed to methadone, and the knowledge-making instances are those that are witnessed first-hand:

> And so this methadone. Just look what's happening with those on methadone. You can't…just now a guy came in, it's sad looking at him. It's all because of your methadone. He's already shaking. [Nikolai]
>
> Well, I don't know, just looking at them [methadone clients], how they're killing themselves, I don't feel like it, I still feel like living. [Kamal']
>
> Well, you can tell that by just looking at the person. I tell you, it's enough to take two to three tablets and one can already see it in your eyes. [Nurlan]

Methadone's bodily incorporations are made real through witnessing. Daniiar, who was enrolled in the methadone program, is a particularly striking case. During our interview, he pointed to his body, outlining the sores with his finger, and said: "these spots right here are ripping apart, the skin. I'm beginning to dry out from these chemicals. I've lost my health. I'm already dying." Health is

[28] Field note, April 3, 2017.

something finite and the methadone-Dimedrol complex, agentic, eats away at it until it disappears. By bringing me into seeing the inscriptions of methadone on the body, Daniiar was creating knowledge about methadone. *Seeing* the devastating effects of the drug—whether on one's own body or the bodies of others—is a prime agent in creating methadone as toxic.

Attempting a pure methadone

I have shown that a toxic methadone and a correspondingly toxic body are made in Kyrgyz prisons. But what happens when methadone is practiced differently in the prison space? Can methadone be navigated as a 'good' and as a 'medicine' rather than an 'evil' and a 'harm? And how are these exceptions made possible?

In the different incorporations of methadone that are enabled by prisoners' practices, there is indeed a methadone without Dimedrol, but this methadone is a minority case. Upon methadone's introduction into Kyrgyz prisons, there was a methadone without Dimedrol, but only momentarily. Akylbek was one of the first methadone participants in prison and recalls his attempts to 'purify' methadone:

> It was me and another guy, we were two of the first to get in there… We also brought in phones and started communicating around the prison. We started talking, "well, it's all okay in here, it's even better, they even give you meals, they give you everything, really, it's like a resort." We presented it in a good light as far as we could, but it didn't work and they started introducing Dimedrol. When they looked from the side of the *obshchak*, "aha, those on methadone basically don't want to work, they pour methadone, what else do they need, aha, they follow up with Dimedrol"…And that's it, a widespread epidemic of abscesses broke out here, i.e. Dimedrol burns veins, then you get sores, kilometer-long bandages. When some young guy gets up and takes a walk around the prison and goes past the narcology unit, he sees this sight, who's sitting there stuck, kilometers of bandages. He asks, "Who's that, what's this? Ah, a methadone user."

This Dimedrol-less methadone, affording access to resources, is just a hope; it remains in a subjugated position. We see that teasing methadone apart from Dimedrol takes work, and this work often fails. Prisoners such as Akylbek who use only methadone are enmeshed with Dimedrol irrespective of their consumption practices. Akylbek's use is affected by the drug use of others' through his encounters. The capacity of others' practices to affect (Deleuze, 1990), then, are stronger than his individual use.

A minority of accounts work to separate methadone from Dimedrol. They enact a methadone object that is, at least in theory, separable, including in its capacity to affect:

> If they're drinking methadone alone and don't mix it with anything, they're normal, adequate people. But if they drink methadone and then grind 10 to 20 tablets of Dimedrol and shoot them up…sometimes they shoot up to 40 to 50 tablets of Dimedrol daily…of course they turn into idiots—their brains stop working. [Nursultan]

> You see, it's not methadone that's the problem. The problem is that people are using it together with Dimedrol and other medicines, you know. They drive themselves into the ground. It's not methadone that kills…of course methadone plays its role too…but it's mostly Dimedrol and other tablets that kill people. They start taking it, and it's impossible to talk to them…It's just unpleasant to look at the person in such a condition, you know. [Nurlan]

> They say that it, that people send, kill themselves into a grave, that it has a stronger effect on the body…Well there's no such thing, if you're not following up with Dimedrol…then everything will be okay. [Ali]

We can see that there is disagreement about the extent to which methadone on its own is also harm producing. But, importantly, whether a methadone without Dimedrol is enacted as harm or health producing, this enactment is consistently done through methadone's relations with Dimedrol.

Although the overwhelming majority of accounts inscribe methadone as the polar opposite of health, there are indeed instances of making a 'healthy' methadone. It is in and of itself significant, and perhaps expected, that this is

done by extracting the methadone object from the methadone-Dimedrol complex. These accounts attempt to do just that to produce a methadone affording calm:

> The harm is from Dimedrol, of course, only harm. Whereas methadone, I don't see any harm. Here, on the contrary, it's like…it's easier, right, calmer to drink, you don't have to steal. [Akylbek]

> Well, again, if you don't mix methadone with other things…So, you've got a normal life and much less problems than with drugs. You don't feel like committing crimes anymore. You're calm when going to bed because you know that you will wake up in the morning, simply go receive your dose and you won't feel sick. [Chingiz]

This is a struggle for a methadone that capacitates the body to recover: "Just imagine, I don't eat, I don't drink, I'm barely able to walk, I don't have health. And then, I go and I drink methadone, and I start moving, my appetite returns" [Turat]. These few voices draw a line between methadone and Dimedrol, aiming to repair and purify methadone to enable recovery. Similar to the global health narratives, they distinguish between 'drugs' and 'methadone,' even labeling the latter a "treatment."

The methadone of recovery is not inextricably intertwined with Dimedrol, but can indeed be teased apart from it. Unlike global health narratives which silence the story of Dimedrol in their attempt to purify methadone, this locally made methadone is pure precisely because it is *not* irreparably tainted by Dimedrol ("Those who are not on Dimedrol I also saw, they drink methadone. Normal, gets better, walks fine"[Bakyi]; "Ninety percent [of methadone patients] use Dimedrol. This is why there's chaos. If they didn't use that shit, Dimedrol, then there wouldn't be all these conflicts and discussions" [Kenzhebek]). It is important to note that these minority negotiations of a pure methadone work to reinforce the very same framework that enacts a toxic methadone: since methadone is linked to Dimedrol, then the methadone purification project must involve practices that work to separate the two. This reinforces the methadone-

Dimedrol complex as the methadone standard—one that has to be disassembled to make way for a 'clean' methadone to emerge.

If one manages to clean methadone off from Dimedrol, a new challenge emerges: why not just take heroin? Just like 'toxic methadone,' the minority 'clean methadone' is made in relation to heroin. As I showed above, heroin is enacted as the cleaner substance to methadone, eliciting less withdrawal and addiction. So, those prisoners who decide to continue with methadone instead of returning to heroin must vehemently defend their positions:

> Well for that [not going on heroin] he'll need a reason, a reason why he doesn't want to…He can say, what else would he say, the heroin is not enough, I'm going through withdrawal…But I know for myself that even if you shoot me up ten times a day, it's going to be useless. [Nikolai]

> They say 'you come off methadone and take heroin. So if he can endure all of that, this pressure, if he can endure it, then that's fine. But if he can't endure it, then, many can't endure it, the pressure they create there, well they'll beat him once, twice, and in the end, well in any case they won't kill him off. [Sasha]

And, conversely, if a person shooting up heroin decides to initiate methadone in prison, as Sasha points out, "relations towards him change for the worse." While continuing methadone initiated in the community is tolerated by prisoner society, the decision to initiate methadone in prison is strongly discouraged:

> Those who are in prison and go on methadone, those I don't really understand. For example, he wasn't drinking [methadone] outside, well he was shooting up, let's put it that way, and so he decided to go on methadone in prison. Well here you don't go through withdrawal that much, that you would have to go on methadone. [Envar]

We can see that the pressure to initiate or continue on heroin is powerful and a strong discursive battle must be waged to hold one's ground in the struggle for methadone patienthood. The methadone defended here is a fragile substance that is made into a medicine through its disentangling from Dimedrol and heroin—a disentanglement which is rarely successful.

Conclusion

At the root of methadone's becoming are the knowledge-making practices of its use. Methadone's material manifestations, such as withdrawal symptoms, physical dependency, and drug embodiments, produce evidence about its substance. Pushing aside health-enabling enactments of methadone, the methadone enacted in prisoners' accounts is a toxic drug.

Locally enacted methadones, including this toxic methadone, are negotiated in relation to a drug assemblage. The relations between methadone and heroin, and methadone and Dimedrol, are key to understanding methadone's toxicity. Through its folding into health-destroying Dimedrol and away from health-producing heroin, methadone becomes a poison rather than a treatment. Methadone intertwines with Dimedrol in complex ways to produce a methadone-Dimedrol complex and affect a sickly 'methadone-body.' The effects afforded by methadone take on, and then become indistinguishable from, those of Dimedrol, a substance constituted as particularly messy in the bodily damage it causes. While global health narratives treat methadone as a discrete and stable object, participants' accounts work to blur the boundaries of these substances, making it impossible to cleanly tease them apart either in practice. Within the margins, a health-producing methadone also comes into view—a testament to the possibility of alternative enactments within this actor-network.

In this chapter I have worked with the idea of the 'methadone body' to explore the material effects of methadone-Dimedrol at the level of the individual subject. I showed that a rotting methadone-Dimedrol body is enacted through the material relations of drugs with other drugs as well as drug use practices. But prisoner society operates with a governing logic that eschews the individual subject in favor of a greater prisoner body. In the next two chapters, I look at the relations between practices of prisoner governance and methadone

implementation in the making of the methadone subject. This form of analysis illuminates the shifting bodies produced through interactions with methadone, which, while remaining unaccounted for by public health, are essential for a competent intervention implementation in the Kyrgyz prison space and beyond.

Chapter 5—The collective body: Legacies of monastic discipline in the post-Soviet prison

Мы считаемся школой тюремного, вернее, полутюремного типа.
- Ну и что?
- Но мы же больше не бузим!
А это неважно. До полного исправления нельзя. В инструкции, понимаете, не положено…Мы не имеем права организовать легальную организацию, поэтому мы организуем нелегальную. Бандиты!
- Теперь клятва! Кто первый?
- Я! Клянусь, до последней капли крови служить нашему общему делу. Если я по малодушию или невольно выдал свою организацию, то пусть запятнает меня общее презрение, и осудят меня всеобщей темной мои товарищи.

(Republic of ShKID, Lenfilm, 1966)

Summary of chapter

In the previous chapter, I argued that different methadone objects produce different material effects. In the chapters that follow, I reverse my analytic lens to attend to how methadone *makes* its environment, particularly in relation to the kinds of subjects it produces. To set the stage, in this chapter, I explore how subjects are governed within prison by outlining how key disciplinary practices constitute the healthy prisoner subject. The emergence of the prisoner subject is an element of local practices, including how health is governed. Yet, disciplinary practices have been overlooked in research on health in post-Soviet prisons. Drawing on qualitative interviews with 40 male prisoners in Kyrgyzstan, this article performs a genealogical analysis by applying models of subjectivity from Christian monasticism to understand how a healthy body

emerges through the contingent governing relations of the post-Soviet prison. An apparatus of 'collective self-governance' produces bodies that extend the self to the collective and blur the boundaries between bodily and moral health. Unlike in the West, the idealization of an autonomous subject in Kyrgyz prison is inimical to agency and, by extension, health. Rather, a healthy body is produced through a healing process that rests on submission to the collective, with the threat of exile imminent.

Introduction

Understanding how disciplinary practices constitute subjectivity has significant implications for policy (Bacchi and Goodwin, 2016). In this chapter, I theorize the post-Soviet prisoner subject as produced through local practices, including how health is governed. Post-Soviet prison governance differs in key ways from that of the West, particularly in the perseverance of self-governing prisons (Oleinik, 2003). Yet, the role of informal governance, wherein prisoners themselves are entrusted with governing, is rarely considered when implementing reforms (Piacentini and Slade, 2015). To theorize the disciplinary apparatus within post-Soviet prison and its subjectification effects in regard to health, I draw on qualitative interviews with Kyrgyz prisoners as well as contingent historical practices within early Christian monasticism. I posit that, within the apparatus of 'collective self governance' that characterizes the post-Soviet prison, healing is commensurate with an agency afforded through the incorporation of the individual into a collective body. I argue that policy interventions targeting individual health are unlikely to succeed in the post-Soviet prison setting. By considering the ways in which these governing rationalities are counterintuitive to Western models of discipline, I provide a point of departure for overcoming the impasses to prison health reform in the post-Soviet space.

Informal prisoner governance: towards a collectivist model

Underpinning the social order of prisons is a tension between allegiances to the formal administration and informal prisoner-run structures (Kupatadze, 2014b, Slade, 2013, Crewe, 2009), with the center of gravity shifting toward the latter where a void is left by ineffective formal institutions (Varese, 2001, Gambetta, 1993). Prisons throughout the world differ with respect to the influence of informal prisoner governance (Morelle, 2014, Skarbek, 2014, Narag, 2017, Nunes Dias and Salla, 2013). Post-Soviet prisons, heirs to the largest penal system of the 20th century, have received little scholarly attention apart from some notable exceptions, which have stressed their resilient self-governing legacies (Oleinik, 2003, Pallot and Piacentini, 2012, Piacentini and Slade, 2015, Symkovych, 2017b, Kupatadze, 2014b). Piacentini and Slade (2015) argue that a disregard for the distinctive collective practices of post-Soviet penal culture has fueled failed prison reforms in the region. Indeed, research within post-Soviet prisons in public health glosses over informal governing structures. As a corrective, I advance a model of governance particular to the post-Soviet prison by tracing how governing rationalities emerge from a set of historical and contemporary disciplinary practices.

Highlighting a departure from individualized models of western penality, characterized by Foucault's famous model of panopticism (1995), several studies direct attention to the collective distribution of governing power within Russian imperial (Gentes, 2008), Soviet (Kharkhordin, 1999), and post-Soviet cultures (Piacentini and Slade, 2015). Laura Piacentini and Gavin Slade, drawing on Oleg Kharkhordin's study of Soviet subjectivity, make the claim that pervasive mutual surveillance within the post-Soviet prison (the many watching the many) differs from panoptic surveillance, which is characterized by a singular point of surveillance (the one watching the many). I turn to a genealogical analysis of monastic modes of punishment to open up space for otherwise unnoticed disciplinary practices within collective self-governance,

that speak both to its particularity and overlap with western penal cultures in more subtle ways than has been previously described.

Previous analyses of cultures of punishment draw connections to religious systems of collective discipline, like ecclesiastical tribunals, but these analyses take on a causal historical character (Spierenburg, 1995, Pugin, 2013). I show that these connections to religious forms of discipline remain a powerful tool for analysis in contemporary post-Soviet prisons, although a historical analysis is not my aim. Rather, I mobilize the well-theorized mechanisms of discipline within Christian monasticism and Soviet governance to understand how health is 'done' in the post-Soviet prison in ways that are not accounted for by western medical technologies. My interest in drawing these parallels is not to map causal historical connections but to theorize the distinctive disciplinary practices that make up the healthy prisoner body. The disciplinary practices of monastic life present a classic paradox in which a variety of collectivizing practices, including mutual surveillance, public confession, and communal ownership, are critical elements of individual self-formation in which the will is strengthened through its abnegation and the individual discovered in collective identification. Monastic disciplinary practices present an important contrast to the plague model of modern Western discipline (the forerunner to panopticism) (Foucault, 2004). While the latter is characterized by quarantining individuals so that disease is made knowable through differentiation ("The division and subdivision of power extending to the fine grain of individuality") (46), the former secures the unity and bodily integrity of the group through intentional contamination. Crucial here is that, within monasticism, sin is cured through exposure rather than segmentation.

The monastic disciplinary apparatus can be likened to the pre-modern management of disease Foucault describes within the leper colony (Foucault, 2004). The leper, failing to be cured through integration into society, was excluded in an effort to purify the collective body ("the global division into two

[healthy and unhealthy] masses…a sort of grand ritual of purification.") (46). Other scholars situate pre-modern modes of punishment within the Russian context. Andrew Gentes (2008) advances the argument that the mode of penology enforced by exile in Tsarist Russia worked to reinforce practices of punishment characteristic of the leper colony. He argues further that this thwarted the 'perfect knowledge' afforded by the documentation, classification, and observation of plague victims. With exile, we are witness, instead, to "the complete failure of the human sciences" (Popkin, 1992).

We mobilize the tensions of the plague versus leper models of subjectivity to argue that collective self-governance affords a sense of decentered agency attuned to the goal of the individual body incorporated as one and the same as the collective. Through the work performed on the body through mutual surveillance, public confession, and communal ownership, a purified collective prisoner body is continually being generated, made possible by an imminent threat of exile.

Focus and approach

This analysis is undergirded by a theoretical approach which sees the body as an effect of practice, situated within a web of shifting, mutually constitutive governing relations (Rose et al., 2006b). That is, a healthy body does not exist, until it is *made* through contingent practices. I leverage this theory to map how the rationalities of collective self-governance, and the subjects constituted within them, emerge from a trajectory of heterogeneous disciplinary practices.

We take a dual methodological approach. First, I carry out a genealogical analysis to draw attention to the historical set of practices (in this case, early Christian monastic disciplinary practices) upon which the governing rationalities of collective self-governance are contingent. After identifying the local governing practices that enact discipline, I draw on prisoners' qualitative interview accounts to identify how a healthy body is *produced* through these

practices. This form of analysis revelas the taken-for-granted ways that health emerges as an "object for thought" (Foucault 1988, p.257) in Kyrgyz prisons today.

For the genealogical analysis, it is important to keep in mind that the post-Soviet prison is a complex, diverse environment in which a variety of disciplinary forces compete and collaborate. It is shaped by historical legacies (e.g. Stalin's Gulag, Soviet penal architecture) as well as rapidly shifting new disciplinary technologies (e.g. western 'evidence-based' medicine, capitalistic drug markets, emergence of transnational Jihadist groups). Here, however, I aim neither to trace linear paths of descent nor to formulate a generalizable typology of post-Soviet prison discipline. Rather, my analytic task is to identify particular modes of reasoning characteristic of collective self-governance. The underpinning assumption here is that taken-for-granted ways of being and thinking are not inevitable, but contingent: "the things that seem most evident to us are always formed in the confluence of encounters and chances, during the course of a precarious and fragile history" (Kelly, 1994: 127). However, this attention to singularity and situated practice does not exclude the task of identifying unifying governmental rationalities or what Niklas Rose calls "family resemblance…formulated within shared rationalities or styles of thinking" (Rose et al., 2006: 88).

For the empirical portion of the study, I carried out fieldwork in Kyrgyz prisons linked to broader projects funded by the U.S. National Institute of Drug Abuse[29] investigating how post-Soviet prison environments shape the implementation of internationally supported opioid addiction treatment (methadone treatment). My primary concern here does not relate to prisoners' accounts of accessing methadone treatment, but, rather, focuses on accounts of everyday disciplinary practices—networks of relations that constitute subjects—within

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these prison settings. The data I draw on, generated between October 2016 and September 2018, comprises qualitative interviews with male prisoners with a history of injection drug use in three prisons near the capital, Bishkek. The interviews were conducted, following written consent procedures, before (n=24) and after (n=20) release from prison into the community.

We explore the production of a healthy prisoner subject through three contingent governing relations. First, I trace the development of the subject in ancient philosophy and especially in Christian monastic practices of confession and self-examination. Following Michel Foucault's (2016) analysis of early monastic Christian confession as a distinctive disciplinary apparatus, I turn to these monastic traditions as an already theorized case of collective self-governance (Graiver, 2017, Asad, 1987, Asad, 1993, Coon, 2011, Smith, 2009). Second, I connect these with the Russian Orthodox Church, and in turn, to the development of the individual and collective in the Soviet Union. Third, drawing on my qualitative interview data, I explore the legacy of collective self-governance through the enactment of the *poniatia* in the contemporary Kyrgyz prison.

The monastic subject

We first turn to early Christian monasticism as a model of subject formation through collective self-governance. According to Foucault (2016), early Christian monasticism, both Eastern and Western, transformed ancient philosophical techniques for the formation of subjectivity around obedience. Each of the Hellenistic schools had sought to discover and defend an active and independent subjectivity; the Christian innovation was a powerful new technique in which power was to be cultivated through submission, the will through obedience. Such obedience, and the interpersonal connections it demands, ceased being a temporary means to the end of active agency (i.e. the student and teacher relationship of the philosophers) but became, instead, a

permanent arrangement. Foucault describes a structure of discipline with three interrelated elements:

> In Christian direction we have an apparatus (*dispositif*) with three fundamentally linked and interdependent elements: the principle of obedience without an end, the principle of incessant examination, and the principle of exhaustive confession. A triangle: listening to the other, looking at oneself, speaking to the other about oneself. (2016: 289)

The whole of monastic life with its ascetic codes and communal property is centered around these injunctions. This continual obedience is explicitly codified in the written rules of the monastery, but it is also reinforced by an elaborate system of practices. Layton (2014), in his study of the fourth century monastic community of Shenoute in Roman Egypt, emphasizes a set of practices, which, taken together represent "the constant spectacle of an entire community performing their pre-established patterns or roles" (85).

Foucault emphasizes the role of perpetual confession in the early monastic discovery of the self (Foucault, 2016). Unlike the practitioners of the ancient philosophical schools, the Christian monk could not rely on his own power of discretion because of a pervasive worry of diabolic deception. Any thought or any commitment to a course of action might be inspired not by God, but by the devil directly. For the monk, the devil is a powerfully deceptive internal force against which *individual* self-examination is useless. In place of the autonomous rational will, the Christian turns to "the examination-confession apparatus" (2016: 297). Unable to trust himself, the monk must place his trust in the other. He learns to verbalize his inner life in order to escape the paradox of perpetual doubt.

Talal Asad examines the development of confession as a disciplinary apparatus within medieval Christian monasticism. Asad emphasizes the willing obedience that subjects/objects of this apparatus evince. The monk appears as both the subject and object of obedience:

> The Christian monk who learns to *will* obedience is not merely someone who submits to another's will by force of argument or the threat of force—or simply by way of habitual, unthinking response. He is not someone who has 'lost his own will…The obedient monk is a person for whom obedience is *his* virtue—in the sense of being his ability, potentiality, power—a Christian virtue developed through discipline. (1987: 159)

For Asad, the push for willing obedience is the crucial distinction between the monastery and other total institutions. Unlike the paradigmatic prison or military cases Asad has in mind, where he claims the disciplinary force has an external component, he argues that the monastery is characterized by a sort of self-governance (Asad, 1987: 187).

In the medieval Christian monastery, the omnipresence of the confessional imperative is now strengthened by the introduction of another apparatus: mutual surveillance: "Within the 'prison with open doors'… there was no single point of surveillance. Within the monastery there existed an entire network of functions through which watching, testing, learning, teaching, could take place. Mutual observation was urged on all" (Asad, 1987: 187). Monks were urged to note any fault and pass by in silence so that they might later denounce these faults when the monks came together in chapter. Rather than place the onus of confession solely on the individual, the rules that Asad examines collectivize the confessional obligation. A logic of relentless self-examination undergirds the necessity of continual mutual surveillance.

This diffusion of the confessional obligation is mirrored more broadly in the structure of monastic life, which is directed toward humbling the monk. It is not just the monk's will, but also his body and property that belong to the collective. The Rule of St. Benedict (2008), a book of rules to establish order among Benedictine monks, condemns the impulse to private ownership in this light—the desire to possess anything of owns, even a book or pen, is indicative of a possessive attitude toward one's own will. Just as with mutual surveillance, the communal ownership of all property is justified in circular terms. The monk

must give up his will in order to receive it back strengthened against sin and the monk must give up everything he owns in order to receive back what he really needs or deserves.

Even the monk's body becomes a site of submission, with corporal punishment generating hierarchy and enacting the reunion of the individual with the collective after sin and confession. Smith (2009) characterizes the widely accepted monastic use of flogging as a communal performance where both the authority of monastic superiors and the obedience of sinners could be enacted. Again, a strikingly similar attitude to corporal punishment exists in the post-Soviet prison setting.

The monk's behavior constitutes a *willing* submission. We should not lose track of this distinctive quality of this regime of disciplinary surveillance. All of these practices enable and originate in a "desire for subjectification." (Asad, 1987: 189). The monastery appears as a complex apparatus of subject formation affecting even the body of the monks. There is a proper way of eating, of praying, of writing, of working, even of sleeping—proper both because the practice is conducive to and reflective of spiritual virtue (Asad, 1993). Layton (2014) describes the character of this system as totalizing, noting that the monk is enjoined to keep his hands and mouth busy with the practice of meditation at every unoccupied moment. This apparatus became the justification and ground of meaning and practice.

So the monastic ideal is twofold, "joining together the principle of willing nothing by oneself with the principle of telling all about oneself" (Foucault, 2016: 266). I argue that these disciplinary techniques, recast as mutual surveillance, public confession, and shared ownership, also form the basic apparatus of the distinctive disciplinary program of the post-Soviet prison. I will briefly trace the historical parallels in monastic techniques of obedience in the Soviet Union before turning to my empirical case study to understand how such techniques shape what it is possible to *become* in the Kyrgyz prison today.

Collective self-governance in the Soviet Union

A body of scholarship social historians of the Soviet period explores the making of the ideal Soviet citizen and her relationship to the individual self and the state. Studies of early Soviet subjectivity, in their quest to outline the strategies employed by citizens to embody the values of Communism, set up a dichotomy between the private pursuit of individual autonomy and the demands of the public sphere (Kotkin, 1995, Fitzpatrick, 2005). This work argues that the individual was subsumed by the demands of state loyalty in a "total avoidance of the confessional genre" (Fitzpatrick, 2005: 151).

More recent work argues for a more nuanced, culturally specific, view of the practices undergirding the Soviet relationship between the individual and the collective (Halfin, 2003, Hellbeck, 2006, Kharkhordin, 1999). Rather than pitting the two against each other, this work brings a more interdependent relationship to the fore whereby a concerted focus on self-realization is manifested through disciplinary practices that seek to align the self with the social whole. Far from being repressed, the self becomes the ultimate focus of a range of prescriptive practices made to integrate "personalities whose personal fulfillment was achieved through heroic labors for the good of society" (Kelly, 2007). This was a process of smoothing out the individual ruptures from greater society, aligning the trajectory of the individual with the greater Stalinist goal of constructing the "New Soviet Man."

And this "New Soviet Man" was indeed not new at all, with roots extending to the practices of the Russian Orthodox Church and pre-revolutionary Imperial Russia. Kharkhordin (1999) tracks the transition of the monastic disciplinary apparatus through the Russian Orthodox Church and into the Bolshevik party discipline of the 1920s and 1930s. Despite the explicit atheism of the founding Bolshevik party members, familiar practices of Christian self-examination, with an unparalleled focus on the self as related to the collective, quickly gained

momentum in governing policy. Indeed, Bolsheviks turned to the cultural resources provided by Eastern Orthodox Christianity to fashion the upstanding Soviet Communist subject (Kopelman, 1908, Panasenko and Belokopytov, 1985). Distinct from Western practices of private confession, public confession and penance was practiced in the Orthodox East. The critical developments for the purposes of this analysis are an increasing emphasis on mutual surveillance, self-criticism, and a modified form of public confession as elements of a disciplinary apparatus that forged collective identity. The Soviet 'self' arose out of a productive dialectic with the collective, and this 'self' was increasingly indexed simultaneously to both the individual as well as wider society.

Notions of the 'collective' (*kollektiv*)—a group of people united in pursuit of a common cause (Getmanec, 1978)—were the bedrock of Soviet society (Kharkhordin, 1999). These social units of production pervaded all social institutions, bringing them into the service of the state by enforcing its greater socialist goals. The collective is not just a contingent association of individuals, but a basic unit of identity. For an example, we can turn to Anton Makarenko's famous children's colony. Makarenko was a Soviet pedagogist whose work with orphans in the 1930s became a standard model of general Soviet discipline. He describes different stages in the development of a *kollektiv* among pupils (Kharkhordin, 1999: 102-103). Critically, the second and third stages turn on the institution of a monastic model of mutual surveillance.

The most dramatic form of self-criticism remains, as I will show, foundational to the apparatus of discipline in the post-Soviet prison: the lay court, where people themselves become judges. Lay courts administered outside the purview of the state were a staple of Soviet jurisprudence since the 1920s. Permeating all establishments including unions and workplaces, these trials served as a vehicle for the masses to gain a socialist consciousness. In the first years of the Soviet period, the party was organized and disciplined around static categories related to an individual's class background. For example, a family background

as a worker made one eligible for positions that the son of a priest never would be. Very quickly, though, this gave way to the valorization of an individual's life choices. The basic structure was adapted from Orthodox public confessional practices already familiar from Foucault and Asad (Kharkhordin, 1999: 212). When either adopting a new status (for instance on entering the Party) or when accused of some transgression, the individual was to undergo a lay trial. Placed in front of her gathered peers, she would relate the relevant deeds, defending the revolutionary character of each. Show trials structured around this mechanism were the cornerstone of Stalin's Purges. These show trials were ostensibly designed to "unmask" the individual and the "ultimate truth" of her "inner moral disposition" through words; they can be seen as *producing* the individual, however (Halfin, 2003). As we will see, even the material structure of such trials, with the individual facing a semi-circle of accusing faces, remains intact in the practices of the post-Soviet prison.

The collective endeavor of Soviet discipline had an individual purpose: achieving a perfect self (Morris, 1987). This was a self capable of reflection and action, a self possessing agency. The goal of monastic discipline was the liberation of a self capable of just such freedom. It was the responsibility of every individual and every collective to engage in a process of self-examination and self-discipline. But even as the explicit goal of collectivization remained individual salvation, the effect was a persistent identification of the self with the collective (Kharkhordin, 1999: 142). The mechanisms of this self-criticism were complex and varied, but, in short, we can say that both the individual party member and each Soviet collective were to remain ordered toward their goals by perpetual watchfulness and openness. In cases of doubt, duty required that potential faults be made public. The link between monastic practices of confession and the Soviet lay trial is clear, but this thread has not, to date, been extended to the prison environment.

With these models of discipline in mind, I now turn to the post-Soviet prison to flesh out the apparatus of collective self-governance, which has deep roots in Soviet structures of punishment. Informal governing structures—responsible for all aspects of prison life from sanitary work to law enforcement—ran to the core of Stalin's vast prison camp apparatus (Healey, 2015). These were reduced, but structurally unchanged, by Khrushchev during de-Stalinization, and propelled to the center of prison life after the fall of the Soviet Union (Applebaum, 2003, Varese, 2001). Dating back to the beginning of Soviet prisoner self-governance, the shift of governing responsibility to the prisoners themselves established a rift between the formal (prison administration) and informal (prisoner authorities), which became a central tenet of prison governance (Piacentini and Slade, 2015). The extent of informal governance varies throughout the post-Soviet space but, in Kyrgyzstan, these forces have the strongest influence in enforcing justice, policing hierarchical boundaries, and prescribing punishment (Kupatadze, 2014b).

The disciplinary apparatus of Kyrgyz prison

Zeroing in on public confession, mutual surveillance and communal ownership as practices, which produce a virtuous prisoner subject within monastic and Soviet governing rationalities, I follow these practices within the study participants' accounts to identify how governing takes place in the Kyrgyz prison today. Prisons in Kyrgyzstan, called colonies, are open, camp-like spaces surrounded by an outer wall. The territory within the wall is divided between 'red' spaces—managed by the formal administration—and 'black' spaces, managed by the prisoners themselves. The formal administration, often incapable of providing even basic necessities, cedes authority to the prisoners. Informal prison leaders, in turn, provide extralegal governance in the form of security, mediation, and material goods.

The informal governance of the prison is centrally mediated by the *poniatia*—a set of unwritten laws that guide all aspects of prisoner life. Discipline is negotiated, practiced, and experienced according to the *poniatia*. A prisoner's actions—or *postupki* ('deeds')—in accordance with, or in opposition to, these informal rules determine his hierarchical status within criminal subculture. For example, stealing from a fellow prisoner—called a 'rat's deed'—is a grave infraction of the *poniatia* and could result in demotion in the hierarchy. Those at the top (*blatnye*), who are judged to have lived most committedly in accord with the *poniatia*, carrying out valuable and bold deeds, are most virtuous, healthy, and able to govern. Those at the bottom (*obizhennye*), who have breached the *poniatia* most severely, are socially ostracized. In the middle are the *poriadochnye*, who make up the bulk for the prison population. The *poniatia* are central to prisoners' way of life: they affect how subjects look, see, feel, and understand the world. In effect, they set limits on what it is possible to *be*.

Confession

The *poniatia* are enforced and understood through "trials"—a prisoner on trial must reflect on his actions and answer for his transgressions. For instance, when entering a new prison or after an accusation, confession is expected to bring a prisoner's deeds to light. The central principle of this system is self-criticism. Narrating one's deeds in front of the group elicits judgment as to the virtue of the subject, establishing his status in the hierarchy, and enacting, materially, who he is. This pervasive—if not compulsive—attention to the status of the self is located in certain confessional practices. Two parallel structures of confession are present in Kyrgyz prison, both of which model those described by Asad in the monastery (Asad, 1987: 190). In the first, penance is prompted by a public accusation. In the second, self-examination and remorse prompts reconciliation. In either instance, a lay trial familiar from Soviet practices of party discipline follows. The prisoner is called on to narrate and justify his actions before a circle of peers. He might relate the details of a

particular case or offer a narrative of his entire life. In doing so, he makes his life into a meaningful whole, in which disparate events become conjoined in a criminal autobiography. We might describe this as the self being invited to perform a repair, a recovery, upon itself in relation to a normative conduct, as a means of smoothing-out its biographical and other disruptions. Crucially, this is a *material* process wherein the self is becoming through enacting itself in relation to a sense of its ontological disturbance, momentarily stabilized by its incorporation into, rather than separation from, the circulating body of the collective.

The practice of confession is rooted in a *desire* to find a place and sense in the prisoner body. Yet confessional practices are not without negotiation or calibration. The individual body may not simply or easily map onto the ideal collective. Confession enacts differential subjectivities according to a coded hierarchy. We might say that the individual is afforded a chance to defend himself and is sentenced accordingly. But this language suggests that the collective confronts individuals and then decides their worth. The practice of the lay trial suggests, rather, that confession is constitutive of subjectivity. The *kollektiv* continually investigates itself and confession works to make and position subjects. Trials do not just reveal the status of the individual, they also work to (re)establish order. The primary objective of the trial is not to determine individual innocence or guilt but to confront and categorize something unsettled, properly positioning the individual. There is a palpable fear that, in the absence of this constant negotiation, those morally unworthy would contaminate the greater prisoner body. Prisoners—almost unanimously—claim the prison world, without the *poniatia*, would be overtaken by *bespredel*—a difficult to translate Russian word akin to chaos, disorder, lawlessness, or mayhem. As Alim explains, "as soon as this is gone, there won't be order, discipline. *Bespredel* will take over." This ordering is a constant process enabled by the imperative to confess and the ever-present gaze of the other prisoners who collectively produce each prisoner subject.

Only with demotion to the lowest *mast'*, the *obizhennye*, is hope of incorporation withdrawn, and the collective no longer concerns itself with its former member's fate. Although contingent on the nature of the deed, relegation to the lowest rung of the prisoner hierarchy, while only a last resort, is an ever-present possibility. Ejection from the collective is the ultimate punishment and enacts a 'becoming other' of the self, where the self is made unknowable and ejected to the periphery, beyond prisoner life. This is reminiscent of the pre-modern treatment of disease outlined in "the grand ritual of purification" enabled by exile into the leper colony (Foucault 2004: 46). In contrast to the 'perfect knowledge' generated through quarantining plague victims, exile to the *obizhennye* is akin to Anton Chekhov's ethnographic account of the exiled in *Ostrov Sakhalin*, which he describes as: "the failure of panoptical mastery" (Popkin, 1992: 40).

Typically, and ideally, confession works to bring the suspect member back into the fold. Recovery is the driving force and desire of the collective prisoner body. In Kyrgyz prisons, the *obizhennye*, in a form of exile, occupy a separate space from the rest of the prisoners:

> He [the *obizhennyi*] can only talk to you sitting on his haunches. You're standing, because you're higher than him, he's lower than you. That's why he doesn't walk on the same path as we do, he runs, he runs across the garden. [Zheenbek]

Confession secures the unity and bodily integrity of the group through intentional contamination, curing sin through exposure, and creating a purified whole. This is driven home by the way that prisoners speak about collective and individual worth using the language of health and sports—when the community is properly managed, the result is a healthy body of "sportsmen." The *obizhennye*, on the other hand, excised from ritual public confession, are rendered beyond knowledge—a last resort when all hope of a cure through incorporation into the collective body is lost.

Mutual surveillance

We can see in Akylbek's (a prisoner with a 20 year history of imprisonment) account that the gaze turned inward—confessing—is accompanied by a mass of horizontal gazes, each providing input: "Thirty people gather and there are two people in the center who had a conflict… And right there, among the people, they take care of the conflict. 'What happened? Who did what? Everyone, give your opinion on this.'" And everyone says their opinion…" Their opinion will not only concern the current deed of the accused but, rather, account for his entire life trajectory, which will be put forward, discussed, and determined to be worthy or unworthy of forgiveness.

This voicing of public opinion—called having the capacity to share one's 'word' (*imet' slovo*)—seeks to perform transformative action on the individual, creating a virtuous subject deemed worthy of the *kollektiv*. Envar recounts the procedure:

> Say that I stole a phone but I have good deeds in my history. The *obshchak* [the prisoners elite] gathers, and will start asking how I stole it, why, and what for. I'll explain all of this…And then the *poriadochnye* gather around me and they're asked "what can you say about this person?" And each one says their opinion, "yeah, he's a good person. I didn't have something and he gave it to me." And they'll listen to each person and then the *obshchak* decides what to do with me. [Envar]

An overarching theme of transparency and exposure of the self is present throughout prisoners' accounts on the apparatus of public criticism: if one's word has so much power, it should only be provided to the right people in the right circumstances. We can see this in a persistent concern about exposure, even after release from prison. Prisoners say, for instance, that all information eventually comes out into the open and reaches the prisoner *kollektiv*, extending even beyond the walls of the prison ("If they don't find out today, they'll find out in a month anyway…").

The *poriadochnye* often see themselves as participating in a disciplinary program aimed at learning techniques to develop the virtuous self. This practice of self-development occurs through a cyclical process of transgression and self-correction:

> Now I'm sitting here talking to you, you won't hear a single curse word from me…I'm working on myself. I wake up in the morning and I say "I'm not going to curse." I try not to curse, even when I'm talking to friends, it's hard but I fight for it anyway, everything depends on the person. [Nurlan]

This self-correction relies on a type of penance in which the individual is held responsible through mutual surveillance. In the lay trial, not only is the subject examining himself, but, simultaneously, members of his *mast*' (whose word carries value) are standing around him in a circle with their gaze fixed on him. This gives each participant a unique assignment where they are responsible for both watching themselves as well as others. Prisoners proudly claim that these procedures create a sort of egalitarian community where even the middle *mast*' (as opposed to only the *obshchak* elite) have governing capacity: "Every *poriadochnyi* has their own opinion. They listen to him. We're all equal. If for example, someone belongs to the *obshchak*, it doesn't mean that they're holy."

A prisoner's fellow *mast*' members are, in fact, responsible for him and he is responsible for them, as everyone shares responsibility for the group. All the while, the informal leader of the prison colony (the *polozhenets*)—merely the embodiment of mutual surveillance—simply watches on from the sidelines during the trial. Strikingly, this same disciplinary structure was embodied in Makarenko's colony, which later became indoctrinated as the basis of all Soviet discipline:

> The accused was positioned right in the middle of the big circular hall, in the spotlight, with colonists standing in a circle around him…It is as if horizontal surveillance and admonition are intensified to the limit…First, instead of all the prisoners being surveilled by one guard, as in the famous prison design of Jeremy Bentham, a single person is surveilled by

> all. Second, if the surveilled cannot see the surveillant in the Panopticon because of the physical obstruction to their gaze, here each one may see in every direction. This is perfect visibility, but of a strange kind…United together in a circle around the victim, single persons disappear; they become part of a physically invisible yet terrifying *kollektiv*…There's nowhere to look for help, there's nowhere to run. (Kharkhordin, 1999: 113-114)

Makarenko famously, using biological language, called the *kollektiv* a "goal-oriented complex of persons that possesses the organs of the *kollektiv*" (Kharkhordin, 1999: 207). The prisoner *kollektiv*, in this process of self-correction, takes on the qualities of a single body, engulfing its missing part—the individual—to rejoin the whole.

The boundaries between the individual and his *mast'* members are malleable and open: an investigation of the individual reflects on and determines the standing of the *kollektiv*. There is movement between bodies. As Sergei, a prisoner who has been incarcerated five times, said: "we are not our own people here." This blurring of bodily boundaries is produces through the interchangeability of pronouns in participants' accounts where they use the plural "we" to signify their *mast'* when answering questions about themselves. Notice the use of "we" and "I" in Yevgenii's (a member of *blatnoi mast'*) account when he was asked to comment on how he survived prisons in the 1990s:

> Enthusiasm, first, my health, which I've been endowed with since childhood, genetics plays a big role, and I've always, when I was younger, I was always into sports, well, we were all basically like that, able-bodied, athletic. Maybe if the Soviet Union had not collapsed, maybe this wouldn't have happened to us, but it turned out this way somehow, we turned out to be these kinds of children, of the perestroika. [Yevgenii]

He begins to answer the question referring to himself, but the able-body of his fellow *mast'* members soon takes over. His survival incorporates that of other *blatnye* with whom he shares a body and whose bodies were churned through the sociopolitical changes of the post-Soviet transition in concert. The bodies of the individual thus become indexed to those of his *mast'*.

Communal ownership

The collectivist style of prisoner management is incarnated in the form of the *obshchak*—a common fund of pooled gains run by informal leaders and characterized by individual contribution and collective consumption (Finckenauer and Waring, 1998). In fact, two of the six core laws governing criminal subculture revolve around the *obshchak* (Cheloukhine, 2008). Within the prison, like in the monastery, property possession is communal. Prisoner contribution to the common fund is not 'officially' mandatory. But any move to keep private possessions must be justified accordingly by, for example, stating familial need.

Access to material goods from the *obshchak* is proportional to one's standing in the prisoner hierarchy such that those with clean records—the *poriadochnye*—have access, while those in the lower *masti* do not. Again, the virtue of the individual prisoner is enacted communally over a lifetime of assessing and confessing one's deeds. However, once again, the potential for differentiation, as well as manipulation, is evident. While the *obshchak*, in principle, presents as a singular united front against the formal authorities, and is intended to serve the needs of those prisoners in good standing (the *poriadochnye*) who are most in need, its virtue is a topic of heated debate. The myth of the *obshchak* is disputed by some like Almazbek who stated: "Now a small group of people get a bunch of guys into this group and they just milk them for money." Key here is that both the supporters and detractors call upon an idealized image of the *obshchak* as serving the general interests of those prisoners who have proven themselves worthy according to the *poniatia*. The *obshchak* is corrupted when it is judged to serve only the interests of a privileged group of individuals—undoubtedly paralleling Soviet discourse on the *kollektiv* contrasted by its corrupted descent into the "corporation" (Kharkhordin, 1999: 88).

Notwithstanding what side of the debate a prisoner is on, the myth of the *obshchak* as the gold standard of serving—and forming—the individual by way

of the community prevails. While transgressions from this standard are indeed common, the promise of the *obshchak* is a key narrative in shaping a prisoner's experience. The perceived voluntary nature of contribution is the linchpin of the materialization of the *obshchak* into practice. As Nurlan explains: "I went to the meeting room, and I step out, my parents gave me 1000 *som*, so I decide it's important to give 500 *som* to the *obshchak*…'Brother, this is from me to the *obshchak*.'" If giving money or goods to the *obshchak* is in fact voluntary, and prisoners are measured against their contributions—known as "giving to the common good"—then a prisoner aware of this central tenet of the *poniatia* can be assessed according to his choice to contribute. His contribution indeed becomes a measure of his virtue. During the lay trial, these past contributions can work in a defendant's favor, as Akylbek explains: "They [the fellow prisoners] look at what kinds of achievements this person has had, if this guy has spent his whole life serving the common good, there will be a show of it and people will call upon this."

Unlike the paradigmatic monk, the prisoner does not choose the prison, and yet in interviews, prisoners understand themselves as engaging in voluntary obedience. A crucial aspect of this discourse—echoed in virtually all interviews—is the phrase: "everything depends on yourself alone." This is repeated as both an explanation and a justification of the statuses of prisoners and of the prison's informal governance. Prisoners have cultivated a desire to live by the *poniatia* and understand the hierarchy at all levels in terms of willing obedience: if you do not follow the code, you are choosing not to. Of course, myriad constraints on agency exist in the prison environment, but the narrative of a just *poniatia* is indeed a powerful one, extending beyond a mere coping mechanism, to a creation of a unique sense of agency. Through a willing obedience to the techniques of the *poniatia*, an individual can learn to develop criminal virtue. This is a virtue embodied by those at the top, the *blatnye*, who *poriadochnye* describe as having "suffered for our [the prisoners'] way of life, so we're able to live this way" (Sergei) and "suffering for the common good"

(Timur). Adherence to the *poniatia* is understood as 'equalizing,' providing an even playing field for a voluntary choice of obedience.

The self is materialized in relation to the *obshchak*. In this way, contributing to the *obshchak* visibly constitutes the community. This is further highlighted in a unique use of the word "*obshchak"* that, as far as I know, exists only in the criminal subculture in Kyrgyzstan. In prisoners' accounts, the word is articulated in two distinct ways:

> For example, say the whole prison gathers, and the *razgon* [distribution from the common fund] begins…Everybody gets some of this…so, what they distribute to the *poriadochnye* comes from the *obshchak* [1], that's where the money is collected, and not for drugs, or guns…like people think. The money's gathered for the poor ones…The drugs are their own thing. The *obshchak* [2] takes care of that themselves. [Emin]

In the first use of the term, and familiar from the Russian language usage throughout the post-Soviet space, "*obshchak*" signifies the fund of communal possessions that are distributed among the group. In the second use, *"obshchak*" is, surprisingly for most Russian speakers, personified, signifying the prisoner elites who are responsible for the fund. The common good—the ideal of a unified prisoner front—is transformed into the people themselves, in a remarkable ontological shift where the material becomes the human.

Also important here are the boundaries of the *obshchak* and, by extension, the *kollektiv*. The language used in the quotation above suggests that the *obshchak* pertains to "everybody" and the "whole prison." But there is a dissonance for the reader between this claim and the one that immediately follows that only the *poriadochnye* receive the *razgon*. How could the *poriadochnye*—who make up about 60-70% of the prison—constitute everyone?

This tendency to extend the higher *masti* (the *blatnye* and *poriadochnye*) to the entirety of the prison body is almost universal in prisoners' speech. The Soviet notion of the *kollektiv*, a group united for the greater good, is, in its post-Soviet

prison incarnation, limited to the middle *mast'*. The world—and its pertinent rituals such as confession, surveillance, and the *obshchak*—extends only to one's *kollektiv*; the abyss beyond it cannot be spoken or accounted for. The *obshchak*—both in its human and material forms—serves only those who have proven themselves virtuous according to the *poniatia*, thereby excluding the lower *masti*. That is, those not serviced by the *obshchak* are not even conceived to exist; they are beyond human, objects made absent like the exiled in Foucault's proverbial leper colony. The *obshchak* fuses the material and human, pooling subjects together with their shared resources, making their bodies also shared. The *obshchak* is both a metaphor and material device for the making, knowing, and maintenance of the *kollektiv*.

Conclusion

Drawing on studies of disciplinary practices within Christian monasticism and Soviet subjectivity, I characterized the disciplinary apparatus of collective self-governance at work in Kyrgyz prisons. The driving force behind collective self-governance is the idea of the collective body as the repository for both disease and cure. To create a healthy, virtuous collective body, an indecent, unhealthy body must first be incorporated. Only when incorporation into the collective body through the practices of confession, mutual surveillance, and communal property fail is exile beyond the confines of this body imminent. The exiled diseased part (in the case of Kyrgyz prisons, the *obizhennye*) becomes unknowable like in Chekhov's account, an "undistinguished mass" or a "carnival of indistinguishability" (Popkin, 1992: 38). This produces "an epistemological crisis which renders inapplicable the ideal of total surveillance and complete knowledge that underpins power in the panoptic paradigm of Foucault's analysis of the European penal system" (Young, 2013: 1701). We can begin to understand why public health interventions, such as addiction treatment, aimed at creating health through state surveillance and segmentation from the prisoner collective regularly fall short of expectations in post-Soviet prison

settings (Rhodes, 2019). The next chapter takes a closer look to how methadone treatment comes together with collective self-governance.

Chapter 6*:* Methadone governs: the severed prisoner subject

> To say that a body is a whole…skips over a lot of work. One does not hang together as a matter of course: keeping oneself together is something the embodied person needs to do.
>
> (Mol and Law, 2004)

Summary of chapter

Previous chapters explored how methadone fails to fulfill its global promise, functioning as a toxic technology, in the context of collective self-governance. This chapter traces the material dimensions of the prisoner subject by treating methadone as a site of governance to ask the following question: how does the disciplinary apparatus of collective self-governance interact with methadone to produce the methadone subject? I argue that methadone disrupts the key disciplinary practices of the *obshchak* (public confession, mutual surveillance, and communal property), which combine to shape the virtuous prisoner subject. Derailing the territorial integrity of the *obshchak*, state-sponsored methadone enacts governance by severing the individual prisoner from the greater prisoner body through a physical shift away from the *obshchak* and toward an idealized autonomous subject. We must remember that, paradoxically, within collective self-governance, the individual can only be fully formed through his abnegation via the collectivizing practices of the *obshchak*, producing a collective body. Ejected from these practices, the autonomous methadone subject is reduced to nothing but a rotting limb—a part excised from the whole—disappearing and dehumanized.

Focus and approach

In Chapter 4, I described the materiality of methadone's local enactment as harm producing, and in Chapter 5, I described the governing apparatus that disciplines the virtuous prisoner subject. The aim of this chapter is to map the relations between the two: how do methadone and the disciplinary apparatus come together to produce a methadone subject infused with this particular materiality? I consider what methadone enacted in this way 'does'—its governmentality in social relations. In other words, what are the socio-material relations that make up the methadone subject? I ask, how do the disciplinary practices of prisoner subculture bring this local methadone into being and how does this methadone, in turn, produce a particular subjectivity? I argue that methadone itself becomes a resource for governance through its disruption of the disciplinary practices of the *obshchak*. The resulting methadone subject is stripped of his most essential quality: virtuosity and, correspondingly, his governing power.

The focus of my analysis in this chapter is how the prisoner subject and his body are materialized through the governing practices of the prison, including through various substances. I am particularly interested in how subjects are materialized in practice, not only through the body's interactions with psychoactive substances, but through material governing practices. Collective self-governance, a practice of governmentality via its rules, discourses, values, and organizational systems—embodied in the *obshchak*—integrates with and comes up against other social-institutional systems, bodies, and technologies. The implementation of methadone treatment in Kyrgyz prisons is a particularly stark example of how technologies-in-translation transform subjects through their interactions with local governing practices, in this case, the *obshchak*. The *obshchak*—the linchpin of collective self-governance in post-Soviet prisons—can be theorized as an assemblage, an amorphous whole. The *obshchak* is precarious, made through the disciplinary relations of heterogeneous entities,

and held together through the shifting systemic and spatial rituals of the prison. The *obshchak's* mode of organization incorporates various co-functioning human and non-human entities with a role to play in the emergence of new realities, like the collective self-governance particular to Kyrgyz prisons. This incorporation works to collapse the subject/object divide, productively shifting the unit of agency from the individual (as a self) in a system, to the actor-network, which makes up the *obshchak*, wherein methadone and its social relations become self-governing and disciplining. This allows me to unpack how the dimensions of power are formed through the ordering of heterogeneous entities that form a whole through the relations of their parts.

This conceptual lens enables an understanding of how these entanglements—the shifting relations or governing practices of the *obshchak*—come together and fall apart in relation to methadone. By highlighting how the disciplinary practices that make up the *obshchak* interweave with substances, it becomes possible to unpack the materiality of the methadone subject. I treat the methadone subject as emerging relationally from the assemblage of the *obshchak.* This theorization brings the spatial dimensions and the politics of power of the *obshchak* to the fore, illuminating how it holds together and how it falls apart. This assemblage is made up of three key interlinked but independent practices: obeying the other (in sharing property), observing the self (through mutual surveillance), and speaking to the other about oneself (during confession) (Foucault 2016: 289). Together, they make the *obshchak* whole, working to discipline the virtuous subject and producing the collective prisoner body. The changing role of drugs, like heroin and methadone, within prisoner society, however, comes up against and shifts the assemblage of the *obshchak*. This chapter explores the making of the methadone subject through these shifting relations. First, I turn to the ethos of the *obshchak* to give an understanding of the assemblage of the *obshchak* in its idealized form. Then, I move to each of the three key disciplinary practices of the *obshchak* to outline

the interplay of methadone with each, as well as the subjectification effects that flow from this interaction.

The ethos of the *obshchak*

To understand methadone's relations with the assemblage of the *obshchak*, it is first important to understand how the *obshchak* functions. Through participants' accounts, an idealized version of the *obshchak* emerges; this version hinges on the *poniatia*—the governing rules that underpin the values of the *obshchak*. This idealization, however, is disputed territory—with a vocal contingent enacting the *obshchak* as straying too far from its 'preordained' values, or, simply, as "fallen." The *poniatia* are deeply rooted in prisoner society, and even those who enact it as fallen or defunct, refer to the *poniatia*, and the *obshchak*, as a mythologized benchmark of prisoner morality. The ultimate goal of the *poniatia*, emerging through these accounts, is to diminish chaos and produce agency through order. Their seemingly counterintuitive logic is that, by giving oneself up to the informal rules of the *obshchak*, the prisoner acquires independence.

Alim, a prisoner and a former police officer (and, therefore, a member of the reds), spoke at length about the ethos of the *poniatia*. His commentary is useful to consider here as a way of backgrounding the discussion of methadone as governance:

> And the good thing here is that there is really discipline. There are many people, take these *gady* [second to lowest *mast'*], for example, because look, he was assigned to that group for a reason. And there's a reason for why he received this fate…If there was no severity, there'd be chaos. It has to be like this. It's just that over the years, centuries, I don't know, decades, these measures were developed, so that all this remains like this, it's ingrained, so that they don't ignore, well, everybody adheres. If there's no severity, discipline, of course what would happen here, everyone would eat each other, I don't know, kill each other, right?

In Alim's account, the *poniatia* are necessary because they tame the unruly, and, in their pure form, allow for an accurate measure of an individual's worth. For the prisoners living under the auspices of the *obshchak*, they constitute *discipline done well*. Similar to Soviet understandings of the *kollektiv*, the ultimate goal of living according to the *poniatia* [*zhit' po poniatiam*] is the liberation of a self capable of action, a self with agency (see discussion of the *kollektiv* in the "Collective self-governance in the Soviet Union" section, Chapter 5). But this platform for self-fulfillment cannot be created until power is properly distributed among those who live morally according to the *poniatia* and those who do not.

Collective self-governance hinges upon a long-standing divide between prisoner society and the administrative apparatus of the formal state authorities. Prisoners take the governing rationality of the *poniatia*, its history, benefits, and sense of ethics to be in contrast to alternative forms of governance assumed by state control. Alim's narrative of the eclipse of prisoner control of the prison provides a picture of the pragmatic purpose and ethos of collective self-governance through what its loss represents to its beneficiaries:

> Here there are already reds standing guard, blacks don't decide here as before. Here the administration decides nowadays, whatever they say, that's how it'll be in here. Here already, well, I don't know, that's where it's leading, soon gradually there will no longer be such *poniatia*. Convict, prisoner, they won't be divided.

Alim is describing a shift from the old to the new way of enforcing the *poniatia*, ushering in a transformation in the practices of discipline. His words echo the sentiments of many prisoners who hearken back to a vague point in time, after Soviet collapse, perhaps a decade ago, when prisoner governance began to transform from criminally organized informal governance to increased state control. Alim implies that increased state control threatens the ethos of the *poniatia*, creating more sameness among prisoners and, thus, a starker, less negotiated form of hierarchy. Alim associates increased state rule with

corruption. He predicts that the distribution of privilege will shift and that, with weakened informal governance, privileges will be flattened out among the prisoners. Only those with more financial resources or connections to the state will benefit, rather than those who 'deserve' it.

Alim's musings speak to how prisoners' self-governance through the disciplinary practices guided by the *poniatia* requires freedom to distribute privilege to function. A functioning system of collective self-governance is one that can adequately establish a hierarchy according to a subject's virtue rather than the corrupted values of the formal administration such as material goods. When this privilege is distributed 'fairly'—upon a legitimate assessment of one's inner worth—the result is an equitable distribution of power among autonomous agentic subjects. But, of course, the distribution of power can be corrupted within the structures of informal governance:

> Sometimes it [the rule of the *obshchak*] is excessive, you understand. They take advantage of these *progons* [informal laws instated by the *obshchak*], the guys, well, the *shpana* [the young prisoners who enforce the wishes of prisoners at the top of the hierarchy], well, they like their people. They say, "take care of that guy, bring this one in." They sometimes take too much on themselves, excessively, right? And add their own thing. [Alim]

Alim's criticism here is that certain prisoners are exercising too much freedom in governing their own way. As a consequence, his account flags the breakdown of the *obshchak* that occurs when individual prisoners supersede those of the collective, rendering self-governance through the *poniatia* ineffectual. When the *poniatia* are exercised appropriately, Alim is implying, discipline is enacted to enforce the goals of the collective, rather than to elevate individuals with connections to elite status; this is the *obshchak* corrupted.

Indeed, prisoners living under the auspices of the *obshchak* are participating in a disciplinary program for the formation of the self. They realize an ethical self through unwavering obedience to the *poniatia*—obedience to these practices *is*

the very substance of virtue, locally known as "decency." The *obshchak*, therefore, has mythic qualities in prisoner discourse. Whether speaking in support of its sustained success or in opposition to the breakdown of its governing practices, prisoners refer to an idealized *obshchak*: a governing system able to enact order through the adequate assessment of a subject's decency. One participant, when I asked him who the *obshchak* is, responded, "They are the ones who suffer for our soul."

The foremost practice eliciting obedience is the *obshchak* itself. It is in no way a stable formation—it forms an amorphous whole consisting of various entities, including the communal fund of the prison and the ruling prisoner elite. In practice, this object/subject divide collapses—the *obshchak* is simultaneously both (see "Communal ownership" section, Chapter 5). The animate and inanimate component parts of the *obshchak* have a certain autonomy independent of their composite whole, but the "properties of the component parts can never explain the relations which constitute a whole" (DeLanda, 2006: 10). Rather than analyze the parts independently, I focus on their relations in order to unpack how the assemblage of the *obshchak* produces new realities through its interaction with drugs. The role of the *obshchak* in prisoner life has been far from uniform over the course of its history. Especially with the social, economic, and political upheavals of the post-Soviet period, the formal government's hold on power within prisons was drastically reduced. These transformations have reshaped the prisoner subject. Here, I will concentrate particularly on transformations relating to drugs. In the following section, I examine the newly formed prescriptive practices of obedience produced by the *obshchak* in relation to the changing position of heroin in prisoner society. Then, I move on to how methadone re-assembles these practices.

Methadone and obeying the other: communal property

The *obshchak* absorbs heroin[30]

The *obshchak* predates heroin, and works through various commodities, voluntarily donated by prisoners, including food, money, and even health services. As Ruslan explains, "[the reign of the *obshchak*] has been like this since the beginning of time. This is how we live. Let us continue to live this way." Each prisoner can contribute to the fund as they will, and these contributions are shared with all prisoners (except those working for the formal prison administration; hereafter, "the formal administration"). The sharing of commodities is a communal practice—what is contributed is redistributed—and a socializing experience with particular subjectification effects. The contribution and redistribution of money, goods, and services through the *obshchak,* especially to those deemed most in need, instills the values of the *poniatia*. Mirlan explains the ritual contributions to the *obshchak*:

> So we receive a paycheck…so I get 5,000, I leave 1,000 for the *obshchak*, I send 3,000 to my wife, I leave 1,000 for myself. And no one would say anything against him, really, if it's really how it is. But if they find out that he's drinking his money away, they'll have a serious talk with him, "you lied to us, you said that you were sending the money to the kids, while you've been drinking the money away." He'll have to answer[31] for this seriously.

Because all income is shared through contributions to the common fund, each prisoner is responsible for individual expenses. Prisoners equate the notion of being responsible for yourself to being responsible for others. This production of a sense of responsibility occurs on the public stage, extending to prisoners'

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[30] This section is adapted from our manuscript "Governing through Heroin: Drugs and the Resilience of Informal Order in Prisons in Kyrgyzstan," submitted to *Incarceration*, (Slade and Azbel, 2019).

[31] To "answer" it to face physical reprecussions in prison slang.

bodies. Sasha defines a responsible prisoner as one who would serve a fellow prisoner's sentence: "he might take the blame, accept to do time for someone else's crime and go on for another 10 years, that's also what's called *obshchak*." We see that the private and public bodies merge into one, erasing the boundary between the two.

While the *obshchak* can distribute cigarettes or tea or other goods as part of its common fund, its primary exchange and capital is heroin. Every ten days, and on special occasions, such as the birthday of the Thief-in-Law, there is a ritual distribution of resources from the *obshchak* to all prisoners called the *razgon*. This *razgon* is afforded to all prisoners except those interfacing with the formal administration. On all other days, access to resources is intertwined with a prisoner's perceived decency. Those called "the decent ones"—the *poriadochnye*, who make up the middle and largest *mast*' in the prisoner hierarchy—receive resources, at least 'officially,' based on need. In other words, one's moral standing, based on a lifetime of deeds, determines the proximity of the individual to the informal leadership and to social and material capital. This positioning in the prisoner hierarchy can be mutable, depending on one's standing. For example, providing support to other prisoners can be reason for promotion, whereas stealing from others can lead to demotion. The *obshchak* is constitutive of moral position. Only demotion to the lowest *mast'*, the *obizhennye* is permanent.

Heroin is the moral capital and the lifeblood of the *obshchak*. But this wasn't always the case. Since heroin flooded the markets in Kyrgyzstan in the mid 1990s, the *obshchak*'s incorporation of heroin has transformed over time in several key, contested, ways. Prior to 2008, and similar to prisons in other parts of the world, including the United States (Skarbek 2014), prison-based drug dealers in Kyrgyzstan were not independent actors but internalized within gang structures that regulated and profited from the drug market. At this time, drugs were sold through the bazaar, a market where prisoner dealers sold heroin and

shared a percentage of their profit with the *obshchak*. As Yevgenii, who was incarcerated at the time of the bazaar, explained: "There's this room, a person lives there, you go to see him, give him money, he gives you the goods." Anyone with financial resources was able to purchase drugs: "what's important was to have money, you didn't have to work. If you had money, please, sit at home [the barrack], they'll bring it to you at home. What mattered was money."

The bazaars were quickly seen as running counter to the *poniatia*—money, rather than the moral code, was becoming the driving force of life in prison. Yevgenii elaborated:

> It turned out that when money started flowing, some turned a blind eye, let everyone go and get it [heroin]…Everything got mixed up with money, everybody started going to buy. Because everything started collapsing, because everyone was buying, and a lot of it, for example, the *poriadochnye* guys, who had never come across this, they started [injecting]…What are you gonna do, drugs are available and they start… And then, you understand, they start doing such things, that God forbid…they became *gady* [the second-to-lowest *mast'* that has committed infractions according to the *poniatia*]. And they were stealing from their own people…Yes, they became weak in spirit, they couldn't, you understand, turn it down.

Many respondents associated this free-for-all with a degradation of civility, as guided by the *poniatia*. As Yevgenii notes, the indiscriminate selling and use of heroin was equated to a collapse of the *poniatia*. Communal property is heavily regulated by the *obshchak* and stealing from other prisoners (called a "rat's deed") is a grave infraction.

In 2008, this drug distribution mechanism came to a dramatic halt when the new Thief-in-Law, Kamchy Kol'baev—who came to power after bloody altercations between prisoners and the government during which the previous Thief-in-Law was dethroned—put out a *progon* banning the sale of drugs completely and closed the bazaar. This was a major turning point for the make-up of the *obshchak*: all heroin entering the prison is now pooled and controlled by the *obshchak*. It is distributed through the *razgon*, but under different

conditions than before. Whereas funding for the general distribution of resources is taken from prisoners' individual contributions to the *obshchak* (called the people's or *liudskoi obshchak*), drugs can only be purchased with funds from the *vorovskoi,* or the Thief's, *obshchak*. The latter is replenished, in part, through work. Prisoners who work for the *obshchak* (almost exclusively *poriadochnye*) usually make *shirpotreb* (wood-carved goods such as chests and backgammon boards that are then sold). In return, they are rewarded a daily dose of 1mL of heroin (pre-mixed with an unknown concentration). This cleverly avoids the exchange of money for drugs, which is heavily sanctioned by the *poniatia*:

> This one guy made out he was a first timer but actually he had been inside before and he had been selling drugs in prison… and if you are a *baryga* [dealer] then you are a *neput'* [or *gad*, the second to lowest *mast'*]. [Artem]

The rest of the prison receives the heroin *razgon* every tenth day of the month, also in 1mL doses. Again, the amount of heroin received is neither related to one's contribution to the *liudskoi obshchak* nor to the quantity of work produced for the *vorovskoi obshchak*. Consequently, reciprocity is generalized rather than specific, and receiving drugs does not look like a straightforward financial transaction.

This change in heroin policy strengthened the disciplining apparatus of the *obshchak* via three corresponding mechanisms: harm reduction, reduced injection, and exclusion of methadone patients. As I discussed in Chapter 3, heroin delivered through the *razgon* is performed as harm reduction turning heroin into a form of treatment. The goal here is not profit but a reinforcing of the *poniatia* and prisoners' allegiance to them through ritual communal consumptions. This enacts a hardening of the hierarchical boundaries through the regulated distribution of heroin. This is underscored by the *obshchak's* ban on new initiates. That is, the heroin market is, in fact, not looking to expand. By

means of this regulated and monopolized mechanism of the heroin *razgon*, the tenets of the *poniatia* are reinforced through its medicalized enactment.

The negotiation of methadone's incorporation into the *obshchak*

Methadone treatment was introduced as a pilot program into the first Kyrgyz prison in August 2008. Its introduction saw methadone thrust immediately into the political, moral, and material negotiations of prisoner collective self-governance. The result is the exclusion of methadone from the *obshchak*—a matter which continues to be the subject of heated debate within prisoner governance to this day. In this section, I want to focus on prisoners' negotiations with the *obshchak* regarding methadone's incorporation into prisoners' communal property. Through the moments of tension that emerge through these discussions, methadone confers power at the same time as troubling existing power structures. As methadone has expanded into 11 prisons and seven SIZO—covering nearly all facilities in the country—such negotiations have continued, each iteration enacting the methadone subject slightly differently in relation to the *obshchak* and the collective prisoner body.

In the investigation of methadone *as a site of negotiation* in relation to power, and not simply a matter of edict or coercion, those who occupy the middle spaces in the hierarchical system are of particular interest because their status is most up for debate. The *poriadochnye*, the middle and largest *mast'*, are consistently 'in-between' on questions of governing matters. For instance, nationally within prisons, governing allegiances are generally split along *mast'*-lines: the upper *mast*i advocate for informal control of the prison and lower *masti* vie for formal governance, while the *poriadochnye* are split on the issue.[32] They also occupy less stable ground on the question of methadone implementation—an issue closely tied to governance. The upper and lower

[32] Field notes, May 14, 2017.

echelons of prisoner society are defined, more or less, clearly in relation to methadone access: the upper *mast'*, the *blatnye*, are strictly forbidden, according to the *poniatia*, from injecting drugs or signing up for methadone, whereas the lower *masti*, the *gady* and the *obizhennye*, are "fallen" with respect to the *poniatia*, and therefore are no longer subject to the *obshchak's* standards of decency. The picture is more complex for the *poriadochnye*, who experience the moral dangers of methadone intensely, complicating their decision to use methadone, and who indeed make up the smallest proportion of methadone users in prisons today:

> If a *poriadochnyi* starts to use dimedrol [*dimedrolit'sia*; often used with methadone], he'll be thrown out, because of his inadequacy…First they'll [the other *poriadochnye*] go tell [*kursanut'*] the *smotriaschii*…Then the process will begin. The *gady*, the reds, who have committed infractions [*u kotorykh kakie-to postupki*], it's a bit easier for them. They're not monitored in the same way…And the *obizhennye* have it completely easy. No one visits them, they live in their own mess [*kasha*]. [Akylbek]

The *poriadochnye* are partaking in a training program to instill certain moral dispositions through the practices of the *obshchak*: they have more to lose and, therefore, more to negotiate, in terms of their moral standing. Among them, there is a gathering momentum since methadone's introduction into prisons, towards its enactment as a 'bad' and towards imagining a model citizen 'clean' of methadone. But a small number of the *poriadochnye* are indeed enrolled in methadone treatment. Enrollment is a risk for all prisoners, and especially the *poriadochnye*, to manage and negotiate, dating back to when methadone was first introduced.

When methadone was introduced into Kyrgyz prisons, a debate ensued among prisoners—parallel to the debate that was being had at the government level—about whether its introduction was amenable to Kyrgyz social-institutional systems. I will now look at this negotiation in detail. Participants describe that, upon the introduction of methadone by the formal authorities, a 'legal' debate ensued among the informal authorities and the *poriadochnye.* There was a

group of "agitators" [*agitatory*], prisoners who wanted to stop other *poriadochnye* from signing up. They went to the *vor* and argued that when you sign your name in exchange for methadone, you are aligning yourself with the reds, the prisoners whose allegiance lies with the formal administration. Also, the agitators argued, how could *poriadochnye* receive methadone from the same window as the *obizhennye*—the lowest *mast'*. Participants discussed these material practices in terms of whether or not they "befit a decent convict." That is to say, the material act of signing your name in a certain place makes you who you are: a prisoner occupying a certain role in the social system. On the other hand, the *poriadochnye* accessing methadone argued that they also get their meals from the same dispensing window as the *obizhennye*; they just receive them at different times—a practice that is in line with the *poniatia*. Additionally, they pointed out, it is also considered appropriate that the *poriadochnye* sign off on antiretroviral therapy from the formal administration, so why isn't signing off on methadone treatment fine, too? And finally, the supporters noted that when there is a riot against the administration organized by prisoners, the methadone users are always the first to go to the frontline. This discourse establishes dedication to the greater cause of the collective as productive of decency. These arguments relate the material practices productive of individual subject positions with methadone; they make a plea for aligning such practices with the *poniatia* to enact decency.

As Envar, a *poriadochnyi* who had been on methadone, explained, the *vor*, after considering the arguments, decided that participating in methadone treatment will not be banned for the *poriadochnye*: "There is no specific ban [*konkretnogo progona netu*]." The *vor* agreed with the methadone patients but said, according to Envar, "'if you're going to get this methadone treatment, then you shouldn't have any part in heroin treatment.'" Envar added, "He made a very well-reasoned decision [*on vse gramotno obiasnil*]." While steering clear of outright demotion, this move effectively cut the *poriadochnye* on methadone off from the most valued resource in the *razgon*: heroin. The effects of excluding methadone

from the *obshchak* have been monumental for the place of the methadone program in prisoner society. As Turat, a *poriadochnyi* prisoner, explained:

> And all the prisoners taking methadone lived in that barrack…And when, you know, there is such a thing as common *razgon*, on holidays, everyone is given the stuff then. They would not give it to the ones taking methadone. And I do not even need it, when you get down to it. But it was like, "We will not give it to you."

Prisoners who are either regarded as especially virtuous for their practices in accordance with the *poniatia* ("He has to be respected by the people, the young guys. He has to explain life correctly"), or those who make consumer goods [*shirpotreb*] for the *obshchak*, receive heroin daily from the *razgon*. But to receive their portion, they must first quit methadone:

> If he doesn't want to make *shirpotreb*, he can say, what else would he say? "The heroin is not enough, I'm going through withdrawal, still going through withdrawal." They [the *obshchak*] would say, "we'll add heroin for you, how much heroin should we add for you?" …So you get, for example, 20 days. In 20 days you have to come off methadone. You come off methadone and do heroin, and work for the *obshchak*. [Sasha]

> And if he quits methadone, they treat him to heroin [*ugoschaiut ego geroinom*], but it's weak. What's most important is you're not sick for an hour, two. Then you just deal with it, suffer. That's it. Then you're already on heroin, then you need heroin, right. From one to the other… So that you don't get sick, they'll treat you in the morning and in the evening. A mL [*kub*] in the morning, a mL in the evening. [Kenzhebek]

This split ("from one to the other") further enacts heroin and methadone as diametrically opposed substances, the former a "treatment," bringing the individual into the fold of the collective, the latter a "drug," making the methadone subject liminal in the context of collective self-governance. To become a fully formed *poriadochnyi*, one first has to submit to the collective through engagement with the communal property of heroin—the marker and maker of decency.

Methadone's role in observing the self and the other: mutual surveillance

The *obshchak's* function in relation to methadone goes beyond access to material resources. The object of methadone and its subjects are also formed through the materiality of the prison space and, in turn, work to mold the terrain of the prison. Spatiality is the medium through which power is reproduced within the prison and between different *masti*. The space of the prison is intertwined with the *poniatia*, producing and reproducing divides of power. Particular organizations of space, which bring subjects into conversation or accentuate their divides, allow for varying formations of the self. Mutual surveillance—the bedrock of post-Soviet prison discipline (see "Mutual surveillance" section, Chapter 5)—is either enhanced or constrained through the organization of space, etching a moral gradient onto the prisoner subject. In what follows, I trace how moral purity is cultivated through spatial relations.

Freedom of movement and mutual surveillance[33]

Unlike prisons in Western Europe and North America, the spaces of most post-Soviet are large and open (the prisoner-run territory of Prison 3, for example, is 16 hectares). Prisoners are divided up into 'families' [*semeiki*] of four or five people and live in "detachments" of 20 people within dormitories based in military style two-floor barracks. Several dormitories make up one sector. Each detachment has an "overseer" (*smotriaschii*) who reports to the *polozhenets*, the criminal authority. There is one *polozhenets* in each prison ("In every barrack there's a guy who watches over everything… people come up to him and tell

[33] This section is adapted from the manuscript "Governing through Heroin: Drugs and the Resilience of Informal Order in Prisons in Kyrgyzstan," submitted to *Incarceration*, (Slade and Azbel, 2019).

him what needs to be taken care of. And he goes to the *polozhenets* and there's where they solve the problems.") Cultural knowledge, including knowledge regarding informal rules of prisoner conduct, is transmitted through practices of spatiality, such as mutual surveillance (see "Mutual surveillance" section, Chapter 5). Surveillance in the prison does not emanate from one single point. It is diffuse, scattered throughout the prison space, and enabled by practices of informal governance.

An informal practice key to structuring the prison space and transmitting knowledge about informal practices within prison is *khod*, or the opportunity for prisoners to move freely within the prison facility. *Khod* is granted through a tacit formal/informal agreement between the administration and the *obshchak*. It allows for the free flow of information between prisoners and the monitoring of prisoners by other prisoners. Some respondents contrasted *khod* to living under a 'regime' [*rezhim*], signifying that the space and tempo of prison life is determined by the formal administration. In the 'zone,' the prison, where *khod* exists, prisoners can move between areas of the prison known as local sectors—portions of the prison facility which are divided by walls or gates. In Soviet times, such movement was restricted and prisoners stayed localized in their sectors:

> When we were inside [2000-2007] there was nothing, there was no regime whatsoever. [The administration had] the opportunity to stop *khod* but it wasn't used. It was in the Soviet period they had the local sector walls, but when we were in there they just didn't exist, so there was a mutual agreement between the staff and prisoners: you can't stop *khod*. Whatever we have gained from the trash [administration] they can't take back. Because, if they do, we will ask the authority [*polozhenets*] right away, "how did you allow that to happen? To take away what we had?" [Vladimir]

As this respondent suggests, the *polozhenets* has a responsibility to establish *khod.* This is a key element of the 'black' rule of the prison (as prisoners often repeat, "break the red, implement the black," or "*lomat' krasnoe, stavit' chernoe.*"), allowing for more freedom in the flow of goods and fewer

constraints on prisoner association. It is also a critical mechanism for the surveillance of prisoners in all areas of the prison. Daniar explains: "This means to break the rule of the police [*militsia*] and instate our own rule, black rule, so that you can have *khod*."

While *khod* allows for freedom of movement, further divisions in space enable practices of mutual surveillance by surveilling prisoners unfaithful to the *poniatia* and ensuring a 'healthy' prisoner body.

How material divisions within the prison reproduce the *poniatia*

To maintain the order and discipline that Alim alludes to or, simply, to govern, the prison becomes a site of constant surveillance, where both the individual prisoner observes himself and others to bring transgressions to light and individuals in line with collective standards of practice (see Chapter 5). This tightly organized mutual surveillance is made possible by the geography of the prison, which plays a vital role in producing and reproducing a fiercely independent prisoner governance, its hierarchical divides, and resistance to state authority.

Since the formation of the criminal hierarchy, one of its basic tenets has been the opposition to official government structures. This creates a united front, diametrically opposed to formal structures of authority. The prisons are divided into two main areas—one where the power of the administration reigns and the other (much larger) belonging to the prisoners themselves (called the *zhilaia zona* or the "living zone"). Most prisoners live in the prisoner-controlled portion, excluding those seen as "traitors" or collaborators with the formal administration. These collaborators inhabit the territory of the reds (*postanova krasnykh*) and are seen, by informal governing structures, as either escaping infractions committed against the *poniatia* or hiding from informal authority given their history of formal association, such as police work. They work, for

example, in the bread bakery or the cafeteria, which are run by formal authorities. That is, they directly perform the work of the administration.

A barrier is thus erected between the prisoner-run and administrative portions of the prison, with particular effects. For example, the act of retrieving documents necessary for life after prison is complicated by prisoners' fear of walking over to the administrative portion of the prison to receive them—an act that produces the prisoner as a 'red.' Sasha, for example, refused to get his referral to methadone treatment after release for fear of interfacing with the *militsia* (the police)—the prisoners' name for officials of the formal prison administration. The blanket term of *militsia* for all individuals working for the prison administration (notably, excluding the medical staff who occupy a position between black and red) is particularly telling. People who inject drugs have a long and fraught relationship with the *militsia*, including through interactions involving coercion, physical violence, and false confession. Narcology, in particular the Soviet-made branch of addiction medicine, has a legacy of close ties to law enforcement, often intertwined in their prescriptive policies toward drug use (Latypov, 2011). It becomes clear why there is such a lack of trust between prisoners and the *militsia*. The united prisoner front—embodied within the *obshchak*—serves to defend against such incursions.

Another key division in space occurs within the *zhilaia zona*. In prisoner-run facilities, hierarchical boundaries are reproduced through the physical separation of the *obizhennye* from the rest of the prisoner body. They live, eat, and move through the prisoner-run grounds separately from the *blatnye*, *poriadochnye*, and *gady*:

> Well, yes. Yes, yes. He can only talk to you sitting on his haunches, let's say. You're standing, because you're higher than him. He's lower than you. That's why…He doesn't walk on the same path as we, he runs, he runs across the garden. Or on the road, as we say…if there's no one, then he can walk. [Zheenbek]

This rule extends to medical facilities, where the *obizhennye* have specific times when they can see the medical staff ("We're not alone here. We have our time, right, a specific time" [Farkhad]). Even sharing a mug with a member of the *obizhennye mast*' can lead to instant demotion in the hierarchy. This enactment of untouchability prevents contamination. If someone, even inadvertently, shares eating utensils with an *obizhennyi*, they will themselves lose their status in the hierarchy.[34]

Methadone as the territory of the 'reds'

Spatial organization within the prison is mapped by substance use. The use of heroin, methadone, and methadone in combination with Dimedrol (diphenhydramine) are each prevalent in different portions of the prison territory. The *obshchak*, located in a barrack in the prisoner-controlled portion of the prison (*zhilaia zona*; literally, "the living zone"), is the center of heroin distribution. The *poriadochnye* barracks make up the bulk of the *zhilaia zona*. More than half of the *poriadochnye* in the three facilities where this fieldwork took place inject heroin (a general estimate from the participants is 50-70%, which is coherent with previous national representative surveys) (Azbel, 2016b). The *obizhennye*, who live in a separate barrack within this area, only receive the *razgon* three times a month, when it is distributed to everyone in the prison excluding the reds. The *gady* also have a separate barrack, but, unlike the *obizhennye*, they are able to interface with the *poriadochnye* more freely. The *gady* and the *poriadochnye* are more likely to be enrolled in methadone, while the *obizhennye* are more likely to combine methadone with Dimedrol. This relegates methadone and Dimedrol, the most toxic drug, to the administrative and *obizhennye*-inhabited portions of the prison.

[34] Field notes, February 16, 2017.

These divisions in ritual practice and space between prisoners who use methadone and those who do not ensure the seamless functioning of collective self governance. For those who do not use methadone, property is communal, the ritual of the *razgon* is whole, and mutual surveillance is enabled through the unrestricted movement of prisoners in designated parts of the prison (with the exception of the administrative and *obizhennye* portions). Those more likely to sign up for methadone (the *gady*, the *obizhennye*, and 'the reds'—all *masti* who are not under the auspices of the *obshchak* and have "nothing to lose") are cordoned off to separate living quarters and portions of the prison, including where methadone is administered. These lower *masti* interface with 'the reds,' in that they cross paths with the administration, access their substances, and operate outside the territory of the *obshchak*. No longer able to fulfill the virtue-making practices of the *obshchak*, these prisoners are cut off from the collective. This foments suspicion and breaks trust. Key here is that methadone treatment is enacted as the "territory of the reds" (*postanova krasnykh*). Participants' accounts often invoke methadone as a site of translation between the diametrically opposing rationalities of the state, 'the reds,' and the *obshchak*, 'the blacks.' Daniar speaks of how methadone challenges the governing logic of the collective:

> The young ones and the *obshchak*, they pay attention to the prisoners drinking methadone, and think that you're going to dance to the cops' fiddle [*ty idesh' pliasat' pod ikhniuiu mentovskuiu dudku].* You're stepping away from the *muzhiki* [umbrella term for *poriadochnye* and *blatnye*], and from those like you, and you're going there, to the administration, to the cops [*militsia*], to the doctors. This isn't welcome at all, and you'll be subject to a lot of doubt. What are you going there telling them? You're going there talking to the cops and then coming home to the camp, to the barrack, and the *obshchak* sees that you're going there. "What you did there?" So they'll start asking either way…Because you're going there to drink methadone every day. And the cops are sitting there, guarding, watching, so there's no mess around methadone. And all those doctors. What are you saying to them?

Through Daniar's account, we get a sense of the axis of tension created when the *poriadochnye* on methadone violate the spatial divides of the prison that are important for enacting governance. A breakdown of trust ensues.

The opposing formal and formal governing rationalities are reproduced through the spatial distribution of the prison and the site of methadone delivery. But a rare shift in methadone distribution exposes the mutability of these spatial arrangements. Tolonbai, a high-ranking member of the *blatnoi* [the highest] prisoner *mast'*, describes an instance of methadone administration in the 'black' territory of the prison by the *obshchak*:

> I helped the guys many times, after I myself got rid of this illness [drug use], you can call it that, psychological and physical. I wanted to pull people out of it, those I could help I did. With medicine, I helped with methadone…so that those first breaking moments wouldn't be so difficult. And with moral support…You understand, my category of people, from my surroundings, they won't come here [the administrative portion of the prison] to drink it. And you know our country, in Kyrgyzstan, everything can be bought and sold. In the city you can buy it [methadone] for 500 som, the doctors themselves sell it. It's not so hard to find it. You just have to keep the person under control who's using the stuff. It's meant for three or four days—the most difficult time, to reduce the withdrawal. And then you shouldn't use it anymore…Maximum five days, 20mL each day and a person returns to his normal self. I know at least seven people who came off drugs this way. They're still not using heroin, not using methadone, they feel great…They live great lives, have a family.

Strikingly, this is no longer a methadone of toxicity and ill health, but a methadone of healing, a treatment. This methadone is made for a short detoxification, which brings the self back into being. The methadone that heals is made by incorporating the methadone subject into the governing practices of the *obshchak.* The same object administered in a different space is *made* different. Spatial arrangements are not just a medium but a productive force, actively participating in the making of the methadone subject and object.

Methadone as disease and unpredictability

Sultan explained the threat that *poriadochnye* on methadone pose to the stability of the *poniatia* by enacting disorder:

> Those who drink it for treatment, those drink it for treatment, while those who get high, they drink methadone, then follow up with other substances on top. And what happens to them? They don't have control, they can walk over to the *obizhennye*, and whatever. That's why they were confined to living there. [Sultan]

Given that Dimedrol is sold by formal authorities and becomes closely intertwined with methadone (see Chapter 4), accessing methadone is regarded as playing into the hands of the enemy.[35] Such betrayal of the *poniatia* has corresponding physical effects (Chapter 4), which render a subject no longer able to act in accordance with good discipline. As Sultan points out, an unwitting foray into the territory of the *obizhennyi* is a major breach of the *poniatia*. If spatial boundaries are violated, the *poniatia* can no longer be upheld and the conditions for liberation fall out of reach.

Methadone as untouchability

The 'clean' divisions in space, moral standing, and drug use, are again muddled by the *poriadochnye* on methadone. Decent on the one hand, but a traitor on the other, the *poriadochnyi* on methadone occupies both the prisoner-run territory, with the ritual of the *razgon*, and the territory of the administration, with methadone distribution. The placement of the *poriadochnyi* on methadone in the territory of the reds, displaces the boundaries of the entire *obshchak* towards the reds, a space where moral degradation reigns. This displacement is of pivotal importance for the functioning of informal governance: "All the secrets of the criminal world come out from the methadone patients" (Mirlan).

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[35] Field notes, October 17, 2016.

Prisoners living under the auspices of the *obshchak* employ varying strategies to mollify this tension and realign material boundaries with the *poniatia*: separate living quarters, separate delivery windows, and separate access times.

State-sponsored methadone disrupts vital matters-of-concern of prisoner society. Medical technologies are officially deployed by the formal government, but decisions regarding the *poniatia* are made by the informal authorities. Enabled by a system of mutual surveillance, prisoners recognize the informal leader's ability to discern a prisoner's moral standing through his history of abiding by (or straying from) the *poniatia*. In a perfect functioning of the *poniatia*, all deeds (*postupki*) come to the fore through mutual surveillance. In turn, this creates a platform for the authoritative prisoners to rule fairly and for prisoners to act with agency ("everything depends on you alone"). Authoritative prisoners are responsible for ruling on difficult cases. In particular, they are responsible for applying the traditional code to new cases, such as methadone engagement. The justification of this authority depends on their own constant and willing submission to the *poniatia*.

There are slight variations in the way that the *polozhentsi* in the various prisons have confronted the tension elicited by methadone. In prison 16, the treatment of the *poriadochnyi* on methadone is harsher—there are almost no *poriadochnye* on methadone at all—whereas in prison 1, the *poriadochnye* on methadone live with everyone else. This status, however, is currently under review given the orders of the *obshchak* that "it is up to you. Either stop taking it and stay with us, and live as you have been living. Or proceed with the treatment, but you will have to move with them, with the *obshchestvenniki* [the reds]. You will have to live there" (Turat). In prison 3, where most of the fieldwork took place, methadone was distributed in the administrative territory of the prison. Accessing methadone every morning required walking over to this portion of the prison, and sharing space both with the reds and the lower *masti* ("For methadone, they come, first the *poriadochnye* drink it, some

employees watch there, they let them out one by one" [Bakyi]). The *obshchak* in prison 3 therefore decided to house the *poriadochnye* on methadone separately from other *poriadochnye* in the *zhilaia zona*. There is a "separate barrack that drinks methadone" [Bakyi]. This is done "so that methadone users are in plain view for the prisoners and the thieves. So they're visible" (Rostislav). Below is Semen's sketch of the layout of the *zhilaia zona*:

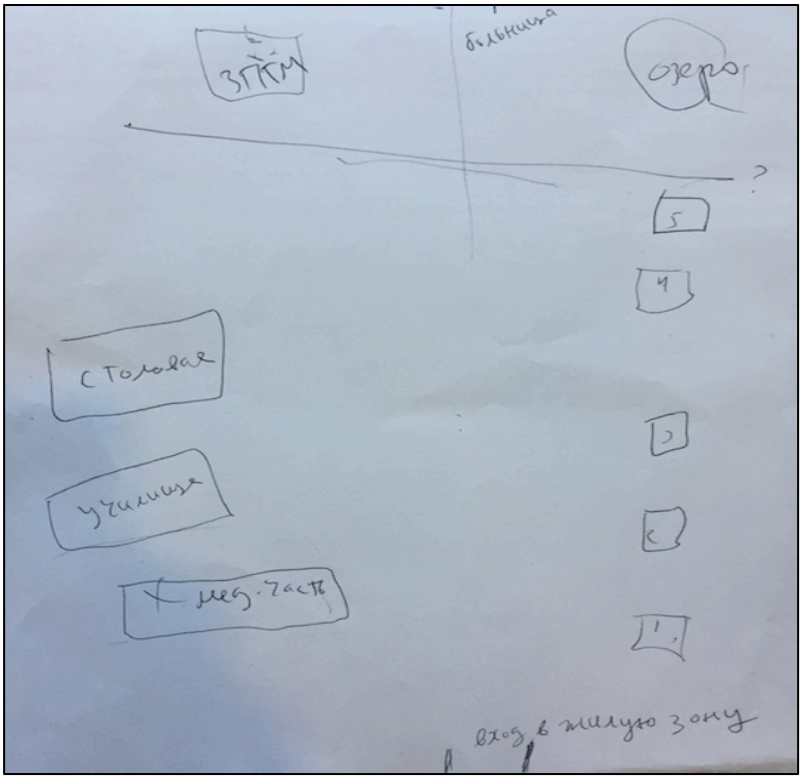

Figure 3—Sketch of the prison.

The methadone patients live in the barrack represented by a square on the top left; it is removed from other barracks behind a wall.

Of note is that these three prisons are instances of the most welcoming treatment of methadone in the country. As noted by former government officials, prisons for first time offenders, where newcomers are being trained in the *poniatia*, forbid methadone altogether.[36] In all prisons, however, these are

[36] Field notes from April 1, 2017.

stark instances of how methadone becomes a site of negotiation in relation to how power is done.

Another way of enacting healing in regard to methadone's blurring of material boundaries has been for different *masti* to access methadone at different times. The *poriadochnye* come first, followed by the in-between *masti*, and, finally, the *obizhennye*. Medical practice, too, adapts to this arrangement, as Nikolai, a doctor explained: "They know their own rules, they do not come with the rest of the prisoners, they come later. Or after lunch… It is their own code. We see no difference. Sometimes we even pity them [the *obizhennye*]. Sometimes they need to be seen first, then we see them separately. They have their own rooms." During the fieldwork, I often saw *obizhennye* avoiding entering the medical facilities and addressing the doctors through a crack in the window from the outside. Similarly, for the needle syringe program, the *obizhennye* "have access, but only on the other side" [Dzharkin]. Power is thus reproduced through these material relations and enacts certain moral placement among those accessing methadone treatment.

Methadone further blurs the separation between moral positioning within the prison and the maintenance of proper government through the site of the methadone dispensing window. A *prodiadochnyi* accessing methadone through the same window as an *obizhennyi* continues to be a major point of contention among prisoners of higher *masti*. It was the underpinning argument provided by the *obshchak* in prison 1 for their campaign "to get the *poriadochnye* to give up methadone, not to take it" [Turat] that began during my fieldwork. Turat continued:

> Another bad thing is that they give us the treatment from the same dispensing window. They [the *obshchak*] go: "You take the medication from the same window with the *obizhennye.*" There was a pen, it was lying there, I had to sign the paper. OK, everybody has their own pen. And now about the dispensing window. They say: "You go to the same room with the *obizhennye*, you take medication from the same dispensing window." They stress this now. I mean, the *poniatia*, it

> prohibits that, that would not work. If you are from the *poriadochnye muzhiki*, you should not go there with the *obizhennye*, you should not be there…let alone be taking something from the same dispensing window…that's how it works.

The *poridochnye* and *obizhennye* are forbidden to come into contact. Their separation maintains purity and moral order. So, here, it is methadone that troubles this separation and maintenance of power through the site of the dispensing window.

There is a strong sense of vulnerability to contamination and a corresponding need to draw material boundaries. Instead of drinking methadone from the disposable cup provided by the program, the *poriadochnye* bring their own personal cup—a way of avoiding the off chance that an *obizhennyi* had drunk from the same cup as them, an instant cause for demotion in the hierarchy. As Kenzhebek explains:

> They treat them [the *poriadochnye* taking methadone] almost like *obizhennye*, with disdain. It's that they're drinking from the same window, the *gady,* the *obizhennye*… And I tell them, "and so what? The cups are separate! And what about going to the clinic, they all go through the same door, don't they?!"

Certain *poriadochnye* on methadone even advocate for a separate dispensing window at the methadone facility.

Most *poriadochnye* on methadone fail to maintain their social status despite such discursive attempts to 'clean' the moral failures of the *obizhennye* from their own practices. Kenzhebek is an exception. He maintains his governing capital despite his methadone use. He explains how:

> For me, I've always gone with my own cup and pen. And I was able to then go and visit the *polozhenets* and the *vor* at any time, they didn't push me away, it was normal. Well, but, it's because I'm older, first of all. Second, I've always tried to maintain order. I show up and if they're all [*poriadochnye* on methadone] clawing their way in [to get methadone], everyone's trying to get in faster. I scold them "you're only 20 people! Five minutes won't make a difference. Don't lie that you're withdrawing!

> You still have methadone in your blood. Calm down, you're decent men [*poriadochnye muzhiki*]. And they [the *obshchak*] see this, that I line them up. But people like me are in the single digits. There's another one like me who drinks methadone…He also goes with him own cup and no one says anything to him. If he'd be injecting [heroin], he'd die. But he stopped injecting and started drinking methadone—he's better now, that's it. He has an appetite and he sleeps well, all's good. See, some people are saved by methadone. Literally.

To maintain his moral standing, Kenzhebek and his fellow *mast'* members on methadone have to physically separate themselves from those of lower standing with whom they are brought into contact through the dispensing window. But these efforts may not be enough. Kenzhebek recalls his practices of 'good governance'—in this case, bringing his group in line with the image of a decent *poriadochnyi*—are a way to facilitate good moral standing and 'make up' for one's methadone use. Methadone use constitutes a failure of criminal citizenship and requires extra effort to enact the healing practices of collective self governance.

Methadone and speaking about oneself: confession

Speaking about oneself is an essential practice of healing among prisoners. As I discussed in detail in Chapter 5, when a rupture in governing practice surfaces, recovery is enabled by bringing the individual back into the collective prisoner body through public confession. A constant injunction to reflect on and speak about oneself ensures that the assemblage of the *obshchak* remains intact—only those ills that are outside the confines of the circulating body are sinful and diseased. Public confession is both diagnostic and restorative. The practice of public speaking about oneself is continuously used among prisoners on methadone to mend the rupture that this substance has brought to the self and to the *obshchak*. Through the material of words, the self performs a recovery, bringing itself in line with normative conduct and repairing fissures. Individual prisoners have the right to defend themselves and make a case for their deeds in a public confession, often leading to a public negotiation to put a new rule

into practice. In this section, I focus on how confession is performed in relation to methadone.

Akylbek's red and black confessions

To understand the relationship between confession and methadone in the context of informal governance, it is important to first unpack the practice of confession to the formal authorities. Akylbek, a participant I interviewed in the community, like most, had experience with confessing to both the informal and formal authorities (the police). Run-ins with the police outside of prison expose people who inject drugs to manipulation at a time of withdrawal, when they are particularly vulnerable to making false confessions under pressure. Motivated by a shortage of heroin in the country, Akylbek signed up for methadone in a clinic in Bishkek in 2007:

> We didn't believe it, that you drink and the symptoms would pass and that's it. And I thought, "That's something, a great thing." At the time I was already having problems with my veins. That is, I didn't know where to shoot up, and I had problems with shooting up at all, so I was so happy with this.

He continued taking methadone when heroin supplies were low, switching back to heroin when possible, until he was sentenced to eight months in Prison 16. At the time, the bazaar was still open so he was able to buy heroin and shoot up consistently. Upon release, he alternated again between methadone and heroin until he was arrested again in 2008. This is the year the bazaar was closed within prisons, so withdrawal was imminent:

> They lock me up again and now into *ROVD* [District Department of Internal Affairs]. The employees themselves were like, "what are you going to do now? There's no heroin [in prison]. The bazaar is closed."…But they don't say that methadone had been opened. They were like, "you're on methadone too, you'll go through withdrawal now." Well and they started asking me to take on other crimes: "we'll give you enough heroin, you'll go in and you'll shoot up heroin for a month or two, and you'll get over withdrawal." I said, "no, no." I didn't agree to it, I thought to myself, "it'll work out somehow."

He arrived in SIZO and learned that methadone was already available there and continued drinking it. He had managed to avoid a false confession—something many participants I interviewed could not avoid, admitting to crimes they did not commit in exchange for a dose.

But soon Akylbek was facing another transition and potential disruption: a transfer to Prison 1. The rumor was that he would have to quit methadone upon arrival in the new prison since the *polozhenets* there did not approve of it. But Akylbek managed to stay in the program. He highlights his "word" as the reason he continued on methadone uninterrupted:

> It depends on the person, if a person can't stand up for their honor and dignity, then of course he'll be stepped all over. But if, say, I can say [*za sebia skazat'*] why, if I can explain, why I'm taking this methadone, what the pluses, the minuses are, adequately explain it to a person, then the way they treat me changes completely. I also went to the *polozhenets* and explained to him "brother, methadone is better for me. I'm not asking for heroin from you. I don't need it."…And I told him, "I don't know, I can inject this whole bottle [heroin for the *razgon* is pre-mixed in large glass bottles and then distributed from a larger syringe to smaller, individual, syringes] right in front of you. And nothing will happen to me. I don't need it." I said to him when they were getting a bottle together for the *razgon*.

Through this confession to the *obshchak*, Akylbek established his standing as a "clean" methadone user, allowing him to continue on the program. He emphasizes the importance of the *way* in which he uses words as directly related to his standing; an "adequate" explanation makes decency. In both cases, facing the uncertain fate of his methadone use, Akylbek chose to reject confessing to the *militsia* and instead opted to confess to the *obshchak*. His words served as the vehicle to establish himself as a legitimate methadone user, one who is not in need of other substances and retains his personal integrity, and allegiance to the *poniatia*. The fractured self is healed through confessional procedures to the virtuous authorities.

Negotiating the self on methadone

Attending to the push and pull of the debate surrounding the substance of methadone reveals the shifting material discursive practices involved in making the methadone subject. The debate revolves around the material practices of accessing methadone. It is certain practices that bring the methadone user into decency (e.g. educating younger generations in the *poniatia*) and other practices that make him indecent (sharing space with the *obizhennye*). But they are not static; the *poniatia* are a space of disagreement, where its edicts are contested and in flux, followed by a momentary crystallization, only to be reformed again. By extension, the discursive and subjectification effects, conferring how power is enacted between different *masti* within collective self-governance, and how it enables different forms of citizenship and access to resources, are also fluid. A testament to this is Evgenii's account, a high-ranking *blatnoi*, who was last in prison ten years ago—before methadone was implemented. Today the *poniatia* strictly forbid *blatnye* from using methadone, or any substances for that matter, so when I asked him about the decency of his post-prison methadone use, he looked at me confused; the question was not even relevant.[37] Before methadone was introduced into the prison setting and intertwined with local governance, its manifestations and subject effects were indeed different from what they are today: a *blatnoi* on methadone and decency could go hand in hand.

During the course of this fieldwork, informal governance continued to shape methadone as a resource in the making of criminal citizenship (known locally as decency [*poriadochnost'*]). While the *vor* made the final decision regarding methadone upon its introduction, the informal prisoner leaders, the *polozhentsi*, are able to enforce this *progon* variably within certain boundaries. In Prison 1 during the course of this study, the *polozhenets* issued a *progon* to *poriadochnye*

[37] Field notes, April 15, 2017.

on methadone to end their participation in the program. Sasha, a long-time methadone user whom I first interviewed in prison and then after release, described the politics involved:

> The *polozhenets* has to take hold now, so that he becomes, well he's a *polozhenets* already, but for the thief [thief-in-law] to confirm him, he has to somehow, to prove himself. And how do you prove yourself? This means he has to take down methadone, or that it's completely gone from prison, or that only *gady* would drink it in prison, whereas the *poriadochnye* would not drink methadone.

Methadone here is a contested site of negotiation in relation to participation in prisoner society. The *polozhenets* is negotiating his positioning in the governing system through the object of methadone. In the same way, the *poriadochnye* on methadone, who constitute a grey moral area, negotiate their standing within criminal subculture through the same substance. Sasha continued:

> So there was a *skhodniak* [a meeting of all *muzhiki* used to settle governing matters] and only the *poriadochnye* were called in. There were over 200 of us, and each one was saying what he thought. And when it was my turn, I told them, "brothers, I won't be able to quit, because I've been drinking methadone for so many years, it's just impossible for me. The year before last, I tried to quit methadone in this prison, my liver was swollen like this, all the sores, everything starts to surface. It's a very serious thing."

Facing the threat of demotion to the reds and a move to the administrative portion of the prison, Sasha experienced immense anxiety, nearly caving under the psychological pressure of continued methadone use. He called upon his body's intertwining with methadone as a way to defend his use ("my bones are all soaked with it"). Sasha was released before a final decision on his demotion was reached by the *obshchak*. When I met him in the community, he was still drinking methadone. Other prisoners who have managed to stay on have negotiated their status through performances of various forms of social capital:

> I said to them 'How old are you?' '30.' 'Well I've been injecting drugs for 35 years and you want to tell me to stop drinking methadone. Get out of

> here and don't come near me"' and "I fought hard before they left me alone. I explained, 'And so what I go to the medical facilities and there are *obizhennye* there. What now? What now?! You want to tell me I'm tainted? No, man. I go with my own cup to get methadone."

Similarly, other participants lay claim to the duration of their injection practices, their status as invalids, and having a clean slate in terms the *poniatia* as a way of securing their citizenship as methadone users within collective self governance.

Methadone as a loss of one's Word

But the methadone users who manage to mend methadone-rifts through confession are the exceptions. Most prisoners who use methadone are indeed those who have failed to practice decency as per the *poniatia*. They are outside the collective body, becoming other. Ideally, confession works to bring the member back into the collective body, but in the case of the *gady*, or the most extreme example, the *obizhennye*, the collective, having failed to heal them through incorporation, ejects them altogether. After all attempts at salvation have been made, ejection is the last resort. Crucial to this loss of citizenship is the corresponding loss of one's word. The lower *masti* no longer have a say in governing matters. They do not take part in the *skhodniak*, so they are not given the opportunity to speak about themselves publicly, to confess their transgressions and mend them through their words. No longer able to confess, these *mast*' members become physically degraded. (These members are more likely to be methadone-Dimedrol users. See Chapter 4 for more on methadone's embodiment.) Confession is a normalizing, healing act in the relationship between an individual and the community. Without this disinfectant, the methadone body becomes a body infected, one with the body of the *obizhennyi*.

For collective self-governance to function, the self has to be fully exposed to other prisoners living under the auspices of the *obshchak*. This allows for the apparatus of self and public criticism to 'properly' evaluate those who embody decency according to the *poniatia*, and those who do not. This is done through

the Word, which is a currency of particularly high value. The care prisoners give to the use of their Word is expressed particularly starkly in Kairat's account:

> Well before going on methadone, you have to inform the *smotraischii*, you inform the *smotriaschii*, he goes further…All the way up to the *polozhenets*, the *polozhenets*, who, what, where's he from, why did he decide to take methadone in prison, was he drinking it outside. If he was drinking it outside, then no problem, but if he's in prison, wasn't drinking, was shooting up, and suddenly wants methadone, then he'll be asked questions. And when there are people sitting around you and you're in the center, and each question is this and that, and God forbid you say the wrong word. You're already being taken down the prisoner hierarchy to the *obizhennye*, you'll have big problems, and not everyone can pull this off.

As we saw in the cases of Sasha and Akylbek, some *poriadochnye* on methadone are able to overcome this confession. They are indeed able to heal their moral and material fractures from the community through self-exposure and criticism. Confession, here, enacts communal harmony. But these cases are exceptions.

Most *poriadochnye* on methadone experience a loss of their Word similar to those of the lower *masti*. In this case, such healing is no longer possible:

> Well, I'm telling you, there are 'blacks' here, *blatnye*. I don't know, for them, they, they don't interact with those who drink methadone. With them it's just, "hello, hello." Their [the methadone users'] word means nothing at all. Methadone users come last. Before it was drug addicts, and now lower than drug addicts, it's methadone users. [Ali]

The collective is formed through confessional practices. It undergoes a harmonious growth of the moral body—an interrelation between the private and public sphere that solidifies the collective body. "Having a word"—having worth to what you say—then, is an essential tool of governance. A word with weight is a word that *does*, *acts*. Through these words, an individual's self and his community are shaped, and decency is enacted. Because of the weight of

one's Word, decent prisoners should, according to the *poniatia*, only provide their Word to the right people at the right time.

The *poriadochnye's* interfacing with the territory of the reds raises the possibility that their 'word' will be given to the wrong people. This is a breach of trust.

> Many don't want to go [on methadone] out of principle, because attitudes change towards him right away. He won't be taken seriously. He loses trust right away generally. He'll be an outcast. [Bashir]

The diminished opportunities for self-surveillance and self-criticism that occur through interfacing with the 'wrong' side call for heightened surveillance and criticism from others.

> He'll be watched, first, and second, they will be listening in on him everywhere, and third, the cops [*militsia*] will start leaking information about this person themselves. [Timur]

The methadone-Dimedrol user, unable to fulfill governing roles, is unreliable.

In interview accounts, the methadone-body is a body without structure: the bones become filled with this liquid, penetrated by it, and the body itself becomes meat jelly [*kholodets*]. The methadone body is not a reliable body—it cannot serve the prisoner subculture since it is, by default, interfacing with the enemy. A body without structure is in fact unpredictable and constantly changing—it cannot be trusted to perform the discipline worthy of a virtuous prisoner ("they don't let them near serious matters"). Such a body is fundamentally ungovernable:

> So, if a person works at a sawmill, for example, and uses Dimedrol with heroin or methadone, it can happen that they fall asleep. That's the end of it—they get into the milling machine and chop a part of their body off. That's why this prohibition exists. [Rostislav]

> He'll not be allowed to take part in the *skhodniak*…He'll not be trusted with anything. [Timur]

> I believe I heard someone say they would start going through garbage, or even put their hands inside toilet bowls. [Salamat]

The othering of the methadone subject performs decency in a particular way: the methadone-user is indecent because he is ungovernable; he fraternizes with the prison administration and so cannot uphold the practices of the *poniatia* that enact virtue. The behavior of the methadone subject raises doubts: what if he has divulged governing secrets to the enemy? Their status in the prisoner community is suddenly in question, equal to that of lower *masti* ("this last *mast*', the methadone-dimedrolers"). Trust is lost, and the 'word' of the methadone user is devalued. We can see why, if the *obshchak* makes the virtuous prisoner and prevents *bespredel*,[38] those who stand outside their assemblage epitomize chaos: "they can't control themselves."

Withdrawal as confession

Prisoners' concerns about exposing the self are persistent. Given the function of mutual surveillance, nothing can be done in secret; someone is always watching to monitor individual prisoners' deeds, for fear that a confession will reach the wrong people. This fear is driven by the collective nature of prisoner society wherein revealing one's 'true soul' reveals that of the group (see Chapter 5 for discussion of the collective). This brings a heightened urgency to the subject of withdrawal from opioids. When a prisoner experiences withdrawal, he is particularly vulnerable to potential manipulation by formal authorities. He exposes himself and, by extension, the entire collective. Indeed, prisoners who inject drugs are acutely familiar with this. Outside of prison, heroin is repeatedly used by the police as a way to manipulate people who inject drugs into signing confessions for crimes they did not commit:

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[38] A difficult-to-translate Russian word meaning chaos, lawlessness, and disorder.

> There, the police would bring it to us. Those who caught me for heroin, they themselves would bring it for me. So that I wouldn't go through withdrawal, so that I calmly sign all the paperwork. It's always like that, when you shoot up, it makes no difference what you sign, the main thing is to sign it. Only later, when it's over, when you come back to your senses, you understand that you signed your own death sentence. Before that, you're in some kind of euphoria. [Kemel']

Prisoners who use drugs fear that the "cops" within prison will use methadone to the same end as they use in the community. Prisoners show a constant worry for being "on the hook," denoting a loss of will or agency.

This fear of being trapped consistently emerges from the data—especially in relation to engaging with methadone. Remarkably, withdrawal is repeatedly described as a sort of confession. While withdrawing from opioids, the prisoner's soul is laid bare, which places a lot of pressure on the context of withdrawal to be managed appropriately:

> And you start going through withdrawal from methadone, a person loses his mind, which, on the part of the administration and in relation to the cops, they also know it. Because of that they also try to somehow, somewhere hook the person who drinks methadone. [Timur]

There is again a loss of agency here: undergoing withdrawal from methadone is perceived as being more difficult than withdrawal from heroin, leaving the prisoner weak and suggestible. But this alone does not pose a threat to a prisoner's decency. As long as withdrawal is managed by the proper authorities, it is considered to be revelatory; if the prisoner has done nothing wrong, he has nothing to fear. But withdrawal managed by the prison guards makes the prisoners vulnerable. As Timur explains:

> His psychology is under the influence, first, of methadone, second, of the cops…Because, if he is discovered by the *obshchak*, he'll really get it, and if he isn't discovered, sooner or later everything comes to the surface.

And this sort of unwanted exposure is exactly where methadone and Dimedrol bring the prisoner.

Methadone demarcates a social body

Methadone incorporates the practices of collective self-governance to produce certain embodied effects. These bodily effects map onto the prisoner moral hierarchy, which maps onto patterns of methadone use. Methadone use corresponds to diminishing governing power. Those at the top of the hierarchy are free from methadone, those in the middle are rarely methadone users, while the lowest *masti* make up the bulk of users. Crucially, this governing power is, in its ideal form, equated to moral worth. Good governance is morally virtuous. It hinges on submission that the *obshchak* and its disciplinary practices materialize through communal property, mutual surveillance, and confession. As I have shown, prisoners accessing methadone experience a breakdown of their civic participation. They cannot submit to the *obshchak* by partaking in the rituals of communal property, they cannot observe and be observed by virtue of leaving the territory of the *obshchak*, and they lose the ability speak about themselves. In this section, I consider how the moral and material body of the methadone subject—a subject of *bespredel*—is formed by methadone's collision with the healing practices of the *obshchak*.

Healing through collectivizing practice

Through the practices of collective self-governance, moral divisions between individuals are enacted. This negotiated hierarchy works to separate the virtuous from the unvirtuous, the moral from the immoral, those capable of being governed from the ungovernable, and the healthy from the unhealthy. Ultimately, it creates agency through submission. Ironically, the agency of the individual subject is solidified through its submission to the collectivizing practices of the group. This submission to the disciplinary apparatus of the *obshchak* is enacted as a healing process. The key relation is the healing of ontological disturbance through incorporation into the collective body. Isolation, or exile into the *obizhennye*, is a last resort; it is incorporation into the

collective that enacts healing (See "Discussion" section, Chapter 5). A case in point is the *obshchak's* incorporation of heroin after the closing of the bazaar. Accessing heroin from the *obshchak* as opposed to buying from individual dealers, transformed the heroin user from a case study in *bespredel* into a patient (See discussion of this incorporation in Chapter 3).

Equating the moral and material

The moral, the linguistic, and the material here are all intertwined. The moral and the material fuse together in such a way that a morally degraded subject is a physically degraded, sick subject. Both are indexed to the collective. Forms of ill health are also moral failings with respect to submission to the collective. The substance of the methadone user can be explored as an effect of collective governing practices. Methadone becomes a marker of fitness, social positioning, and moral value with the *blatnye* at one end, and the *obizhennye* at the other.

The entry and continued implementation of methadone in the prison setting presents an instance of pushing at the boundaries of the *obshchak* and its delineation of *mast*' and moral position. Methadone works to maintain a particular social and moral order through the demarcation of a social body. The body of the individual extends to the entire *mast*'. And when the collective body is whole, it is a healthy body. Prisoners living under the auspices of the *obshchak* see the *vor* as implementing policies of health through the closing of the bazaar, the monopolizing of heroin, the prevention of heroin injection initiation, and ensuring that harm reduction measures are instated during the heroin *razgon*. The language surrounding the *blatnye* is one of fitness and sportsmanship (see "Confession" section, Chapter 5). The *muzhik's* body governs through practices that enable decent moral dispositions: communal ownership, mutual surveillance, and confession. These are all normative factors in the relationship between an individual and the community. But a decent body faces the constant threat of ejection from the collective. When the tenets

of proper discipline are irrevocably violated and healing through incorporation into the collective is no longer an option, the body becomes a body infected.

State methadone, then, governs through rupture and disruption of key disciplinary practice. It constitutes infection, demarcating a similarly ill social body. The *obizhennye*, embedded in the methadone-Dimedrol complex—substances that enact formal governance (See Chapter 3 on methadone as formal governance)—are described as rotting, decomposing bodies (see Chapter 4 on the bodily effects of methadone). The *obizhennye* are pools of infection; upon physical interaction with them, one too will become infected. This shows how moral standing in the hierarchy is transmitted between people: it is a physical contagion. The body of the *obizhennyi* is a methadone body, rotting and degraded, both morally and materially. The endpoint is disappearance (see "The dehumanized methadone-body" section, Chapter 4).

This disappearance is also performed by the language used by other prisoners to describe the *obizhennye*—they are visibly absent from narratives of the "whole prison." By engaging in the disruption of the communal practices of the *obshchak*, they are effectively ostracized and removed from the practices of prisoner subculture that create worth and virtue through the collective body. Rendered unable to participate in the *obshchak*, what remains is a no longer human, othered body. As Salamat noted, "a person begins to transform not into a human, into an animal." The *obizhennye's* material separation is an enactment of a boundary shift from the *obshchak* to the Other.

Beyond the boundary of the *obshchak* lies methadone, constituting ill health and marking a step away from the collective. Given the injunction to heal through re-integration with the circulating collective body, methadone works, instead, to fracture this body. It becomes a site of negotiation in relation to power. The *poriadochnye* on methadone are standing at the threshold of ill health, continuously negotiating their entry back into the fold and away from the Other. The *poriadochnye* on methadone are both decent (as *poriadochnye*)

and indecent (as methadone users). They are both a part of the communal ritual of distribution from the *obshchak* and excluded from it (in regard to heroin). This is a fracture in the governing system, eliciting negotiation to smooth out the ruptures and bring the subject in line with a prisoner-made moral code.

We see that the subject is constituted in a process of breakdown and formation, which brings momentary stability by enacting the self in relation to methadone's ontological disturbance. In this process, unraveling and sewing back together occur simultaneously, each time in a slightly new configuration. This negotiation of messiness enacts healing through the shaping and reshaping of the contours of the body by means of the dynamic and reciprocal relations of the disciplinary apparatus and the substances of methadone, heroin, and Dimedrol. Their dynamic interplay produces multiple methadone subjects that change over time. These moments of negotiating informal discipline have material effects; they are an instantiation of the multiplicity of methadone objects and methadone subjects. But there is also a bounded singularity in the *obshchak* and its enactment of the collective (Law, 2004). The moral and material fabric of prisoner society is crafted through these oscillations between a bounded and a fissured collective.

Rupturing the ethos of the obshchak

It is worth looping back to Alim's statement on the ethos of informal governance to background and conclude my discussion of its unraveling. His account poignantly brings to light the function of the disciplinary apparatus of informal governance through the imagined consequences of its absence. The foreshadowed end of collective self-governance, subsumed by its corruption, lays bare its forms of reason—it elucidates what methadone threatens:

> They'll put them in jumpsuits like it should be, right, like in Western prisons, that's it. It's like they're all the same. No privileges.

With the breakdown of governance, everyone will be the same, irrespective of their worth and their deeds. The Western (presumably United States) prison is enacted as a space of formal governance, where a lack of individuality, symbolized by everyone wearing the same jumpsuit, is underpinned by the presence of a *rezhim* (the reign of formal rule). The prisoners who benefit from this governance do so simply because they are closer to the administration ("only those close to the leadership, well, like the orderlies, former employees…they will have access to privileges"), rather than because of their decency and discipline. The bad bodies will be mixed with the good and the result will be a contagious *bespredel*. When the individual is ejected from the negotiated hierarchy and thrust into a system of evenly distributed power, the 'proper' development of the self, and the agency it affords, is stunted.

Methadone as *bespredel*

Methadone tears through the critical elements of self-formation, infecting others with *bespredel*. The individual prisoner undergoes a process of becoming through his folding into the collective, but methadone slices the individual out spatially and ritually. In this way, methadone ruptures the disciplinary practices that hold the collective body together, disrupting the assemblage of the *obshchak* and enacting a state of *bespredel*. In the territory of the reds—the territory of methadone—arbitrary rule and chaos reign, causing a breakdown of the disciplinary apparatus. Thus, methadone enacts deterritorialization, disassembling the disciplinary practices of the *obshchak* and unraveling its moral system. The idealized autonomous subject ushered in by methadone does not hold here. The mechanisms of governance are recognized as enabling agency whereas methadone, by contrast, brings about loss of agency and descent into disorder. Methadone as practiced in prison today, similar to pre-2008 heroin, is ungovernable—it is a fluid substance one cannot trust.

The project of methadone incorporation, then, is a project of creating virtue, or "decency" through practice. The debate surrounding the acceptance of methadone for the *poriadochnye* brings competing ontological formations to the fore—an instantiation of the "the micropractices through which the truth of a particular practice is established" (Asad, 1993: 14). Methadone's negotiation invokes the material field of power relations through which objects and subjects are continuously being made, and which here surrounds the *poniatia*—a set of practices that valorize the relations of spatiality, including how substances are dispensed. Through these relations, the decent body is brought into being as a product of dynamic discursive-material relations.

Chapter 7—Discussion

Summary of chapter

At the core of this PhD is a critical engagement with the project of translation. Driven by methadone intervention delivery challenges in Kyrgyz prisons, I have investigated methadone objects and subjects as emergent from the material-discursive relations of methadone's implementation practices. This research has been driven by the tensions that have emerged from a fracture with the 'evidence-based' framework that I began with. This productively reversed the trajectory of my inquiry into causal deterministic effects of psychoactive substances interacting with a human body to explore, instead, the relational and situated production of substances and bodies. In this chapter, I conclude on the methadone objects (Chapters 3 and 4) and subjects (Chapters 5 and 6) that have emerged from this fracture. I reflect on how this research itself is an intervention with onto-political effects, producing a boundary shift in the making of the methadone subject and working to challenge mainstream conceptualizations of intervention translation in public health. I conclude with what understanding reality and its effects as contingent implies for how further disruptions might proceed to open up a space for change.

Summary of the thesis

This thesis is comprised of seven chapters, drawing on empirical findings from fieldwork in prisons in Bishkek, to map the socio-structural relations, performances, and subjectivities of methadone. Framed around issues of governance, I demonstrate how methadone materializes and is materialized, how it affects bodies and is affected by bodies, how it makes the prison space and is made by the prison space. I delineate methadone effects (drug effects, subjects, systems, spaces) as matters of translation between the disciplinary

power relations within prison governance, incorporating both human and non-human actors. These findings bring me to reflect on what a different kind of intervention translation may look like, one that erodes monopolistic assumptions of the dualism between evidence and practice.

Discussion of findings

First, I summarize and conclude on the findings from each of the preceding chapters. I began with an investigation into how the object of methadone is materialized through national stakeholder discourse in Chapter 3. Theorizing discourse as practice in that it co-constitutes objects, I explored how Kyrgyz national policy texts, interview transcripts with stakeholders, and the "hinterland"[39] (Law, 2004: 33-34) of practices surrounding them *act* to coordinate methadone in particular, yet overlapping, ways (Bacchi and Goodwin, 2016: 35). Following Bacchi's "What is the problem represented to be?" approach, I treated these texts as proposals that constitute the problem they purport to address. Very simply, this approach starts with the premise that what we propose to do about something, is not merely a response, it is *productive*. Our solution is indicative of how we constitute the underlying 'problem' (Bacchi and Goodwin, 2016: 15). And this has tangible effects for how we live our lives including how objects are materialized. Rather than preceding the texts at hand, methadone is made within them.

I showed that methadone treatment, as proposed in Kyrgyz national policy, constitutes the problem it purports to address as a medical problem. This proposal, in turn, makes methadone objects through how it is put to use. In Eastern Europe and Central Asia, there is a politics, spearheaded by the Russian Federation, of methadone as an addictive drug similar to heroin (Colborne,

[39] John Law (2009) uses the term "hinterland" to refer to the routinized and persistent patterns of relations that enact realities into being in particular ways.

2016). The Government Program,[40] for example, departs from this politics through its medicalized discourse to produce methadone as a non-*narkotik* treatment for opioid addiction and HIV prevention. This methadone is overlapping and co-constitutive with 'evidence-based' global methadone, which folds methadone into the incontrovertible goal of reducing new cases of HIV.

But, within the same proposal are, at once, contrasting problematizations and methadone objects. Receding into the background of national policy and strongly enacted in stakeholders' interview accounts is a methadone "made otherwise" (Law and Singleton, 2000, Mol, 1999). Historical contingencies of a loss of formal state control of the prison system have contributed to the making of methadone as formal governance, carving it out as distinct from heroin as informal governance. Veering sharply from 'evidence-based' discourse, this methadone is *more than medical* and entangled with the complex power relations of the prison. Importantly, both the globalized and the local methadone are enacted as distinct from heroin but, yet, they rely on it as an "absent presence" to delineate what methadone is and what it is not (Law and Singleton, 2005, Lancaster et al., 2017a).

This form of analysis does two things. First, it highlights that methadone is not an object traveling and adapting to a new context, it emerges as ontologically distinct through various sets of stakeholder practices (Rhodes, 2018, Rhodes et al., 2019, Rhodes and Lancaster, 2019). Multiple methadones are made at once, in relation to each other and to heroin. While certain discourses are more authoritative—in this case, the globalized medicalized methadone in policy—less 'official' discourses around the margins produce a different methadone: a methadone of formal prisoner governance. Second, the objectivization of methadone as a matter of governance makes certain ways of thinking about its

[40] This is a document outlining Kyrgyz national policy on methadone treatment implementation.

performance possible. Emerging from this local rendering of methadone are discursive and subjectification effects that draw on methadone enabling and limiting state governance—a manifestation of methadone previously unexplored in the prison context. Certain things about methadone become sayable while others do not, particularly in terms of methadone's performance. Rather than the global health methadone of HIV prevention and addiction recovery, noted by public health scholars for its exceptional availability in Kyrgyzstan (see "Kyrgyzstan as an exception to the rule" section, Chapter 1), the local methadone does not perform in relation to such problematizations. In fact, health is conspicuously missing from its performance. Rather, methadone performs according to how well it makes formal relations "congeal" (Foucault, 1987). The hope for the elusive physically presentable methadone subject becomes aligned with the hope for an economically re-invigorated state conferring formal governing potential.

In Chapter 4, I continued to explore the multiplicity and movement in methadone's making to trace how it was being produced through prisoners' accounts. I followed how the methadone object moves in an actor-network of substances through its capacity to affect. I treated methadone, Dimedrol, and heroin as the prime actors in a drug assemblage and traced the different ways they came into connection with each other through their practices of use to produce different effects. First, I showed that methadone-in-practice entangles with health-destroying enactments of Dimedrol while it diverges from harm-reducing enactments of heroin. Two embodied effects produce this methadone as toxic: dependency and withdrawal. Methadone is enacted as 'worse' in relation to heroin-as-medicine and is made even worse when methadone comes into contact with Dimedrol. The relations between methadone, heroin, and Dimedrol are instrumental to understanding how 'drugs' or 'medicines' are made. Key here is that embodied effects are elements of a network of effect-making, involving both human and non-human actors, rather than a simple drug-human actor interaction (Rhodes et al., 2019, Gomart, 2002, Duff, 2013,

Dennis, 2016a, Lancaster et al., 2017a). This underscores how drug effects are made through their *use*, rather than being inherent to the substance itself (Keane, 2013, Lancaster et al., 2017a, Barad, 2003).

Second, I followed methadone's patterns of use to notice its folding into the substance of Dimedrol. Methadone becomes a Dimedrol-methadone complex, where the two coalesce into a bounded substance made even more toxic in combination. This complex is at odds with public health discourse, which refers to the simultaneous use of two substances as "polysubstance use" (Azbel, 2013), enabling a line to be drawn between two singular objects. This allows for the dependence and withdrawal experienced by users of the complex to be attributed to Dimedrol rather than methadone. This, in turn, enables a clean excision of methadone from the methadone-Dimedrol complex within policy proposals that seek to increase methadone uptake without accounting for its entanglements with Dimedrol. But this thesis rests on the premise that substances, rather than possessing solid or stable effects, are made within social practices (Dennis, 2016b, Gomart, 2002, Duff, 2013). Methadone and Dimedrol, then, come together into an assemblage of effect, complicating the very notion of 'polysubstance use' and, by extension, the policy responses to the problem of methadone uptake.

Third, I describe the material effects of methadone-Dimedrol, wherein a 'methadone body' materializes—a damaged body on the verge of death (Rhodes et al., 2019). This allows us to see how the embodiment of methadone enacts evidence about methadone treatment as an intervention. Methadone's effects, similar to Rhodes' study of methadone in Kenya (Rhodes, 2018) and stakeholders' accounts of the methadone subject in Chapter 3, are "*seen* to be believed." Through witnessing methadone's bodily effects, one's own as well as others' bodies are affected; in this case, they become inhuman. While 'evidence-based' discourse dichotomizes intervention and context, these knowledge-making effects of methadone's use tell a different story. Evidence and practice

are made in concert, rather than intervention effects lagging behind and diverging from an a priori evidenced intervention (Mol, 2002).

The ways in which methadone is put-to-use is an element of local practices, including how subjects are governed in relation to the disciplinary practices of prisoner subculture. In Chapter 5, we[41] drew on models of monastic and Soviet discipline to conceptualize how an apparatus of 'collective self-governance,' comprised of public confession, mutual surveillance, and communal property, develops 'decency' (the local term for virtue). This occurs through a ritualized form of life centered around the *obshchak*, an assemblage, consisting of both human and non-human elements that combine to produce the virtuous prisoner. In contrast to modern western disciplinary apparatuses, for this idealized prisoner, bodies, space, and language all manifest a merging between individual and collective identity. Ultimately, collective self-governance generates a collective prisoner body. Below, I draw out the implications that this disciplinary apparatus has for understanding how health is made in relation to methadone. I show that, paradoxically, the idealization of a stable autonomous subject that methadone engenders is inimical to agency and, by extension, health. Rather, a healthy body is produced through healing via submission, the indexing of the individual body to the collective, and blurring the boundaries between bodily and moral health.

First, troubling the individualizing understanding of health that lies at the heart of Foucault's plague model in panopticism, I described how healing is differently performed in Kyrgyz prisons through the incorporation of the digresser into the greater prisoner body, rather than his isolation. Mobilizing studies of discipline in medieval monasticism (Asad, 1987) and Eastern

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[41] "We" refers to my co-authors, Evan Winter Morse and Tim Rhodes, on the manuscript, *The Collective Body: Legacies of Monastic Discipline in the Post-Soviet Prison*, under review at Theoretical Criminology.

Orthodoxy[42] (Kharkhordin, 1999) allows us to see that, through these mechanisms of submission, agency is produced: to become free, one must submit, to develop a self, one must give it up, to gain agency, one must be sanctioned and surveilled. And this agency is co-produced with health; in effect, to become healthy, the body must be contaminated. Of course, any ideals of perfect free choice are illusory. But what is notable here, rather, is that 'good governance,' with its prescriptive program aimed at training obedience, is defined as enabling free choice.[43] The *obshchak* is enacted, even by detractors, in relation to equality, individuality, independence, and the *healthy body*. So the investigation of the particular mechanisms used to attain these ideals becomes central.

Secondly, these disciplinary mechanisms produce ambiguous bodily boundaries, indexing the individual to the collective body such that an individual cannot be imagined separately from the collective; the whole becomes more than the sum of its parts. This has parallels with Deleuzian ideas of bodily incorporations wherein a separable human subject is lost (Deleuze

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[42] Indeed, this is a very Eastern Orthodox concept: to become immortal, Christ had to first die. The justification for Soviet collectivization was, similarly, that it empowers the individual. Seeing submission to the *obshchak* through the lens of Orthodox theology becomes a useful tool for understanding the making of the collective body through submission to the whole.

[43] I came to appreciate the collapse of the inner (soul) versus outer (body) distinction through its importance within religious practices. Especially productive for this has been thinking through the parallels between medieval monastic discipline and the work performed on the virtuous prisoner body in Kyrgyzstan. The understanding of agency I refer to here is non-intuitive to Western modes of producing freedom, which are undergirded by Protestant theology. In its most extreme form, within Calvinism, the individual is confronted with the choice to be good or bad and they actively choose faith and Jesus. In Orthodoxy, however, the individual recognizes they are weak and the Church has techniques for making them stronger. For example, if the individual disciplines themselves to pray every day, they will gain strength; the individual thereby becomes a champion of the soul by doing work on the body. This is similar to Sufism where bodily purity is one with spiritual purity and a 'good' person is one who has conquered their body. See Flueckiger (2006) for a discussion of the capacity for spiritual healing in Sufism in relation to postpartum and menstruating women (138).

and Guattari, 1987). Nonetheless, the individual and his deeds, even while enmeshed with the collective, are a focal point of the *obshchak*'s disciplinary program: the health of the collective hinges on the healing of the individual. Since the *obshchak*, in its idealized form, establishes a baseline set of practices that liberate the individual to act out their virtue with full agentic potential, it follows that an intense scrutiny is directed at the individual's 'deeds' or *postupki* (similar to the trials familiar from Stalin's Purges) (Hoffmann, 2003). And third, virtue, developed through a lifetime of deeds, has an isomorphic relationship with bodily health.

These enactments of informal discipline here have material effects whereby certain bounded selves are ontologically present or absent. While there is multiplicity, for instance, at the moments of confession where resolving difference is a matter for negotiation, there is equally an apparent bounded singularity—the sense of collective—beyond which lies an object boundary shift to something Other (Law, 2004).

Engagement with methadone is one such 'deed,' and can, therefore, be put on 'trial' to produce virtue and, by extension, health, in particular ways. In Chapter 6, I conceptualized the interrelations between the politics, power, and spatiality of methadone by looking at how it features as a site of governance in relation to the disciplinary apparatus of the *obshchak*. I treat methadone as agentic, a technology with governing potential (Fraser et al., 2014, Duff, 2015), "loaded with morality," a "political actor," with "normative actions" (Harbers and Popkema, 2005: 231). Therefore, I traced how methadone travels through the terrain of the *obshchak*, conflicting or coinciding with this assemblage, to negotiate social positioning through mundane and multiple human and non-human relations and technologies. Using methadone, and *being a methadone user*, is predominately enacted in relation to a decency—the crux of positioning in collective self-governance—which extends health to acquiring agency through the making of a collective body. The methadone in translation has

disruptive potential in relation to the integrity of the agentic self, formed through integration into the collective. This creates a toxic methadone subject, which is at odds with those imagined by evidence-based medicine. Since, as I have shown, this mode of governance forms the self and the body, methadone is not a matter of different representations of a presumed fixed essence; it is not just perceived as, but literally is, a degradation of the body and moral fabric of prisoner society.

The challenge to improving health outcomes for people who inject drugs in prison in Kyrgyzstan rests on a fundamental misconception of health as produced by the disciplinary practices of collective self-governance. Global expert knowledges subjugate local situated knowledges on the production of health (see "Methadone as formal governance," Chapter 3). Both enact their technological intervention in a liberationist framework: for public health, the state's methadone is freeing; for the *obshchak*, it is fundamentally subjugating. For the former, methadone is an individual choice that frees a person from the negative health consequences of addiction; criminal subculture, however, is a barrier to the realization of a healthy self through the policing of hierarchical boundaries. For the latter, it is exactly the opposite. Methadone excises the body from a collective that realizes the self, rendering it unable to submit—a move essential for agency—and therefore both physically and morally sick.[44] With this in mind, how do we intervene to produce a healthy/virtuous collective body?

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[44] Nonetheless, it is important to note the similarity of the frameworks used by both parties; rather than an overriding systematic dispute about the grounds of knowledge formation, both are operating with a similar understanding of health and agency as the ultimate goal. The difference lies within the two competing models within 16th century medical discourse for reaching these goals: isolation via the plague model or contamination via the leprosy model (see Chapter 5).

How do we intervene on a collective body?

Although this case study is limited to the Kyrgyz prison context, with its situated governing practices, it has broader implications for intervention translations in prison settings globally and implementation science in particular. The questions taken up in this thesis speak to greater questions regarding public health within differing social-institutional systems including how governmentality enables health, governs the patient's body, and shapes what medicines *become*. Alternate forms of governmentality affect and are affected by public health discourses, institutions, and interventions in sometimes unexpected ways. The site of methadone treatment implementation in Kyrgyz prison is particularly useful for exploring these questions because it is a stark example of the different translations that an intervention can make as well as the fractures and collisions between the different forms of intervention that can ensue.

Prisoner society *done* differently

This thesis extends penal sociology scholarship by allowing for an appreciation of health *made* differently in prisons outside of the Global North. An understanding of the governing rationalities underpinning this disciplinary aparatus serves as a critique of the dominant approach to prisoner health, driven by studies in a small number of countries in the Global North (Wacquant, 2002). This critique propels a move from an individually oriented model to one that appreciates the production of health as a collective endeavor offering a crucial—and up until now disregarded—starting point from which to implement health reforms in prison settings. While this study focused on Kyrgyz prisons, previous criminological scholarship suggests it can be extended to other prison settings worldwide characterized by a culture self governance (Oleinik, 2003, Crewe, 2009). Interventions, medical or otherwise, that work to

excise the individual from the collective are unlikely to succeed in self governing prisons.

Counter-intuitive to Western rationalities of healing, which follow a plague model characterized by isolation rather than integration (as per Foucault's panopticon), healing in the post-Soviet prison produces health by incorporating the individual into the greater prisoner body. The disciplinary apparatus in Kyrgyz prison serves as a case study in the inapplicability of panoptic modes of power. The onset of disciplinary practice that Foucault characterizes through a panopticism, in which health is enacted through a plague model, does not sit with the disciplinary practices of punishment within the post-Soviet space. Healing in Kyrgyz prisons is enacted, rather than through segmentation and surveillance made possible by quarantining the plague, through exclusion, or exile, characteristic of the leper colony.

Particular governing rationalities must be taken into account when intervening within the prison space, as it is through them that subjects and objects take shape. This is paramount for how health researchers and implementers intervene in the prison, particularly—but not limited to—in regard to the translation of health interventions. I encourage future studies in the post-Soviet prison and self-governing prisons worldwide to critically examine the effects of medical interventions within the realm of collective self-governance.

Ontological politics

I have shown that a set of very fluid methadone subjects and objects are produced locally that differ dramatically from those of 'evidence-based' methadone. The methadones enmeshed in prison-based politics of governing are translations of a different order to the incremental tinkering of implementation science to adapt an intervention to fit its context. Attending to the ways in which reiterated ritual practices inscribe bodies in particular ways has brought a prisoner subject into view that remains unaccounted for by

Western biomedical technologies. Performed through the "unruly" and "messy" bodies of its users, the embodied effects flowing from the methadone enacted in practice in Kyrgyz prisons is a degradation of the moral and material fabric of the prisoner body. The translation of methadone into the domain of the *obshchak* creates something entirely new and unexpected: a harm rather than a health producing methadone. The methadone of harm *appears* as a singular object (Law, 2002) when it is in fact multiple, but this does not make it any less 'real' (Hollywood, 2004: 80). Since there is no 'out there' methadone, but there are other, also real, alternatives, which one do we perform?

An ontological politics (Mol, 1999, Law and Hassard, 1999) can bring us closer to a response. 'Ontological politics' (Law, 2010) is the exploration of how to proceed given the inextricability of the real and the political (Mol, 1999: 26), or the interconnectedness of fiction and fact (Haraway, 1991a). As Bacchi and Goodwin (2016) explain:

> By emphasizing a plurality of practices, it becomes possible to insist that the realities we live are contingent, open to challenge and change. Because things could be otherwise, the firming up of particular social arrangements is seen to involve politics, used here in an expansive sense to mean the active shaping or making of the taken for granted. (4)

The practices of implementation have transformed the intervention. The effect potential is not universal. The building blocks of reality become mutable. It follows, then, that being attuned to how care is materialized in relation to everyday modes of conduct helps generate new and different ways of knowing. This has the radical consequence of opening up reality for contestation (Mol, 1999).

In attending to how methadone emerges otherwise in an assemblage of social and material governing practices (DeLanda, 2006) of collective self-governance, I invite the questions, "what kind of intervention translation do we want?" and "how do we get there?" In answering them, I engage with the pragmatic and political dilemmas concerning how to act in an approach which is oriented

toward relational materialism. My dual position as a researcher embedded in both mainstream public health and critical sociology provides a platform for engaging directly with the tension produced between the global and local methadones. It is therefore important to reflect on how my research practices, beyond just putting forward critique of the patriarchal character of biomedicine, have "generated differences and so potential tensions between the practices of different professionals and the materialities that they enact" (Law, 2010: 16). Treating this research itself as an intervention with onto-political effects (Rhodes and Lancaster, 2019), I harness the tensions it has generated to introduce a corrective for both relational materialist and public health research into intervention translation.

Proposal

In what follows, I provide a two-pronged proposal for intervening within the Kyrgyz prison to produce a virtuous/healthy collective body. First, I advocate for a re-thinking of the way we do research with a view of marrying *knowing* and *acting* in a way that allows us to notice contingency, multiplicity, and flux. I argue that social scientists highlighting this multiplicity have been insufficiently activist to enact tangible change. Secondly, as a corrective, I propose a *situated* intervention translation—a translation that intervenes within the web of relations to reproduce local ways of doing health.

A new way of researching intervention translation

As a response to the intervention translation challenges within public health, I call for implementation science to consider how material-discursive practices as well as those of our intervening are generative of the world we study. Previously unnoticed ways of being and doing, then, are made possible.

This thesis engages in an ontological politics because it is itself an intervention; it has re-configured the pre-given methadone of 'evidence-based' medicine. Entering into a relational encounter that challenges and changes taken-for-

granted evidence, it makes typically absented, marginalized realities noticeable. Seeing our work as productive prompts us as researchers to reflect on what evidence is made into facts through our practices. As Bacchi notes, "With this broader canvas, policy workers are encouraged to reflect on the role they play in governing practices…What sorts of effects follow from governing in a particular way, effects that are typically ignored in a focus on 'measurable outcomes?" (Bacchi and Goodwin, 2016: 9)

Considering our role, as researchers, in producing realities alters how we intervene, how we *do* implementation science. Implementation science performs a technical service to bring practice in line with evidence. Tim Rhodes' and Kari Lancaster's concept of ''evidence-making'' intervention (Rhodes et al., 2016), on the other hand, sees evidence and practice as being made simultaneously. This framework sets the stage for an implementation science that embraces a 'flat' ontology where nature and culture, or evidence and practice, are intertwined rather than hierarchical in their relations. A 'flat' ontology attunes our scientific work to the "*emergent effects* in implementation *events* rather than delineating causative points and pathways between specific health interventions and outcomes" (Rhodes et al., 2019: 13, original emphasis). This productively disrupts the notion that evidence speaks for itself. It re-orients us as researchers from an approach that seeks to bridge the gap between evidence and practice to a reflection on what objects are made into facts through practices, including the research practices of implementation science (Rhodes and Lancaster, 2019).

On this basis, we may speculate about how to intervene differently. Noticing interventions and their effects as "objects-in-practice" (Mol, 2002), fosters what Isabelle Stengers has called 'speculative knowing'—a way of knowing that opens up space for speculation on how objects, subjects, and effects are made otherwise and the possibilities of making them otherwise (Stengers, 2018). As Coleman and Ringrose note, "mapping connections is not only a task of

investigating what there is, then, but is also concerned with unpacking what might be. It is a methodology of looking differently at connections" (2013: 125). By mapping the relations of practices, then, this thesis has opened up a space for proposals that were not previously possible and, correspondingly, opened up paths for action that were not previously considered. How, then, should these paths be put to use? That is, what are the next steps for implementation scientists?

Relational materialist approaches produce an impasse

In our manuscript on methadone translation as a matter of implementation practices in Kyrgyz prisons (Rhodes et al., 2019), my colleagues and I at the London School of Hygiene and Tropical Medicine begin to speculate on working with the other substances in methadone's assemblage: "We notice, for instance, that the heroin enacted in practice is afforded multiple forms of high, capital as well as treatment potential" (2019: 14). But we stop short of suggesting how to intervene differently with methadone or heroin in this setting, differentiating instead between an 'evidence-based' implementation science which seeks "closure on what works under what conditions" and a speculative 'evidence-making' approach which "invites dialogue about what might be done in light of how intervening is made to matter" (Rhodes et al., 2019: 14). We caution against an approach that seeks closure and call, instead, for "dialogue on what might be done." The driving force here, as opposed to 'evidence-based' approaches, is that through speculative intervention, different heroins and methadones are brought into dialogue. The hope is that, by folding herself as an actor in the assemblage of intervention, the interventionist will pave the way for doing things differently through the possibilities that dialogue creates.

In concluding with speculation, we reproduced an impasse common in new materialist literature on intervention translation, which tends to notice multiplicity (objects and subjects made multiple through their relations) (Rhodes et al., 2019) and foster speculative knowing without fully engaging

with the ontopolitical implications of different ways of knowing. Indeed there are very few relational materialist works that elaborate on how to intervene in practice.[45] Isabelle Stengers encourages scientists to "take sides," yet cautions against a "'single' right answer" (Stengers, 2018: 3-4). In her book, *Matters of Concern*, María Puig de la Bellacasa writes:

> The speculative then connects to a feminist tradition for which this mode of thought about the possible is about provoking political and ethical imagination in the present. But the ethical discussions in this book are also speculative because they try to avoid defining a normative framework. But affirming the speculative in ethics invokes an indecisive critical approach, one that doesn't seek refuge in the stances it takes, aware and appreciative of the vulnerability of any position. (2017: 7)

In arguing for a speculative ethics—wherein an ethics situated within the specific and changing relations between humans and non-humans replaces abstract general norms—Puig de la Bellacasa embraces indecision. Similarly, in regard to alternative performances of interventions, Mol asks the questions, "How should we choose?" and "What are the effects that we should be seeking" (Mol, 1999: 86)? But she does not lay out a response, instead she comments, "If each therapeutic intervention achieves something different, what *counts* as *improvement* may similarly *tend to become less obvious*" (1999: 183, original emphasis). Since the effects of any health intervention are always bound to specific relations within assemblages that are constantly shifting, she emphasizes that we can no longer assess effectiveness. The corresponding

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[45] Stengers has been critiqued for "taking herself out of the flight" by providing "only suggestions…to try to activate the imagination" (Perezgonzalez, 2018: 124). Teun Zuiderent-Jerak's Situated Intervention: Sociological Experiments in Health Care has been critiqued for containing "relatively little information about how to conduct situated intervention in practice" (Wehrens, 2017: 1326). For an example from anthropology, Eugene Raikhel, in his study of Russian narcology, writes, "the book is neither a critique nor a defense of the practices in Russian narcology per se. As an anthropologist I am more concerned with complicated the very terms in which the debate takes place" (2016: 5-6).

conclusion is that our ethics is bound to the exigencies of these shifting relations, never fixed or universal. By following the flux of practices, Puig de la Bellacasa and Mol draw our attention to new ontologies that emerge and disappear, correspondingly precluding any fixed solutions.

Returning to the case study at hand, the displacing of methadone for heroin was neither advocated by me nor my colleagues inhabiting the 'evidence-based' and 'evidence-making' approaches that I straddle (public health and sociology of health). The former has outlined distinct steps for how to intervene (suggesting treatment with Naltrexone) while the latter has steered clear of any precise position in favor of a dialogue created by this analysis, resting on the speculative possibility that heroin is less damaging than methadone in this setting.

Treating evidence and practice as separate and distinct, an 'evidence-based' response to the unanticipated performance of methadone in this setting has been to attempt the translation of a different 'evidence-based' intervention, Naltrexone, an opioid agonist for treating addiction (Aboujaoude and Salame, 2016), which would block the pleasurable effects of heroin. But this leads me to question whether aiming to secure future implementation effects by extending interventions made known in other sites would merely repeat the impasses outlined in this thesis. Bypassing the role of local relations in the making of objects in translation poses the threat of producing new, unexpected effects that simply recede into the background of subjugated knowledges (see Chapter 3).

Rather than tending towards a sense of closure characteristic of 'evidence-based' science, the 'evidence-making' approach has sought to enable a dialogue created by the ontological politics of this analysis. The hope of this speculative approach is to move beyond the "impasses of the present" (Savransky et al., 2017: 5) to fold the knowledge it has created into an altering of how heroin and methadone interventions are done and evidenced. This investigative move is in

and of itself an intervention (such as this thesis). But, advocating a singular heroin treatment becomes problematic within a relational material perspective that takes objects, despite holding together as singular composites, to be constantly in flux (Law, 2004, Mol, 2002). Consequently, the roadmap for how to proceed, rendered too 'singular' and 'universal,' becomes untenable.

This creates an impasse. A proposal for how research should act will by definition espouse a normative framework that imposes a level of singularity on a multiple ever-changing world. How does one "take sides" (Stengers, 2018: 3-4) without making universals or binaries? How do we make-up realities better without falling into the 'delocalized' concepts championed by 'evidence-based' approaches that make us "vulnerable to the seductions of power whenever they judge states of affairs in the universal terms such concepts claim to authorize" (Stengers, 2010: 61-62)? Confronted with this paradox, 'evidence-making' approaches, in an effort to avoid normative judgments, stop short of proposing any 'concrete'[46] steps for action beyond a speculative possibility. I have to then raise a, perhaps provocative, question: if critical social scientists reject advocating any one intervention and medical professionals continue translating interventions with hope of a universal effect potential, who is putting to use the valuable lessons from an approach that recognizes multiplicity? How do we move towards the effects that we want?

Overcoming the impasse

I hold that it is at best naïve to suggest that any action without a normative framework is possible. The rejection thereof misses the normative frameworks underpinning the assumptions behind, for example, the discourse of 'dialogue

[46] With the use of the term 'concrete,' I do not mean to advocate for extracting oneself from the dynamic relations involved in the making of methadone. I do, however, hold that a proposal, like an object, can hold together 'more or less' stably. A concrete proposal, then, would embrace this temporary stability to suggest an intervention that can hold together more strongly over space and time, while still attending to its flux.

as a conduit to change' embraced by 'evidence-making' intervention—a discourse rooted in a specific western philosophical tradition (Plato et al., 2008). Indeed, every epistemological inquiry is normative post the collapse of the fact/value dichotomy we saw in 1970s theory (Putnam, 2002). Ironically, then, the same accusation of normativity can be applied to 'evidence-making' approaches that they themselves wield at 'evidence-based' approaches. Rather than attempting to extract ourselves from normative frameworks, let us, researchers, implementers, and policymakers, be upfront and explore the normative assumptions we enact with a view of how to proceed.

In order to make proposals for intervention translation work, I have had to embrace normative frameworks on several key fronts; it is precisely this move that has allowed the proposals that follow to materialize. First, I am making the value judgment that technological translations into Kyrgyz prisons that intervene, interfere, and disrupt are at all worth pursuing. This approach is rooted in a sense of different performances of intervention objects in different times and places, yet it recognizes the need for a *relatively* 'stable' proposal in order to enact change. A level of compromise is necessary for enacting policy solutions while staying attentive to the complex ways that actors are interconnected in shifting ways with shifting effects. Intervention translation therefore requires a negotiation between the universal stability of 'evidence-based' and situated instability of 'evidence-making' intervention. Any proposal will be flawed, subject to variability and unintended consequences, but the threat of no proposal in a field of 'evidence-based' intervention is far greater.

Second, the ability to choose a mode of action to propose is predicated on the understanding that a choice between multiple methadones and heroins, which co-exist and depend on each other, is at all possible. Although choosing between multiple objects is fraught because of their interconnectedness, continuities of practice hold objects together in ways that produce apparent stability (Mol, 1999: 85). The work of my colleagues at the London School of Hygiene and

Tropical Medicine and I on methadone, for example, “notices that methadone is a virtual singular held together as a composite which prevents it from falling apart despite its multiplicity in practice” (Mol, 2002, Law, 2004 cited in Rhodes et al, 2019: 4).

Furthermore, the mapping of relations that this thesis performs produces a framework for the events that implementation scientists can inscribe to produce health. In the process of affecting, we as implementation scientists are choosing between entangled and multiple entities in that altering one pulls and pushes on the others. Recognizing this complexity, it becomes useful to ground our steps forward in the assemblages that produce multiple substances and subject positions. In other words, I am putting forward the argument that solutions that acknowledge interconnectedness and stay attentive to the push and pull of the web of relations is the best mode of action we have.

Third, I have made assumptions about the effects we, as researchers, should be seeking and the parameters that define health and deterioration. Embracing the local definition of health as the making of the virtuous body, I advocate stepping out of the biomedical model to see health as in line with “the capacities of people and collectivities to engage productively with social, economic, political and cultural milieux” (Fox, 2017). As researchers and policymakers, we would be well-served to look beyond the traditional confines of individual bodies to health *made differently*. This call is summed up by Fox and Alldred:

> Human skin no longer has the weird property it had in dualist sociology - of separating everything human that is inside it (flesh, thoughts cultural beliefs, feelings, desires) from everything else 'environmental' that is outside. Materialism's rejection of a distinction between nature and culture is not some arbitrary hang-up over dualisms. Rather, it is a necessary re-thinking that recognizes first—as Haraway has noted - that the nature/culture division was founded upon a supremacist politics of sexualization, racialization and naturalization of the West's Others. (2016: 44)

In the case of Kyrgyzstan, health is made collectively through a body that takes shape, and develops agency and virtue, through practices that integrate many individual bodies.

Intervening to affect relations

As an implementation scientist edged toward relational materialism, I take the responsibility to not take myself out of the fight. We, as actors in the network, contributing relationally to the making of methadone bodies, are still allowed to want, and to alter the dynamics of practice regarding how researchers and implementers think and do intervening. The theoretical shift of this research makes it uniquely positioned to act on how to do this. I suggest that in answering Mol's question, "What effects do we want?" we embrace and bring our normative frameworks to the surface in attempt to reach beyond voyeurism into action (Bourgois and Schonberg, 2009: 297). Otherwise, as Haraway points out, "in the consciousness of our failures, we risk lapsing into boundless difference and giving up on the confusing task of making partial, real connection" (Haraway, 1991a: 27).

The steps forward lie in a particular understanding of power and resistance. In an approach that decenters human agency, power is no longer a top down force, or something that is possessed (Braidotti, 2013). Rather, it is the product of micropolitical forces within assembled relations at the local level. And resistance, cutting across the dualism of structure and agency, is no longer an essentialized human agent responding to structural forces of domination. Resistance in a 'flat' ontology shifts focus from interior essential structures to "relations of exteriority" (DeLanda, 2006: 10-11). Resistance to powerful forces lies in the "relational capacities of assembled bodies, things and social formations within assemblages" (Fox and Alldred, 2018: 323).

To create less hegemonic relations, we have to be "radically empirical" (Fox and Alldred, 2018: 323) in researchers' response by affecting the micropolitics—the affects between human and non-human actors. Since overarching hegemonic

structures are illusory, hierarchies can dissipate: “power can have continuity only so long as it is replicated in the next event, and the one after that, and may quickly evaporate when affects in an assemblage alter” (Fox and Alldred, 2018: 323). DeLanda echoes this: "a component part of the assemblage may be detached from it and plugged into a different assemblage in which its interactions might be made differently” (2006: 10). In other words, assembled relations depend on continued repetitions of relations for groups to exert dominance over each other; a dominance that can be countered by disrupting the material forces that stabilize certain assembalges (Fox and Alldred, 2018: 324).

How then do public health researchers choose which assemblages to stabilize? Drawing on Deleuze and Guattari’s molar versus molecular forces (Deleuze and Guattari, 1987: 216), Fox and Alldred (2018) distinguish between ‘aggregation’ (grouping) and ‘disaggregation’ (producing singularity) through the affects within an assemblage (324). They give the example of resisting the ‘aggregation’ of people according to race through tutoring (‘disaggregation’) to increase individual abilities. Fox and Alldred associate resistance with ‘disaggregation’ which they distinguish from control over others through ‘aggregation.’ They do, however, note that this distinction is not a given.

An essential take away from this thesis is that the roles of ‘aggregation’ and ‘disaggregation’ are inverted in terms of their production of health in Kyrgyz prisons. Health is marked by an individual’s increased aggregation with the collective body, conversely to typical understandings of the ‘becoming-healthy-body’ where illness is “marked by increasing dependency” (Fox and Alldred, 2017: 137). This reversal is particularly non-intuitive for western audiences, but an understanding of the health producing assemblage, grounded in practices of medieval monasticism (Chapter 5), brings us closer to seeing health as submission. ‘Evidence-based’ methadone, on the other hand, ‘disaggregates’

the individual from the collective body through a network of practices I outlined in this thesis.

Accordingly, I propose working towards a situated intervention that, having mapped the way that relations within an assemblage capacitate health, aims to change the micropolitics of these relations with a view of producing health. Bodies and objects gain status through their relationships to ideas, objects, and other bodies (Haraway, 1991b: 201); it follows that it is precisely these relations that researchers need to change to enact different bodies. As Butler (2015) writes, "the body is less an entity than a living set of relations; the body cannot be fully dissociated from the…environmental conditions of its living and acting" (65). To alter the body, to make a health producing body, we have to alter the multitudinous relations of human and non-human actors folded into its becoming. How, then, do we influence the capacity of others to affect and be affected in an assemblage (Deleuze, 1988: 101)—the cascade of events that comprise the world around us (Fox and Alldred, 2017: 8)?

A relatively 'stable' proposal

To move toward a healthy (equivalent to a virtuous) collective body, researchers and implementers need to 'aggregate,' or repeat the practices that create a whole, to stabilize the collective body assemblage. I have outlined an assemblage of health, including a number of discursive-material relations that enable the making of a virtuous collective body (national drug policy discourses, practical texts of Kyrgyz stakeholders, Dimedrol, heroin, the visual appearance of the methadone body, communal property, confession, a prisoner's *mast'*, the *poniatia*, formal/informal relations of the prison, the architecture of the prison, the *obshchak* as a communal fund, the *obshchak* as the prisoner ruling class, the ritual practices of informal governance such as the *razgon*, the changing theoretical approaches of this PhD etc.). While an intervention into every relation is impossible, we can affect the interactions in a series of relational and material implementation events that link bodies with

other actors in the assemblage to enable the 'aggregation' of the collective body. As I have demonstrated, it is this stabilization of the collective body that enables health (see Chapter 6).

First, as implementation scientists, we must be cognizant of the way that the material actors, like the architecture of the prison, for example, interact with the medical interventions we put forth and with what material effects. The interaction between the 'red' portion of the prison (the administrative zone) and the *poriadochnye* enacts a sick prisoner body, effectively 'disaggregating' the individual from the collective body, which is enabled through interactions with the 'black zone.' I recommend that *poriadochnye* accessing methadone be provided with methadone within the 'black zone.' This can include a re-positioning of the methadone dispensing window to the 'black zone,' or under the purview of the prisoners themselves. There are other aspects within the material interaction of methadone and the methadone dispensing area that can be altered. The provision of individual cups for receiving methadone provided to each prisoner to carry with them would prevent the (un)making of the virtuous prisoner through the potential sharing of vessels with prisoners of lower *masti*.

A key mode of aggregation is ritual practice within collective self-governance. The ritual distribution of the *razgon*, for example, enables a circulating collective body to take shape. Implementation science can work within, rather than outside of the *razgon*. This research has already taken a step in this direction by engaging directly with the *obshchak* as well as with the formal prison administration about the *obschak*—something that has previously been avoided by public health interventionists. I was initially apprehensive about discussing informal governance with the Prisons Department, erring more towards presenting quantitative findings—it was less controversial to talk about 'neutral' issues like HIV rather than touch upon the *obshchak*, which would be an indirect acknowledgement of the lack of control the formal

administration has over the prisons. But by building an ongoing relationship with the Prisons Department through biannual presentations of the study findings, my colleagues from Yale University and I became more comfortable in broaching these issues. To my surprise, this produced a dialogue about the influence of informal governance on health at the national level, with the Deputy Minister of Prisons even sharing feedback regarding the hierarchical structures among prisoners.

Second, as implementation scientists consider what kind of treatment we want to translate, we must keep in mind that the opportunities for change lie within modes of resistance that are already present. As Mol notes:

> Answers to that question [of what effects we should be seeking] are incorporated in the information, but also in the techniques, we currently live with. They tend to be implicit, entangled and inextricably linked up with the various performances of any one disease. (1999, 86)

I have shown that the substances of heroin, and methadone, Dimedrol are not separate entities; they are co-produced and depend on one another to materialize in particular ways. Their materialization is therefore *part* of the local governing practices of the prison. The choice between what kind of treatment to implement, then, becomes "choice incorporated" (1999: 86), embedded within the local governing practices of Kyrgyz prison. In other words, what resources for resistance are there in the present in Kyrgyz prisons which show us how things might be made otherwise?

Given that the major governing divides, also co-produced, are between formal and informal governance (which also depend on each other for, as Mol writes, "what is 'other' is also within") (1999: 95), the substances that researchers implement must coherently reinforce these modes of governance in order to keep the collective body whole. The bodies that emerge through the ritualized distribution of heroin through the *razgon* are inscribed as health producing bodies, gaining agency and virtue through their submission to the ritualized practices of the *obshchak*. I therefore suggest noticing and intervening

differently with heroin to work within, rather than outside, of informal governance. I propose that global efforts translating methadone into Kyrgyz prisons would do less local damage were they to experiment with translating heroin as a technology of treatment and health intervention rather than methadone. But, importantly, when translating, implementation scientists must consider how heroin, also multiple and relational, is made-to-be different according to its situation.

A particular heroin treatment program already exists through the *razgon* (see Chapter 6) but it has remained hidden from view beyond the confines of the *obshchak* as implementation scientists have not researched it or engaged with it. Because the relative stability of a particular way of doing intervention is intertwined with its modes of implementation, however, the heroin treatment program I promote must be consistently monitored for a multiplicity of effects. Accordingly, an implementation science inquiry into the materializations of heroin treatment has to be equally dynamic to be able to respond to constant flux. Such 'evidence-making' inquiry would attend to whose heroin was being implemented, under what circumstances, and how it was evidenced according to its events of implementation.

Third, rather than abandoning methadone all together, I call for an implementation of formal methadone treatment for those excluded from informal heroin treatment. This would involve a methadone translation through an implementation science that considers the ways that the methadone object comes together with Dimedrol and formal governance. A recognition of these entanglements would make for a more tailored methadone program that comes together with the bodies that are excluded from the *obshchak* through their relations with formal governance. The *obizhennye* interact with formal governance spaces and objects, embodying a boundary shift to Other. However, methadone and Dimedrol are intertwined in this relation; methadone users inject Dimedrol to potentiate a high that methadone does not provide (see

Chapter 4). This complicates the claim that methadone is health producing; the methadone-Dimedrol complex produces a rotting body devoid of the capacity to act.

The entanglements of methadone and Dimedrol in practice need to be acknowledged by implementation science. Currently, these are silenced within public health, where Dimedrol is completely absent. An exception is a manuscript my colleagues and I wrote about Dimedrol and methadone 'polysubstance use.'[47] This manuscript concludes: "the disorganized behavior and physical deterioration associated with Dimedrol injection is falsely attributed to methadone and further vilifies it." We see here that 'evidence-based' discourse teases apart methadone and Dimedrol in a way that is not commensurate with their entanglements in practice. This teasing apart is estranged for the methadone-Dimedrol complex on the ground, stalling productive discussions about how to move forward given their blurred boundaries.

A discussion needs to be had with the public health community, prisoners who use drugs, and local stakeholders about how to work with the methadone-Dimedrol complex being materialized on the ground in Kyrgyzstan. Such a move, hitherto not done, would in and of itself be radical as it would challenge the 'pure' 'evidence-based' methadone so heavily supported by international health organizations and 'evidence-based' research. Perhaps this can be the beginning of a heroin program of formal governance, enabling a healthy body for those outside the *obshchak*, or the provision of a liquid Dimedrol[48] for

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[47] Meyer et al., 2019, A Qualitative study of diphenhydramine injection in Kyrgyz prisons and implications for harm reduction efforts, to be submitted to the Harm Reduction Journal.

[48] The Dimedrol (diphenhydramine) currently used is consumed in pill form Liquid diphenhydramine, on the other hand, can be injected with a lower risk of skin and soft tissue infections.

methadone patients. In any case, an acknowledgement in research and policy of the way that pleasure is experienced through drug use (Dennis, 2016b) can open up space for an intervention translation that enables healing for *masti* outside of the auspices of the *obshchak*.

Future inquiry and intervention translation to affect the health of prisoners in Kyrgyzstan will entangle with the assemblage of the substances, spaces, and bodies I have described. But implementation scientists will be better served to stay attuned to the dissipation and formation of new subjects and objects as relations shift. Nonetheless, let us answer Haraway's call to "take responsibility for the social relations of science and technology" (1991a: 27) and "stay with the trouble" (2016) by translating in a manner in tune with local ways of becoming. By grounding inquiry within collective self-governance, this research has produced a mode of intervention translation that folds into, rather than counters, local productions of health. This has allowed us to notice and act on health in unintuitive ways that notice the collective production of health through bodies whose boundaries are intertwined. Future interventions can lay the groundwork for translations that are more than a mere extension of already evidenced effects, to become a 'situated accomplishment' (Stengers, 2018) that creatively experiments with effects made otherwise.

Appendices

Appendix A—Study information sheets and consent Forms

Stakeholders

Информированное Согласие на участие в исследовании Йельского Университета совместно с ОФ «СПИД Фонд Восток – Запад в КР» и ГСИН КР

(соглашение на участие в устном интервью для сотрудников колонии)

Название: Проект МАК - Kyr: Отношение к заместительной поддерживающей терапии метадоном (ЗПТМ) для лечения опиоидной зависимости в Кыргызской Республике.

Главный исследователь: Доктор, профессор медицинского факультета Йельского университета Фредерик Алтис (Frederick L. Altice, MD)

Цель: Изучить мнение/отношение к заместительной поддерживающей терапии метадоном (ЗПТМ) для лечения опиоидной зависимости в Кыргызской Республике.

Приглашение и описание исследования. Мы приглашаем Вас принять участие в исследовании потому, что: 1). Вы являетесь сотрудником уголовно-исправительной системы в КР на время проведения исследования; 2). Вы обладаете ценным опытом и знаниями по лечению опиоидной зависимости метадоном среди заключенных и о возможных перспективах доступности к лечению для лиц, недавно вышедших на свободу, что представляет интерес для целей исследования; 3). Ваш возраст – старше 18 лет;

За время исследования, мы планируем охватить 30 заключенных и 30 недавно освободившихся бывших заключенных с опиоидной зависимостью, включая тех, кто получал и не получал лечение метадоном в исправительных колониях, а также 15 сотрудников колоний, обладающих опытом и знаниями по ЗПТМ в колониях КР.

Чтобы принять решение об участии в исследовании мы предоставим информацию об условиях его проведения, возможном риске и пользе. С этой формой информированного согласия Вы можете ознакомиться самостоятельно или обсудить с интервьюерами. После ознакомления с условиями проведения исследования, Вам будет предложено, если Вы

хотите принять участие в исследовании, подписать эту форму соглашения.

Задача и описание исследования. Исследование направлено на: 1). изучение влияния пребывания в исправительных колониях на здоровье заключенных с наркотической зависимостью, 2). изучение доступности к ЗПТМ; 3). описание факторов, влияющих на преемственность к лечению метадоном во время заключения в тюрьме и после освобождения. Данное исследование будет направлено на разработку вмешательств по улучшению здоровья заключенных в Кыргызской Республике.

Методика проведения исследования. Исследование включает проведение в конфиденциальной обстановке: 1). интервью в виде беседы с интервьюером, независимого от службы ГСИН КР (около 30 минут). Во время беседы с интервьюером будут озвучены вопросы о Вашем опыте и знаниях о ЗПТМ в колониях; причинах, влияющих на приверженность к ЗПТМ среди заключенных с опиоидной зависимостью, а также о Вашем мнении/отношении к ЗПТМ в КР.

У Вас есть право отказаться участвовать в исследовании в любое время и/или отказаться отвечать на любые из вопросов интервью. Данные интервью без Ваших персональных данных будут учтены в обобщенных результатах всего исследования и помогут изучить условия предоставления медицинской помощи лицам с наркотической зависимостью в колониях.

Разговор будет записываться на диктофон. Ваше имя не будет использовано и все ответы останутся анонимными. Если Вы не захотите отвечать на какой-нибудь вопрос, Вы можете сообщить об этом интервьюеру. Все то, чем Вы поделитесь во время интервью, будет храниться в тайне и будет использовано только в анонимной форме для исследовательских целей; эта информация не будет сообщаться сотрудникам тюрьмы или каким-либо третьим лицам. В соответствии с тюремными процедурами мы не обязаны сообщать руководству тюрьмы о каких-либо незаконных действиях, таких как потребление наркотиков в колониях. Если Вы укажите какую-либо идентифицирующую Вас информацию, она будет удалена из записи интервью.

В случае возникновения вопросов по методике проведения исследования, Вы можете обратиться к интервьюеру за пояснением. Если Вы согласны принять участие в исследовании и после подписания формы соглашения, Вы получите копию этой формы для личных архивов.

Риск. Вы можете чувствовать себя некомфортно, отвечая на некоторые вопросы. Ваши ответы с личной информацией останутся строго конфиденциальными, не будут распространяться и/или использоваться без Вашего разрешения. Другое неудобство, связанное с участием в исследовании - это время, которое требуется для интервью, а также то, что интервью будет записываться на диктофон. Ваше интервью будет закодировано и какие-либо личные идентифицирующие Вас данные не будут записаны на диктофон, либо будут удалены из записи в случае, если подобная информация будет озвучена Вами в ходе интервью.

Выгода и польза. Существует ряд преимуществ участия в исследовании. Это исследование имеет выгоду для системы правосудия и здравоохранения, страны. Участвуя в исследовании и анонимно делясь Вашим уникальным и ценным опытом, Вы поможете другим нуждающимся людям. Выгода для системы правосудия и здравоохранения состоит в том, что результаты исследования помогут улучшить оказание медицинской помощи для заключенных с опиоидной зависимостью в тюрьме и в гражданском секторе после освобождения. Наконец, для страны результаты исследования будут использованы для улучшения жизни граждан, в том числе бывших заключенных.

Мотивационное вознаграждение. За участие в исследовании и в знак благодарности за Ваше время, Вы получите в подарок карту для пополнения счета мобильной связи «Мегаком» номиналом в 300 мобильных единиц.

Конфиденциальность. Вся информация, предоставленная Вами в ходе исследования, будет закодирована личным идентификационным кодом. Связь идентификационного кода с Вашими данными будет зафиксирована в отдельном файле. Файл будет храниться в закрытом кабинете на защищенном паролем компьютере. Доступ к файлу будет иметь научный сотрудник исследования. В случае публикации или обсуждения результатов исследования на конференциях, данные интервью будут использованы исключительно совокупно с полученными результатами всего исследования без Ваших персональных данных. Ваша личная информация никоим образом не будет использоваться, так что Ваша анонимность гарантирована и защищена.

Добровольное участие и отказ. Участие в исследовании является полностью добровольным. Вы можете отказаться от участия в исследовании на любом этапе и в любое время. Вы имеете право отказаться отвечать на любые из вопросов интервью. Ваш отказ от участия ни в коем случае не будет преследоваться наказаниями или негативными последствиями для Вас лично. Ваш отказ никак не повлияет на ваш статус сотрудника колонии. Ваше решение участвовать или не участвовать в исследовании не будет оглашено

тюремному персоналу или кому бы то ни было другому. Вы не теряете никакие права, подписывая эту форму.

Вопросы. Мы использовали некоторые технические и профессиональные термины в этой форме. Пожалуйста, не стесняйтесь задавать вопросы об исследовании или условиях его проведения. Обдумайте и взвесьте все «за» и «против» прежде, чем подписывать это соглашение. Если Вы хотели бы узнать больше об исследовании или у Вас возникли сомнения, которые Вы хотели бы развеять, прежде чем принимать решение, не стесняйтесь обращаться к научному руководителю проекта - доктору Фредерику Алтису (+011 203 737 2883) или координатору исследования в Кыргызской Республике – представителю Общественного Фонда «СПИД Фонд Восток – Запад в КР» по телефону: +996 770-81-12-70. Для удобства связи с представителем ОФ «СПИД Фонд Восток – Запад в КР» Вам достаточно будет произвести дозвон /«маяк» на указанный номер телефона, после чего Вам перезвонят. Это обеспечит Вам бесплатность мобильной связи с нами.

Авторизация и разрешение: Я прочитал/а (или кто-то прочитал мне) эту форму и я решил/а участвовать в исследовании, описанном выше. Общие цели и задача исследования, а также возможные риски и неудобства были удовлетворительно объяснены. Подписывая эту форму, я даю разрешение исследователям использовать де-идентифицированную информацию обо мне. Моя подпись также указывает, что я получил/а копию этой формы соглашения.

Имя/Код: _____

Подпись: _____

Дата: _____

Подпись главного исследователя: _____
Дата: _____

или

Код/подпись интервьюера: _____
Дата: _____

Если у Вас есть дополнительные вопросы по поводу этого исследования, Вы можете связаться с координатором исследования - представителем ОФ «СПИД Фонд Восток – Запад в КР» по телефону +996 0770 81-12-70, произведя дозвон/ «маяк». Если Вы хотели бы поговорить с кем-то другим, чтобы обсудить проблемы в отношении

данного исследования или обсудить Ваши права как участника исследования, Вы можете связаться с Йельским университетом: +011 203 785-4688.

Исследование проводится Медицинским факультетом Йельского университета совместно с Общественным Фондом «СПИД Фонд Восток – Запад в Кыргызской Республике» и Государственной службой исполнения наказаний при Правительстве Кыргызской Республики.

Prisoners

Информированное Согласие на участие в исследовании Йельского Университета совместно с ОФ «СПИД Фонд Восток – Запад в КР» и ГСИН КР

(соглашение на участие в устном интервью до освобождения)

Название: Проект МАК - Kyr: Отношение к заместительной поддерживающей терапии метадоном (ЗПТМ) для лечения опиоидной зависимости в Кыргызской Республике.

Главный исследователь: Доктор, профессор медицинского факультета Йельского университета Фредерик Алтис (Frederick L. Altice, MD)

Цель: Изучить мнение/отношение к заместительной поддерживающей терапии метадоном (ЗПТМ) для лечения опиоидной зависимости в Кыргызской Республике.

Приглашение и описание исследования Мы приглашаем Вас принять участие в исследовании, потому что: (а). Вы находитесь в колонии, где проводится исследование; (б). Планируемое время выхода из колонии не менее 7 (семи) дней и не более 180 дней (шести месяцев) для мужчин и, не более 270 дней (девяти месяцев) для женщин; (с). Вы обладаете ценным опытом и знаниями о потреблении наркотиков и лечении опиоидной зависимости заместительной поддерживающей терапией метадоном (ЗПТМ), что интересно для исследования; (д). Ваш возраст старше 18 лет.

Чтобы принять решение об участии в исследовании мы предоставим информацию об исследовании, возможном риске и пользе. С этой формой Вы можете ознакомиться самостоятельно или обсудить с интервьюером. После ознакомления с исследованием Вам будет предложено, если Вы хотите принять участие в исследовании, подписать эту форму соглашения.

Данный этап исследования включает проведение интервью в виде беседы с интервьюером, чтобы Вы могли поделиться своим опытом и знаниями о лечении опиоидной зависимости, а также Вашем отношении к ЗПТМ. Данные исследования без Ваших персональных данных будут учтены в обобщенных результатах исследования и помогут изучить условия предоставления медицинской помощи лицам с опиоидной зависимостью в исправительных колониях и после освобождения в гражданском секторе.

Задача исследования. Исследование направлено на: 1). изучение влияния пребывания в исправительных колониях на здоровье заключенных с опиоидной зависимостью; 2). изучение доступности к ЗПТМ; 3). описание факторов, влияющих на преемственность к лечению метадоном во время заключения в исправительных колониях и после освобождения в гражданском секторе. Исследование будет направлено на разработку вмешательств по улучшению здоровья заключенных в Кыргызской Республике.

Методика проведения исследования. Данный этап исследования включает проведение устных интервью в виде беседы с интервьюером в конфиденциальной обстановке продолжительностью около 40 минут. Всего по исследованию для интервью с Вами будут проведены встречи с интервьюерами 3 раза: 1 раз сегодня и, в случае Вашего согласия на продолжение участия в исследовании после Вашего освобождения – еще 2 раза (через 1 и 6 месяцев после освобождения).

Интервьюер будет озвучивать вопросы о Вашем жизненном опыте употребления наркотиков; о том, что Вам известно о лечении опиоидной зависимости. Разговор будет записываться на диктофон. Ваше имя не будет использовано и все ответы останутся анонимными. Если Вы не захотите отвечать на какой-нибудь вопрос, Вы можете сообщить об этом интервьюеру. Все то, чем Вы поделитесь во время интервью, будет храниться в тайне и будет использовано только в анонимной форме для целей исследования; эта информация не будет сообщаться сотрудникам тюрьмы или другим заключенным. В соответствии с тюремными процедурами мы не обязаны сообщать руководству тюрьмы о каких-либо незаконных действиях, таких как потребление наркотиков или совместный прием наркотиков. Если Вы укажите какую-либо идентифицирующую Вас информацию, она будет удалена из записи интервью.

У Вас есть право отказаться участвовать в исследовании на любом из его этапов и в любое время и/или отказаться отвечать на любые из вопросов интервью.

Если Вы согласны участвовать в исследовании, нам потребуется Ваше согласие, которое подтвердит Ваше участие в исследовании. В случае возникновения вопросов по исследованию, Вы можете обратиться к

интервьюеру за пояснением. Если Вы согласны принять участие в исследовании и после подписания этой формы соглашения, Вы получите копию этой формы для личных архивов.

Риск. Вы можете чувствовать себя некомфортно, отвечая на вопросы о формах поведения с риском для здоровья. Ваши ответы с личной информацией останутся строго конфиденциальными, не будут распространяться и/или использоваться без Вашего разрешения. Другое неудобство, связанное с участием в исследовании - это время, которое требуется для интервью, а также то, что интервью будет записываться на диктофон. Ваше интервью будет закодировано и какие-либо личные идентифицирующие Вас данные не будут записаны на диктофон, либо будут удалены из записи в случае, если подобная информация будет озвучена Вами в ходе интервью.

Выгода и польза. Существует ряд преимуществ участия в исследовании. Вы получите информацию о влиянии употребления наркотиков на Ваше здоровье. На основе полученной информации, Вы сможете самостоятельно принять решение о том, как получить необходимую Вам помощь и/или лечение. Мы специально разработали это исследование так, чтобы принимали участие только те люди, которые готовятся к освобождению, чтобы они знали, куда обратиться за медицинской помощью и социальной поддержкой в гражданском обществе после выхода на свободу.

Это исследование имеет пользу для системы правосудия и здравоохранения, страны. Участвуя в исследовании и анонимно делясь Вашим уникальным и ценным опытом, Вы поможете другим нуждающимся людям. Выгода для системы правосудия и здравоохранения состоит в том, что результаты исследования помогут улучшить оказание медицинской помощи для заключенных с опиоидной зависимостью в тюрьме и в гражданском секторе после освобождения. Наконец, для страны результаты исследования будут использованы для улучшения жизни граждан, в том числе бывших заключенных.

Мотивационное вознаграждение. За участие в исследовании сегодня и в знак благодарности за Ваше время, Вы получите в подарок гигиенический набор общей стоимостью 345 сом. И, если Вы будете согласны продолжить участие в исследовании после Вашего освобождения, то Вам будут даны в подарок стандартные 300 мобильных единиц для пополнения счета «Мегаком» с нарастанием за участие на всех сессиях исследования через 1 и 6 месяцев после освобождения, а именно: 1). сегодня (1 месяц после освобождения) за устное интервью (II), компьютерное анкетирование (III), экспресс тест на опиаты по моче (I) – 300 мобильных единиц и дополнительно 100 мобильных единиц; 2). через 3 месяца после освобождения за компьютерное анкетирование (IV) и экспресс тест на опиаты по моче (II) – 300 мобильных единиц; 3). через 6 месяцев после освобождения за

устное интервью (III), компьютерное анкетирование (V), экспресс тест на опиаты по моче (III), экспресс тест на ВИЧ по слюне (II) – 300 мобильных единиц и дополнительно 300 мобильных единиц.

Конфиденциальность. Вся информация, предоставленная Вами в исследования, будет закодирована личным идентификационным кодом. Связь идентификационного кода с Вашими данными будет зафиксирована в отдельном файле, который будет храниться в закрытом кабинете на защищенном паролем компьютере. Доступ к файлу будет иметь научный сотрудник исследования. В случае публикации или обсуждения результатов исследования на конференциях, данные интервью будут использованы исключительно совокупно с полученными результатами всего исследования без Ваших персональных данных. Ваша личная информация никоим образом не будет использоваться, так что Ваша анонимность гарантирована и защищена.

Добровольное участие и отказ. Участие в исследовании является полностью добровольным. Вы можете отказаться от участия в исследовании на любом этапе и в любое время. Вы имеете право отказаться отвечать на любые вопросы. Ваш отказ от участия ни в коем случае не будет преследоваться наказаниями или негативными последствиями для Вас лично. Ваш отказ никак не повлияет на ваш статус заключенного, на дату освобождения и на качество медицинских услуг, которые вы получаете. Ваше решение участвовать или не участвовать в исследовании не будет оглашено тюремному персоналу, работникам медицинской службы колонии или кому бы то ни было другому. Вы не теряете никакие права, подписывая эту форму.
Вопросы. Мы использовали некоторые технические и профессиональные термины в этой форме. Пожалуйста, не стесняйтесь задавать вопросы об исследовании или условиях его проведения. Обдумайте и взвесьте все «за» и «против» прежде, чем подписывать это соглашение. Если Вы хотели бы узнать больше об исследовании или у Вас возникли сомнения, которые Вы хотели бы развеять прежде, чем принимать решение, не стесняйтесь обращаться к научному руководителю проекта - доктору Фредерику Алтису (+011 203 737 2883) или координатору исследования в Кыргызской Республике – представителю Общественного Фонда «СПИД Фонд Восток – Запад в КР» по телефону: +996 770-81-12-70. Для удобства связи с представителем ОФ «СПИД Фонд Восток – Запад в КР» Вам достаточно будет произвести дозвон /«маяк» на указанный номер телефона, после чего Вам перезвонят. Это обеспечит Вам бесплатность мобильной связи с нами.

Авторизация и разрешение: Я прочитал/а (или кто-то прочитал мне) эту форму и я решил/а участвовать в исследовании, описанном выше. Общие цели и задача исследования, а также возможные риски и

неудобства были удовлетворительно объяснены. Подписывая эту форму, я даю разрешение исследователям: 1). использовать де-идентифицированную информацию обо мне; 2). использовать номера телефонов людей из моего окружения (одного или двух) и позвонить им для контакта со мной после освобождения. Моя подпись также указывает, что я получил/а копию этой формы соглашения.

Имя/Код: _____

Подпись: _____

Дата: _____

Подпись главного исследователя: _____
Дата: _____

или

Код/подпись интервьюера : _____
Дата:_____

Если у Вас есть дополнительные вопросы по поводу исследования, Вы можете связаться с координатором исследования - представителем ОФ «СПИД Фонд Восток – Запад в КР» по телефону +996 0770 81-12-70, произведя дозвон/ «маяк». Если Вы хотели бы поговорить с кем-то другим, чтобы обсудить проблемы в отношении данного исследования или обсудить Ваши права как участника исследования, Вы можете связаться с комитетом исследований Йельского университета: +011 203 785-4688.

Исследование проводится Медицинским факультетом Йельского университета совместно с Общественным Фондом «СПИД Фонд Восток – Запад в Кыргызской Республике» и Государственной службой исполнения наказаний при Правительстве Кыргызской Республики.

Appendix B—Participant pseudonyms and demographics

Stakeholders

Pseudonym	Position
Dzharkin	Prison medical staff
Dmitriy	Prison security staff
Irina	Prison medical staff
Alima	Prison medical staff
Azad	Prison security staff
Liazakat	Prison medical staff
Sasha	NGO employee
Rano	NGO employee
Nurgul	Prison medical staff
Marina	NGO employee
Valerii	NGO employee
Evgenii	Informal prisoner leader
Tolonbai	Informal prisoner leader
Talgat	Informal prisoner leader
Yevgeny	Prison medical staff

Bulat	Prison medical staff
Nikolai	Prison medical staff
Nursultan	Prison medical staff
Akimzhan	NGO employee
Esenbek	NGO employee
Taalaibek	NGO employee
Aleksei	Informal prisoner leader

Prisoners

Pseudonym	Age	Ever enrolled in methadone	No. times in prison	*Mast'*
Mirlan	32	Yes	7	Poriadochnyi
Salamat	43	No	1	Obizhennyi
Rostislav	24	No	6	Poriadochnyi
Semen	37	No	5	Poriadochnyi
Sergey	32	No	5	Poriadochnyi
Sultan	35	No	2	Poriadochnyi
Tair	48	No	7	Poriadochnyi

Zheenbek	46	Yes	4	Red
Ibragim	47	No	6	Missing
Kairat	59	No	4	Red
Kalmurat	41	No	7+	Red
Kamal	37	No	7	Poriadochnyi
Kemel	60	No	5	Missing
Bakir	46	Yes	5	Poriadochnyi
Bakyi	42	No	5	Red
Bakyt	26	No	4	Obizhennyi
Barat	54	Yes	4	Obizhennyi
Bakhtiiar	38	Yes	4	Obizhennyi
Bashir	28	No	3	Obizhennyi
Ali	42	Yes	4	Gad
Alibek	32	Yes	1	Poriadochnyi
Alim	37	Yes	1	Red
Turat	44	Yes	3	Poriadochnyi
Tursun	47	No	3	Poriadochnyi
Farkhad	32	Yes	2	Poriadochnyi
Nurlan	43	No	7+	Gad

Chingiz	39	No	5	Red
Viktor	46	Yes	1	Poriadochnyi
Umar	25	Yes	4	Obizhennyi
Emin	22	No	3	Gad
Envar	37	No	6	Red
Aigul’	27	Yes	2	Poriadochnyi
Rustam	20	Yes	2	Obizhennyi
Nikolai	21	Yes	1	Obizhennyi
Kenzhebek	57	No	7+	Poriadochnyi
Akylbek	39	Yes	6	Poriadochnyi
Daniiar	36	Yes	6	Poriadochnyi
Artem	47	Yes	6	Red
Vitalii	26	Yes	2	Poriadochnyi
Vladimir	40	Yes	4	Poriadochnyi

Appendix C—Interview guide for prisoners

In line with the qualitative interview approach, the Guide is a flexible tool to direct the conversation with the participants and to elicit their stories regarding the key domains listed below. The interviewers will be using "active listening" techniques and will have discretion to decide the order in which they may bring up domains, ask questions, and use further probes during the interview with each participant, to gather the richest data possible. The interviewers may also use additional questions and/or probes not listed in the Guide if the participant brings up relevant issues that may be worthwhile to explore further.

Preamble - Purpose: Establishing initial rapport

Meet and greet the participant, ask how they are doing, refer back to the interview process they experienced in the first interview, and reinforce that, as with the first interview, their story will be valued and will be taken seriously and with respect.

"It is very good to see you again. Just to recap what I had said when we first met, we are hoping to learn more about what people who have served their sentence in Kyrgyzstan think about addiction, methadone maintenance therapy, and HIV risk, and the experiences they had with these issues. We would also like to know what you think about how and why some people may start drug injection or methadone treatment in prison, about the attitudes of other people in prison towards such prisoners, and about support for people living with substance use disorder in prison and in the community. Your input will be very helpful in designing a program for PWID to encourage the use of harm reduction services, improve their quality of life, reduce stigma and social isolation, and reduce the HIV risk."

"I'll be asking some questions and recording our conversation. I am eager to hear and to learn from you and your experiences. Some questions may be similar to what we discussed last time; I ask them again because we would like to know your thoughts about these issues now that you are living in the community. I am not here to look for right or wrong, and it is your opinion that is of value. We may be asking you some questions that may appear sensitive to you. In situations where this may seem uncomfortable, there are a number of ways in which you may respond. This may include speaking abstractly about events or activities that may be related to others and perhaps not to yourself, as well as making sure that you do not provide a full name that might completely identify another prisoner and/or staff member. If there is a question you do not wish to answer please kindly advise, however I ask you to be as open as you can and say what you think. Everything you share today will be kept confidential and only used in anonymized form for research purposes; it will not be shared with the prison department or other prisoners. We don't have to report any

illegal activities, like drug use and sharing. If you mention any identifying information, it will be deleted from the interview recording. How does this sound? Do you have any questions before we begin?"

Clarify any questions that may arise.

"I am going to start the recording now."

Start recording.

I. Introduction and reentry challenges

1. "I would like to start by asking you a few questions about your life before your incarceration. Think about the month before your incarceration. "
   Probes:
   - "What was a typical day like? What were you doing with your time?"
   - "Where did you live? Who were you interacting with?"
   - "Who were the people who supported you? What kind of support did they provide (for example, financial, emotional…)?"
   - "What kinds of things were you concerned about?"
2. "Tell me about your life since you were incarcerated."
   Probes:
   - "Have you noticed any changes in your health since you were incarcerated?
   - How has your health changed?"
3. "Do you feel that you are able to get medical care whenever you need it now?"
   Probes:
   - "Tell me about the kinds of medical care you received in prison."
   - "If no, what prevents you from getting the medical care you need?"
4. What do you feel will be the biggest challenge when you are released from prison?
   Probes:
   - How will you handle this challenge?
   - How easy will it be for you to get medical care/find employment/housing/reestablish relationships?

II. HIV Treatment & Disclosure

5. "When is the last time you got an HIV test?"
   Probes:
   - "Did you get your result?"
   - "Do you feel comfortable telling me about the results?"
6. "Who have you talked to about your HIV diagnosis?"
   Probes:

- "Is there someone who you would like to tell about your status but have not told?"
- "If yes, what is stopping you from telling them?"

7. "Have you ever taken HIV medicine (ART)? Are you taking it now?"
   Probes:
   - "If no, what has kept you from getting HIV medicine (ART)?"

III. Within-prison drug use

8. "If somebody in prison craved drugs, what were their options?"
   Probes:
   - "Could they obtain drugs? Which drugs?"
   - "How do they go about it?"
   - "What if they have no/little money?"
   - "What would motivate prisoners to initiate injection drugs in prison?"
9. "Describe the process of razgon (the free giveaway of liquid heroin in prison)."
   Probes:
   - "Can you describe the process from beginning to end: from mixing the solution to injection."
   - "What are the rules from taking from the obschak? Who can and who can't?"
   - "When is the obschak open? What are some reasons the obschak might be closed?"
   - "What do people do when the obschak is closed to get drugs?"
   - "What is the difference between injecting from the obschak or outside of the obschak in prison?"
10. "Describe a situation in prison where you experienced withdrawal or felt the urge to use drugs."
    Probes:
    - "What did you do when you experienced cravings in prisons?"
    - "Has there ever been a time when you wanted to use drugs in prison but you couldn't? What happened?"
11. "Tell me about the last time that you injected in prison."
    Probes:
    - "Tell me about the whole process: How do you get the drugs? The syringe? How do you find a private place to take them?"
    - "How did you decide who to shoot up with?"
    - "How was this different from taking drugs in the community?"
12. "Tell me about the kinds of needles you used to inject in prison."
    Probes:
    - "When you inject, about how many people use the same needle before or after you injected?"
    - "What concerns (if any) do you have about sharing needles? What do you do about that?"

- "Do you ever try to clean the needle before you inject? How? Do you think it's important to do that?"
- "Where do you think its more common to for several people to use the same needle, in prison or SIZO? In prison or in the community? Why?"

13. "Do you ever use NSPs in prison?"
    Probes:
    - "Do you know anyone who does?"
    - "Do other prisoners know who is using NSPs?"
    - "Where they treated differently by other prisoners? By staff members?"
    - "What reasons may a prisoner have for abstaining from using NSPs?"
14. "Did you ever have to hide your drug use in prison?"
    Probes:
    - "Whom did you hide it from?"
    - "Why did you have to hide it?"
    - "How did you hide this?"
    - "What are some reasons someone would want to register as a drug user? Why would someone not want to?"

IV. Experiences with drug treatment

15. "What should opioid dependent people do for their addiction in prison? What about after release?"
    Probes:
    - "Should they get medical treatment? If so, what kind?"
    - "When should methadone treatment be an option for someone?"
    - "What are the reasons that someone may agree (or disagree) to take methadone in prison? After release?"
16. "Are you on the methadone program? Were you on it before?"
    If <u>no</u>:
    - "What has to change for you to continue/start methadone?"
    - "How long were you on it before and why did you stop?"

    If <u>participated in prison</u>:
    - "Was it safe to take methadone in prison?"
    - "Did other prisoners know you were taking methadone?"
    - "Did they treat you differently after you started taking methadone?"
17. "Do you wish to continue/start methadone after release? Did you end up continuing it/starting it?"
    Probes:
    - "How easy or difficult will it be to start methadone after release?"
    - "What is different between taking methadone in prison and in the community?"

18. "Tell me about your life before you started taking methadone. Now tell me about your life after you started taking methadone."
    Probes:
    - "Do you let some people know you take methadone? How do you go about it?"
    - "Do you have anyone in your life who thinks you should not take methadone? Why?"
    - "How easy would it be to increase your methadone dose if you needed to? Decrease? How would you feel if you could increase your dose? Decrease it?"
19. "Do you know anyone in prison on the methadone program?"
    Probes:
    - "Do other prisoners know they were on methadone?"
    - "How are they treated by prison staff? By other prisoners?"
    - "Was anyone ever aggressive or violent towards them? Can you tell me what happened?"

    If <u>yes</u>:
    - "Is there a type of prisoner that may not be bullied for being on methadone? What are they like?"
20. "Do you know anything about the division of prisoners into groups/castes?"
    Probes:
    - "How is it decided who will pertain to what caste? What could possible reasons be for moving between castes?"
    - "Are there certain castes that cannot use NSP or methadone?"
    - "What caste would the people from your group pertain to?"
21. "What are some reasons a person on methadone may continue using other drugs?"
    Probes:
    - "What is the difference between methadone patients who continue using drugs and those who don't?"
    - "What would need to happen for them to stop using other drugs?"

"Thank you very much for your time. Are there any questions you would like to ask of me at this point?"

Topic guide for prisoners, later iteration

RELEASE

- How did prison prepare you
- Met expectations after release?
- Current problems, esp. police

METHADONE

- Where easier to take it?
- How was it decided it was wrong in prison? Who decides and why?
- Starting in prison vs. community. What if coming in already on MT?
- How to get people to switch from razgon to MT? Or vice versa?
- What if demoted in caste, start MT then?
- Place and process of delivery make a difference? 'bolnichka sviatoe mesto'
- Did progon happen? Consequences?

OBSCHAK & JUSTICE

- Novyi avtoritet: what makes him an avtoritet? What's relationship to him?
- Shmon warning. How does obschak know there will be shmon? They let prisoners know? What do they hide?
- Как вольные понятия отличаются от внутриных понятий? Who What are the poniatia? Why are they necessary? Who makes them? Have they changed? How learn them? In all prisons?
- Someone coming in for the first time, how do they determine that they're a certain caste. как отличается усиленный режим от особого и строгого?
- Example of a good act and a bad act? Why wrong?
- How is it decided if поступок is wrong? Who interprets rules? How does someone confess?
- How is it decided who gets into obshchak?
- Conflict: How are conflicts resolved? Who has the final say?
- Punishments: which? How demoted?
- Exceptions: What if they didn't know what they were doing when they did the wrong thing? What if there is no evidence?
- How does the skhodniak work? What is the process like? Describe beginning to end.
- How does progon work? How find out about it?

WORK AND RAZGON

- What's changed since new vor? Work? Castes? Razgon?
- Was the razgon free during the time of the bazaar?
- Why was the bazaar closed?
- Is working mandatory now? Is working mandatory now? Do reds work for obschak?
- Which work done and by whom?
- What you get in return? does every job get razgon? MT patients?

- Sharing? How bring pol'za to obschak?
- What do you get for making shirpotreb? Money? Or heroin? What do gady and obizhennye get for working for the obschak?
- Do they have the option of working for the administrtation instead? Is that more lucrative?
- So there is a magazin? Who is it run by?
- Kto esche stoit na tachkovke?
- What can heroin be exchanged for?
- What do менты get for bringing heroin into prison for obschak?

***PONIATIA* AFTER RELEASE**

- Still exists? How?
- How works in MT program?

MISC

- How was interview in prison?
- How other people see us
- What is health?
- Everything depends on yourself. Где больше все от тебя зависит?

Appendix D—Stakeholder interview guide

This Interview Guide is a DRAFT. In line with the qualitative interview approach, the Guide is a flexible tool to direct the conversation with the participants and to elicit their stories regarding the key domains listed below. The interviewers will be using "active listening" techniques and will have discretion to decide the order in which they may bring up domains, ask questions, and use further probes during the interview with each participant, to gather the richest data possible. The interviewers may also use additional questions and/or probes not listed in the Guide if the participant brings up relevant issues that may be worthwhile to explore further.

Preamble—Purpose: Establishing Initial Rapport

Meet and greet the participant, ask how they are doing, ensure they understand the interview process and reinforce that their story will be valued and will be taken seriously and with respect.

"We are hoping to learn more about what the staff who work in the State Penitentiary Service of Kyrgyzstan think about addiction, methadone maintenance therapy, and HIV risk, and the experiences they had with these issues in course of their work. We would also like to know your thoughts about how and why some people may start drug injection or methadone treatment in prison, about the attitudes towards such prisoners, and about support for people living with substance abuse disorder in prison and in the community. Your input will be very helpful in designing a program for PWID to encourage the use of harm reduction services, improve their quality of life, reduce stigma and social isolation, and reduce the HIV risk."

"I'll be asking some questions and recording our conversation. I am eager to hear and to learn from you and your experiences. I am not here to look for right or wrong, and it is your opinion that is of value. We may be asking you some questions that may appear sensitive to you. While we would greatly value a complete and thorough response, we would not want to put you into any situation that may put you in jeopardy from any other prisoners and/or prison authorities. In situations where this may seem uncomfortable, there are a number of ways in which you may respond. This may include speaking abstractly about events or activities that may be related to others and perhaps not to yourself, as well as making sure that you do not provide a full name that might completely identify another prisoner and/or staff member. If there is a question you do not wish to answer please kindly advise; however I ask you to

be as open as you can and say what you think. Everything you share today will be kept confidential and only used in anonymized form for research purposes; it will not be shared with the prison department or any of your colleagues. How does this sound? Do you have any questions before we begin?"

Clarify any questions that may arise.
"I am going to start the recording now."
Start recording.

I. Work environment and culture

1. "I would like to start by asking you a few questions about the work you do. Could you describe your work to me?"
   Probes:
   - "What is your role and main responsibilities?"
   - "How long have you been in your current role?"
   - "How would you describe a typical work-day?"
   - "What are some of the challenges you experience related to your work?"
   - "What about your job is the most satisfying or personally fulfilling?"
   - "What is especially difficult about your work?"
   - "Do you have any safety concerns at work?"

II. Perceived Risks among the Target Population(s)

2. I heard there is some informal hierarchy among prisoners. Could you describe it to me?
   Probes:
   - "Can all prisoners use all services that could benefit them? If any group cannot use services (e.g. at a specific time) why is this so?"
   - "Which prisoner groups require additional services?"
   - "How would you know if violence occurs among prisoners, for example, rape?"
   - "I heard so-called 'prison bosses' could influence inmates and drug use. How does this play out?"
3. Who are your clients? What risks do they face in prison and outside?
   Probes:
   - "Do you work with prisoners who have substance use disorders?"
   - "How would you know if a prisoner is using drugs?"
   - "How do you treat injuries or medical complications associated with injection drug use (e.g. abscesses)?"
   - "How would prisoners obtain drugs?"
   - "What do prisoners do to reduce their risk of HIV transmission?"
   - "If a prisoner asked your advice about needle exchange/HIV risk reduction/ methadone, what would you tell them?"
   - "What are the biggest challenges for prisoners who are returning to the community?"

- "What does the prison department do to refer prisoners to treatment (e.g methadone) after release?"

III. Health Service Delivery in Prisons

4. How does the prison health system respond to risks we just talked about?
   Probes:
   - "Are there any guidelines or policies for (1) HIV prevention; and (2) addiction treatment?"
   - "Could you describe any programs or interventions?"
   - "What is the biggest challenge to these programs?"
   - "What kinds of things could stop a prisoner who wants methadone or needle exchange from signing up?"
   - "What could help reduce drug injection in prison?"

IV. Staff Perceptions of Addiction and Experiences with Addiction Treatment

5. What are the common approaches for treating addiction in prisoners?
   Probes:
   - "What are your thoughts about 'harm reduction'?"
   - "In your view, what does recovery from addiction mean?"
   - "What do you think about methadone?"
   - "What do prisoners think about Methadone treatment?"
   - "If a prisoner approached you for advice about methadone, what would you say to them?"
   - "In your observation, how do peers treat prisoners who take methadone?"
   - "In your observation, how do staff treat prisoners who take methadone?"
   - "What are some of the concerns that prisoners express about starting or continuing methadone?"
   - "What complaints (if any) have you received from prisoners taking methadone?"

"Thank you very much for your time. Are there any questions you would like to ask of me at this point?"

Appendix E—Glossary of Kyrgyz prison slang

Term	Transliteration	Translation
166 статья	*166 stat'ia*	A conviction for fraud.
Базар	*bazar*	A market within prison where individual prisoners sold essential goods including heroin in exchange for money. Was closed around 2008, after the new thief-in-law came to power.
Барыга	*baryga*	Dealers in contraband. *Barygi* are outlawed according to the *poniatia*.
Беспредел	*bespredel*	A difficult to translate Russian word, meaning disorder, lawlessness, or mayhem. Prisoners often invoke methadone as conferring *bespredel*.
Блатные	*blatnye*	The highest caste in the prisoner hierarchy.
Блатхата	*blatkhata*	A house or apartment where people within the criminal subculture gather to do drugs.
Бродяга	*brodiaga*	Second in command in the prison after the *polozhenets*.
Вор в законе	*vor v zakone*	Thief-in-law, the leader of the criminal subculture.

Гады	*gady*	Second to lowest caste in the prisoner hierarchy; also known *neputi*.
Гаситься	*gasit'sia*	To hide from the *obshchak*.
Греть общак	*gret' obshchak*	To contribute to the common fund.
Грузиться	*gruzitsia*	To admit to a crime that one didn't commit.
ГСИН	*GSIN*	State Penitentiary Service
Димедролиться	*dimedrolit'sia*	To inject Dimedrol.
Дневальный, шнырь	*dneval'nyi*	A prisoner who works as a guard or an aid for the formal administration.
Доза	*doza*	A dose or 'hit' of a drug.
Жилка, жилая зона	*zhilka, zhilaia zona*	The portion of the prison where prisoners live, the 'red' zone.
Затягивать	*zatiagivat'*	To get drugs into prison from the outside.
Заформшачился	*zaforshmachilsia*	Originating from the noun *forshmak*—an eastern European dish made of ground meat or fish, common in Jewish cooking where it is a cold appetizer pâté made of herring. פֿאָרשמאַק [forshmak] in Yiddish. Meaning bad quality. Used in prison slang, it means to be

		demoted in the prisoner hierarchy.
ИВС	*IVS*	Temporary detention center or temporary containment cell run by the police.
Козлы	*kozly*	Prisoners who cooperate with the formal administration. Literally, goats.
Колеса	*kolesa*	Pills. Literally, tires.
Колония	*kolonia*	Prison. Literally, colony.
Колония-поселение	*koloniia-poselenie*	A halfway house.
Колотить понты	*kolotit' ponty*	To show off.
Колоться	*kolot'sia*	To shoot up.
Конкретный запрет	*konkretnyi zapret*	Something that's strongly prohibited according to the *poniatia*. A breach of a *konkretnyi zapret* is called a *postupok* and can result in demotion in the hierarchy. Literally, a concrete ban.
Копытить	*kopytit'*	To get something difficult, to make money despite the challenges. Literally, to dig the ground with hooves.
Косяк, Запороть	*kosiak, zaporot'*	To break the rules of the poniatia despite knowing better; a minor

косяк	*kosiak*	infraction as opposed to a *postupok* which is a major infraction.
Красные, дневальные, общественники	*krasnye, dneval'nye, obshchestvenniki*	Terms for a *mast'* that works for or cooperates with the official prison administration; also known as *kozy*.
Крыса, крысятничество	*krysa, krysniachestvo*	Someone who steals from other prisoners (one of the major infractions of the Understandings). A rat.
Куб	*kub*	A 'mil.' One mL, usually referring to a dose of heroin.
Кумар	*kumar*	Withdrawal
Курсовать	*kursovat'*	To let the criminal authorities know.
Лайба	*laiba*	Syringe
Ломка	*lomka*	Withdrawal
Мазаться	*mazat'sia*	To take drugs. Literally, to smear in.
Малолетки	*maloletki*	People, usually prisoners, who are under 18. Literally, juveniles.
Масть	*mast'*	A prisoner's caste in the hierarchy. Literally, a suit, like in playing cards.
Менты	*menty*	Cops
Мужики	*muzhiki*	All the prisoners who are neither working for the administration (the

		reds) nor the lowest caste (the *obizhennye*). These include all prisoners in good status according to the Understandings, namely, the *poriadochnye* and the *blatnye.*
Насухо (бросать наркотики)	*nasukho (brosat' narkotiki)*	To go cold turkey
Не канает	*ne kanaet*	A phrase used to mean that something is not *comme il faut* according to the practices of criminal subculture.
Непути	*neputi*	The second to lowest caste in the prisoner hierarchy; also known as *gady*.
Обиженные	*obizhennye*	The lowest caste in the prisoner hierarchy; this status is for life.
Общак	*obshchak*	Prisoners' common fund and/or the elite prisoner caste that runs this fund.
Общественник	*obshchestvennik*	A prisoner who works for the administration, synonym of *neput'* and the reds.
Отряд	*otriad*	Squad or division, a larger grouping of prisoner barracks.
Перекумаривать	*perekumarivat'*	To go through withdrawal.

Петухи	*petukhi*	Members of one of the lower castes in the prisoner hierarchy; possibly men who has sex with men.
ПИН	*PIN*	People who inject drugs
Побочка	*pobochka*	Side effects
Положенец	*polozhenets*	The highest criminal authority in a prison
Положняк	*polozhniak*	Essentials or necessities that the formal administration is required by law to provide to the prisoners.
Получать кайф, кайфовать	*poluchat' kaif, kaifovat'*	To get high
Понятия, воровская идея, воровской закон, неписаный закон	*Poniatia, vorovskaia ideia, vorovskoi zakon*	Literally, the understandings. The criminal code, the law of informal governance. Also called "the unwritten law."
Кайфажор	*kaifazhor*	A person who loves to get high to the point of greed. Literally, one who knocks back highs.
Понятия	*ponyatiia*	The Understandings. The informal criminal code that guides life within and outside of prison.
Порядочные	*poriadochnye*	The second to highest and largest caste in the prisoner hierarchy. Literally, the decent ones.

Поступок	*postupok*	To commit a major infraction against the poniatia, often results in demotion in the hierarchy
ПОШ (программа обмена шприцов)	*POSH*	Needle syringe program
Прогон	*progon*	A special message from the criminal authorities that could be announcing the appointment in the criminal hierarchy, or a ban on a certain behavior
Прописка	*propiska*	An official government registration at a certain address. A *propiska* is often necessary to access services such as healthcare. Many prisoners do not have the documents needed to receive one.
Разгон	*razgon*	A ritual distribution from the obshchak, also including heroin.
Режим	*rezhim*	Security level of a prison or, more generally, discipline.
Санчасть	*sanchast'*	Medical unit within a prison
Свиданка	*svidanka*	A room within prison where prisoners can have visitors. The formal authorities manage access and it can be used as a form of negotiation in the tug of war

		between formal and informal control of the prison.
Семейники	*semeiniki*	Prisoners united in a group of mutual support and trust, usually in reference to a handful of prisoners who live together. Literally, family.
СИЗО	*SIZO*	Pre-trial detention center, a jail. People are detained in SIZOs are before they receive their sentences; this process can last years. Unlike the open architecture of prisons, these facilities have cells.
Смотрящий	*smotriashchii*	A member of the obshchak accountable to the *polozhenets*. Literally, an overseer. There are *smotriaschii* who are in charge of managing various aspects of prisoner life, including the *razgon*.
Сом	*som*	The official currency of the Kyrgyz Republic
Сходняк, сходка	*skhodniak, skhodka*	A meeting of senior prisoner hierarchy members where governing decisions including those regarding prisoners' ranking in the hierarchy are made.
Точкованный, стоять на	*tochkovannyi,*	A prisoner with special status who receives heroin more often than the

точковке	*stoiat' na tochkovke*	regular razgon. That is, more often than three times a month, usually twice a day.
Травятся	*traviatsia*	To take drugs. Literally, to get poisoned.
Уделять внимание	*udeliat' vnimanie*	To share (mostly used to signify when the criminal authorities give out drugs). Literally, to devote attention.
УДО (условно-досрочное освобождение)	*UDO (uslovno-dosrochnoe osvobozhdneie).*	Parole
Ханка	*khanka*	An injected opioid homemade from poppy straw. Heroin is more common than khanka in Kyrgyzstan.
Ходка	*khodka*	Conviction or stint in prison
Чек	*chek*	One unit, or 'hit,' of heroin.
Черный	*chernyi*	Literally, black or someone who lives under the auspices of the *obshchak.*
Чифир	*chifir*	A type of strong tea brewed in prisons to get high. Consists of a high tea leaf to water ratio.
Шмон	*shmon*	Frisk, shakedown

Этап	*etap*	Prisoner transport system. A lengthy process for transporting prisoners from one facility to another.
Яма	*iama*	A place where people gather to use drugs.

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